



*Working together with you  
to improve health*

ANNUAL REPORT 2002



## VISION

MPHI will be a unique public trust which will enable communities to apply state-of-the-art community health practices.

## MISSION

The mission of MPHI is to maximize positive health conditions in populations and communities through collaboration, scientific inquiry, and applied expertise which:

- *Carry the voice of communities to health policy makers, scientists, purchasers, and funders;*
- *Advance the application of scientific health practices in communities; and*
- *Advance community capacity to improve health and reduce disparities among population groups and geographic areas.*

## VALUES

MPHI's board of directors, management, and staff are committed to uphold these values in our work, relationships, and governance:

- *Collaboration and inclusiveness among MPHI, government, communities, and institutions in approaching matters of the public's health.*
- *State-of-the-art research, education, and demonstration as vehicles for advancing health practice.*
- *Leadership and service for the benefit of community, rather than to advance institutions, partners, or staff.*
- *Prevention of disease and promotion of health.*
- *Ethical behavior in all scientific, professional, and interpersonal matters.*
- *Quality, professionalism, and integrity in the work we do, the people we hire, and the workplace we create.*
- *Innovation and continuous improvements in the workplace, as our assurance of maintaining our responsiveness and utility to our clients.*



Michigan's public health community is being challenged today as never before. Together with Governor Jennifer Granholm, we are being forced to make tough choices, sometimes between the very important and the vital. We are faced with a situation in which we must increase our efforts to improve the health and well-being of our citizens while, at the same time, paying close attention to the need to streamline our strategies and find creative ways to "do more with less."

It is a tough road and our journey is complicated by the fact that we must address not only many of the same chronic diseases and public health problems we have faced in the last century, but also a multitude of new and profound challenges.

Today we must address not only prevention and control of disease, but also the hazards posed by the physical environment, social problems, and lifestyle risks. We also must be ever vigilant and prepared at a moment's notice to confront new and emerging infectious diseases, multi-drug-resistant pathogens, and even the growing threat of bioterrorism and other terrorist attacks.

The public health community's charge is indeed a large one and we must face it with creativity, stamina, and a sense of purpose.

Soon after her election last November, Governor Granholm released her plan for Securing Michigan's Future. In it she details what she sees as the most important goals for our state's health care community: "We need leadership willing to stand up for the families of Michigan and give them the help they need for affordable health care. Instead of the old-time, backroom bargains, we need to open the door to fresh ideas and new approaches that help all of our people get the quality care they deserve."

Governor Granholm's plan calls for an end to "the adversarial posture of Lansing" and advocates bringing together "all those involved in protecting Michiganians' health: policymakers, health care professionals, business, labor, and our families."

At MPHI, we couldn't agree more. Taking a collaborative and multi-sector approach to solving our state's health-related challenges is more imperative today than ever.

Like the Governor, we believe the health of our citizens is the very foundation of our success as a society and that we must work to ensure that public health is a crucial priority, not only for policymakers but also for all of us. We also believe that the prevention of illness and injury is the mainstay of that foundation. That is why MPHI is working side-by-side with other stakeholders to find and implement new, creative ways to address those needs and ensure our future by improving the health of all Michigan's citizens.

As legislatively authorized in Michigan Public Act 264 of 1989, MPHI will continue to work with the Michigan Department of Community Health (MDCH) and our three partner universities—Wayne State University, the University of Michigan, and Michigan State University—as well as with other public health stakeholders, to find solutions that will not only save Michigan lives, but also improve them. We are proud of the fact that MPHI is recognized nationally as a model for university, government, and community research and practice partnerships, and we believe we earn that reputation each and every day.



As you peruse these pages, take a moment to reflect upon the diversity and the breadth of the work being done at MPHI and what it means to our common bottom line—the health and well-being of our state and its residents.

The projects highlighted in these pages are a small sampling of what we are accomplishing in conjunction with other public health stakeholders. There are dozens of other collaborative success stories of which we also are justifiably proud.

One of those is the High-Risk Hepatitis B Vaccination Program, in which MPHI and MDCH staff worked with staff of STD, family planning, and adolescent health clinics throughout the state to provide hepatitis B vaccines to high-risk adolescents and young adults ages 13 to 21. Through the combined efforts of MDCH, MPHI, and the 86 local health clinics participating in the program, approximately 32,500 adolescents and young adults engaging in high-risk behaviors have received more than 53,600 doses of hepatitis B vaccine that they might not have otherwise received.

Just as important is the fact that the project and its methods will now serve as a model for collaboration among other public health institutions, particularly those working in vaccine screening and administration. When coupled with the growing body of hepatitis B literature and prevention knowledge, the project findings should lead to more effective communication programs and materials, and ultimately to a more fully protected generation of adolescents and young adults.

That's the kind of success we can all appreciate!

For Michigan's future,

Janet Olszewski  
President, MPHI Board of Directors &  
Director, Michigan Department of Community Health



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Executive Director, MPHI

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MPHI has six different programs that provide collaborative research, development and educational services in community health and all work toward a common goal—improving the health of Michigan residents.

