



# **OPERATIONS GUIDE**

**Division of Family and Community Health  
Bureau of Family, Maternal and Child Health  
Population Health and Community Services Administration  
Michigan Department of Health and Human Services**

**Maternal Infant Health Program (MIHP)  
Operations Guide  
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# 1.0 INTRODUCTION TO MIHP

## Evidence for the Effectiveness of the Maternal Infant Health Program (MIHP)

Strong evidence for the effectiveness of the MIHP has been published in professional journals with the conclusion that the MIHP is effective at improving maternal prenatal and postnatal care and infant care.

“MIHP reduced risk for adverse birth outcomes, with particular advantage for black women.”

Roman L, Raffo JE, Zhu Q, Meghea CI. A statewide Medicaid enhanced prenatal care program: impact on birth outcomes. *JAMA Pediatrics*. 2014 Mar;168 (3):220-7. doi:10.1001/jamapediatrics.2013.4347.

Enrolling in the program in the first two trimesters and receiving screening and at least three additional face-to-face MIHP prenatal contacts decreased the likelihood of having adverse birth outcomes – low birth weight, very low birth weight, preterm births, and very preterm births - for women of all races, with the MIHP effects more robust for black women.

Roman L, Raffo JE, Zhu Q, Meghea CI. A statewide Medicaid enhanced prenatal care program: impact on birth outcomes. *JAMA Pediatrics*. 2014 Mar;168 (3):220-7. doi:10.1001/jamapediatrics.2013.4347.

The latest published study further showed:

- ✓ Infants with any MIHP participation had reduced odds of death in the first year of life compared with matched nonparticipants.
- ✓ Infant death odds were reduced both among black infants and infants of other races.
- ✓ Neonatal death and postneonatal death odds were also reduced.
- ✓ Enrollment and screening in MIHP by the end of the second pregnancy trimester and at least 3 additional prenatal MIHP contacts reduced infant mortality odds further.

Meghea CI, You Z, Raffo JE, Leach RE, Roman LA. Statewide Medicaid Enhanced Prenatal Care Programs and Infant Mortality. *Pediatrics* Vol. 136 No. 2 August 1, 2015 pp. 334 -342 (doi: 10.1542/peds.2015-0479)

A Return on Investment fact sheet indicates that Medicaid can save over 1.2 million dollars a year on women participating in the MIHP. This is a 138% return on investment or savings of \$1.38 on each \$1.00 spent due to the reduction of preterm and very preterm births.

Peters C, McKane, P. Meghea, C. Michigan Department of Community Health. “RETURN ON INVESTMENT: Cost Savings to Medicaid from Maternal Infant Health Program due to Reduction in Preterm Birth Rate.” ROI Fact Sheet Series Volume 1, Issue 1 (2015).

Michigan’s MIHP can be a successful approach, not only in reducing costs, but more importantly, in reducing infant mortality in a diverse disadvantaged population. Further evidence indicates that infants with home visiting services have better odds, not only of staying alive, but also of thriving, which is a top priority for Governor Rick Snyder and the MDHHS.

## Purpose of the *MIHP Operations Guide*

The *MIHP Operations Guide* is designed to be a comprehensive reference for MIHP providers and is intended to be used in conjunction with the *Medicaid Provider Manual*. The *Operations Guide* should not be construed as a substitute for the *Medicaid Provider Manual*, which is the official MIHP policy reference source. Although the *MIHP Operations Guide* was conceptualized as a one-stop place for providers to obtain answers to their MIHP questions, it is not intended to replace technical assistance offered by

MDHHS MIHP consultants. MDHHS anticipates the primary users of the *MIHP Operations Guide* to be the following groups:

- Potential and new MIHP providers who need detailed program information for start-up purposes
- Newly-hired staff who need an orientation to MIHP
- MIHP staff who need to identify or verify program requirements or procedures
- Persons interested in learning how Michigan implements the MIHP

## How to Use the *MIHP Operations Guide*

The authoritative source for the Maternal Infant Health Program (MIHP) is the *Medicaid Provider Manual* which can be accessed at [Medicaid Provider Manual](#). The *MIHP Operations Guide* is to be used with MIHP policies in the *Medicaid Provider Manual*. Medicaid policy is not incorporated within the *MIHP Operations Guide*. MIHP providers should be very familiar with both documents.

To locate information about a particular topic in the *MIHP Operations Guide*, start with the Table of Contents or use the “Find” function. If you can’t find what you’re looking for, please contact one of the MDHHS MIHP consultants identified in the following section.

The *MIHP Operations Guide* is only available electronically. It is updated periodically, at which time MIHP providers receive an email notice that changes have been made. Providers are strongly encouraged to make it a practice to refer to the electronic *Guide*. If you do print out a particular section for ease of use, it is your responsibility to ensure that you are always working from the most recent version incorporating all updates.

The Michigan Department of Health and Human Services (MDHHS) wants to make the *MIHP Operations Guide* as user-friendly as possible. Please forward your questions or comments about the *Guide* to one of the consultants listed below.

## MDHHS MIHP Consultant Contact Information

MDHHS welcomes your questions about the MIHP. For additional information, contact one of the MDHHS MIHP consultants listed below:

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## MIHP Web Site

MDHHS maintains an MIHP web site at [www.michigan.gov/mihp](http://www.michigan.gov/mihp). The site includes:

- A brief overview of the program
- Information on locating MIHPs across the state
- Information on becoming an MIHP provider
- MIHP forms and forms instructions
- MIHP trainings
- MIHP news
- Resources and other items of interest to MIHP providers, prospective providers, and families.

## MIHP Coordinators Directory

A document titled *MIHP Coordinators Directory* includes updated contact information for each MIHP provider, including the counties and communities they serve and the name of their MDHHS MIHP assigned consultant. The *Directory* is posted on the MIHP web site. It is updated frequently, so be sure to use the most recent version. The *Directory* is maintained as an Excel spreadsheet, which allows you to sort MIHP providers by county.

### Identifying MIHP Specialty Providers

The *MIHP Coordinators Directory* also indicates which providers specialize in serving persons who speak Arabic, Chaldean or Spanish, are deaf or hard of hearing, or are blind or visually impaired. Use the MIHP *Personnel Roster* submission process to update your roster if you have identified staff who speak a language other than English.

## MIHP Overview

### Origins

In 2013, Medicaid paid for a total of 49,932 live births in Michigan. This constitutes 44% of all births in the state, up from 41.3% since 2007. In order to qualify for Medicaid, families must meet program criteria, including low-income level status. It has been well-established that low socioeconomic status is a major risk factor for infant mortality and morbidity.

In an effort to reduce infant mortality and morbidity among pregnant and infant Medicaid beneficiaries, the Michigan Department of Health and Human Services (MDHHS) initiated the Maternal Support Services (MSS) Program in 1987 and the Infant Support Services (ISS) Program a few years thereafter. MSS was

designed to address the psychosocial issues and logistical barriers (e.g., lack of transportation) that prevented many pregnant Medicaid beneficiaries from obtaining or benefitting from prenatal care. ISS was designed to promote health and development throughout infancy.

MSS/ISS services were essentially home-based, delivered by a qualified team that included a registered nurse, a licensed social worker, a registered dietitian, and an endorsed infant mental health specialist (if available). MSS/ISS providers were given broad leeway in determining how services were delivered, resulting in a great deal of variation across providers. Data-reporting requirements were minimal.

MSS/ISS providers could bill for the initial assessment and 9 professional visits during pregnancy and for an initial assessment and 9 home visits during infancy. An additional 9 visits could be provided during infancy when requested in writing by the medical care provider. Up to 36 visits could be provided when the infant was drug or alcohol exposed. Women were nearly twice as likely to participate in MSS as they were to participate in ISS.

## Redesign

In 2004, MDHHS undertook an effort to study and redesign MSS and ISS in order to improve program outcomes. As a result, MSS and ISS were consolidated and renamed the Maternal Infant Health Program (MIHP). The most significant redesign change, however, was MDHHS's decision to convert MIHP to a population management model.

## Population Management Model

A population management model is population-based, meaning that the health of the entire target population is addressed in addition to the health of individuals within the population. For example, in MSS/ISS, pregnant women and infants were screened to determine if they were program-eligible; in MIHP, all pregnant and infant Medicaid beneficiaries are program-eligible. MIHP providers strive to identify as many eligible women and infants as possible and to "touch" each one. At a minimum, this involves administering a risk identification tool and providing the beneficiary with an educational packet and a phone number, in case help is needed later in the pregnancy or infancy. Other key features of a population management model are: care coordination; a strong focus on outcomes; systematic risk screening; use of specified, evidence-based interventions tied to level of risk; comprehensive data collection; development of a centralized database/registry; and use of data to drive program decisions in order to improve program quality.

The MIHP population management approach requires providers to focus on the following tasks:

1. Engage all Medicaid-eligible pregnant women and infants in MIHP.
2. Identify risk factors for all Medicaid-eligible women and infants, using standardized *MIHP Risk Identifier* (assessment) tools that generate stratified (no, low, moderate, high and unknown) risk profiles.
3. Develop a *Plan of Care* based on *Risk Identifier* results, beneficiary priorities, and professional judgment.
4. Deliver prescribed, evidence-based interventions, targeting identified risks and beneficiary priorities.
5. Measure specified outcomes.

For quality assurance purposes, MDHHS reviewers conduct onsite program certification reviews. Consultants provide consultation and technical assistance, along with ongoing program monitoring of MIHP providers, as they did with MSS/ISS providers.

## Administration by MDHHS

MIHP is jointly administered by two areas within the Michigan Department of Health & Human Services: Medical Services Administration (MSA) and Population Health & Community Services Administration. The MSA is responsible for promulgating Medicaid policies, assisting providers to implement Medicaid policies, entering into and monitoring contracts with Medicaid Health Plans, and making payments to Medicaid providers. Within the Population Health & Community Services Administration, the Bureau of Family, Maternal and Child Health is responsible for developing MIHP procedures, providing technical assistance, certification and monitoring program providers.

## Goal of MIHP

The goal of MIHP is to support Medicaid beneficiaries in order to promote healthy pregnancies, positive birth outcomes, and infant health and development. MIHP services are intended to supplement prenatal and infant medical care. MIHP provides care coordination and health education services, focusing on the mother-infant dyad. Care coordination services are provided by a registered nurse and licensed social worker, one of whom is designated as the care coordinator. Health education services may be provided by a registered nurse, a licensed social worker, a registered dietitian (with a physician order), and an infant mental health specialist, depending on the beneficiary's particular needs.

During the pregnancy, the MIHP professional staff assists the woman to circumvent barriers to obtaining prenatal care (e.g., lack of transportation) and to make changes that increase the likelihood that her infant will be healthy at birth (e.g., decrease use of tobacco, alcohol or drugs; seek treatment for depression; improve management of a chronic disease; etc.). Staff provides education on topics related to the woman's own particular needs, offers guidance and encouragement as she endeavors to make changes, and facilitates referrals to other services and supports, as needed.

After the birth of the infant, the MIHP staff continues to support the mother and begins to monitor the infant's health, safety and development. The staff ensures that the infant has a medical care provider, encourages the mother to take the infant to see the provider for regular well-child visits (and when medical attention is indicated), and helps the mother to follow through with the provider's recommendations. The staff also assists the mother to address any safety risks (e.g., no car seat, environmental toxins, not using safe sleep practices, etc.). In addition, the staff administers standardized tools to screen for potential developmental delays in the following domains: communication, gross motor, fine motor, problem solving, personal-social, and social-emotional. If screening results indicate a potential delay in any of these domains, the staff refers the infant to *Early On Michigan* for a comprehensive developmental evaluation. The staff may also provide basic developmental guidance for the mother to assist her to promote her infant's health and development.

The MIHP provider **must** provide nursing and social work services. The provider must provide nutrition counseling services **or** refer beneficiaries to other local agencies that offer the services of a registered dietitian. The provider must provide infant mental health services **or** refer beneficiaries to other local agencies that offer the services of an infant mental health specialist, if available.

## MIHP - One of Multiple MDHHS Initiatives to Reduce Infant Mortality

The ultimate, long-term goal of MIHP is to reduce infant mortality and morbidity in the Medicaid population. Infant mortality is a critical indicator of the overall health and wellness of all Michiganders. Although some progress has been made, infant mortality is a very complex problem that requires a multi-faceted approach using the State of Michigan Infant Mortality Reduction Plan to strategically address the infant mortality rates in Michigan.

## Infant Mortality Rates in Michigan

Infant mortality rates in Michigan indicate significant health disparities among population groups. Michigan's overall infant mortality rate (2013) was 6.7 deaths per 1000 live births. Racial and ethnic disparities persist; as shown below, the African American, Native American, Hispanic, and Arab rates remain higher than the White rate: ([Source: MDHHS Vital Records and Health Statistics](#))

- White: 5.7/1000
- African American: 13.1/1000
- Hispanic: 10.3/1000
- Arab: 7.8/1000
- Native American: fewer than four deaths

## Practices to Reduce Infant Mortality through Equity (PRIME)

Funded through the W.K. Kellogg Foundation, the MDHHS Bureau of Family, Maternal & Child Health has developed Practices to Reduce Infant Mortality through Equity (PRIME), a project to reduce racial disparities in infant mortality between Blacks and Whites and between Native Americans and Whites in Michigan. The intent of the project is to develop a quality assurance process that will include increased monitoring of social determinants of health: the social and economic conditions in which people are born, grow, live, work and age. The key is to identify how the determinants impact infant mortality and implement strategies at the state, local and program levels to aid in decreasing the number of infant deaths in Michigan.

## Other MDHHS Approaches to Combat Infant Mortality

In recognition of the complexity of the infant mortality problem, MDHHS has several other approaches that, in addition to MIHP and PRIME, are intended to help combat infant mortality. These initiatives include the State of Michigan's Infant Mortality Reduction and Prevention Initiative, Fetal-Infant Mortality Review Program, Michigan Maternal Mortality Surveillance, Family Planning Program, Perinatal Care System, Fetal Alcohol Spectrum Disorders Program, Safe Delivery of Newborns Program, Infant Safe Sleep Initiative, Eliminating Non-Medically Indicated Elective Delivery before 39 Weeks Initiative, the Nurse-Family Partnership Program, and the Maternal, Infant and Early Childhood Home Visiting Program.

## Michigan Infant Mortality Reduction and Prevention Plan

In 2012, Michigan developed and released a comprehensive infant mortality reduction plan based on the [Life Course Theory \(LCT\)](#) and [Perinatal Periods of Risk \(PPOR\)](#) using a health equity lens to strategically impact infant mortality. Implementation of the plan is ongoing. An updated plan will be released in late 2015 focusing on expanded infant mortality reduction efforts statewide. To learn more, visit: the MDHHS Infant Mortality Reduction Initiative web site at [www.michigan.gov/infantmortality](http://www.michigan.gov/infantmortality).

## Social Determinants and Contributing Factors for Infant Mortality

A fishbone diagram titled *Social Determinants and Contributing Factors for Infant Mortality* (link is titled *Root Causes of Infant Mortality*) and a document titled *Health Disparities and Social Justice List of Definitions* (link is titled *Health Disparities Definitions*) are at the MIHP web site under the heading "New Employee and Waiver Staff."

## MIHP Providers

There are about 150 MIHP providers operating in Michigan at any given time, each serving one or more counties. The urban, more densely-populated counties have the greatest concentration of MIHP providers.

MIHP providers include: local public health departments, federally qualified health centers, community-based organizations, and private entities such as hospitals, home health agencies, and individually-owned businesses.

In order to become an MIHP provider, an agency must apply to the MDHHS and complete a multi-step process, successfully culminating in program certification.

