

Q & A MIHP Coordinator Meetings, March 2011

Generic Questions on Forms

1. When does the grace period end (for all the new forms)?
The grace period was from July 2010 to December 2010. It ended December 31, 2010.
2. Dates are the same on the bottom of the new forms! Please update the dates when you change forms.
We are doing this.
3. Could you please discuss what exactly constitutes an electronic signature?
The MDCH Public Health Legal Adviser responded to four questions about the use of electronic signatures in MIHP on March 17, 2011, as follows:

Question 1: *Whether a "typed" signature on a MIHP form that is imported into an electronic medical record constitutes a valid signature. From the information provided, I assume the typed signatures were inserted during a period starting in July of 2010, until the use of signature pads was instituted.*

Short answer: *Yes, an electronic signature has the same legal significance as a written signature as long as it is intended to be a signature, and the creation of the signature can be attributed to the person. Note that the efficacy of the security procedures in place will pertain to a determination of whether a signature is attributed to a person.*

Citations: *Under the Uniform Electronic Transactions Act, (MCL 450.831 et seq), an electronic signature can be any symbol or process associated with a record as long as it is used with the intent to sign the record, so a typed signature can be used. (MCL 450.832(h)). A record or signature shall not be denied legal effect or enforceability solely because it is in electronic form. (MCL 450.837(1)). An electronic signature satisfies the legal requirement for a signature. (MCL 450.837(4)). Also, the context and surrounding circumstances of the creation of the signature and record determine how these acts will be attributed to a person, and include demonstration of the efficacy of the security procedures applied in the creation or execution of the signature or record. (MCL 450.839).*

Question 2: *Whether scanned and imported documents are considered "authentic." According to the information you provided, the scanned referral and consent forms are saved in a secure computer file and imported into the client's EMR.*

Short Answer: *Yes, a scanned record has the same legal effect as a written record. Further, if there is a legal requirement for retention of a record, the requirement*

is satisfied by retaining an electronic record as long as the record accurately reflects the information in the final form, and remains accessible for further use.

Citation: "Electronic record" means a record created, generated, sent, communicated, received, or stored by electronic means. (MCL 450.832(g)). An electronic record has the same legal effect and enforceability as a written record. (MCL 450.837(1) and (3)). If a law requires that a record be retained, the requirement is satisfied by retaining an electronic record of the information as long as the electronic record accurately reflects the information set forth in the record after it was first generated in its final form as an electronic record or otherwise, and remains accessible for later reference. (MCL 450.842(1)). A record retained in this manner also satisfies a legal requirement to retain a record in its original form, as well as for evidentiary, audit, or similar purposes unless the subsequent law specifically prohibits the use of an electronic record for a specified use. (MCL 450.832(4) and (6)).

Question 3: *Whether there are any restrictions for the use of signature pads in MIHP.*

Short answer: Electronic signature software and pads are designed for the capture, binding, authentication, and verification of electronic signatures in digital documents. As long as the intent and attributability requirements set forth above are satisfied, then the legal requirements for a signature would be satisfied.

One question remains, and it pertains to whether there are any specific requirements or restrictions related to the use of the MIHP form. I am not familiar with this form. To the extent this is a form that is used by a government agency (DCH), the Department of Management and Budget has jurisdiction to determine the extent to which each department will send and accept electronic records and signatures. (MCL 450.848). If applicable, do you know whether this particular form has been approved for electronic use?

Note: These provisions apply to any electronic record or electronic signature created, generated, sent, communicated, received, or stored on or after October 16, 2000.

4. Can information/lines be added to the state forms?
The forms cannot be altered. They must contain the same data elements in the same order as the forms posted on the web site.
5. We are a clinic-based MIHP provider. Do we still have to send the communications forms to the doctors in our clinic?
Yes, you do need to communicate with the physician using the MIHP forms, unless there is documentation in the chart that the physician does not wish to receive these communications. (MIHP Q&A, 11-04-10, page 8.)

POC-Part 3

1. POC-Part 3: What date do we put on the forms checklist? The last date signed?

Yes, the last date signed.

Educational Packets

1. Can we put the FDA Birth Control brochure info in the maternal package? It is a great resource to staff teaching during PS.

Yes. We agree that it's a great resource and we recommend that you use it when you talk with clients about family planning. You can download and print the guide or request 50 free copies at a time.