## CHILD AND ADOLESCENT HEALTH

*Teri Covington, MPH, Senior Program Director  
(tcovingt@mphi.org)*

This program focuses on technical assistance and support to state and local partners in the design, implementation and evaluation of innovative, multidisciplinary and community-based programs in maternal, child and adolescent health. The program houses the National Maternal Child Health Resource Center for Child Death Review. Key projects include:

- *The National Maternal Child Health Resource Center for Child Death Review*
- *The Michigan Child Death Review Program*
- *Fetal and Infant Mortality Review*
- *The Michigan Abstinence Partnership*
- *The Michigan Antibiotic Resistance Reduction Program*
- *The CDC Maltreatment Surveillance Project*

## CENTER FOR COLLABORATIVE RESEARCH IN HEALTH OUTCOMES & POLICY (CRHOP)

*Greg Cline, PhD, Senior Program Director  
(gcline@mphi.org)*

CRHOP's focus is on collaborative public health research, program evaluation, surveillance systems and public health training. Innovative technologies are used to create systems and conduct research for development, design and implementation of health outcomes and policy analysis, research management and understanding of health improvement, outreach and promotion, disease management and clinical outcomes. Some key projects are:

- *Michigan Emergency Department Community Injury Information Network*
- *Michigan Medical Examiners Database*
- *Crime Victims Services Commission Grants Monitoring*
- *National Tribal Youth Justice Evaluation Work First Client Satisfaction Survey*
- *Women, Infants and Children Conference Planning*

## CENTER FOR LONG TERM CARE

*Carl Gibson, PhD, Senior Program Director  
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In addition to its unique support services to Michigan's state survey agency, the Center partners with other educational and health service entities to strengthen organizations and communities. Its mission is to improve and promote quality of care and quality of life by mentoring professionals in the long term care continuum in clinical practices, management skill building, and the art of caregiving.

## HEALTH PROMOTION AND DISEASE PREVENTION

*Amy Slonim, PhD, Senior Program Director  
(aslonim@mphi.org)*

This program works collaboratively with the Michigan Department of Community Health Chronic Disease and Injury Control Division to optimize scientific inquiry and program development, implementation and evaluation focused on positive health outcomes. Program focus is in the areas of: cancer, nutrition, asthma, dementia, diabetes, osteoporosis, injury prevention, and managed care.

## OFFICE OF TECHNOLOGY AND INFORMATION SYSTEMS (OTIS)

*Jeff Wehl, MA, Senior Program Director  
(jwehl@mphi.org)*

OTIS provides information system development, technical project management, IT staffing, Internet services, and technical support to clients, and also manages MPHI's internal information systems and provides technical support to our own staff and projects. Key projects include:

- *Medicaid HIPAA Transactions Rule Compliance Project*
- *Michigan Health Alert Network Support*
- *Michigan Disease Surveillance System (MDSS) Implementation Support*
- *Michigan Childhood Immunization Registry (MCIR) Support*
- *Interagency Technical Support Project*
- *www.hline.org*
- *www.mihealth.org*

## SYSTEMS REFORM

*Cindy Cameron, PhD, Senior Program Director  
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The mission of the Systems Reform Program is to assist groups to use outcomes-based strategic planning, implementation and evaluation to reform their health, human service, and education systems to increase the effectiveness of services for children and families.

*“The Child and Adolescent Health staff at MPHI have developed knowledge and procedures which serve to improve practice and programming across several disciplines to greatly improve child and adolescent health.”*



## IMPROVING OUR UNDERSTANDING of CHILD MALTREATMENT DEATHS in MICHIGAN

*By Theresa M. Covington, MPH and Stacy Meade, MPH*

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Children are our future, and we don't expect them to die. Over the past half century, that expectation has only grown stronger, as far fewer children are dying today than did 50, 20 or even 10 years ago, thanks to advancements in medical care, nutrition, and perinatal health and increased knowledge and technology regarding unintentional injuries.

As time goes on, we watch as the statistics regarding natural and accidental deaths of children decline, and that gives us comfort. Although we know these numbers probably contain some margin for error, we believe as a society that we now have a fairly good idea of how many children die each year as a result of chronic disease, infectious illness, pre-term birth, motor vehicle accident, fire, drowning, and other natural and accidental causes.

Unfortunately, that is not the case with child maltreatment deaths. In fact, we now know that too many child maltreatment deaths are not reported as such and, therefore, are not being tracked and addressed.

In 1998, the U.S. Congress directed the Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control to take its first steps toward the prevention of child maltreatment. The following year, the CDC convened child maltreatment experts from around the country and charged them with developing a plan of action. When they completed their plan, one of its main strategies was the development and implementation of a National Surveillance System for Child Maltreatment.

It has long been suspected that child maltreatment cases are vastly undercounted across the nation and, in fact, studies in recent years have supported this concept. The CDC has determined that states are, indeed, underreporting child maltreatment cases, albeit unintentionally, by relying solely on vital statistics data obtained from death certificates for their counts. Data from these sources often include only the most severe cases of physical abuse and do not reflect the total number of children that die. Underreporting limits our ability to prevent child abuse. In order to implement effective solutions, we must first have a clear understanding of how many and what types of children (age, race, gender) are affected.

*Why Child  
Maltreatment Death Is  
Underreported*

In September of 2001, Michigan was one of only three states to be awarded a competitive, three-year grant from the CDC to develop a model surveillance system that will improve our ability to more accurately count the number of children who die each year from abuse and neglect. In the first year of the project, it became apparent that child abuse deaths in Michigan are not accurately counted.

“The CDC project highlights inconsistencies between agencies and within agencies regarding historical child death data, the nature of child deaths, and the manner in which they were reported,” said Steve Yager, Family Advocate for the Michigan Family Independence Agency (FIA). “The project has created an opportunity for Michigan to review the manner in which information regarding child deaths is collected, reported and utilized in prevention efforts.”

One example of these inconsistencies occurred in 1999. That year, the Michigan Department of Community Health (MDCH) Division for Vital Records and Health Statistics reported 16 maltreatment deaths, while the Michigan FIA reported 48 abuse and neglect deaths to the National Child Abuse and Neglect Data System.

### What We're Doing

**The MPHI Child & Adolescent Health Program** (CAH) as the CDC grantee, is leading the CDC-effort to examine the epidemiology of child maltreatment deaths in the state of Michigan. The goals of this project are two-fold: 1) to create a working, standardized definition of child abuse and neglect fatalities, and 2) to utilize this definition to create an accurate picture of child maltreatment fatalities in Michigan.