## **MIHP Provider Coordination with Medicaid Health Plans (MHPs)**

Most pregnant and infant Medicaid beneficiaries are required to enroll in Medicaid Health Plans (MHPs). There are approximately 11 MHPs operating in Michigan at any given time. MDHHS contracts with MHPs to provide medical health care, mental health care for mild to moderate mental health concerns, transportation, and case management for Medicaid beneficiaries. Since MIHP providers work with pregnant MHP members to reduce psychosocial and logistical barriers to accessing and benefiting from medical care, it's clear that MIHP providers and MHPs must closely coordinate their activities.

Coordination is critical, takes considerable effort, and can be time-consuming, particularly in major urban areas with multiple MHPs and MIHP providers. To ensure that this coordination takes place, MDHHS requires each MIHP provider to enter into an *MIHP - MHP Care Coordination Agreement (CCA)* with MHPs serving a common county or group of counties. The CCA must be signed by both parties. The CCA covers services provided by the MHP, services provided by the MIHP provider, medical coordination, transportation, quality improvement, grievances and appeals, and dispute resolution.

## **MIHP Provider Coordination with Medical Care Providers**

In addition to coordinating with the MHP that is responsible for overall management of the beneficiary's health care, the MIHP provider also must coordinate with the beneficiary's medical care provider. The medical care provider may be a physician, certified nurse midwife, pediatric nurse practitioner, family nurse practitioner, or physician assistant. Since the MIHP provider and medical care provider are both striving to ensure that the beneficiary has the best possible care, it's important that they communicate regularly. Medicaid policy identifies points at which the MIHP provider must inform the medical care provider about the beneficiary's status.

## **MIHP Assumptions**

MIHP, which is designed to promote healthy pregnancies, positive birth outcomes, and infant health and development, provides care coordination for pregnant and infant Medicaid beneficiaries. MIHP promotes health equity and provides health education services targeting the psychosocial, nutritional, and health risks specific to each pregnant woman and infant. MIHP providers supplement medical (prenatal and infant) care, assisting medical care providers to improve the beneficiary's health and well-being by identifying and addressing the social determinants of health (psychosocial, nutritional and health education needs).

MDHHS developed the following assumptions for the MIHP:

1. The Maternal Infant Health Program (MIHP) will be co-managed by Medicaid and the Division of Family and Community Health in participatory planning with key stakeholders, including the women who participate in the program.
2. Resources are limited, and MIHP cannot address all issues for all beneficiaries.
3. Systems of care vary across communities.
4. The MIHP focuses on motivating beneficiaries and coordinating services.
5. The MIHP is based on a population management model.
6. The MIHP has a statewide database that is used for population management purposes, including tracking, reporting, and outcomes measurement.

7. Risks are determined systematically.
8. Interventions are prioritized to address (1) identified risks, (2) anticipated service levels, and (3) specified domains/areas. They are based on evidence or best-practices. Plans of care are tailored to individual beneficiaries based on readiness for change in addition to identified risks.
9. Interventions are delivered by providers operating within the program policy and professional scope.
10. Payment is Fee-For-Service (FFS) by "visit".
11. Providers must meet program expectations, including implementation of outreach strategies.
12. Providers require ongoing training and oversight.
13. The MIHP is evaluated on an ongoing basis using a variety of methodologies and is outcome based.

## **MIHP Service Process**

MIHP is a home visiting program, providing care coordination and health education for pregnant and infant Medicaid beneficiaries. MIHP providers make use of available community resources and provide health education and support to address the beneficiary's identified risks. Once a potential beneficiary has agreed to a face-to-face meeting and signed the *Consent to Participate in Risk Identifier Interview/Consent to Participate in MIHP* and the *Consent to Release Protected Health Information*, the MIHP provider uses a standardized, system-wide service process, involving the following components:

1. Administration of the *Maternal or Infant Risk Identifier*.
2. Assisting the beneficiary to identify her individual needs, goals, and resources.
3. Facilitating the development of an individualized *Plan of Care*, incorporating the beneficiary's stated needs, goals, and resources.
4. Assisting the beneficiary to locate resources.
5. Facilitating connections with providers of services and supports; advocating on behalf of the beneficiary to obtain services, if needed.
6. Providing educational and other services as indicated in the *Plan of Care* during visits.
7. Coordinating implementation of the *Plan of Care*; ensuring that services are rendered; monitoring beneficiary's use of services; and coordinating services when multiple providers are involved.
8. Assisting the beneficiary with problematic situations and various needs, as they arise with a focus on the social determinants of health.
9. Using Motivational Interviewing and coaching the beneficiary toward self-empowerment and self-management.
10. Maintaining communication with the beneficiary to evaluate whether the *Plan of Care* is effective in meeting her goals.
11. Modifying the *Plan of Care*, as needed.
12. Communicating with medical care provider and Medicaid Health Plan.
13. Determining if specified, desired service outcomes are achieved.

## 2.0 MEDICAID PROVIDER RESOURCES

Medicaid providers must be familiar with Medicaid policies, procedures, and forms, including those pertaining to covered services and billing, all of which are subject to change. Providers are responsible for implementing changes in policies and procedures as of the dates they become effective. The resources described below are intended to assist providers in their ongoing efforts to keep current on the Medicaid program.

### The Centers for Medicare & Medicaid Services

As Medicaid providers, MIHPs are expected to follow all pertinent regulations and guidance issued by The Centers for Medicare & Medicaid Services (CMS), US Department of Health and Human Services. CMS administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and parts of the Affordable Care Act. The CMS web site can be accessed at [www.cms.gov/](http://www.cms.gov/).

### Medicaid Policy Manual Web Site

The *Medicaid Provider Manual* can be accessed at [Medicaid Provider Manual](#). The *Manual* addresses all health insurance programs administered by the MDHHS.

Each chapter within the manual is linked with all other manual chapters and appendices. Users can easily navigate from chapter to chapter by clicking on the bookmark navigation keys located on a palette on the left side of the screen. Users can also navigate from section to section within each chapter by clicking on the Section Titles within the Table of Contents.

Updates to the Medicaid Provider Manual, including contact information contained in the Directory Appendix, are made on a quarterly basis to reflect information that has been added, deleted, changed via policy bulletins and other communications during the previous quarter. For this reason, providers are encouraged to utilize the electronic format of this manual. A policy bulletin, detailing the manual changes made each quarter, is sent to all Medicaid enrolled providers.

To review the MIHP chapter in the [Medicaid Provider Manual](#) in its entirety, click on "Maternal Infant Health Program" in the bookmarks column on the left. MIHP providers must also be familiar with other relevant chapters in the *Medicaid Provider Manual*, including, but not limited to, the following:

- Medicaid Provider Manual Overview
- General Information for Providers
- Beneficiary Eligibility
- Coordination of Benefits
- Billing and Reimbursement for Professionals
- Children's Special Health Care Services
- Healthy Michigan Plan
- Emergency Services Only Medicaid
- Maternity Outpatient Medical Services (MOMS)
- Medicaid Health Plans
- Family Planning
- MI Health Link
- MI Choice Waiver
- Special Programs
- Urgent Care Centers
- Appendices
- Acronyms
- Directory
- Glossary
- Forms

## Medicaid Provider Web Site

MDHHS maintains a web site for Medicaid providers at [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). It provides direct links to information on a variety of topics including: Hot Topics, Provider Enrollment, Eligibility Verification System, Policy and Forms (including Michigan Medicaid Approved Policy Bulletins), Draft Policy Bulletins for Public Comment, Billing and Reimbursement, and Communications and Training.

## Michigan Medicaid Policy Bulletins

Michigan Medicaid Approved Policy Bulletins and Michigan Medicaid Proposed Policies are available at [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). Click on “Policy and Forms.”

## Billing and Reimbursement

Information about Community Health Automated Medicaid Processing System (CHAMPS) enrollment and procedures, Medicaid provider billing and reimbursement, including electronic billing, explanation codes, National Provider Identifier (NPI) Registry, provider specific information, and fraud and abuse reporting requirements, is available at: [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). Click on “Billing and Reimbursement.”

Provider Updates – Medicaid Alerts, including Biller “B” Aware notices, are available at [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). Sign up for alerts from both Medicaid and CHAMPS to ensure that you are receiving information regarding policy updates and upcoming Medicaid/CHAMPS opportunities at [http://michigan.gov/mdch/0,1607,7-132-2945\\_5100-145006--,00.html](http://michigan.gov/mdch/0,1607,7-132-2945_5100-145006--,00.html).

MIHP billing codes and fee screens (reimbursement rates for various covered services) may be found at [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). Click on “Billing and Reimbursement,” then on “Provider Specific Information,” and then on “Maternal Infant Health Program.” This database is updated at least once annually. [Billing and Reimbursement](#) is a direct link to the database. The database is also accessible from the MIHP web site at [www.michigan.gov/mihp](http://www.michigan.gov/mihp). Click on “Providers, then “Current Providers,” then “Policy and Operations,” and then “MIHP Medicaid Fee Database and Instructions.”

## Billing Training

Communications and training information for billing agents is available at [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). Click on “Communications and Training.”

There is also an online training titled *Overview of Maternal Infant Health Program Training Course*, which is required for all MIHP provider applicants and billers. This training may be accessed at the MIHP website.

## Medicaid Provider Helpline

Providers with questions about Medicaid billing may call the toll-free number below:

**CHAMPS Enrollment/Michigan Medicaid Provider Support 1-800-292-2550**

Another option is to send an email to [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov) with “ATTN: Craig Boyce or Julie Withers” in the subject line. Write “MIHP Question” in the body of the email and explain what you need from them. They will contact you with their response.

## MIHP Medicaid Provider Forms and Instructions

MIHP providers must use standardized forms developed by MDHHS. The forms are available at the MIHP website at [www.michigan.gov/mihp](http://www.michigan.gov/mihp) under the “Providers” tab on the left side of the web page.

## **Reporting Suspected Medicaid Fraud, Waste or Abuse**

The MDHHS Office of Inspector General (OIG) audits Medicaid claims and investigates suspected fraud, waste, and abuse. The OIG recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation and prosecution. To report suspected Medicaid fraud, waste or abuse to the OIG, call the Medicaid Fraud Hotline (toll free) at 855-MI-FRAUD (643-7283) or submit an online complaint at [MDHHS - Report Medicaid Fraud and Abuse - State of Michigan](#).

For additional information, see Chapter 13 - *Reporting Medicaid Billing Fraud, HIPPA Violations, and Quality of Care Concerns*.

## 3.0 MIHP GOAL AND PRIMARY PARTNERS

All pregnant and infant beneficiaries enrolled in the following Medicaid programs are eligible for MIHP: Healthy Kids for Pregnant Women and Children, Group 2 Pregnant Women Program, Maternity Outpatient Medical Services (MOMS), and Healthy Plan Michigan. Beneficiaries at highest risk for pregnancy complications, poor birth outcomes, and delays in infant growth and development are offered MIHP services to address these concerns; beneficiaries at lower risk for these negative outcomes are offered services that correspond to their needs.

As MIHP services are intended to supplement medical (prenatal and infant) care, MIHP providers closely coordinate their efforts with medical care providers and with Medicaid Health Plans (MHPs), since most pregnant and infant beneficiaries are MHP members.

### Description of Medicaid Health Plans

Medicaid Health Plans (MHPs) are managed care organizations that provide or arrange for the delivery of comprehensive health services to Medicaid enrollees in exchange for a fixed prepaid sum or per-member-per-month prepaid payment without regard to the frequency, extent or kind of health care services. An MHP must have a certificate of authority from the State as a Health Maintenance Organization (HMO).

MDHHS contracts with MHPs to provide medical health care, out-patient mental health care for mild or moderate mental health concerns, transportation, and case management for Medicaid beneficiaries. Mental health care for individuals with serious mental illness is carved out from the MHPs and provided by Community Mental Health Services Programs.

MHPs may provide incentives to their members to encourage them to use prenatal and pediatric care. Once an MIHP beneficiary is enrolled in an MHP, the MIHP provider may encourage the beneficiary to take advantage of the incentives that may be offered by her MHP for completing prenatal care visits, the postpartum visit, and well-child visits.

### Mandatory Enrollment of Pregnant Women into Medicaid Health Plans

Most pregnant Medicaid beneficiaries are required to enroll in a MHP, although there are some exceptions. Voluntary populations may choose to enroll in an MHP or to select fee-for-service coverage. Voluntary populations include: Migrants, Native American Indians, and most individuals who are dually Medicare/Medicaid eligible. Women in the MOMS Program are not eligible to enroll in a MHP.

### Michigan Enrolls

MDHHS contracts with MAXIMUS, Inc. to enroll Medicaid beneficiaries in MHPs. This service is called Michigan Enrolls. After a pregnant woman's Medicaid application is approved, she receives a letter from Michigan Enrolls, asking her to select an MHP. **Michigan Enrolls phone counselors (1-888-367-6557)** are available to answer her general questions about Medicaid benefits (including MIHP), provide information on which doctors, pharmacies and hospitals are part of each MHP, and help her choose a plan. MIHP providers also may help a woman choose a MHP, if she needs assistance. If the woman does not select a MHP within 30 days, she is automatically assigned to one.

## Infant Automatically Enrolled in Mother’s Health Plan

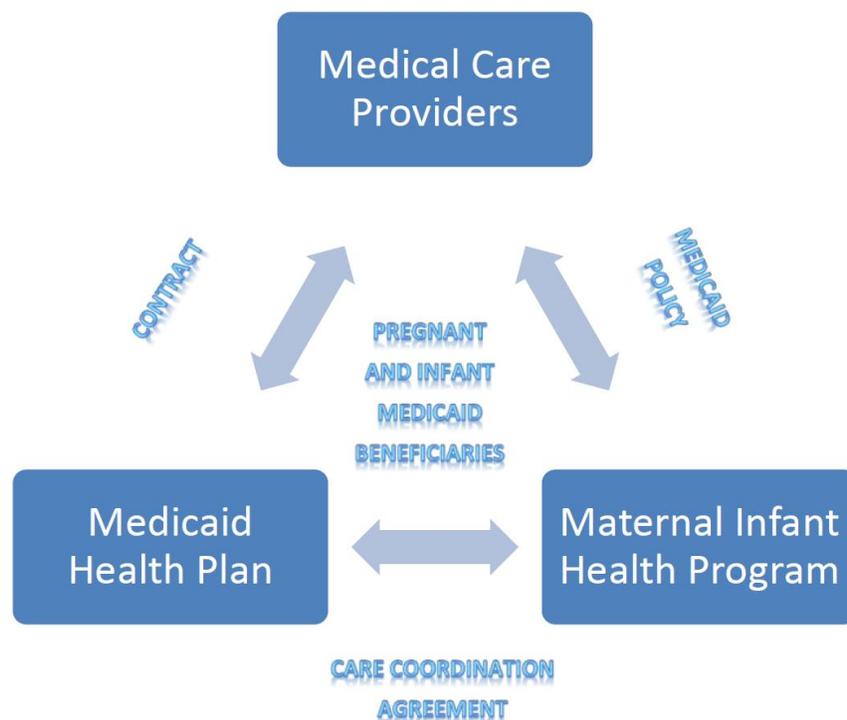
When her infant is born, the newborn child is automatically enrolled in the mother’s health plan and continues eligibility for 12 continuous months without any interruption or spend down. Health Plan responsibilities begin at the time of the child’s birth. The mother must report the birth to the Department of Health and Human Services in order to obtain the infant’s Medicaid ID number, which providers must have in order to be able to submit Medicaid billings.

## Accessing Information about Medicaid Health Plans

There are approximately 11 MHPs operating in Michigan at any given time. A list of MHPs by county, MHP contact info, MHP enrollment data, and a sample standardized MHP contract are available at: [Medicaid Health Plans State of Michigan](#). Contact information may also be accessed at the MIHP website.

## MIHP Providers, Medicaid Health Plans, and Medical Care Providers: Partners in Providing Coordinated Care for MIHP Beneficiaries

The MIHP provider, Medicaid Health Plan (MHP), and medical care provider are active partners in assuring that MIHP beneficiaries are systematically identified and provided with quality, coordinated care.