<http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM207070.pdf> (to print)

<http://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm116718.htm> (to order)

Professional Visit Progress Note

1. For education packet reviewed (on progress note): please clarify what needs to be documented there and exactly which packets are considered there.

Check the appropriate box (maternal, infant or NA) and just write in the topic covered.

2. Progress note – Education Provided: Topics. Do you want the education materials listed that the educational topic came from? For example: *Healthy Start, Grow Smart* - 4th month – safety (or whatever)?

No, just write in the topic covered.

3. Where should proof that *Healthy Start, Grow Smart* and maternal packets were given to MOB be documented?

Where do you want us to document that we have given out the *Healthy Start, Grow Smart* series?

The next time we revise the POC-Part 1, we will include check-off boxes so you can indicate “handed out brochure” or “helped client sign up for text4baby.” Until then, please document in progress note.

Discharge Summary

1. On *Discharge Summary*, what determines whether MIHP services are “completed” or “not completed?”

The determination is made based on clinical judgment.

2. On *Discharge Summary* standards (?cut off) related to risk level vs. unknown .

We don't understand this comment. Please clarify.

Developmental Screening

1. ASQ-3 and ASQ-SE – are both assessments required for every baby?

Yes, unless the baby is already in Early On or is being screened by another program using these tools.

2. Are we supposed to do the ASQ-3 and ASQ: SE at each milestone (2 months, 4 months, 6 months) or just once if OK?

Can you clarify when the ASQ-3 and the ASQ: SE need to be done?

You are not required to do the ASQ-3 and ASQ: SE at every potential administration interval. The table below explains how often to repeat screening based on the results of the previous screening.

Total Score Category	Take This Action
<i>Score is below the cutoff; further assessment with a professional may be needed</i>	<i>Refer the infant to Early On for a comprehensive developmental evaluation</i>
<i>Score is close to the cutoff; provide learning activities and monitoring</i>	<i>Repeat the screening in two months</i>
<i>Score is above the cutoff; development appears to be on schedule</i>	<i>Repeat the screening in four months</i>

See the MIHP Operations Guide, pages 71-75 for detailed information about using the ASQ-3 and ASQ: SE.

3. Where do we get the ASQ Materials kit or do we use what's available in the home?

You can purchase the ASQ-3 Materials Kit from Brooks Publishing at <http://agesandstages.com/>. Or, you can use materials that are available in the parent's home. The advantage to using materials in the home is that you can show parents how everyday items can be used to promote child development.

4. Are we required to use the ASQ Summary Sheet?

Yes, you are required to use it and to keep a copy in the client record.

5. How can you require that we administer the ASQ to a twin or triplets who are not enrolled in MIHP?

With the re-design, all twins, triplets, etc., are enrolled in MIHP. However, you only bill MIHP services under one infant's Medicaid ID number.

6. What if we don't open the ISS case until the infant is 2 months old? We wouldn't have done a one-month ASQ-3. This seems to be a problem according to the *Operations Guide/Indicator #27*.

The Operations Guide on page 74 states: "If the infant is two months or older and at least two Bright futures "not yet" boxes are checked, administer the ASQ-3 within two weeks." You would skip the one month ASQ and start by doing the two month ASQ-SE.

7. If we don't have an infant program, do we still need the infant developmental screening tools?

No, but the MIHP provider agency to which you transition your clients after the baby is born must use them. Please be sure that your partnering transition agency is using the developmental screening tools.

Infant Mental Health

1. We would welcome an IMH specialist in our MIHP, but we operate with LPHO funding and local funding, both of which are decreasing. We can't add more staff at this time but would encourage existing staff to obtain training. The training should be free and accessible.
We can provide free training on incorporating IMH principles into everyday MIHP practice, but don't have funds to support individuals to become endorsed by the Michigan Association for Infant Mental Health (MI-AIMH). Persons who are interested in endorsement should contact MI-AIMH.
2. Related to IMH, not sure if the question of PS was involved in past of mom and infant assessment of "long-term impact."
The Abuse/Violence section of the maternal component of the Infant Risk Identifier asks: "As a child were you ever involved with CPS?" and "How long were you in the custody of CPS?" Responses to these items potentially could be considered in an outcomes analysis, if that is your question. The literature is beginning to indicate that it's beneficial to provide IMH services during pregnancy for a woman who may have difficulty with infant attachment because of her own family history or other factors. However, in MIHP we don't ask about a woman's CPS history as a child until after her baby is born. We will look at the possibility of the development of a simple tool that MIHP professionals can use to determine when an infant mental health services referral should be considered. We would include "history of CPS involvement when mother was a child" and "history of CPS involvement since mother has had her own children" in this tool.
3. You might want to consider inviting a representative from MI-AIMH to the Infant Mental Health Collaborative Suzette discussed.
There will be two MI-AIMH representatives on the Collaborative.