As part of this effort, CAH is collaborating with five stakeholders to obtain information on all potential abuse-related deaths of children ages 0–9 during 2000 and 2001. Their partners include the MDCH Division for Vital Records and Health Statistics; the FIA; the Michigan State Police; the County Chief Medical Examiners; and the County Child Death Review Teams.

As the information is obtained, it is brought before a workgroup consisting of a panel of experts from public health, medicine, social services, law enforcement, and the legal community. Members of the workgroup have developed a working definition of child maltreatment that they use when reviewing all suspicious deaths of children.

The working definition includes neglect deaths, as well as physical abuse deaths. Neglect is the most under-counted and misdiagnosed form of abuse. Examples of neglect-related deaths include child victims of car crashes whose intoxicated parents were the drivers at fault, bathtub drowning victims whose parents left the young infants unsupervised, or children who die of infectious diseases and whose parents did not seek medical attention.

In its first year, the project has identified over 100 abuse and neglect-related fatalities in Michigan. The project hopes to use their findings to identify more precise surveillance methodologies, and to help guide state child abuse prevention efforts. During the second and third year of the grant, computer models and data collection tools will be used to streamline the process. The development of software that can link data from reporting sources will reduce the staff time required to manually conduct one-to-one comparisons of child deaths from each source.

Ultimately, the CDC Cooperative Agreement for the Surveillance of Child Maltreatment in Michigan will allow Michigan to gain a more accurate picture of its child fatalities that result from abuse and neglect. In addition, the CDC will study the project results from Michigan, and the other states working on this grant, and use the analysis to synthesize a model that can be useful to all states to capture the true incidence of these tragedies.

“MPHI has taken child death review far beyond merely looking at child abuse death certificates” observed Vincent J. Palusci, MD, MS, chairman of the FIA Fatality Citizen Review Panel Child Fatalities and child abuse consultant to the Michigan CDC project. “As a national leader in developing the process, resources and expertise to learn from fatality, MPHI, through this cooperative agreement with the CDC, has moved this field to true prevention of all child death from all causes. The Child and Adolescent Health staff at MPHI have developed knowledge and procedures which serve to improve practice and programming across several disciplines to greatly improve child and adolescent health.”



*“Ensuring that we collected good information in a manner that required the least effort from the local emergency preparedness coordinators was our primary goal.”*

## ASSESSING EMERGENCY PREPAREDNESS *in* MICHIGAN

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*By Greg Cline, PhD*

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The MPHI Center for Collaborative Research in Health Outcomes & Policy (CRHOP) has supported the Michigan Department of Community Health's (MDCH) assessment of emergency preparedness by evaluating the preparedness of all 45 local public health departments in the state of Michigan.

The main purpose of the assessment has been to provide MDCH with a baseline from which its Office of Public Health Preparedness (OPHP) can begin its planning efforts to support local preparedness to cope with bioterrorism threats and other public health emergencies. (OPHP works to ensure state and local public health preparedness for protecting Michigan citizens against chemical, biological and radiological health threats arising from terrorist acts, accidents, and other incidents that can result in exposure to harmful agents.)

OPHP Assessment Coordinator Beth Bacon stressed the importance of the evaluation efforts to the overall planning process in Michigan: "Our goal is to understand where the local health departments are along the path of emergency preparedness so we may best be able to support their efforts," she said.

CRHOP evaluation team members say evaluating the level of local preparedness was not always easy.

"Assessing emergency preparedness at the local level during a time when everyone is ramping up to plan for emergency situations, dealing with state budget cuts, and fielding local concerns about West Nile virus has been a challenge," Research Associate and Project Leader Jay Fiedler, MS, said.

"Ensuring that we collected good information in a manner that required the least effort from the local emergency preparedness coordinators was our primary goal," Fiedler continued. "This was especially delicate as many of the emergency preparedness coordinators had just been hired, and a few of the local agencies had not completed the hiring process."

### What Was Involved

The assessment of emergency preparedness covered the gamut of planning for emergency public health operations.

CRHOP project staff used a slightly modified instrument developed by the Centers for Disease Control and Prevention (CDC) to collect their information. Every effort was made to establish close cooperative relationships with the emergency preparedness coordinators at each local public health department in order to facilitate the process. CRHOP offered agencies the option of site visits by project staff, and many of the local emergency preparedness coordinators accepted.

"Having a member of the assessment team spend a day with us at our agency cleared up a lot of the questions we had concerning how to complete the assessment," observed Melinda Dixon, MD, interim medical director for the City of Detroit Health Department. "The chance to meet a staff person face-to-face and problem solve made the process move much faster than it would have otherwise."

CRHOP Research Associate Mary Thompson, MBA, noted that the local health departments wanted to know where they stood in terms of preparedness.

"This assessment helps them better answer questions from their own constituents and gives them a single repository for tracking their progress across the spectrum of preparedness for local public health emergencies," she explained.

CRHOP staff also partnered with the MPHI Office of Technology and Information Systems (OTIS) to add the project's assessment instrument to an instrument that was already being used to assess each local public health department's progress with Michigan's Health Alert Network. Now that the two are combined, authorized local public health departments can use a single, secure, remote-access web site to continuously update their data as changes occur.

### Next Steps

MPHI-OTIS Project Coordinator Earl Sauers, BS, BA, said the group's goal for the immediate future is to make the remote access site more user-friendly.

"Along with our colleagues in MPHI-CRHOP, we expect to be able to revise the site so that it can easily answer many of the most common questions that our local users have," Sauers said. "This will make it easier for them to accomplish their updates without placing phone calls to people in Lansing."



## LONG TERM CARE PROFESSIONALS EDUCATING *for* LONG TERM CHANGE

*By Carl A. Gibson, PhD*

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### *Specialized Remediation Services*

The MPHI Center for Long Term Care develops and delivers unique products and services that promote care and service excellence in the long-term care environment. During this past year, the Center supported its specialized remediation services with the State of Michigan, expanded its Long Term Care Leadership Institute's array of trainings, and continued to incubate new services for the health care community.