## MIHP and MHP Care Coordination Agreement

To ensure that coordination takes place between the MIHP provider and the MHP, MDHHS requires both parties to sign an *MIHP and MHP Care Coordination Agreement (CCA)*. MIHP providers must have a signed CCA with every MHP in their service area. The CCA, titled *Sample 3 (Sample of Care Coordination Agreement)*, is available in the [Medicaid Provider Manual](#) in the *Forms Appendix* and at the MIHP web site.

The CCA defines the relationship, responsibilities, and communication expectations between a particular MIHP provider and a particular MHP serving the same geographic area. It includes language stating: the MHP and MIHP provider will coordinate transportation for mutually-served beneficiaries, as both are required to arrange health-related transportation for beneficiaries; the MHP and MIHP provider will exchange appropriate information about mutually-served beneficiaries; and that the MHP shall provide a referral for MIHP services for those pregnant MA beneficiaries who are not currently receiving MIHP services. There is an unwritten expectation that the MHP will refer infant beneficiaries to MIHP, as well. Although the CCA seems to imply that the MIHP signing it will receive referrals from the MHP, this may or may not be true. The MHP is not required to send referrals to every MIHP serving the same geographic area. The MHP can choose to refer only to the MIHPs that they believe provide the highest quality service.

However, the MIHP must always notify the MHP when they enroll one of the MHP members, even if the MHP does not make referrals to the MIHP. It is expected that the MIHP will notify each MHP at least monthly regarding MHP members who have been enrolled in the MIHP during the previous month, using the *MIHP-MHP Collaboration Form* at the MIHP web site, or another mutually agreed-upon form. It is recommended that the MIHP also notify the MHP that a member has been discharged, but this is not required.

Each MHP has a person who is designated as the contact person for MIHP. The MIHP provider and designated MHP contact person are encouraged to meet together to develop a working relationship, learn about the services and incentives each provides, and discuss the provisions in the CCA. The MIHP provider and the MHP may not delete language from the CCA template, but they may add language, if both are agreeable.

It may take time for new MIHP providers to get CCAs from each MHP in their service area. You can serve an MHP member if you do not yet have a CCA with the member's MHP. Contact your consultant if you have any questions about obtaining a CCA or need assistance in obtaining a CCA from a particular MHP. If you are missing one or more CCAs at the time of your certification review, the reviewer will ask you for documentation from your consultant stating the consultant was notified that you have made repeated efforts to obtain the missing CCAs.

You do not need a signed *Consent to Release PHI* in order to share information with the beneficiary's Medicaid Health Plan. MDHHS legal counsel has determined that your communications with the MHP are covered under the HIPAA exemption for payment, treatment and operations. MHPs have the right to see the beneficiary's entire MIHP record.

## **MI Health Link Integrated Care Organizations**

MI Health Link is a joint Medicare and Medicaid demonstration designed to integrate care for individuals in Michigan who have both Medicare and Medicaid. Beneficiaries participating in MI Health Link will receive both Medicare and Medicaid coverage, including Part D prescription drugs, through new managed care entities called **Integrated Care Organizations (ICOs)**. ICOs will partner with existing Pre-paid Inpatient Health Plans (PIHPs) to serve individuals who receive Medicare and Medicaid-funded behavioral health services.

Most persons under the age of 65 must receive Social Security Disability benefits for 24 months in order to qualify for Medicare. This means that they have disabling physical and/or mental health impairments. Persons who have Medicare and Medicaid coverage require a high level of care coordination.

MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care, all in a single program designated to meet individual needs. ICOs will give providers information and resources to support care coordination through timely communication across care team members and through the use of an interoperable electronic platform called the Care Bridge.

- *Assessments*: ICOs will conduct an initial assessment to identify enrollees' needs and make referrals to specialized service providers.
- *Integrated Care Teams (ICTs)*: An ICT, led by the ICO Care Coordinator, will be offered to the enrollee. The team will help manage and coordinate care by participating in the person-center planning process. Membership will include the enrollee and the enrollee's chosen allies, primary care physician and, as applicable, LTSS Supports Coordinator and PIHP Supports Coordinator. The enrollee and team may also include other providers who are needed.
- *Integrated Individualized Care and Supports Plan (IICSP)*: Through the assessment and the person-centered planning process, the IICSP will be developed with the enrollees and the ICT to identify the supports and services that will best help enrollees meet their needs and care goals. ICT members will provide timely access to care and services identified in the plan and communicate plan facilitation through the Care Bridge.
- *ICO Care Coordinators*: Each enrollee will have Care Coordinators to facilitate communication among the enrollee's providers, including physicians, long term supports and services providers and behavioral health providers. They will also help connect enrollees to other community-based social services to help them live as independently as possible.

In general, individuals who meet all of the following criteria will be eligible to enroll in an ICO:

1. Reside in the counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne, or any county in the Upper Peninsula
2. Are age 21 or older
3. Have full Medicare and full Medicaid benefits
4. Are not enrolled in hospice

There are approximately 31,000 dual-eligible women of child-bearing age in Michigan, each of whom is potentially eligible for MIHP, should she become pregnant or have an infant. On occasion, MIHP may serve a woman who has both Medicare and Medicaid coverage. MIHP agencies need to contract with a beneficiary's ICO in order to be reimbursed for MIHP services.

MI Health Link is jointly administered by the federal Centers for Medicare & Medicaid Services (CMS) and the Michigan Department of Health and Human Services (MDHHS), the Michigan State Medicaid Agency. For additional information: [http://www.michigan.gov/mdch/0,4612,7-132-2945\\_64077---,00.html](http://www.michigan.gov/mdch/0,4612,7-132-2945_64077---,00.html) or see Bulletin MSA 14-57, distribution date December 29, 2014, at [http://www.michigan.gov/documents/mdch/MSA\\_14-57\\_477754\\_7.pdf](http://www.michigan.gov/documents/mdch/MSA_14-57_477754_7.pdf).

## **MIHP Communications with the Medical Care Provider**

An MIHP provider must obtain a signed *MIHP Consent to Release Protected Health Information* from the beneficiary or the beneficiary's caregiver in order to release information to the medical care provider. If your agency is both the medical care provider and the MIHP for a given beneficiary, you still need to obtain a signed *MIHP Consent to Release Protected Health Information*.

If the beneficiary is an infant, you must have the mother's consent to share Maternal Considerations with the infant's medical care provider. Her consent would be documented on the infant's *MIHP Consent to Release Protected Health Information*.

If consent is obtained, MDHHS requires the MIHP provider to share specified beneficiary information with the medical care provider, to use standardized forms to communicate this information, and to meet specified timeframes in communicating this information.

The MIHP provider uses standardized forms to share beneficiary information at enrollment, whenever there's a significant change in status, and at service closure. The forms provide space for the medical care provider to identify issues that he or she would like the MIHP provider to address with the beneficiary. At the request of the medical care provider and with the consent of the beneficiary, the MIHP provider forwards a copy of the beneficiary's *Plan of Care*, which identifies all of the MIHP interventions being implemented by the MIHP team.

## When Beneficiary Changes Medical Care Providers

When a beneficiary or caregiver informs you that she or her infant has a new medical care provider, ask her to update her *MIHP Consent to Release Protected Health Information* by adding the new medical care provider's name and initialing and dating it. After you have obtained her authorization, send the new provider a copy of the initial *Prenatal or Infant Care Communication* form with a note explaining that it was originally sent to a previous medical care provider when the beneficiary first enrolled in MIHP. Send subsequent medical care provider communications to the new provider.

## Obtaining Medical Care Provider Authorization for MIHP Services

**MIHP providers must have authorization from a medical care provider in order to:**

1. Provide the services of a registered dietitian
2. Provide an additional 9 infant visits after the initial 9 visits are completed
3. Provide an additional 18 infant visits after the first 18 visits are completed when the beneficiary is a substance-exposed infant

The MIHP may have access to a medical care provider who will issue a standing order covering one or more of these situations. A template titled *Key Elements of a MIHP Standing Order*, which covers all three situations, is at the MIHP web site. A copy of the standing order must be placed in the beneficiary's chart. Standing orders must be reviewed and signed by the medical care provider annually.

If the MIHP does not have access to a medical care provider who will issue a standing order, the MIHP must obtain the authorization from the beneficiary's medical care provider, as needed. The order can be verbal or written.

## Verbal Orders if There Is an Urgent Concern

Verbal orders should only be utilized if there is an urgent concern that requires the beneficiary to be seen that same day. In all other cases, the medical care provider should send a written order in response to the MIHP authorization request.

**A verbal order may only be taken by the SW or RN. The process is as follows:**

1. The RN or SW calls the medical care provider, explains the situation, and requests the verbal order.
2. The medical care provider verbally issues the order over the phone.
3. The RN or SW documents why the extra visits are needed and what the medical care provider stated on the phone on a *Professional Visit Progress Note* or *Contact Log* and faxes it to the medical care provider that same day, requesting the signed order be returned within 24 hours. If the medical care provider does not return the signed order within 24 hours, the RN or SW follows up with the medical provider at least weekly, until the signed order is received. Each follow-up contact must be documented in the chart.
4. If the written order is not received from the medical care provider, the agency cannot bill for the professional visit.

The requirement that verbal orders be documented as described above will be enforced when the *Cycle 6 MIHP Certification Tool* goes into effect.

Specific guidelines for coordinating services with MHPs and medical care providers are provided in *Chapter 8 – MIHP Service Delivery*.

## 4.0 BASIC DESCRIPTION OF MIHP SERVICES

### Types of MIHP Services

MIHP provides care coordination and education services for maternal/infant dyads. Care coordination services are provided by a registered nurse or a licensed social worker. Education services are provided by a registered nurse, a licensed social worker, a registered dietitian, or an infant mental health specialist. MIHP staff providing these services use a supportive approach based on Motivational Interviewing principles.

### MIHP Care Coordination Services

Care coordination services include:

1. Administration of *Risk Identifier* and completion of *Plan of Care, Part 1* (RN or SW; must be signed by both)
2. Development of *Plan of Care, Parts 2 – 3* (RN and SW; must be signed by both)
3. Implementation of *Plan of Care, Part 2* (two or more of the four disciplines)
4. Documentation of visits (two or more of the four disciplines)
5. Monitoring implementation of *Plan of Care, Part 2* (Care Coordinator: RN or SW)
6. Coordination with Medicaid Health Plans (Care Coordinator: RN or SW)
7. Coordination with Medical Care Provider (Care Coordinator: RN or SW)
8. Conclusion of MIHP services (any one of the four disciplines; only the RN or SW can do the *Discharge Summary*.)

The registered nurse or the licensed social worker is designated as the care coordinator for each beneficiary. The registered dietitian and the infant mental health specialist cannot function as the care coordinator.

The care coordinator is responsible for coordinating and monitoring all services provided to the beneficiary, including referrals and follow-up. It is the role of the care coordinator to advocate for the beneficiary when necessary and ensure that she is involved in her own care plan development and service arrangements to the greatest possible extent. It is the ultimate objective of the provider to empower the beneficiary to successfully navigate the health care system. Detailed information about MIHP care coordination services is provided in *Chapter 8 – MIHP Service Delivery*.

### MIHP Education Services

In addition to coordinating the beneficiary's care, the MIHP provider delivers or arranges for the delivery of a variety of education services. Education services are provided as part of the implementation of the *Plan of Care, Parts 1 – 2*. MIHP-reimbursable education activities are described in the grid below:

Education Services Category & Discipline	MIHP-Reimbursable Activities
<b>Health Education</b> Registered Nurse or Licensed Social Worker	Communication of information to improve knowledge of maternal and infant health and to foster the motivation, skills and confidence (self-efficacy) necessary for beneficiaries to take action to improve individual risk factors and risk behaviors, and to navigate the health care system.  Covers: •One-on-one/dyad visits
<b>Nutrition Education</b> Registered Nurse or Licensed Social	Communication of basic, general information about nutrition during pregnancy and infancy for beneficiaries who do not have significant nutrition risks or health concerns that are affected by or related to their diet.

<p>Worker or Registered Dietitian (requires physician order)</p>	<p>Covers:</p> <ul style="list-style-type: none"> <li>•One-on-one/dyad visits only</li> </ul>
<p><b>Social Work</b> Licensed Social Worker or Registered Nurse</p>	<p>Provision of psychosocial support, problem-solving assistance, and facilitation of referrals for beneficiaries with risks in the mental health, alcohol abuse, substance abuse, or domestic violence domains. Does NOT include clinical social work practice (i.e., assessment, diagnosis and psychotherapy). Also includes assisting any beneficiary with basic needs.</p> <p>Covers:</p> <ul style="list-style-type: none"> <li>•One-on-one/dyad visits only</li> </ul>
<p><b>Nutrition Counseling</b> Registered Dietitian</p> <p>(NOTE: Requires medical care provider order.)</p>	<p>Provision of medically-necessary, individualized nutrition counseling for health problems that are affected by or related to diet (e.g., inadequate maternal weight gain, nausea/vomiting, expecting multiple births, eating disorder, fetal growth restriction, hypertension, unhealthy pre-pregnancy weight (over or under), gestational diabetes; pica, etc.; premature infant, infant with eating difficulties, poor infant weight gain/not following growth curve, etc.)</p> <p>Covers:</p> <ul style="list-style-type: none"> <li>•One-on-one/dyad visits only</li> </ul>
<p><b>Infant Mental Health (IMH) Services</b> IMH Specialist</p>	<p>Provision of home-based, parent-infant intervention where the parent's condition and life circumstances or characteristics of the infant threaten parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. The IMH specialist may:</p> <ol style="list-style-type: none"> <li>1. Assess need for infant mental health services, using recommended objective tools that measure: infant social-emotional development (Ages and Stages Questionnaires: Social/Emotional, Devereux Infant-Toddler Assessment); parent-infant attachment (Massie/Campbell Scale of Mother Infant Attachment during Stress); and parental depression (Edinburgh Postnatal Depression Scale).</li> <li>2. If assessed need is low-moderate, provide brief, direct parent-infant intervention and/or referral to other parenting support program.</li> <li>3. If assessed need is high, encourage beneficiary to accept referral to Community Mental Health Services Program (CMHSP) or other mental health provider for clinical infant mental health services; facilitate referral; support beneficiary to follow through with treatment. If beneficiary refuses referral, provide support with goal of getting her to accept treatment, and provide brief, direct parent-infant intervention.</li> </ol> <p>Covers:</p> <ul style="list-style-type: none"> <li>•One-on-one/dyad visits only</li> </ul>
<p><b>Childbirth Education Group Classes (CBE)</b></p>	<p>Provision of group classes to prepare first-time mothers for the experience of childbirth, using a curriculum covering topics specified by Medicaid. Topics include, but are not limited to, the following: pregnancy; labor and delivery; infant care and feeding; postpartum care; and family planning. The curriculum is relevant for all first-time mothers, regardless of risk level in any particular MIHP domain. (See <i>Medicaid Provider Manual Chapter, MIHP, Section Childbirth Education</i>).</p>

<b>Parenting Education Group Classes (PE)</b>	Provision of group classes to develop positive parenting skills and attitudes and facilitate interaction among parents, using a curriculum covering topics specified by Medicaid. Topics include, but are not limited to the following: feeding; elimination; illness; injuries; patterns of sleep, rest, activity and crying; hygiene; developmental milestones; emotional needs; toxic and/or hazardous waste; immunizations; and day-to-day living with children. The curriculum is relevant for all parents, regardless of risk level in any particular MIHP domain. (See <i>Medicaid Provider Manual Chapter, MIHP, Section Parenting Education</i> ).
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All MIHP professionals must function within their scope of practice.

## Staffing

### Required and Optional Staff

The MIHP provider is required to provide the services of a registered nurse and a licensed social worker. At least one of these two required disciplines must work for the provider, but the other discipline may be contracted through another agency.

The provider is not required to provide the services of a registered dietitian or infant mental health specialist. However, MIHP beneficiaries must have access to the services of all four disciplines, as needed.