Certification Reviews

1. Who is assigned to review Allegan County HD in December 2011?
This has been resolved.
2. On the maternal chart review tool under *Maternal Plan of Care – Part 1*, where do you document the follow-up appointment is scheduled?
It is noted on the MATERNAL PLAN OF CARE/PART ONE (M002) continued section just below "Beneficiary received MHP care coordinator's contact information" and above "RN Signature."
3. Could the "review form" be available in e-form so we can use it as an internal audit tool?
Yes, it will be emailed to coordinators upon completion.
4. Certification Tool – Item #26: "Actively linked to or be a member of a local Part C/Early On Interagency Council and the Great Start Collaborative Council." Why is there no reciprocal

referral for these agencies /initiatives or requirement that they refer all Medicaid moms and infants to MIHP?

It is important for providers to develop relationships with the Early On ICC, the GSC, and other entities that are in a position to refer to MIHP. Please contact your state consultant if you wish to discuss this further.

5. Consistently document calendar or business days on review tools.
We will make the language consistent on the review tools.
6. On *Professional Visit Progress Note Review Form*, will “Desired Outcome” be removed?
It has been removed.

Reimbursement

1. How will billing correction (CHAMPS) be corrected – overpaying for home visits?
Please call the Provider Support Line.
2. Regarding CHAMPS reimbursement – if we bill \$80 for an office visit we are getting reimbursed the full \$80 and not the \$63 or even the \$79 for home visit.
As of mid-May, providers were still getting overpaid for office visits (\$83.72 instead of the correct amount of \$60.72). As long you bill for an amount that is under the cap of \$83.72 for a professional visit in home, you will be paid the exact amount billed. For example, if you bill an actual cost of \$80, you’ll be paid \$80; if you bill an actual cost of \$70, you’ll be paid \$70. If you are receiving overpayments, Medicaid will recoup them at some point, possibly without advance notice.
3. Does billing date and date of progress note signed have to be the same?
The date billed for service must be the same as the date of the visit documented in the progress note. The date that the bill is submitted may be different from the date of service.
4. Who else has the authority to assign Medicaid ID numbers other than DHS? Our county is having frequent problems with children with two numbers. DHS says “someone else is signing them up.”
There has been a miscommunication. Only DHS has the authority to assign Medicaid ID numbers.
5. With the new changes in MIHP, must all drug-exposed visits (36) be done prior to the infant’s first birthday?
No. When an infant being served by MIHP reaches 12 months of age, the provider should continue to serve the infant until all allowable MIHP visits have been used or the infant’s Plan of Care goals have been achieved, whichever comes first. (MIHP Operations Guide, 12-22-10, page 15.)
6. Thirty-minute visit. Time in - time out.

All professional visits must be a minimum of 30 minutes in length. This is not to say that visits must be limited to 30 minutes. Providers may opt to make longer visits if they determine that it's financially viable for them to do so. The start time and end time for each visit must be documented in the progress note.

7. If an MIHP staff member was certified in infant message and taught/demonstrated infant message in the home – is that a billable Medicaid service?

The visit would be billable as a regular MIHP professional visit, but infant message is not a separate Medicaid-billable service. Teaching a parent to use infant message is a strategy to promote parent-infant attachment.

MIHP Evaluation

1. For collection data: What is the difference between missing and incomplete?

Missing means the space was blank. Incomplete means there was a "0" in the space.

2. How about a phone client (satisfaction) survey?

This will be decided after the pilot is completed.

3. What/when should you have the client fill out the (satisfaction) survey? At third visit? Post partum? At closure of services?

The pilots will receive complete written instructions – the survey will be administered at the close of services.

4. When is the Medical Record Review anticipated? Will this go along with our reviews?

Stay tuned – information on this will be available soon. The MSU record reviews will not be done concurrently with certification reviews.