For five years, the Center's Collaborative Remediation Project (CRP) has provided valued remediation services to nursing facilities statewide as an alternative to other state-imposed enforcement remedies. Using a collaborative model unique to Michigan, the Center's team works with facility staff to develop Directed Plans of Corrections, implement corrective actions, and enhance the facility's current care and monitoring systems. A variety of Directed In-Service Trainings on significant clinical issues is available to facilities that want to focus on clinical systems analysis and staff education.

One of the primary objectives of the project is to assist each facility with establishing an effective quality assurance process with the goal of sustained compliance. Over the years, the Center's team has found that nursing facilities that effectively utilize the CRP services have an average compliance rate of 93 percent to 96 percent when revisited by the State Survey Agency.

Another unique activity offered by the Center is the Resident and Family Education service. Under the Michigan's Resident Protection Initiative, the Michigan Medicaid Program contracts with the Center to provide these important educational opportunities—at no charge—to nursing facility residents and family members. A number of program topics are currently available, including: "The Basics of Long Term Care," "The Art of Visiting," "Alternatives to Restraints," "Understanding the Person with Alzheimer's/Dementia," and "Communicating and Connecting with Alzheimer's/Dementia Residents." These one-hour programs are scheduled at the facility's convenience and can be used for community outreach.

A significant component of the CRP involves the Accredited Remediator service. The Center reviews individual remediators and their credentials, accredits them, and maintains a corps of remediators to meet State Survey Agency requests for temporary managers, administrative advisors, or clinical advisors for facilities

needing administrative or clinical assistance. Additionally, the Center serves as an agent of the State of Michigan in the facilitation of other specialized resident-focused services.

### *LTC Leadership Institute*

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The LTC Leadership Institute, which the Center began in April 2001, partners with a variety of multi-disciplinary educational and health care organizations, including universities and other non-profit associations, to address the educational needs of professionals in health care.

The Center facilitates the semi-annual Joint Provider/Surveyor Training each year. This past year, 700 professionals participated in the spring event and 800 participated in the fall event; both events offered nationally recognized speakers. These trainings are legislatively directed to focus on survey compliance issues with which nursing facility professionals struggle.

### *Other Key Trainings*

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The Center also lent its expertise to a number of other significant training events during 2002, including:

- The Second Annual Long Term Care Interdisciplinary Team Conference. Understanding dementia and behavioral issues was a key topic of the two-day conference. The Center purposefully has charged a modest registration fee for this conference to encourage facilities sending staff from multiple disciplines to develop their professional skills from an interdisciplinary framework.
- The Wayne State University Institute of Gerontology's Annual Issues in Aging Conference. The Center hosted and co-sponsored this May conference for academic and research professionals from across the country.
- The Dynamics of Nursing Conference. The Center co-sponsored this three-day, fall event with the Michigan Chapter of the National Association of Directors of Nursing Administration. The conference delivered a crucial overview and provided extensive resource materials for both beginning and experienced directors of nursing.
- The Michigan Society for Infection Control's semi-annual two-day conferences in the mid-Michigan area. The Center facilitates these conferences, which are considered a key training link for better managing infection control issues in nursing facilities.

In addition, the Center and the Geriatric Education Center of Michigan continued their co-sponsorship of videoconference training and mentoring services for the successful Continuous Quality Improvement project. Each year, an average of six nursing facilities participate in this rewarding training.

The Center also continues to forge partnerships with other organizations that are resident-centered in their educational objectives. This includes faculty support for trainings of the Bringing Eden Alternative™ to Michigan, and support of the annual Edna Gates Conference sponsored by Eastern Michigan University's Alzheimer Education unit.

### *The Center's Incubator Role*

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The Center is proud to have served as an incubator for several projects, including as the training home office for the Michigan Region of the Eden Alternative.™ Through its volunteer board of directors, the BEAM (Bringing Eden Alternative™ to Michigan) developed into an independent non-profit organization and moved out of the Center in January to its own location.

In another success story, the Center served for more than three years as a contract agent of the Michigan Department of Consumer & Industry Services (DCIS) for the survey and certification of critical access hospitals and rural health clinics.

The State of Michigan initiated an expansion of the on-site survey services within the Center, and the rapid growth of that project soon precipitated the development of it as an independent service program within the Institute, known as Specialized Provider Surveys (SPS). The SPS now operates as an entity distinct from the Center, providing yet another example of the Center's role in nurturing high-demand services that can grow and succeed on their own.

*“There has been a growing understanding among staff that has created the “magic” of the database and surveillance. The BCCCP clinical staff and statisticians have learned each other’s language and way of thinking, optimizing the development and opportunities to create a database that has extensive utility.”*



## WORKING TOGETHER *to* SOLVE DATA PROBLEMS *and* IMPROVE CANCER SCREENING SERVICES

*By Susan Harris, PhD, Michael D. Carr, MA, Paulette M. Valliere, PhD, and E.J. Siegl, MA, OCN, RN*

The Michigan Breast and Cervical Cancer Control Program (BCCCP) provides comprehensive cancer screening and diagnostic services to low-income women between the ages of 40 and 64 in all 83 counties in Michigan. Since the program’s inception in 1991, more than 80,000 eligible women have been screened and more than 1,000 breast cancers and 430 cervical cancers have been detected.

Today, behind the screenings and follow-up sits an expansive database—the Michigan Breast and Cervical Information System (MBCIS). This software has gained state and national attention, both for its design and for the efficiencies it affords statewide data surveillance and quality clinical care and follow-up.

In April 2002, the State of Michigan acknowledged the insight and dedication of the individuals behind the MBCIS by awarding its Quality Recognition System Certificate of Teamwork Achievement to the Michigan Department of Community Health (MDCH)/MPHI BCCCP Data Processing Improvement Team.