The provider may choose to directly provide nutrition counseling and infant mental health services (i.e., have a registered dietitian and infant mental health specialist on staff), to contract with an individual or another agency for these services, or to refer beneficiaries to other local agencies that offer these services. If the MIHP provider opts to directly provide nutritional counseling and infant mental health services, the provider may hire or contract with qualified professionals and bill Medicaid for these services.

If the MIHP provider chooses not to provide nutrition counseling services directly, they must refer a beneficiary who needs an RD to another provider (e.g., WIC, MHP, local hospital, local health department, or community health center) that has the capacity to provide high-risk nutrition counseling services. If the MIHP provider chooses not to provide infant mental health services directly, they must refer a beneficiary who needs an IMHS to another provider (e.g., Community Mental Health or other infant mental health provider).

### Both Required Disciplines Must Regularly Conduct Visits

Both required disciplines must regularly conduct professional visits. The MIHP professionals with the most relevant expertise should provide the services for a particular beneficiary, based on her unique needs and goals. This means that relatively few beneficiaries will require the involvement of just one discipline, while most beneficiaries will require the involvement of two to four disciplines. MIHP interventions are detailed in *Chapter 8 – MIHP Service Delivery*.

### Minimum Staffing Requirement

At a minimum, the MIHP staff must include the MIHP Coordinator, one registered nurse (RN), and one licensed social worker (LLBSW, LLMSW, LBSW, or LMSW). The coordinator may also serve as an RN, SW, RD, or IMHS.

Staffing must be sufficient to meet the needs of beneficiaries. New providers must have proof that they have at least one registered nurse and one licensed social worker on staff before they can begin to provide MIHP services.

## Back-up Staffing Plan

Providers must have back-up staffing plans in place in case they become void of one of the required disciplines for either one of the following reasons:

1. RN or SW takes a planned leave of two to six weeks duration (e.g., vacation, maternity leave, etc.) and intends to return to work. In this situation, the agency must have a back-up plan for a beneficiary to access the services of the missing discipline in an emergency situation.
2. RN or SW leaves the agency and the agency needs to hire a replacement. Providers must notify their consultant within 5 business days via email whenever they do not have at least one nurse and one social worker on staff for more than six consecutive weeks. The consultant will reply in writing. This documentation from the consultant must be shown to the reviewer at the certification review.

If the MIHP is totally void of one of the required disciplines due to a staff vacancy, it must be for a period of less than 3 months and the provider's back-up staffing plan must be implemented throughout the entire hiring process. If the vacant position is not filled within 3 months, no back-up staffing plan has been implemented, and ongoing communication with the consultant is not being maintained, the MIHP may be decertified.

The back-up plan must be implemented on the date that the RN or SW leaves the agency. The length of time that an MIHP agency may operate with "back-up" staff will be at the discretion of MDHHS. Ongoing contact must be maintained with your consultant during this period.

The back-up staffing plan must specifically indicate how the agency will assure that beneficiaries will have access to critical services when the agency is temporarily void of one of the disciplines. Back-up staffing generally is done in the following ways:

- a. The agency identifies an RN or SW who agrees to provide MIHP services during the course of the hiring process. This individual completes MIHP new employee training, presents proof of licensure, signs a confidentiality agreement, and is listed on the *MIHP Personnel Roster*. The MIHP may bill for MIHP services provided by this individual.
- b. The agency makes an agreement with another MIHP that will "lend" an RN or SW to the first agency, if needed.
- c. In rare, extenuating circumstances, options other than "a" and "b" above may be approved at the discretion of MDHHS. Contact your consultant to discuss alternative options.

## Nutrition Education and Nutrition Counseling

It is important to distinguish between nutrition education and nutrition counseling:

**Nutrition education** is the communication of basic, general information about nutrition during pregnancy and infancy for beneficiaries who do not have significant nutrition risks or health concerns that are affected by diet. This includes beneficiaries who score low risk on the *Risk Identifier* maternal nutrition domain. Nutrition education may be provided by the registered nurse, licensed social worker, or registered dietitian.

**Nutrition counseling** is the provision of medically-necessary, individualized counseling for health problems that are affected by or related to diet (e.g., maternal gestational diabetes, obesity, anorexia, bulimia, lactose intolerance, etc.; infant digestive disorders, inappropriate weight gain, failure-to-thrive, etc.). Nutrition counseling may be provided only by a registered dietitian.

When a high maternal nutrition risk or a high infant feeding and nutrition risk is identified, nutrition counseling services must be provided by an RD or there must be documentation that a referral was offered or made, as documented on a *Professional Visit Progress Note*.

The MIHP must provide nutrition counseling or make the necessary arrangements for nutrition counseling. Nutrition counseling may be available through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the beneficiary's MHP, or a local hospital, health department, or community health center, etc.

The record must clearly identify the entity that is providing nutrition counseling services. If the provider opts to refer beneficiaries to other agencies that offer these services, the MIHP provider cannot bill for services provided by these other agencies.

## **Obtaining a Medical Care Provider Order for RD Services**

Because dietitians are not licensed in Michigan, a medical care provider's order must be obtained before an RD can provide services to a MIHP beneficiary, as specified below:

The MIHP provider may have access to a medical care provider who will issue a standing order covering all MIHP beneficiaries needing the services of a registered dietitian (RD) because of health problems that are affected by diet (e.g., maternal gestational diabetes, obesity, anorexia, bulimia, lactose intolerance, etc.; infant digestive disorders, inappropriate weight gain, failure-to-thrive, etc.). The standing order can state that it applies to any MIHP beneficiary who has nutrition needs requiring the services of an RD. If a beneficiary is seen by an RD pursuant to a standing order, a copy of the standing order must be placed in the beneficiary's case record. Standing orders must be reviewed and reauthorized annually.

If the MIHP provider does not have access to a medical care provider who will issue a standing order, the provider must obtain an order from the beneficiary's medical care provider (e.g., physician, physician assistant, midwife, etc.) before arranging for nutrition counseling services by an RD.

Additional information on obtaining medical care provider authorization for MIHP services is provided in *Chapter 3 – MIHP Goal and Primary Partners*.

With a medical care provider order, the RD may visit a beneficiary, even if a nutritional risk was not identified through the *Maternal or Infant Risk Identifier*. In this case, the RD would document the need for the visit (e.g., beneficiary requests nutrition education or counseling). Any visit by an RD with a medical care provider order in place and a nutritional need identified, although possibly a minor need, is billable and payable. While in the home addressing nutritional needs, the RD may touch on other domains (e.g., family planning).

In order to bill for a visit made by the RD, the agency must:

1. Have a medical care provider's order for an RD visit.
2. List the RD on the *MIHP Personnel Roster*.
3. Have a completed *Risk Identifier* and signed *Plan of Care*.
4. Have the RD document the visit in the beneficiary's chart on a *Professional Visit Progress Note*.

## **Infant Mental Health Services**

Infant mental health services may be needed for purposes of implementing a beneficiary's *Plan of Care*. Infant mental health services are available through Community Mental Health Services Programs (CMHSPs) for families who need intensive parent-infant intervention. In the CMHSP system, these services are referred to as Medicaid home-based services for infants and toddlers.

However, some beneficiaries who need infant mental health services may not meet CMHSP criteria for intensive home-based services. If infant mental health services are not available through other agencies in the local area, the MIHP provider is encouraged to explore the feasibility of hiring an infant mental health specialist. Infant mental health specialists must meet the qualifications specified in the *Medicaid Policy Manual*, including licensure by the State of Michigan and endorsement by the Michigan Association for Infant Mental Health. We encourage you to explore hiring an IMH specialist.

It is perfectly acceptable for a beneficiary to receive MIHP services and infant mental health services concurrently. Infant mental health services can continue after the infant ages out of MIHP.

## **MIHP Coordinator Role and Qualifications**

The MIHP Coordinator is responsible for oversight of all aspects of the program. The following is a position description for the MIHP Coordinator which was developed with the assistance of MIHP providers across the state:

### **Role of MIHP Coordinator:**

To implement the Maternal Infant Health Program in compliance with Medicaid requirements and fidelity to the model, in order to provide high-quality home visiting services that promote healthy pregnancies, positive birth outcomes, and infant health and development.

### ***Duties and Responsibilities***

1. Write, update, and enforce internal policies and protocols that comply with Medicaid requirements.
2. Coordinate the program: develop and/or monitor contracts, produce reports, manage crisis situations.
3. Oversee professional billing process and coordinate with internal billing department.
4. Provide and coordinate professional development activities for staff, including orientation and training.
5. Supervise staff.
6. Facilitate case consultation across disciplines.
7. Monitor and coordinate staff workloads.
8. Develop and maintain updated list of community resources for use by staff and beneficiaries.
9. Conduct and coordinate program outreach and marketing activities.
10. Communicate and collaborate with other community agencies, including other MIHPs; represent MIHP on local/regional coalitions and governing bodies.
11. Communicate with Medicaid Health Plans and medical care providers.
12. Oversee and monitor referral, intake and follow-up.
13. Prepare for certification reviews and submit Corrective Action Plans, as required.
14. Implement continuous quality improvement; conduct chart reviews (to assure every record is complete), productivity analyses, consumer satisfaction analyses, and MDHHS data reports; implement quality improvement strategies based on the findings.
15. May provide direct services; conduct home visits, carry a caseload.
16. Ensure entry of MIHP data into the MDHHS database.
17. Review and interpret reports; share with staff and partners, as appropriate.
18. Ensure that beneficiaries are being appropriately served.

### ***Qualifications***

Bachelor's degree preferred.

### ***Experience***

Experience coordinating a health or human services related program or project.

### **Skills and Knowledge**

- Ability to implement a program in compliance with required policies and procedures
- Quality improvement process skills
- Leadership and supervision skills
- Ability to organize and coordinate the work of others
- Communication and interpersonal skills
- Training skills
- Computer skills
- Ability to problem-solve
- Ability to follow through and follow up
- Ability to multi-task
- Detail-oriented
- Flexible

### **Professional Staff Qualifications**

Qualifications for the MIHP RN, SW, RD and IMHS are specified in Medicaid policy. A professional who meets the qualification requirements for more than one MIHP discipline (e.g., social work and infant mental health) may provide both services for MIHP beneficiaries. However, only one billable visit is allowed per beneficiary per day.

### **Licensure and Verification**

It is the responsibility of the MIHP provider to maintain proof of current registration or licensure for all professionals providing services on behalf of the agency. Professional staff must have one of the following registrations or licenses in order to provide MIHP services:

RN	Registered Nurse
LLBSW	Limited Licensed Bachelor's Social Worker
LLMSW	Limited Licensed Master's Social Worker
LBSW	Licensed Bachelor's Social Worker
LMSW	Licensed Master's Social Worker

Michigan professional licenses may be verified by the Department of Licensing and Regulatory Affairs (LARA) at [www.michigan.gov/lara](http://www.michigan.gov/lara). Click on "Verify a License" in the "Quick Links" column on the right. There should be a copy of the current license, a copy of the license or registration verification, and a copy of the resume or degree or transcript in the personnel file of every MIHP professional on staff. All three of these documents will be required in Cycle 6.

The MIHP Coordinator must carefully track the license expiration dates for all professional staff. A professional with an expired license must not conduct any MIHP visits as of the date of expiration. Per Medicaid policy, services provided by a professional with an expired license will not be reimbursed.

### **MIHP Personnel Roster**

Providers must assure that professional staff are qualified to provide MIHP services. Providers must use the *MIHP Agency Personnel Roster* to document specific information about the qualifications of each person on the MIHP staff, including everyone who is authorized to use the State of Michigan Single Sign-On (SSO) System for purposes of entering data into the MDHHS database.

The *Personnel Roster* must be updated and submitted to MDHHS (even if there are no updates) within 30 days after the end of every quarter (quarters end on Dec. 31, March 31, June 30, and Sept. 30).

## MIHP Personnel Roster Due Dates

Quarter	Personnel Roster Due Date
1 <sup>st</sup> Quarter: October 1 - December 31	January 30
2 <sup>nd</sup> Quarter: January 1 – March 31	April 30
3 <sup>rd</sup> Quarter: April 1 – June 30	July 30
4 <sup>th</sup> Quarter: July 1 – September 30	October 30

### Staffing Waiver Requests

At times, a provider may be unable to find a fully qualified professional to fill a particular position. In this case, the provider can request that certain personnel requirements be waived. Education and licensing/registration requirements cannot be waived, but requirements for having a specified amount of maternal and child health experience could possibly be waived, depending on the situation.

A provider who is unable to find a staff person who fully meets staffing requirements must submit a waiver application in writing to MDHHS, explaining why a waiver is being requested and stating that the provider will assure that the appropriate in-service training will be provided for the individual in question. MDHHS examines the validity of each waiver request and approves or disapproves accordingly within three business days of receipt of an accurate and complete request.

Providers who wish to submit a waiver application should go to the MIHP web site at [www.michigan.gov/mihp](http://www.michigan.gov/mihp) and click “Providers” and then “Current MIHP Providers” to obtain the following documents:

1. Professional Staff Waiver Application Instructions
2. Required Training for New and Waiver Professional Staff
3. Professional Staff Waiver Training Matrix
4. Topics Relevant to MIHP Practice
5. Social Determinants and Contributing Factors for Infant Mortality
6. Health Disparities and Social Justice List of Definitions
7. Notice of New Professional Staff Training Completion
8. Notice of Waiver Completion

The waiver application must be approved by MDHHS prior to MIHP employment. Waiver staff must complete professional development activities beyond those required for all new staff, including a minimum of six beneficiary visits conducted jointly with experienced MIHP staff. Waiver staff must be mentored by someone who practices the same discipline. In other words, a nurse must be mentored by another nurse and a social worker must be mentored by another social worker.

Waiver staff training must be completed within six months of the date that an individual begins employment as an MIHP professional staff. Visits provided by an unqualified staff who has not obtained a waiver are not billable.

### Staff Supervision

MDHHS strongly encourages MIHP agencies to provide reflective supervision for MIHP professional staff. The Michigan Association for Infant Mental Health has developed *Best Practice Guidelines for Reflective Supervision/Consultation*. These guidelines, which distinguish between administrative, clinical and reflective supervision, are excerpted below. Additional information on reflective supervision may be found at [www.mi-aimh.org](http://www.mi-aimh.org).

## **Best Practice for Reflective Supervision/Consultation Guidelines**

The intent of these guidelines is to emphasize the importance of reflective supervision and consultation for best practice and to better assure that those providing reflective supervision and consultation are appropriately trained.

### Distinguishing Between Administrative Supervision, Clinical Supervision and Reflective Supervision/Consultation

Supervisors of infant and family programs are generally required to provide administrative and/or clinical supervision, while reflective supervision may be optional. Put another way, reflective supervision/consultation often includes administrative elements and is always clinical, while administrative supervision is generally not reflective and clinical supervision is not always reflective.