5. Will the MIHP evaluation coincide with the MDCH accreditation cycle? Cycle 5 starts in 2012. Please consider this for LHDs administering MIHPs.

No, the MIHP evaluation will not coincide with the MDCH accreditation cycle.

6. For IHCS. We are very interested in outcomes data from maternal and infant summaries.

Once the Discharge Summaries become electronic, we'll be able to generate reports with outcomes data.

7. Can the data reports include the number of eligible pregnant women in the county?

Including this in data reports is under discussion.

8. Percentage of unplanned pregnancies.

Including this in data reports is under discussion.

9. Can we get the state aggregate data reports along with our provider data reports?

Yes, we will forward the aggregate data reports along with the provider data reports.

10. Regarding incomplete screeners: It would be helpful to have to the end of the pregnancy to complete the screener. By the time recipient gets Medicaid, we know of the Medicaid, and

we have time to go into database to wrap up incomplete screeners...three to four months goes fast!

The Maternal Risk Identifier provides a snapshot of risks at program entry, which is important for purposes of evaluating program outcomes. It must be completed at entry, with the exception of the Medicaid ID number. Please add the ID number once you receive it.

Training

1. Can you remind folks this training is video-taped and will be on website for viewing later? Can you do this at the end of the day and in your presentations?

We will do this.

2. Can we watch the motivational interviewing as a group and still get the certificate of completion?

The sign-in sheet will serve as documentation for certification review purposes, but you can print out individual certificates if you like.

3. How exactly do we access the CEIs for motivational interviewing? I've tried.

There are instructions on the web site. Go to "Presentation Resources" in the right-hand corner and follow the instructions.

4. How often do required trainings need to be completed (e.g., smoking, motivational interviewing – part 1)?

Required trainings need to be completed just once, as long as you have the certificate of completion (or sign-in sheet for a group). However, all staff persons are encouraged to review the trainings whenever they feel they need a refresher.

5. We would like to have more time to talk to other programs and see how they do things (at the Coordinator meetings).

We will keep this in mind as we plan future meetings.

6. Not sure how many people were from Bay-Midland-Huron-Tuscola-Central Area (7 at least). Could a meeting be held in Central MI area? Or at least rotated to that area?

We're looking at options to make sure we can include as many people as possible at our trainings, given that some MIHP providers are facing travel restrictions.

7. Consider having smaller meetings specifically for discussion and networking – maybe just with sites in same region.

We don't foresee an increase in training funds to allow for additional regional meetings. However, providers in some regions do choose to meet on their own, and state consultants may participate in these meetings (at least by phone) when invited.

8. Is it possible to get links to Melissa's video clips emailed to us?

You can access these links from Melissa's presentation on the web site. If you have any difficulties, contact your state consultant.

Other

1. Can there be a central place such as MCIR that the fluoride treatments can we recorded, so that we do not over-fluorinate?
Questions have arisen about the implications of having MIHP staff do fluoride varnishes, so the proposed policy to sanction this activity is currently on hold. DCH may consider using MCIR to track fluoride treatments in the future.
2. Can there be a form or “roster” for access to SSO that we send to mihp@michigan.gov when there are additions or removals?
We will look into this.
3. When changes are made to the Coordinators Directory, it would help if the latest changes could be highlighted.
We will do this.
4. Only one infant per household is allowed to be enrolled. Clients may now be living with extended family. If more than one infant is in the home, and there are two separate parents, are we allowed to enroll both infants? Needs of parents/clients may be totally different.
Yes.
5. RD is not wanting to discuss family planning at each visit – says it’s not relevant to her educational background. What verbiage can she use to meet indicator?
Reducing unintended pregnancies is a fundamental infant mortality reduction strategy and everyone on the MIHP team needs to know how to talk with a client about family planning. All MIHP staff should be familiar with (and carry with them on professional visits) the Birth Control Guide available from the FDA. You can download the guide or request 50 free copies at a time.
<http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM207070.pdf> (to print)
<http://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm116718.htm> (to order)
6. Can photo/name badge be from agency – ours do not have program-specific on it. Staff works in many programs.
Yes, but then staff also must give the client a program- specific business card.
7. Will substance abuse interventions include drugs other than alcohol? We have a large heroin/narcotic using population.
Yes.