### *Taking a Team Approach to Problem-Solving*

From the very beginning of the BCCCP, the U.S. Centers for Disease Control and Prevention (CDC) mandated a surveillance system that could track who received care under the BCCCP and what type of care they received using federal funds. From 1991 through April of 1999, local health departments and the MDCH/MPHI data surveillance and monitoring staff were reliant on a DOS-based Fox Pro System designed by the CDC. This system required monthly compilation of program data on a state server to fulfill CDC reporting requirements, as well as downloading of files exported from the CDC. Medical record chart reviews and data reviews provided the basis for showing adherence to CDC standards of timeliness and completeness of care.

As “Y2K” approached, there were concerns about the ability to maintain DOS-based systems. This concern was the stimulus for a decision to develop a newer system that would allow for real time, meaningful performance indicators that could increase the BCCCP team’s ability to understand who was being screened and how follow-up was being conducted, as well as the timeliness of both.

The new data system, implemented in April 1999, enabled state program staff to generate reports of overall data quality and adherence to CDC performance indicators. Staff’s analysis of the program data resulted in a plan for staff to visit and assess all the local BCCCP coordinating agencies throughout Michigan. From June to September 2000, the MPHI data quality analyst and the MDCH Continuous Quality Improvement (CQI) nurse consultant conducted site visits and worked individually with each participating health agency to resolve clinical and data issues that were identified. The visits had a measurable impact, and by September 2000, overall program quality issues had decreased by 28 percent and clinical issues had decreased by 39 percent. However, from October to December 2000, overall program issues decreased by less than 1 percent (several data issues actually increased), and clinical issues decreased by only 9 percent.

These problems were attributed to the decreased involvement of state staff working closely with each agency, a premise that was supported by local agency staff, who

voiced frustration that they were being sent “too many reports” to deal with what they perceived as an overwhelming “error list,” yet had little assistance from state staff regarding how to resolve these issues.

In response to this challenge, the Michigan BCCCP staff convened the Data Processing Improvement Team in January 2001. The team was comprised of the BCCCP data manager and research statistician from MPHI, and the BCCCP CQI nurse consultant and program director from MDCH.

The goal of the team was to reduce duplication of data processes used by state staff in monitoring and evaluating the CDC performance indicators of timeliness and appropriateness of care delivered to BCCCP women. Using a CQI process, this combined team of clinical and data experts implemented changes to their current data evaluation process. Instead of automatically mailing the “error” reports to the agency coordinators and assuming the coordinator would understand (without guidance) what needed to be done with the reports, the reports were first analyzed by the data quality analyst and the two BCCCP nurse consultants.

The CQI team members reviewed the reports to identify trends in data or clinical issues that were specific to each agency. Once the trends were identified, the quality analyst and the nurse consultants worked individually with appropriate staff from each agency to develop a plan to resolve those issues.

The revised BCCCP data process improvement plan was implemented from late January to March 2001. During that time, overall program issues decreased by 25 percent, and clinical issues decreased by 42 percent. These improvements were the result of the team’s efforts to identify, and work with, local agency staff who are responsible for implementing the process improvements, rather than sending reports to the local program coordinator, who may, or may not, have the day-to-day responsibility for dealing directly with program issues.

The BCCCP data process improvement plan continued through September 2001. By the end, the state BCCCP team had successfully streamlined the overall program reporting process, thereby addressing the needs of both the state and local BCCCP staff.

Revision of the reporting process has helped both state and local BCCCP staff view the bigger picture of clinical and data issues combined, rather than treating them as two separate entities within the program. Instead of working independently, local health agency clinicians and data entry personnel are now collaborating together to resolve identified process issues in their program.

The changes have streamlined organizational processes at both state and agency levels and resulted in improved efficiency and effectiveness. Now, data entered in the client’s chart matches the data entered into the database, and the time required to develop and review similar reports has been reduced for both staffs.

Most importantly, there has been an increased adherence to the CDC timeliness performance indicators, the breast and cervical timeliness indicators measure the number of days from an abnormal screening result to the final diagnosis. The CDC benchmark for timeliness of clinical care is 75 percent of abnormal cases receive a final diagnosis within 60 days. The Michigan BCCCP increased adherence to the timeliness indicators from 79 percent (FY 1999–2000) to 92 percent (September 2001) for abnormal breast screenings and from 50 percent (FY 1999–2000) to 78 percent (September 2001) for abnormal cervical screenings.

During FY 2002, the breast timeliness indicator has averaged between 85 percent and 90 percent, and the cervical timeliness indicator has averaged from 71 percent to 76 percent.

The quality of care delivered in the BCCCP is reflected in the data sent to the CDC every six months and determines future funding levels for the program. CDC’s benchmark is a maximum 5 percent “error rate” of missing or incomplete program data. The Michigan BCCCP error rate has decreased to 0.8 percent out of 271,718 records sent for review.

In recognition of the success of Michigan’s data processing improvement process, the CDC highlighted the Michigan Quality Improvement program on its national program web site. The Michigan BCCCP is regarded as a model for this quality improvement process, and several other states have consulted Michigan program staff for guidance in implementing or revising their own quality improvement programs.

*“Michigan’s Medicaid HIPAA Conversion Team is proud to note that its HIPAA outreach effort is among the most comprehensive and advanced efforts in the nation.”*



## EDUCATING MICHIGAN’S MEDICAID PROVIDERS *About* HIPAA TRANSACTIONS COMPLIANCE

*By Jeffrey S. Weihl, MA, and Maithili Vadula, MS*

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As the U.S. economy becomes increasingly digital, the health care sector lags noticeably behind. In a time when consumers expect to do business electronically and to have their information available online and mobile, the business of health care remains largely paper based.

Lack of standardization of health care information and health care business transactions has meant that business-to-business transactions are complex, labor intensive, and expensive. The promises of information technology and automation have remained just out of reach for health care providers, payers and consumers.