Administrative supervision relates to the oversight of federal, state and agency regulations, program policies, rules and procedures. Supervision that is primarily administrative will involve the following objectives:

- Hire
- Train/educate
- Oversee paperwork
- Write reports
- Explain rules and policies
- Coordinate
- Monitor productivity
- Evaluate

Clinical supervision/consultation, while case-focused, does not necessarily consider what the practitioner brings to the intervention nor does it necessarily encourage the exploration of emotion as it relates to work with an infant/toddler and family. Supervision or consultation that is primarily clinical will most likely include many or all of the administrative content that are listed above, as well as the following:

- Review casework
- Discuss the diagnostic impressions and diagnosis
- Discuss intervention strategies related to the intervention
- Review the intervention or treatment plan
- Review and evaluate clinical progress
- Give guidance/advice
- Teach

Reflective supervision/consultation goes beyond clinical supervision to shared exploration of the parallel process, i.e., attention to all of the relationships, including that between practitioner and parent, between parent and infant/toddler, and between practitioner and supervisor. It is critical to understand how each of these relationships affects the others. Of additional importance, by attending to the emotional content of the work and how reactions to the content affect the work, reflective supervision/consultation relates to professional and personal development within one's discipline. Finally, there is often greater emphasis on the supervisor/consultant's ability to listen and wait, allowing the supervisee to discover solutions, concepts and perceptions on his/her own without interruption from the supervisor/consultant. The components of reflective supervision/consultation include:

- Form a trusting relationship between supervisor and practitioner
- Establish consistent and predictable meetings and times
- Ask questions that encourage details about the infant, parent and emerging relationship

- Listen
- Remain emotionally present
- Teach/guide
- Nurture/support
- Integrate emotion and reason
- Foster the reflective process to be internalized by the supervisee
- Explore the parallel process and allow time for personal reflection
- Attend to how reactions to the content affect the reflective process

## Sex-Offender Registry Check

The MIHP provider may wish to check the Michigan State Police Sex-Offender Registry before making an offer of employment to an individual who will work directly with MIHP beneficiaries. The registry is available at <http://www.mipsor.state.mi.us>. The provider may also wish to do a criminal history check using the Michigan Department of State Police's internet criminal history access tool (ICHAT) at <http://apps.michigan.gov/ICHAT/Home.aspx>.

## Required Identification Badges for MIHP Direct Service Staff

MIHP staff persons who work directly with beneficiaries in their homes or at other community locations must carry identification (ID) cards or badges with them at all times. This is to assure beneficiaries that staff are legitimately affiliated with the MIHP. An ID card or badge should include a picture of the staff person, the staff person's name, the program name, the phrase "Maternal Infant Health Program (MIHP)" if it is not included in the program name, and the name of the agency. The ID card or badge must be presented when meeting a beneficiary for the first time and whenever a beneficiary asks to see it. It is not sufficient to use a business card as a badge.

## Eligibility and Duration of MIHP Services for the Mother-Infant Dyad

MIHP is intended for beneficiaries enrolled in the following Medicaid programs:

- Healthy Kids for Pregnant Women and Children
- Group 2 Pregnant Women Program
- The Healthy Michigan Plan
- Maternal Outpatient Medical Services (MOMS)

Pregnant beneficiaries enrolled in the programs listed above are automatically eligible for MIHP. Medicaid enrolled beneficiaries may decline to participate in the MIHP. To facilitate pregnancy related services, the pregnancy must be reported to the MDHHS caseworker as soon as possible.

## Maternal MIHP Eligibility

Under the Healthy Kids for Pregnant Women program, a woman is eligible for Medicaid throughout her pregnancy, the month her pregnancy ends, and for two calendar months following the month her pregnancy ends (*Bridges Eligibility Manual, Michigan MDHHS*). For example, if she gives birth on any day in September, she remains eligible through November. Once the beneficiary delivers her baby, she should be encouraged to see her medical care provider for her postpartum visit while her Medicaid coverage is still in effect.

If the local Michigan Department of Health and Human Services (MDHHS) office terminates Medicaid coverage for the pregnant woman earlier than two full months after the birth month, contact her MMDHHS worker to determine the reason. If the reason does not appear to be in keeping with Medicaid policy, contact your consultant.

The spend-down requirement for Medicaid beneficiaries in the Group 2 Pregnant Women Program (spend-down waived for pregnant women) is typically met after the first prenatal visit. If there are questions regarding spend-down requirements, the beneficiary is advised to consult her MDHHS caseworker.

A woman may not be pregnant at the time of application to the Healthy Michigan Plan. If she applies while pregnant, she will be referred to Healthy Kids for Pregnant Women. However, if she becomes pregnant while enrolled in the Healthy Michigan Plan, she may choose to remain in the Plan or switch to Healthy Kids for Pregnant Women during her pregnancy.

## **MOMS Beneficiaries Eligible for Prenatal MIHP Services Only**

Women in the MOMS program are eligible for MIHP, but only during the prenatal period. MIHP providers will not receive reimbursement for postpartum visits to women in the MOMS program. Postpartum care provided in the MOMS program is limited to medically necessary ambulatory services.

## **Infant MIHP Eligibility and Age Limit**

Although MIHP serves the mother-infant dyad, a distinction is made between maternal and infant services for billing purposes. After the infant is born, the provider must observe the infant during every visit with the primary caregiver.

Infants are eligible for MIHP from birth to 12 months of age, as long as they are covered by Medicaid. Infants who are covered by MICHild insurance do not qualify for MIHP. If a teenager with MICHild insurance becomes pregnant, she must apply for Healthy Kids for Pregnant Women Medicaid or Maternal Outpatient Medical Services (MOMS) in order to be eligible for MIHP services.

MIHP was specifically designed to serve infants from birth to 12 months of age. The *Infant Risk Identifier* and infant interventions are not designed to meet the developmental needs of toddlers. An infant who is 12 months of age or older should not be enrolled in MIHP.

When an infant being served by MIHP reaches 12 months of age, you should attempt to find a more age-appropriate program for the infant. If the infant reaches the age of 18 months and continues to be served by your MIHP, you are required to submit a written request to your consultant so that consideration may be given to allow you to continue serving the beneficiary. This documentation, including the written approval from your consultant, must be maintained in the beneficiary record.

If there are two or more infants in the home and each has different parents, all of the infants may be enrolled in MIHP.

## **MIHP Enrollment Period**

Ideally, MIHP serves the mother-infant dyad from early in the pregnancy, through the postpartum period, and throughout infancy, to the extent of maximizing authorized visits to meet *Plan of Care* objectives. However, a Medicaid-eligible pregnant woman may enroll in MIHP at any point during her pregnancy and a Medicaid-eligible infant may be enrolled in MIHP at any point during infancy up to 12 months of age.

MIHP services may be provided for a woman with a positive home pregnancy test before her pregnancy has been confirmed by a doctor. However, the provider should help her access a medical care provider for confirmation of the pregnancy as soon as possible.

## Primary Caregiver Definition

Most often, the primary caregiver of an infant enrolled in MIHP is the infant's mother. However, if the mother is not functioning as the primary caregiver, the MIHP provider may visit with another individual who is serving in that capacity, such as the father, grandmother, aunt, other relative, or foster parent.

Primary caregiver is defined as the parent or non-parent who has the greatest responsibility for the daily care of the infant. If the primary caregiver has a job or attends school, the provider must accommodate her schedule, rather than conduct home visits with another person who provides child care while the mother is at work or school.

In some situations, the mother or parent may designate someone else as primary caregiver. For example, in a three-generation migrant farmworker family where the grandmother cares for the baby 15 hours per day while the mother is working, you would ask the mother to identify the primary caregiver at the time of the *Risk Identifier* visit. If the mother says that the grandmother is the primary caregiver, the *Risk Identifier* is still done with the mother, but infant visits are conducted with the grandmother.

## Infant in Foster Care

If an infant who was previously open to MIHP while living with his biological mother is placed in foster care and the foster parent wants MIHP services to continue, it is acceptable to serve the infant and foster parent. In this case, you obtain signed consents (to participate in MIHP and to release PHI) from the foster parent and continue to implement the infant's *POC 2*. If a new issue is identified with the infant, add the appropriate domain to the *POC 2*. If a Maternal Consideration surfaces with the foster parent, add the appropriate domain to the *POC 2*.

If an infant is in foster care at the time of MIHP enrollment, administer the *Infant Risk Identifier* with the foster parent.

Do not disclose information on the infant's biological family to the foster parents and if the infant returns home, do not disclose information on the foster family to the biological family. The MDHHS child welfare worker is the person responsible for sharing information about the two families.

If the infant is still in foster care at the time of discharge, indicate the intervention numbers that were achieved with both the mother and the foster family on the *Discharge Summary*. Note in the comments section of the *Discharge Summary* that you have been working with the foster parent and do not know mother's status at discharge.

## Beneficiary Needing Skilled Nursing Care and MIHP Services

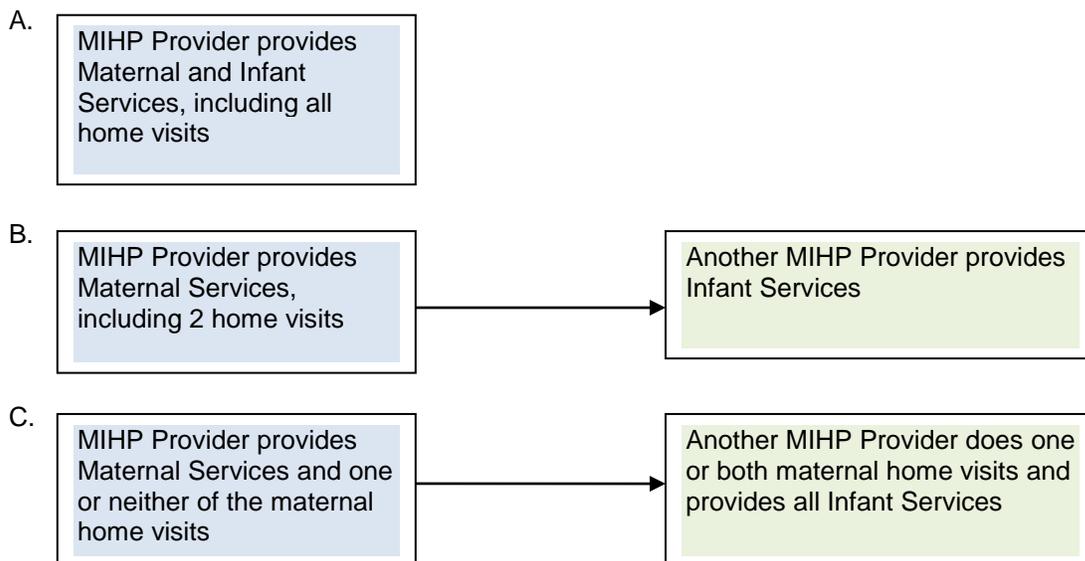
If an infant or mother requires skilled nursing care, such as feeding tube or incision care, it should be provided by a skilled home health nursing agency. A beneficiary concurrently may receive skilled nursing care and MIHP services from the same home health nursing agency, if the agency is a certified MIHP provider.

## Mother-Infant Dyad Service Options

All providers are required to serve the mother-infant dyad in one of three ways. The options include the following:

1. Provide all maternal and infant services directly.
2. Provide all maternal services, including the two required home visits, and after the baby is born, transfer the dyad to a second certified MIHP provider, per a written agreement.
3. Jointly provide maternal services with a second certified MIHP provider who conducts one or both of the two required home visits, and after the baby is born, transfer the dyad to the second provider, per a written agreement.

The above options are diagrammed below:



Option A is used by almost all MIHP providers. Options B and C have been used by a few prenatal clinics as of 2010. That year, Medicaid policy changed to require MIHP providers to offer both maternal and infant services. Providers that had previously provided maternal services only (prenatal clinics) were exempted from this policy. However, maternal only MIHP providers must assure that two maternal home visits and infant services are provided for all mother-infant dyads.

Maternal only providers are providers that entered into a formal written agreement with one or more MIHP providers for the provision of maternal home visits and/or infant services. The agreements were signed by both parties. For additional information, see *Mother-Infant Dyad Guidelines for Maternal-Only MIHP Providers* are on the MIHP web site.

## **5.0 REIMBURSEMENT FOR MIHP SERVICES**

### **Billing Integrated Care Organizations for Services to MI Health Link Beneficiaries**

Integrated Care Organizations (ICOs) are responsible for authorizing and paying for Medicaid and Medicare services for MI Health Link beneficiaries. An MIHP provider that serves a MI Health Link beneficiary must discuss the contract, including payment methodology, directly with the beneficiary's ICO.

### **Billing MDHHS through the Community Health Automated Medicaid Processing System (CHAMPS) for Services to Medicaid Fee-For Service Beneficiaries**

Bills are submitted to MDHHS electronically, using the Community Health Automated Medicaid Processing System (CHAMPS). This requires the MIHP provider to obtain a National Provider Identifier (NPI) and to complete the CHAMPS enrollment process. The MIHP provider must obtain an NPI as a facility, agency or organization, not as an individual. If an agency already has an organizational NPI number, there is no need to get an additional organizational NPI. The provider should have only one NPI number for MIHP billing and data entry. The provider must provide proof that they have been approved as a Medicaid provider with an MIHP specialty before attending a New Provider Orientation. NPI numbers are in the public domain.

The MIHP provider submits bills directly to MDHHS through CHAMPS. If the beneficiary also has commercial health insurance, the provider needs to coordinate benefits with the other insurer per Medicaid policy.

There is an online training titled *Overview of Maternal Infant Health Program Training Course*, which is required for all MIHP provider applicants. This training may be accessed at the MIHP web site. For additional information on billing and reimbursement, see *Chapter 2 – Medicaid Provider Resources*.

### **Medicaid Fee-for-Service Reimbursement**

Although most pregnant and infant Medicaid beneficiaries are enrolled in MHPs, MIHP services are reimbursed on a fee-for-service basis by MDHHS. This means that the provider is paid a specified fee for each individual MIHP service rendered to the beneficiary (i.e., each assessment visit, professional visit, professional visit - substance exposed infant, childbirth or parenting education course, or transportation service).

Providers must use particular procedure codes when billing for MIHP services. Diagnosis codes must also be indicated. Review the range of maternal, postpartum and infant diagnosis codes that are available to determine the appropriate code.

MIHP billing codes and fee screens (reimbursement rates for various covered services) may be accessed at the MIHP web site by clicking on "MIHP Medicaid Fee Database".

### **Missed Appointments and Phone Calls are Not Billable**

Missed appointments are not billable. If a provider travels to visit a beneficiary as scheduled and finds that the beneficiary is not at home, or if the beneficiary misses an appointment for another MIHP service (e.g., transportation) arranged by the provider, the provider may not bill Medicaid. Also, the provider may not bill the beneficiary for MIHP services. Phone calls to beneficiaries are never billable.

## Reimbursement for Different Types of MIHP Services

Although MIHP serves the mother-infant dyad, a distinction is made between maternal and infant services for billing purposes. Some services are billed to the mother's Medicaid ID number and other services are billed to the infant's ID number. After the infant is born, the provider must observe the infant during every visit with the mother.

The general types of MIHP reimbursable services are as follows:

1. Assessment (using *Maternal or Infant Risk Identifier*) in home or office
2. Professional visit in home or office
3. Professional visit - drug-exposed infant
4. Childbirth and parenting education classes
5. Transportation

Reimbursement rates vary by type of service. MIHP services are described in detail in *Chapter 8 – MIHP Service Delivery*. Special considerations with respect to each of the five service categories are discussed below.

### 1. Assessment

Assessment involves the administration of the *MIHP Maternal Risk Identifier* or the *MIHP Infant Risk Identifier*. These are standardized tools that are used to determine a beneficiary's risk level in multiple domains and overall. Results are used to create the beneficiary's *Plan of Care (POC)*. *POC* development is not a separately billable MIHP service. Before you can make any other visits or bill for the *Risk Identifier*, you must have administered the *Risk Identifier*, entered the *Risk Identifier* data into the MDHHS database, and developed the *Plan of Care, Parts 1-3*. A complete assessment includes the *Risk Identifier* and the complete *POC, Parts 1-3*.

Most often, the *Infant Risk Identifier* is completed with the infant's biological mother. However, if the biological mother is not the infant's primary caregiver, the *Risk Identifier* is completed with the individual who is functioning as the primary caregiver.

The *Infant Risk Identifier* visit must be billed under the infant's Medicaid ID number.

You cannot bill for an incomplete *Risk Identifier*.

If it takes two visits to complete the *Risk Identifier*, you can only bill for one *Risk Identifier* visit. You may not bill for a second visit until you complete the *Risk Identifier*.

Reimbursement for the *Maternal Risk Identifier* is limited to one *Maternal Risk Identifier* for each eligible Medicaid beneficiary each pregnancy.

To bill for assessment visits, the provider must use a Place of Service Code. See *Reimbursement for Professional Visits Depends on Place of Service* later in this chapter.