To address this vexing problem, Congress and the health care industry agreed that standards for the electronic exchange of administrative and financial health care transactions are necessary to improve the efficiency and the effectiveness of the health care system. This agreement culminated in the passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

While HIPAA is most often thought of as legislation that will protect the privacy and confidentiality of health care information, the standards that the law sets for electronic transactions, national code sets, and identifiers will have far reaching, and perhaps revolutionary, effects on the country’s health care system. It is anticipated that the cost savings to providers and payers will be significant, and that adherence to HIPAA regulations will be a large step toward making a fragmented and patchwork system more efficient.

The HIPAA-mandated rules for standard electronic transactions will govern nearly all electronic health care commerce (including claims, claims payments, health plan enrollment, and eligibility determination) beginning on Oct. 16, 2003. All health care providers, payers, and health plans are required to convert their information systems by that date so they meet the new standards.

To ensure that the Michigan Medicaid program would comply with the new rules, the Michigan Department of Community Health (MDCH) realized it must undertake a major renovation to the Medicaid Management Information Systems (MMIS) that processes claims and reimbursement. Because of the fundamental changes required, the process must also examine, and possibly change the underlying business rules governing these operations.

MDCH staff also realized these tasks would be significantly larger and more complex than the renovations they had done for the “Y2K” conversion, and that they did not have the necessary resources, so they issued a request for proposals to conduct the necessary alterations.

The MPHI Office of Technology and Information Systems (OTIS) won the competitive bid to provide MDCH with additional programmers, project managers, business analysts, and quality assurance managers, as well the provider outreach efforts necessary to make the conversion a success.

To address these needs, MPHI assembled and organized a multi-partner, multi-year, and multi-phase project. The teams' highly qualified and experienced consultants began work on the project in January 2002, and they are on track to successfully convert Medicaid's enrollment, claims processing, and payment system by the October 2003 deadline.

In order to realize the benefits intended by the HIPAA legislation, the Michigan Medicaid program must make sure that those providers that participate with Medicaid's current proprietary claims system are able to continue to do business electronically. The program also must encourage providers that currently submit paper claims to convert to electronic claims and electronic payment. It is hoped that the conversion to national standard formats will ultimately make it easier for providers to convert to electronic transactions.

Because the administrative costs of processing paper claims can be as much as 25 times the costs of processing electronic claims, the Medicaid program stands to reduce its claims processing costs substantially. Because electronic claims are usually processed more accurately and more rapidly than paper claims, the conversion also should result in similar administrative savings for providers.

### *Creating the Tools for Change*

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In order for the conversion to be successful, not only must the information systems be converted, but health care providers that participate in the Medicaid program must be informed of the changes, trained in the use of the new formats and codes, and be given the ability to test their own conversions prior to the deadline.

The project team has designed a major outreach and coordination effort to help the conversion go as smoothly as possible. Frequent dialog between the project team, Medicaid, and Michigan's other major payers (Blue Cross Blue Shield and Delta Dental) helps ensure that the changes required of health care providers are coordinated between payers wherever possible.

The HIPAA project outreach team works in close cooperation with the associations that represent health care providers that participate with Medicaid. Specialized communication plans are developed for each group that seek to design specific messages, training programs, and materials that integrate best with the ongoing training and communication activities of each provider group.

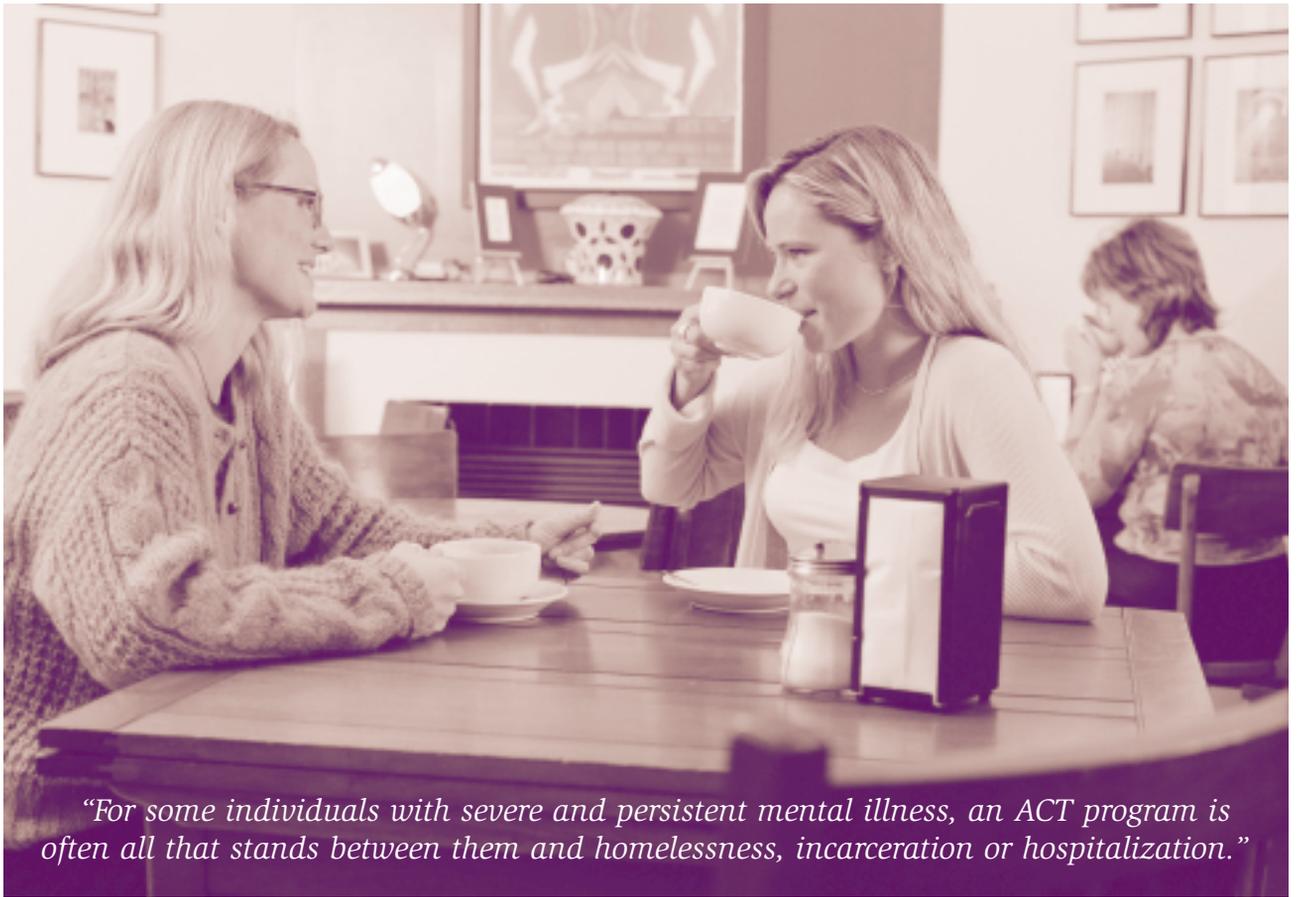
The outreach staff have created two vibrant and rapidly changing HIPAA web sites ([www.michigan.gov/mdch](http://www.michigan.gov/mdch) and [www.mihealth.org](http://www.mihealth.org)) that organize all MDCH policy bulletins, provider letters, billing manuals, and other relevant documents. The sites are constantly updated to include the latest status reports and to provide responses to frequently asked questions. Regular "e-newsletters" are sent to targeted provider groups via e-mail, and the correspondences contain hot-links to take readers directly to new web resources.

Web-based training is another of the team's important strategies for success. By partnering with the Michigan Virtual University, the MPHI-based team provides the Michigan Medicaid program with the ability to rapidly create highly effective tutorials and online courses that give providers access to training opportunities on a schedule that works for them. The online "HIPAA Transactions Primer" course gives Medicaid providers a basic understanding of the HIPAA transactions rules and is available free of charge at [www.healthcare.mivu.org](http://www.healthcare.mivu.org).

The outreach staff also has created a wide array of printed materials, including brochures, postcards and flyers, to regularly draw Medicaid provider attention to conversion tools and training opportunities. Because the conversion project is fairly complex and requires coordinated action between many parties, the team's strategy is to stay in regular contact with provider groups and to provide them with many options for communication and training.

Michigan's Medicaid HIPAA Conversion Team is proud to note that its HIPAA outreach effort is among the most comprehensive and advanced efforts in the nation. The success of the project is due in large part to three conscious strategies adopted by the MPHI team. First, bring on board highly qualified individuals and organizations and dedicate them solely to the training and outreach function. Second, integrate the outreach staff with the other technical and policy teams. Finally, concentrate on developing ongoing relationships with provider groups, not just materials.

Together, these strategies ensure that the communication with providers will be timely, useful and effective.



*“For some individuals with severe and persistent mental illness, an ACT program is often all that stands between them and homelessness, incarceration or hospitalization.”*

## IMPROVING SERVICE SYSTEMS *for* PERSONS *with* SEVERE *and* PERSISTENT MENTAL ILLNESS

*By Cynthia A. Cameron, PhD*

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In 2001, the Michigan Department of Community Health (MDCH) and MPHI Systems Reform formed a partnership to apply for a grant from the Flinn Family Foundation to improve the mental health system’s use of evidenced-based clinical practices. Assertive Community Treatment (ACT) was selected for study.

ACT is a widely used service delivery model in Michigan and one of a handful of evidenced-based treatment models for persons with severe and persistent mental illness. ACT programs were first introduced in the late 1960s as a means of reducing hospital admissions and improving outcomes for persons with severe and persistent mental illness who would not use traditional outpatient services or for whom such services did not produce good results.

Persons with severe and persistent mental illness live, work and play in our communities. They are part of the fabric of our communities, as are individuals from any other group of people who have talents to share and needs to be met. Some, however, find that their mental illness takes a toll on their ability to work, maintain relationships with family and friends, and adequately care for themselves. For these individuals, an ACT program is often all that stands between them and homelessness, incarceration or hospitalization.

*Gathering the  
Information for Change*

Michigan is one of six states that have PACT (Program for Assertive Community Treatment) programs available throughout the state. MDCH has taken a leading role in disseminating the ACT service model throughout the Michigan public mental health system; in 2002, Michigan had 95 ACT teams serving more than 7,000 persons.

The Flinn Family Foundation grant supports evaluation activities designed to assess current practices of Michigan's ACT programs and determine the fidelity of these practices to the ACT model and Michigan Medicaid standards.

The MDCH/MPHI team is investigating the relationship between model fidelity and positive outcomes for consumers. Their research efforts will inform MDCH policy and system improvement mechanisms, including identification of best practice, the development of performance indicators, and the identification of practices associated with positive outcomes for consumers.

In 2002, the team surveyed all 95 ACT teams in Michigan regarding their current practices; 70 ACT teams responded to the survey. Model fidelity was assessed with regard to key elements of the ACT model using criteria developed by the Lewin Group during its national review of ACT programs. Using these criteria, components of the ACT model were determined to be: 1) above the model standards; 2) within range of the model standard; or 3) below the model standards.

The fidelity measure was applied to the 70 ACT teams that responded to the survey. The initial analysis of these self-reports indicated a wide range of model fidelity.

Also in 2002, the MDCH/MPHI team selected sites to participate in additional data collection through site visits. The team used model fidelity, specific key practices indicated in the survey, and geographic location to select a purposeful sample of 13 teams for these site visits; 12 agreed to participate.