### 2. Professional Visits

Except for transportation, childbirth education classes, and parenting education classes, MIHP services are provided through one-on-one/dyad, face-to-face meetings, lasting at least 30 minutes. These meetings are referred to as professional visits. Professional visits are never conducted with groups of beneficiaries. The specific purpose of professional visits is to implement the *Plan of Care*, which is based on the beneficiary's *Risk Identifier* and professional judgment.

## Maternal Professional Visits

A pregnant woman is allowed a total of 9 visits in addition to the assessment visit, which is billed using a different code. If the woman experiences a fetal loss (miscarriage or stillbirth) or the death of an infant before an infant case is opened or before the infant's Medicaid ID is issued, the provider may continue to serve her until the 9 visits are used or her Medicaid coverage ends, whichever comes first.

A minimum of two home visits are required for maternal beneficiaries. At least one home visit must be conducted during the prenatal period and at least one maternal visit must be conducted after the infant is born. You need to save at least one maternal visit to be conducted postpartum. This postpartum visit is billed under the mother's Medicaid ID.

If the maternal beneficiary is hospitalized or incarcerated, MIHP visits must be suspended until she is released.

## Infant Professional Visits

An infant is allowed a total of 9 professional visits in addition to the assessment visit, which is billed using a different code. Another 9 visits may be provided if an order from the infant's medical care provider is obtained. The order can be verbal or written.

As stated earlier in this chapter, verbal orders should only be utilized if there is an urgent concern that requires the beneficiary to be seen that same day. In all other cases, the medical care provider should send a written order in response to the MIHP authorization request.

A verbal order may only be taken by the SW or RN. The process is as follows:

1. The RN or SW calls the medical care provider, explains the situation, and requests the verbal order.
2. The medical care provider verbally issues the order over the phone.
3. The RN or SW documents why the extra visits are needed and what the medical care provider stated on the phone on a *Professional Visit Progress Note* or *Contact Log* and faxes it to the medical care provider that same day, requesting the signed order be returned within 24 hours. If the medical care provider does not return the signed order within 24 hours, the RN or SW follows up with the medical provider at least weekly, until the signed order is received. Each follow-up contact must be documented in the chart.
4. If the written order is not received from the medical care provider, the agency cannot bill for the professional visit.)

The requirement that verbal orders be documented as described above will be enforced when the *Cycle 6 MIHP Certification Tool* goes into effect.

Alternatively, you may use a standing order for the second set of 9 infant visits. A copy of the standing order must be placed in the record. Standing orders must be reviewed and signed by the medical care provider annually. Additional information on obtaining medical care provider authorization for MIHP services is provided in *Chapter 3 – MIHP Goal and Primary Partners*.

## Infant Death

In the event of an infant death, the provider may continue to serve the mother if she had been in MIHP prior to the birth and there are maternal visits left, or until her Medicaid pregnancy coverage ends, whichever comes first. Contact Tomorrow's Child at <http://www.tomorrowschildmi.org/> for resources to support families who have experienced a pregnancy loss or infant death.

## Hospitalized Infant

If an infant is hospitalized after MIHP enrollment, no infant visits can be provided until the infant is discharged from the hospital. This is because the infant must be present at all infant visits and visits cannot take place at a hospital or an incarceration facility.

## All Professional Visits

The *Risk Identifier* must be administered and the *POC 1-3* developed before professional visits are initiated. If there's a need for an emergency visit after the *POC 2* is developed, but before both of the required *POC 3* signatures have been obtained, then the discipline conducting the visit must have knowledge of the *Risk Identifier* results and the *POC 2*.

Providers may visit only one beneficiary/dyad at a time.

High risk domains must be addressed within the first three visits and this must be documented on the *Professional Visit Progress Note*.

It is expected that visits will be scheduled to accommodate the beneficiary's needs (e.g., work schedule). Beneficiaries who cannot be seen during the agency's operating hours must be transferred to another agency that can accommodate their schedules. It is also expected that providers will make appropriate accommodations for Limited English Proficient, deaf and hard of hearing, and blind and visually impaired MIHP beneficiaries. Required accommodations are detailed in the *MIHP Certification Tool*, Indicator #19, on the MIHP web site. Requirements for serving persons with Limited English Proficiency are discussed in *Chapter 6 – Becoming an MIHP Provider*.

Visits should be spaced throughout the period of MIHP eligibility. For example, all 9 maternal visits should not be completed within three months for every woman who enrolls in MIHP early in her pregnancy. Although there are times when this may be required for a particular woman, it should not be done routinely.

If the MIHP provider sends out more than one professional on a home visit, it should last at least 30 minutes, and can only be billed as a single visit. This is true under all circumstances, including when two staff make a joint visit due to concern for staff safety.

Missed appointments are not billable. A visit made solely for the purpose of securing a transfer consent from a beneficiary is not billable. You cannot bill for a visit if a beneficiary is enrolled with another MIHP unless the beneficiary has requested a transfer and there is a documented emergency.

MIHP providers are eligible for Medicaid reimbursement for one professional visit (CPT 99402) per beneficiary (or family unit) per calendar day regardless of place of service. If an emergent situation is identified during a professional visit, the MIHP provider should refer the beneficiary to the appropriate resource for further assistance. Two professional visits (CPT 99402) on the same day are not reimbursable.

The date of service on a billing must be the same as the date the professional visit was conducted. The date that the bill is submitted may be different from the date of service.

To bill for professional visits, the provider must use a Place of Service Code. See *Reimbursement for Professional Visits Depends on Place of Service* later in this chapter.

## **Conducting *Risk Identifier* and Emergency Professional Visit on the Same Day**

There are very rare occasions when a beneficiary has an emergency need identified during the initial *risk assessment visit*. At that time, the care coordinator may assist the beneficiary in seeking additional resources or emergency services. If the RN or SW determines that the services of a second discipline are needed on the same day of service as the *risk assessment visit*, two separate encounters may be billed. Documentation in the beneficiary's medical record must clearly state the "emergency" need for the second visit. The risk assessment visit and professional visit (by a different discipline) should be made at separately identifiable, documented times. Again, this is only for clearly documented emergency situations.

## **Conducting a Postpartum and *Infant Risk Identifier* Visit on the Same Day**

MIHP serves the maternal/infant dyad. When infant services are initiated, an *Infant Risk Identifier* may be billed as a separate visit from a maternal postpartum professional visit when these services are performed on the same date of service. Documentation must substantiate why it was necessary to perform both visits on the same date of service.

Performing postpartum and *Infant Risk Identifier* visits on the same day is only recommended in special, limited circumstances so as not to overwhelm the new mother with information. The *Medicaid Provider Manual, MIHP Chapter, Section 2.9A*, outlines the maternal postpartum visit: "An MIHP provider may complete and bill an infant risk identifier visit separate from a maternal postpartum professional visit. A maternal postpartum professional visit may be made on the same date of service as the infant risk identifier visit. Providers MUST document when both visits need to be done on the same date of service. The maternal visit MUST be a minimum of 30 minutes and be reflected in the professional note."

The rationale for performing both visits on the same day is at the discretion of the provider. The primary reason that documentation is required is to assure that the needs of the beneficiary are met and that both services are not provided on the same day merely for the convenience of the provider.

Both visits may be conducted by the same individual. All subsequent professional visits for that family should be "blended visits" and billed as "blended visits" under either the parent's or the infant's Medicaid ID number.

## **3. Professional Visits – Drug- Exposed Infant**

To use the professional visit - drug-exposed infant billing code (96154), there must be documentation that:

- a. Visits are rendered according to the beneficiary's *Plan of Care*, based on *Infant Risk Identifier* results and professional judgment.
- b. The infant is, in fact, drug exposed.
- c. The infant's first 18 professional visits were billed using the preventive counseling code (99402).
- d. A medical care provider order has been obtained authorizing drug-exposed infant visits.

## **Documentation that Infant is Drug Exposed**

The provider must document that the infant was born with the presence of an illegal drug(s) and/or alcohol in his circulatory system, or that he is living in an environment where alcohol or substance abuse is a danger or suspected. Documentation that the infant was born with substances in his circulatory system can be obtained from the medical care provider. Documentation of suspected substance or

alcohol abuse by the mother or others in the home most often consists of professional observations made by the medical care provider or the MIHP provider.

Signs of suspected abuse may include the following: the mother is involved with Child Protective Services related to alcohol or substance abuse; the mother appeared to be high or intoxicated while pregnant; the mother shows signs of being high or intoxicated post-delivery; the mother's breath smells of alcohol; the home smells of marijuana; someone in the home uses medical marijuana; there are street drugs or drug paraphernalia in the infant's home; others who live in the home show signs of intoxication, substance use, drug dealing; etc.

If the medical care provider or the MIHP provider documents suspected alcohol or substance use/abuse, the MIHP provider may use the professional visit – drug-exposed infant billing code, after the first 18 visits. Signs observed by the MIHP provider must be documented in *MIHP Professional Visit Progress Note*. MIHP providers may use the drug-exposed infant visit billing code, even if the beneficiary denies using drugs or alcohol.

### **99402 is Used for First 18 Infant Visits**

MIHP providers may be reimbursed for a maximum of 36 professional visits for a drug-exposed infant. The provider must use the 99402 code to bill the first 18 infant visits, even if the infant is substance exposed at enrollment. After the first 18 visits, the MIHP provider switches to the professional visit drug-exposed infant billing code (96514) for purposes of implementing the *Plan of Care*. It is important to bill for two (2) units with 96514, as it is a 15 - minute code. If you do not bill for a quantity of two, you will only receive half of the reimbursement to which you are entitled. For each visit billed using the 96514 code, the *Substance Exposed Code Professional Visit Progress Note* must be used.

### **Using the Substance-Exposed Infant Interventions during the First 18 Visits**

The MIHP substance-exposed infant interventions can be used during the first 18 visits, even though they are not billed using the drug-exposed infant billing code. Any time you use the substance-exposed infant interventions, you must use the *Substance Exposed Code Professional Visit Progress Note*, whether or not you are using the drug-exposed infant billing code.

### **Medical Care Provider Order for Additional Infant Visits**

The first 9 infant visits do not require a medical care provider order. If there continues to be a need, the second 9 visits do require a medical care provider order. Additionally, all 18 visits under the drug-exposed infant code require an order. The order can be verbal or written. A verbal order is only used in an urgent situation when the beneficiary must be seen that day.

A medical care provider may write a standing order authorizing all additional infant visits (after the first 9 visits), including additional drug-exposed infant visits. A copy of the standing order must be placed in the beneficiary record. Additional information on obtaining medical care provider authorization for MIHP services is provided in *Section 3 – MIHP Goal and Primary Partners*.

To bill for professional visit - drug-exposed infant, the provider must use a Place of Service Code. See *Reimbursement for Professional Visits Depends on Place of Service* later in this chapter.

## **4. Childbirth and Parenting Education Classes**

Childbirth education (CBE) and parenting education (PE) are provided to groups of people in a classroom setting and cover a variety of topics that are relevant for all beneficiaries regardless of risk level in any particular domain. There are separate billing codes for CBE and PE classes.

### **Childbirth Education Classes**

MIHP providers are required to encourage every first-time mother to complete a childbirth education (CBE) course. The parent must attend at least  $\frac{1}{2}$  of the classes or cover at least  $\frac{1}{2}$  of the curriculum described in the course outline, before Medicaid is billed.

If your MIHP does not provide CBE classes and refers the beneficiary to an alternative community resource that offers CBE, such as a hospital or another MIHP, the other entity bills for providing the service.

If your MIHP serves an area where there are absolutely no CBE resources, contact your consultant to determine the best way to provide CBE for your beneficiaries.

### **Childbirth Education in the Home**

Under limited circumstances (e.g., beneficiary can't leave home because of a medical condition or she entered MIHP very late in her pregnancy), the provider may choose to conduct in-home CBE as a separately billable service. In this case, the beneficiary record must document the need for one-on-one CBE, where CBE was provided, and that at least  $\frac{1}{2}$  of the CBE curriculum was covered. The progress note can be used for documentation purposes.

Alternatively, CBE may be provided in the home and billed as a professional visit. This may be done when there are other extenuating circumstances (e.g., the beneficiary is too anxious or intimidated to participate in a group class).

Case records must document the need for one-on-one childbirth education and where services were provided.

### **Parenting Education Classes**

MIHP parenting education classes can be billed one time per infant or per family in the case of multiple infants. Parenting education classes are not available to parents during pregnancy. They must be billed under the infant's ID number. The parent must attend at least  $\frac{1}{2}$  of the classes or cover at least  $\frac{1}{2}$  of curriculum described in the course outline, before Medicaid is billed. For additional information on CBE and PE classes, see *Chapter 8 – MIHP Service Delivery*.

## **5. Transportation**

Transportation is NOT a required service within the Medicaid State Plan for MIHP. MIHPs may provide transportation assistance. Transportation is provided by the MIHP only when no other means are available.

It is the role of MIHP providers to assist the beneficiary to obtain transportation. Transportation needs must be assessed for each MIHP beneficiary. The need for transportation assistance must be documented. When a transportation need is identified, the beneficiary must be referred to the appropriate

resource (e.g., local MDHHS office, Medicaid Health Plan, etc.). MIHP documentation of referral for transportation services is vital, as well as documentation noting that the provider followed up on the referral.

## **Responsibility for Transportation**

The Department of Health and Human Services has the responsibility for providing medical transportation services to Medicaid Fee for Service (FFS) beneficiaries (see *Bridges Administration Manual (BAM 825)* for reference. Managed Care Organizations (Medicaid Health Plans) have the responsibility of providing medical transportation to their beneficiaries.

MHPs are responsible for providing transportation for their members to medically-related services; MIHP **does not** provide medical transportation for MHP members. MIHPs may provide transportation to medically-related services for Fee-For Service (FFS) beneficiaries.

MIHP beneficiaries are entitled to medical and non-medical pregnancy-related transportation while their Medicaid applications are pending. Once their Medicaid applications are approved and they are enrolled in an MHP, the MHP must provide their medical transportation, while the MIHP may continue to provide their non-medical transportation, unless it is provided by the MHP.

Pregnant women who are enrolled in an MHP before they are referred to MIHP are provided with medical transportation by their MHP. When these women enroll in MIHP, they become eligible for non-medical transportation through MIHP, unless it is provided by the MHP.

Responsibility for transportation has been assigned as follows:

### **FFS except in Wayne/Oakland/Macomb Counties:**

MIHP arranges for transportation to medical/health care (including pharmacy), mental health, SA, WIC, CBE, parent education classes, to visit infant in hospital.

### **FFS in Wayne/Oakland/Macomb Counties:**

Same as above, except for transportation to medical/health care, which is provided by LogistiCare Solutions.

### **MHP except in Wayne/Oakland/Macomb Counties:**

MHP arranges for transportation to all medical/health care (including pharmacy). MIHP can arrange for transportation to WIC, CBE, parent education classes, mental health, and SA, if not provided by the MHP.

### **MHP in Wayne/Oakland/Macomb Counties:**

Same as above, but LogistiCare Solutions will also transport to dental, mental health and SA.

## **Coordinating Transportation with the MHP**

The MIHP (except for a tribal MIHP provider) and the MHP are required to coordinate transportation for all mutually served beneficiaries. The MIHP should develop a relationship with the MIHP contact person at every MHP in the service area in order to coordinate transportation. A list of *Medicaid Health Plans MIHP Contact Persons* is available at the MIHP web site.

If you have a beneficiary whose transportation needs are not being met by MDHHS or her MHP, work directly with that organization to resolve the issue. If the issue remains unresolved, contact your MIHP

consultant. Be prepared to provide specifics so the consultant can attempt to get a resolution at the state level.

## Documenting Transportation Services

MIHP providers must document transportation arrangements in the beneficiary's record. If there is a transportation domain in the beneficiary's *POC 2*, you must document that transportation was provided for the beneficiary and identify the provider on a *Professional Visit Progress Note*.

If you provide and bill for transportation services, you must document each trip billed for each beneficiary, incorporating all elements required in Medicaid policy.