The MPHI Systems Reform evaluation team spent a day visiting the sites of each of the 12 participating ACT teams. During each site visit, Systems Reform team members conducted a group interview with the ACT team concerning factors that were contributing to their success and factors that were considered barriers to their success. At each site, the MPHI evaluators randomly selected 10 consumers for in-depth interviews regarding their functioning and use of ACT services; interviews were completed with 120 consumers.

*Helping ACT Teams  
Improve Their Services*

The System Reform evaluation team is beginning the analysis of this rich set of information detailing client and staff perceptions of ACT. Initially, they have concentrated on the comparison of model fidelity measured by team self-reports with client reports of frequency and types of services received.

Preliminary analyses indicate discrepancies in team and client perceptions of the services being delivered.

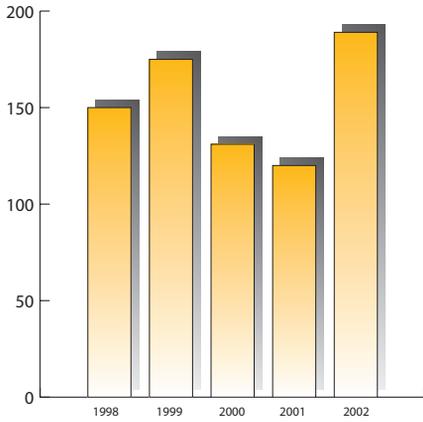
During 2003, the MPHI Systems Reform evaluation team will conduct analyses of the relationships between model fidelity and client outcomes. The results of these analyses will be used to develop a self-assessment tool that ACT teams can use to assess their practices. The tool will help teams to identify both their strengths and areas for improvement in relation to the ACT model. The evaluation team will offer technical assistance meetings throughout the state to teach ACT teams how they can use the self-assessment tool and to help them gain the skills they need to plan and implement changes in practice.

#### WHAT CLIENTS SAY ABOUT MICHIGAN ACT TEAMS

"[They're] compassionate [and] show they care. [They] don't just pretend or put on. [They] show by what they do for you."

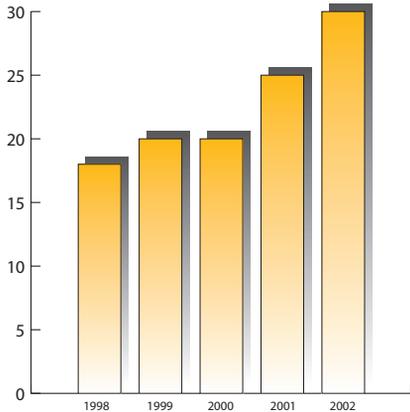
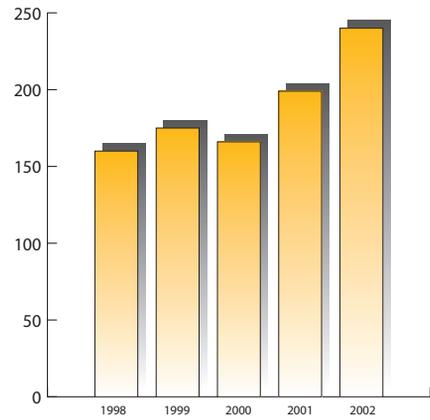
"[They] didn't give up on me. I was a terrible client the first year."

"[ACT] gives you a place to come where you can talk. It gives you active support you wouldn't have anywhere else."



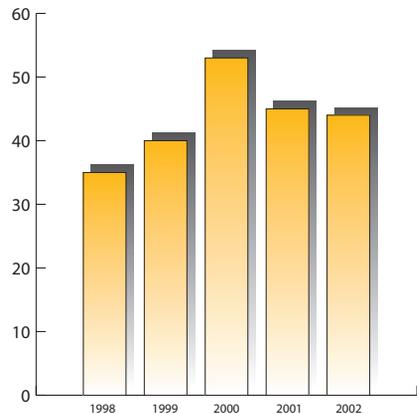
NUMBER OF PROJECTS UNDER MANAGEMENT

NUMBER OF EMPLOYEES



ANNUAL INCOME (IN MILLIONS)

NUMBER OF FUNDING SOURCES





- American Legacy Foundation
- Arbor Circle Corporation
- Association of Public Health Laboratories
- Battle Creek Community Foundation
- Bill Brown Associates
- Blue Cross Blue Shield of Michigan Foundation
- Center for Health Care Strategies
- Children’s Hospital of Michigan
- Children’s Trust Fund
- Council of Michigan Foundations
- GlaxcoSmithKline
- Harvard School of Public Health
- Health Management Associates
- Michigan Health Professional Recovery Corporation
- Michigan Primary Care Association
- Muskegon Community Health Project
- P & G Pharmaceuticals
- Regents of the University of Michigan
- Robert Wood Johnson Foundation
- Shiawassee Regional Education Service District
- Southeastern Michigan Health Association
- State of Michigan
  - Department of Community Health
  - Department of Consumer and Industry Services
  - Department of Education
  - Department of Environmental Quality
  - Department of Management and Budget
  - Department of State Police, Office of Highway Safety Planning
  - Family Independence Agency
- State of Texas, Department of Transportation
- Task Force for Child Survival and Development
- U.S. Department of Health and Human Services
  - Agency for Healthcare Research and Quality
  - Centers for Disease Control and Prevention
  - Centers for Medicare and Medicaid Services
  - Health Resources and Services Administration
  - National Institutes of Health
    - National Cancer Institute
    - National Library of Medicine
  - Program Support Center
- U.S. Department of Justice, Office of Juvenile Justice Delinquency Prevention
- W.K. Kellogg Foundation
- Walther Cancer Institute
- Wayne County Department of Public Health
- Wayne State University
- Wyeth-Ayerst Pharmaceuticals



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