It is acceptable to provide transportation for a woman who declines professional visits. However, documentation must indicate each of the following: why visits are not being provided; that the woman was offered professional visits on more than one occasion; that the woman was offered a choice of different dates/times for professional visits; and why her MHP is not providing transportation, if applicable.

## MIHP Transportation for Nurse-Family Partnership Participants

The Nurse-Family Partnership (NFP) is a prenatal, infant and early childhood home visiting program with similarities to MIHP. One difference between the two programs is that MIHP provides transportation assistance while NFP does not. A few communities have both MIHP and NFP services available. In these communities, MIHP can provide transportation assistance for an NFP participant without administering either the *Maternal or Infant Risk Identifier* or developing a *Plan of Care*. This is an exception to the requirement that the *Risk Identifier* must be administered and the *POC* must be completed before MIHP services can be provided. Medicaid beneficiaries are not to participate in both MIHP and NFP simultaneously except for transportation services.

NFP, MIHP and the MHP (if beneficiary is in an MHP) should collaborate to determine the most appropriate and beneficial arrangements to assure health care transportation for NFP beneficiaries.

## Reimbursement for Professional Visits Depends on Place of Service

Reimbursement for professional visits depends on the place of service, reflecting the travel time and costs associated with visiting beneficiaries. When a provider travels to the beneficiary's residence or to a community site requested by the beneficiary, the reimbursement rate is higher than the rate paid if the beneficiary travels to the provider's office or clinic.

MIHP is a home visiting program. At least two of nine maternal visits must be conducted in the home. At least 80% of all professional infant interventions across the total agency caseload, on average, must be provided in the infant's home.

Every effort should be made to provide visits in the home. If a beneficiary absolutely declines home visits (e.g., she lives with her mother who does not want agency workers in her home), you don't need to continually ask her if you can make a home visit, but the situation needs to be documented in her chart.

When submitting a claim, the provider must use a Current Procedure Terminology (CPT) Code (see [Billing and Reimbursement](#)) and a Place of Service Code. Place of Service Codes used by MIHP providers are defined below:

### Code 11 Office

Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF),

where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

NOTE: The office code includes the following:

- a. The provider's office or clinic
- b. A building contiguous with the provider's office or clinic
- c. The provider's satellite office or clinic, including a community site arranged or rented by the provider (e.g., a school, a mobile home club house, etc.), where four or more beneficiaries are invited/scheduled to be seen on a given day

NOTE: If the provider's office and the WIC office are in the same building, and the provider visits the beneficiary at the WIC office, the provider bills this as an office visit.

NOTE: A hospital-based clinic providing MIHP services must use the office or home code, not hospital codes, to bill for MIHP services.

### **Code 12 Home**

Location, other than a hospital or other facility, where the patient receives care in a private residence.

NOTE: If a provider visits several beneficiaries who live in the same building (e.g., public housing) on the same day, the provider bills for separate home visits.

NOTE: This code is used if the beneficiary is residing in transitional housing, such as a domestic violence shelter or a homeless shelter.

### **Code 15 Mobile Unit**

A facility/unit that moves from place to place equipped to provide preventive, screening, diagnostic, and/or treatment services.

NOTE: The Mobile Unit code includes what is referred to in Medicaid policy as a community visit. The community visit takes place at a community site when the beneficiary cannot be seen at her home or at the provider's office for good reason (e.g., beneficiary does not want family member to know she is in the MIHP). The community visit takes place at a location that is agreed to by the provider and a beneficiary, such as a restaurant or school. If the provider is doing outreach at another agency (e.g., MDHHS or WIC office) which is not adjacent to the provider's office, and the provider administers a *Risk Identifier* and enrolls a new MIHP beneficiary there, this is considered to be a community visit.

#### **To clarify further:**

1. If you see four individual women on the same day at same shelter, apartment building, etc., you would bill for four home visits because the shelter, apartment building, etc., is their place of residence.
2. If you see four individual women on the same day at the same restaurant, MDHHS, school, etc., you would bill for four office visits.
3. If you see one to three individual women on the same day at the same restaurant, MDHHS, school, etc., you would bill for one to three community visits.

When documenting a visit provided in a place other than a home or office, check the "Other" box on the *MIHP Professional Visit Progress Note*, and indicate where the visit took place. In the "If Other, Why?" field, insert the reason why the visit was not conducted at home or at the office. "Other" location visits

should be billed using the Mobile Unit Place of Service Code 15. These visits are reimbursed at the home visit rate.

The place of service codes listed above do not apply to *Federally Qualified Health Centers, which must use Code 50 to bill for MIHP services.*

## Blended Visits

There are times when two or more beneficiaries in the same family have MIHP cases open simultaneously. These times include the following:

1. The postpartum period while the mother is still eligible for MIHP and the infant is eligible for Medicaid (generally about 2-3 months).
2. The entire period of infancy for Medicaid-eligible twins, triplets, and other multiples.
3. The period during which an infant is MIHP eligible and the infant's mother is Medicaid eligible due to another pregnancy.

In these situations, *Risk Identifiers* are billed under each family member's own Medicaid ID number. However, when two or more family members have had a *Risk Identifier* completed, professional visits (after the *Risk Identifier* visit) must be blended. This means that two (or more) beneficiaries are served at the same visit, but the visit can only be billed under the Medicaid ID number of one of the beneficiaries.

Blended visits are documented on a *Professional Visit Progress Note* in the record of the beneficiary whose Medicaid ID number is being used for billing purposes. It's up to you to decide which ID number to use, based on the needs of the beneficiaries. If the mother's needs are greater, use her ID number until all of her visits have been used. You cannot go back and forth, billing each visit under a different ID number.

Blended visits are documented on a single *Professional Visit Progress Note*. There is a checkbox at the top of the *Progress Note* to document that a visit was blended. Interventions provided for the beneficiary whose Medicaid ID number is being used are documented in the domain section of the progress note. Interventions provided for all other family members are documented under "other visit information." If you are billing under the mother's Medicaid ID number and providing service to the infant, document the infant's information under "other visit information." If billing under the infant's ID number and addressing the mother's identified risks, document the mother's information under "Maternal Considerations."

Although blended visits are documented on the same *Progress Note*, each beneficiary has a separate *Consent to Participate*, *Consent to Release Protected Health Information*, *Risk Identifier*, *Plan of Care (Parts 1-3)*, and *Discharge Summary*. Each infant beneficiary also has one or more *ASQ-3 Information Summaries* and one or more *ASQ: SE-2 Information Summaries* in the chart.

## Postpartum Period

As soon as possible after the birth of the infant, complete an *Infant Risk Identifier* and *POC, Parts 1-3* for the infant. If you choose to continue to bill under the mother's ID and additional maternal risks are identified by the *Infant Risk Identifier* that weren't included in the mother's *POC*, revise the mother's *POC* to incorporate the additional risks. Update and sign the mother's *POC 3*, acknowledging the addition of new domains, and send a *Prenatal Communication* to the maternal medical care provider to inform the provider of the additional maternal risks. If you choose to bill under the infant's ID, provide maternal interventions in keeping with the Maternal Considerations identified by the *Infant Risk Identifier*.

If the mother has not reached 9 maternal visits by the time her infant is born, you may utilize her remaining visits during the two-month postpartum period, billing under her Medicaid ID number. In this case, you would only document the maternal interventions on the *POC 2* and *Discharge Summary* because you are billing under the mother's Medicaid ID number. Once the 9 maternal visits are exhausted, you can then begin to bill under the infant's ID number.

## Multiple Births

In the case of multiple births, the following documents are to be completed separately for each infant:

1. *Consent to Participate in Risk Identifier Interview/Participate in MIHP*
2. *Consent to Release Protected Health Information*
3. *Risk Identifier*
4. *Plan of Care*
5. *ASQ-3 and ASQ: SE-2 Information Summary Sheets*
6. *Discharge Summaries*

However, you only need to send one medical care provider communication if all multiples have the same medical care provider. In this case, document information about the infants whose Medicaid ID numbers are not being billed in the “Comments” section.

*Risk Identifier* and *Discharge Summary* data for each of the infants are entered into the database. The electronic *Infant Risk Identifier* requires you to enter the maternal data for each infant. The *Infant Risk Identifier* is billed under each infant’s own Medicaid ID number. However, professional visits (after the *Risk Identifier* visit) must be blended, with documentation on all infants on the same *Professional Visit Progress Note*, and all services billed under one infant’s Medicaid ID number.

With multiples, you cannot bill one infant’s Medicaid ID number for the initial 9 visits and then bill another infant’s Medicaid ID number for any other visits. You cannot switch back and forth. Choose one infant and bill under that infant’s ID number consistently. Choose based on the needs of the beneficiaries. For example, if one infant’s needs are greater, you could choose to bill under that infant’s ID number. If not, you could bill under any of the infant’s ID numbers. Additional blended infant visits for the sibling group may only be provided if a physician’s order authorizing additional visits is found in the chart.

Although *Discharge Summaries* are completed for all multiples, only the *Discharge Summary* for the infant whose Medicaid ID number is being used for billing purposes is completed in its entirety, and only the interventions provided for the infant being billed are reflected on this *Discharge Summary*. For the other multiples, an abbreviated *Discharge Summary* is done. Please see *Discharge Summary Forms Instructions* for details. A chart reviewer would need to look at “other visit information” on the *Progress Notes* in the billable infant’s chart to see what interventions were provided for the other multiples.

## Infant is an MIHP Beneficiary and Mother Becomes Pregnant

If you’re visiting an infant and find out that the mother is pregnant, complete the infant visit and document the pregnancy in the infant’s chart. You can come back later to do a *Maternal Risk Identifier* or you can do the *Maternal Risk Identifier* that day, as long as you document why it was necessary to do it on the same day (e.g., if requested by the mom or if a great distance must be traveled).

Develop the mother’s *POC (Parts 1-3)*, and place it in her chart or add it to the family chart. As is the case for all beneficiaries, the *POC* must be completed before any professional visits can be provided. Bill the *Maternal Risk Identifier* visit under the mother’s ID number.

You may choose to continue to bill visits under the infant’s ID number or to start billing under the mother’s ID number. Whether or not you are billing under the infant’s ID number, you must complete the *ASQ-3s and ASQ: SE-2s* on the infant. Document the blended visit in the chart of the beneficiary whose Medicaid ID number is being used to bill the visit. If billing under one family member’s Medicaid ID number and providing service to the second family member, document the second family member’s information under “other visit information” on the *Professional Visit Progress Note*.

If you choose to continue to bill under the infant’s ID and additional maternal risks are identified by the *Maternal Risk Identifier* that weren’t included in the infant’s *POC 2* as Maternal Considerations, revise the infant’s *POC 2*

to incorporate the additional risks. Update and sign the infant's *POC 3*, acknowledging the addition of new domains, and send an *Infant Care Communication* to inform the infant's medical care provider of the additional maternal risks, if the mother has consented to release PHI to the infant's medical care provider. Also, send a *Prenatal Communication* to the maternal medical care provider, since you will be addressing the mother's pregnancy-related domains in blended visits.

## **Maintaining Charts When Two or More Family Members Have Open MIHP Cases**

You may file the documents for all of the family members being served in one of three ways:

1. In a family chart.
2. In the chart of the beneficiary whose Medicaid ID number is being used for billing purposes.
3. In a separate chart for each family member. If you maintain separate charts, a *Notification of Multiple Charts Open (099)* must be placed in each chart. This form alerts MDHHS consultants and certification reviewers that information about this family is filed in several different charts, reducing the amount of time spent searching for documents during onsite visits. Some agencies find it helpful to have a separate chart for each beneficiary, but to file the charts of all family members in a single hanging folder.

## **The Critical Importance of Documentation for Purposes of Medicaid Reimbursement**

As reiterated throughout this entire discussion on MIHP reimbursement, Medicaid requires MIHP providers to carefully document the provision of services in the beneficiary's case record. MDHHS provides standardized forms for this purpose. The forms and instructions for completing them are available at the MIHP web site at [www.michigan.gov/mihp](http://www.michigan.gov/mihp).

## **Documenting Begin and End Times for MIHP Professional Visits**

MIHP visits must be at least 30 minutes in length in order to be billable. MIHP providers must document begin and end times in the case record for every professional visit. The *MIHP Professional Visit Note* form provides a space to record this information. As a quality assurance activity, it is recommended that the MIHP Coordinator routinely contact a random sample of beneficiaries to verify their visits have been at least 30-minutes long.

## **Date of Service**

The date of service on each claim submitted to CHAMPS must match the actual date of service on the *Risk Identifier* or the *Professional Visit Progress Note*. The date that the progress note was completed and signed may be different from the "Date of Visit" documented on page one of the progress note.

## 6.0 BECOMING AN MIHP PROVIDER

### Criteria for Becoming an MIHP Provider

Medicaid has specified a comprehensive set of criteria for becoming an MIHP provider. The criteria cover staffing, capacity to provide services geared to the mother-infant dyad, contractual arrangements, facilities, outreach, processing referrals, required services and service protocols, linkages to referral sources, the beneficiary records system, confidentiality, communication with medical care providers and MHPs, and other aspects of provider operations.

### MIHP Provider Application Process

Provider eligibility is discussed in the *Medicaid Provider Manual, General Information for Providers, Section 2*. This section states: “An eligible provider who complies with all licensing laws and regulations applicable to the provider’s practice or business in Michigan, who is not currently excluded from participating in Medicaid by state or federal sanction, and whose services are directly reimbursable per MDHHS policy, may enroll as a Medicaid provider.” This means that the number of MIHP providers cannot be limited.

Medicaid requires MIHP providers to be certified by MDHHS. A prospective MIHP provider must complete a multi-step application process in order to become certified. The detailed step-by step *MIHP Application Process*, with timelines, is at the MIHP web site. A brief overview of the process is as follows:

1. Prospective provider reviews MIHP web site.
2. Prospective provider sends name, phone number, email address and request to attend an MIHP provider inquiry meeting to [newproviderapplication@michigan.gov](mailto:newproviderapplication@michigan.gov).
3. MDHHS MIHP sends date of next inquiry meeting to prospective provider. Inquiry meetings are held four times a year in Lansing and last 1½ hours.
4. Prospective provider attends inquiry meeting to learn more about the application process. At the meeting, an MIHP consultant goes over the actual application and discusses what is involved in becoming an MIHP provider. Participants must arrive on time or they are turned away.
5. Prospective provider uses the *MIHP Application Template and Rating Grid* form to submit a formal application. The application must include agency protocols describing their processes for implementing key MIHP policies. Protocols must cover all of the elements specified by the MDHHS. Protocols are reviewed at the time of application and at every certification review. Required protocols for the current certification cycle are at the MIHP web site.
6. MDHHS MIHP approves or does not approve the application.
7. If application is approved, prospective provider submits required proofs:
  - a. Proof that CHAMPS has approved you as an MIHP Medicaid provider (letter from Provider Enrollment or screen shot of you accessing CHAMPS)
  - b. Proof of purchase of the Ages and Stages Questionnaires - 3<sup>rd</sup> Edition
  - c. Proof of purchase of the Ages and Stages Questionnaire: Social Emotional - 2<sup>nd</sup> Edition
  - d. *MIHP Personnel Roster* indicating that both required disciplines (registered nurse and licensed social worker) have been hired
8. MDHHS MIHP determines whether or not the submitted proofs are acceptable.
9. If the proofs are acceptable, the prospective provider attends the next full-day MIHP orientation meeting. Orientation meetings are held twice a year.
10. At the end of orientation, provider is granted provisional certification to begin providing services.
11. Provider is added to the *MIHP Coordinators Directory* and begins to provide services.
12. About six weeks after the orientation, an onsite consultation is provided.
13. About three months after the orientation, another onsite consultation is provided.
14. About six months after date of the orientation meeting, the provider’s first certification review is conducted.

The process can be lengthy, depending on the applicant's movement through the required steps. Typically, it's between three and nine months after attending the inquiry meeting that an applicant is approved to deliver services.

Technical assistance on how to start up a business is not provided by MDHHS. Providers are responsible for securing and paying for their own legal counsel.

For information on the certification review process, see *Section 9 – MIHP Quality Assurance*.

## Required Computer Capacity to Use MIHP Electronic Database

MIHP providers are required to enter beneficiary *Risk Identifier* and *Discharge Summary* data into the MDHHS MIHP electronic database. Data collection is intended to improve MDHHS's ability to monitor programs and evaluate program outcomes.

Each provider must have a process for timely, efficient entry of data into the database. Data entry can take place at the provider's office, at the beneficiary's home, or at another location where confidentiality is assured.

Internet access is the core requirement to use the database. The State of Michigan determines which Internet browsers must be used. Check with your consultant for the most current information on required browsers. If you use an Internet browser that is not recommended by the State of Michigan, you may have significant, technical difficulties and errors entering and accessing your data.

## Provider Authorization of MIHP Electronic Database Users

The MIHP provider must authorize staff members to use the State of Michigan Single Sign-On (SSO) System in order to enter MIHP data into the MDHHS electronic database. Unauthorized staff will be denied access. Only individuals working for the MIHP provider can be authorized.

Any staff authorized by the coordinator to use the SSO System may enter *Risk Identifier* and *Discharge Summary* data into the MDHHS database. This includes support staff.

The SSO authorization process is as follows:

1. The MIHP Coordinator emails a complete and updated *MIHP Personnel Roster* with the first and last name(s) of all staff members. The license numbers and expiration dates for staff RN's and SW's, work experience, etc., must be entered. All of the fields on the *Personnel Roster* **must** be completed. An **X** is placed under the **SSO/MIHP column** to indicate the staff member(s) that will be using the MIHP electronic database. The MIHP Coordinator lists the new usernames in the body of the email.
2. An updated *Personnel Roster* is required to be emailed to [mihp@michigan.gov](mailto:mihp@michigan.gov) within 30 days after the end of every quarter (quarters end on December 31, March 31, June 30 and September 30). Due dates are: January 30, April 30, July 30 and October 30. To maintain access, all staff members authorized to use SSO must be listed on the current *MIHP Personnel Roster*.
3. If you wish to authorize a new staff member to use SSO prior to the end of the quarter, you must submit a complete and updated *MIHP Personnel Roster*. You are required to submit an updated *Personnel Roster* when there is a staff change.
4. The MIHP provider receives an email message confirming the names of the authorized users.

Questions regarding this process should be directed to your consultant.

## Registration of Individual Authorized Users through Michigan's Single Sign-On System

Authorized individual(s) must register through Michigan's Single Sign-On (SSO) System. Only individuals who are registered with SSO can access the database. The registration process is outlined below:

1. Individual (s) goes to the state's Single Sign-On (SSO) System web site at <https://sso.state.mi.us>
2. The individual follows the instructions on the SSO web site to obtain a User ID and Password.
3. The individual writes down and safeguards the User ID and Password.

Every authorized user must create their own SSO user name and password. MIHP Coordinators cannot create usernames for staff members. Because MIHP data is protected health information, each staff who will have access to SSO must sign a confidentiality agreement before being authorized as a user.

An individual who works for more than one MIHP agency must have a separate SSO System authorization and password for each agency, given that access is based on the agency's NPI number.

## Confidentiality Requirements for Transmission and Maintenance of MIHP Beneficiary Information

MIHP providers carefully must follow the *MIHP Field Confidentiality Guidelines* developed by MDHHS. The guidelines are available at the MIHP web site. Please take special note of the following points:

1. Beneficiary information must be encrypted before it can be sent electronically. Using the beneficiary's name, even though no other identifying information is provided, is not acceptable in communications sent to medical care providers or MHPs. MIHP providers that wish to send communications electronically must use encryption software.
2. All staff with access to protected health information must sign confidentiality statements. This includes the coordinator, professional staff, administrative staff, data entry staff and anyone else who has access to PHI. The agency must keep these statements on file.
3. If an agency violates the Health Insurance Portability and Accountability Act (HIPAA), the agency, not MDHHS, is responsible for securing legal counsel should it become necessary. MDHHS attorneys do not represent MIHP agencies that breach confidentiality or in other legal matters.

You are not required to encrypt information on your smart phone if the beneficiary indicates that calling or texting her is the best way to reach her. The beneficiary is asked this question during the administration of the *Risk Identifier*.

All staff must have a copy of the *MIHP Field Confidentiality Guidelines*. Agency contracts must include language requiring contractors to meet HIPAA standards, including record retention requirements for contractors who store the agency's paper or electronic records.

## Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is the Health Insurance Portability and Accountability Act of 1996, a law intended to make it easier for people to keep their health insurance when they change jobs. The law set standards for the electronic exchange of patient information, including protecting the privacy of such records. The U.S. Department of Health and Human Services issued the Privacy Rule to implement that aspect of the law, and its Office of Civil Rights is in charge of enforcing it.

HIPAA was enacted to cover three specific areas:

1. Insurance portability or the ability to move to another employer and be certain that insurance coverage will not be denied
2. Fraud enforcement and accountability
3. Administrative simplification

Insurance portability and fraud enforcement and accountability have been active since 1996; however, it took until April 2003 to enact administrative simplification. In January 2013, further amendments were made to HIPAA law, to further protect patient privacy, secure health information and enhance standards to improve privacy protections and security safeguards for consumer health data. The final omnibus rule greatly enhances a patient's privacy protections, provides individuals new rights to their health information, and strengthens the government's ability to enforce the law. Administrative simplification refers to the guidelines that impact healthcare providers in the communications with other providers, families, friends and the media. The overall intent of this act is to make it easier for the consumer to obtain seamless care, irrespective of the number of different providers they see; while still protecting the confidentiality and privacy of the patient.

**Covered entities** are health plans (including health insurance companies and employer sponsored health plans), health care clearinghouses, and health care providers that engage in defined electronic standard transactions, which generally relate to insurance reimbursement. Examples include hospitals, ambulances/EMTs, private physicians and social workers. MIHP providers are considered covered entities.

**Protected Health Information** is *individually identifiable* health information created, received, transmitted and/or maintained by a covered entity. This includes information relating directly or indirectly to the person's past, present or future physical or mental health, the provision of care to the person, and the person's health care bills and payments. This information includes the following demographics:

1. Name
2. Address (all geographic subdivisions smaller than state, including street address, city, county, or ZIP code)
3. All elements (except years) of dates related to an individual (including birth date, admission date, discharge date, date of death, and exact age if over 89)
4. Telephone numbers
5. FAX number
6. Email address
7. Social Security number
8. Medical record number
9. Health plan beneficiary number
10. Account number
11. Certificate/license number
12. Vehicle identifiers and serial numbers, including license plate numbers
13. Device identifiers or serial numbers
14. Web URLs
15. IP address
16. Biometric identifiers, including finger or voice prints
17. Full-face photographic images and any comparable images
18. Any other unique identifying number, characteristic, or code

## Privacy and Security

Any method used to transmit protected health information must be secure, including verbal transmission. Be sure not to discuss a beneficiary with another individual in a public setting of any kind, on the phone or face-to-face. Do not talk to any unauthorized person (family, friends, etc.) about a beneficiary at any time or any place, even if you do not state the beneficiary's name. Do not indicate the beneficiary's residence in a unit any smaller than a zip code.

Agencies are required to become familiar with HIPAA and understand how the law affects MIHP program operations. You may read more at <http://www.hhs.gov/ocr/privacy/index.html>.

## Required Infant Developmental Screening Tools

An important MIHP infant intervention is developmental monitoring. MIHP providers must purchase and use the following standardized screening tools from Brookes Publishing for this purpose:

*Ages and Stages Questionnaires, 3<sup>rd</sup> Edition (ASQ-3)*

Available in English and Spanish

Purchase from Brookes Publishing at <http://www.brookespublishing.com/store/books/squires-asq/index.htm>

*Ages and Stages Questionnaires: Social-Emotional (ASQ: SE-2)*

Available in English and Spanish

Purchase from Brookes Publishing at <http://www.brookespublishing.com/store/books/squires-asqse/index.htm>

MDHHS also requires that agencies purchase the *ASQ-3 User's Guide* and the *ASQ: SE-2 User's Guide* and the *ASQ-3 Learning Activities* book with CD-ROM.

## Requirements for Serving Persons with Limited English Proficiency

On Aug. 11, 2000, President William J. Clinton signed an executive order, Executive Order 13166: *Improving Access to Service for Persons with Limited English Proficiency, to clarify Title VI of the Civil Rights Act of 1964*. The executive order was issued to ensure accessibility to programs and services to otherwise eligible individuals not proficient in the English language. The executive order stated that individuals with a limited ability to read, write, speak and understand English are entitled to language assistance under Title VI of the Civil Rights Act of 1964 with respect to a particular type of service, benefit, or encounter. These individuals are referred to as being limited English proficient in their ability to speak, read, write, or understand English, hence the designation, "LEP," or Limited English Proficient.

The executive order states that: "Each federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities."

Not only do all federal agencies have to develop LEP plans as a condition of receiving federal financial assistance, additionally, recipients have to comply with Title VI and LEP guidelines of the federal agency from which funds are provided as well. Recipients of federal funds, including MIHP, range from state and local agencies to nonprofits and organizations. Title VI covers the recipient's entire program or activity. *This means all parts of a recipient's operations are covered, even if only one part of the recipient's organization receives the federal assistance.*

Between 1990 and 2013, the LEP population grew 80 percent from nearly 14 million to 25.1 million. The growth of the LEP population during this period came largely from increases in the immigrant LEP population. The most dramatic increase occurred during the 1990s as the LEP population increased 52

percent. The growth rate then slowed in the 2000s and the size of the LEP population has since stabilized. Over the past two decades, the LEP share of the total U.S. population has increased from about 6 percent in 1990 to 8.5 percent in 2013.

Spanish has been the predominant language spoken by both immigrant and U.S. - born LEP individuals. About 64 percent (16.2 million) of the total LEP population speaks Spanish, followed by Chinese (1.6 million, or 6 percent), Vietnamese (847,000, 3 percent), Korean (599,000, 2 percent), and Tagalog (509,000, 2 percent). Close to 80 percent of the LEP population spoke one of these five languages.

In Michigan, Spanish and Arabic languages meet the threshold for inclusion in LEP mandates. Of the approximately 81,000 LEP individuals in MI, 42.9 % are Spanish speaking, 26.3 % speak Arabic, followed by Bengali (2.8%), Albanian (2.2%) and Vietnamese (1.8%).

MIHP agencies have options in serving persons with LEP. For example, they may hire an interpreter (verbal communications) and/or translator (written communications) or purchase these services from a commercial entity such as LanguageLine. All interpreting and translation services used by MIHP must meet LEP guidelines. For additional information, go to the Office of Civil Rights link on the MIHP web site under "Policy and Operations."

## **Guidelines for an Office in the Provider's Place of Residence or Other Location where Beneficiaries are Not Seen**

MDHHS has developed guidelines for providers using their place of residence as an MIHP office or who have offices in other locations where beneficiaries are not seen. Providers with these types of offices are required to follow the guidelines. The guidelines are available at the MIHP web site.

A provider whose home address is listed as their office address in the *MIHP Coordinator Directory* may choose to list a P.O. Box instead. To make this change, send an email to [MIHP@michigan.gov](mailto:MIHP@michigan.gov), indicating the P.O. Box as the contact address for your business. Note that MDHHS must have your current home address on file for MIHP use.

## **Emergency Services**

MIHP agencies must provide for beneficiary emergencies that occur after hours or over the weekend. Beneficiaries need to be informed about accessing services outside of the agency's operating hours. The agency must ensure that there is an after-hours message with emergency information on the main MIHP agency phone system, including directions to call 9-1-1 or go to the ER.

The phone number given to beneficiaries to access MIHP services must have the after-hours message. If an agency gives out two phone numbers, both must have the after-hours message. If the agency phone is a personal cell phone, it must have the have the after-hours message.

## 7.0 MIHP MARKETING AND OUTREACH

### Marketing the MIHP in the Community

Marketing the MIHP is an ongoing activity for MIHP providers. Marketing is the process of promoting awareness of MIHP in order to engage partners as prospective referral sources to refer potential beneficiaries to the MIHP.

Typical community marketing strategies include the following:

1. Conducting MIHP presentations at community agencies, places of worship, and other locations where community members come into contact with pregnant, low-income women or infants.
2. Placing and maintaining posters and brochures or fliers in locations frequented by pregnant, low-income women (e.g., WIC agencies, local health departments, grocery stores, dollar stores, etc.).
3. Developing good relationships with entities that are in a position to refer a significant number of women to the MIHP (e.g., WIC agencies, MHPs, medical care providers, etc.).
4. Providing potential referral sources with an easy referral process.
5. Participating in local coalitions that work to improve maternal and child health or to coordinate services for identified children and families, such as:
  - a. Infant mortality reduction coalitions
  - b. Great Start Collaboratives (local groups building early childhood comprehensive systems focusing on Physical Health Care, Social-Emotional Health Care, Parenting Education and Family Support, Early Care and Education, and Basic Needs)
  - c. Fetal-Infant Mortality (FIMR) Teams
  - d. *Early On* Local Interagency Coordinating Councils

A standardized *MIHP Provider Information Sheet* has been developed for MIHP providers to distribute statewide to medical care and social service providers. The *MIHP Provider Information Sheet* can be downloaded and printed from the MIHP web site. Although it was designed in color, it also prints out well in black and white.

Providers need to repeatedly market their services to potential referral sources due to staff turnover to ensure health and human services workers have access to current information about MIHP services and as a reminder of the MIHP services available especially new MIHP providers. Different providers market their services in different ways. For example, some conduct marketing activities on an ongoing basis; others do a week-long blitz once a year. Only providers that have a single, regular referral source (e.g., prenatal clinic) are exempt from conducting outreach activities.

It's important to thoughtfully cultivate relationships with prospective referral sources. There are many ways to do this, but all successful referral relationships are built on a foundation of respect and professionalism. Your knowledge of your program, demeanor, communication style, appearance and behavior reflect not only on your particular MIHP, but on MIHP statewide.

### Marketing the MIHP to MHPs

MHPs are contractually required to assign their pregnant and infant enrollees to an MIHP, but they are not required to assign them to all of the MIHP providers operating in a given county. MHPs can choose to refer to the MIHPs that they believe are providing the highest-quality services and that dependably share information with them. In most counties, there are several MIHP providers. In densely-populated, urban counties, there may be more than 50 MIHP providers available to provide services.

It's the MIHP provider's responsibility to ensure that every MHP operating in the same county as the provider is very familiar with the provider's MIHP. It is well worth the provider's time to develop good working relationships with each MHP so that the MHP will feel confident in referring its members to the provider's program. Working relationships are promoted by the requirement that there must be a *Care Coordination Agreement (CCA)* between each MHP and MIHP operating in the same county. The CCA, titled *Sample 3 (Sample of Care Coordination Agreement)*, is available at [Medicaid Provider Manual](#) in the Forms Appendix. A list titled *Medicaid Health Plans: MIHP Contact Persons* is at the MIHP web site.

## **Marketing the MIHP to Medical Care Providers**

MIHP services are intended to supplement prenatal and infant medical care in order to promote the beneficiary's health and well-being. A medical care provider may be a physician, certified nurse-midwife, pediatric nurse practitioner, family nurse practitioner or physician assistant. As a group, medical care providers have not been a primary source of referrals to MIHP, likely because many of them are not familiar with MIHP. MHPs do educate their network providers about MIHP and encourage them to make MIHP referrals, but MHPs do not contractually require their providers to refer to MIHP.

It's important for MIHP providers to market themselves to medical care providers, especially obstetricians and pediatricians, so that the medical care providers will make MIHP referrals and understand how the MIHP provider will coordinate with them when they are serving the same beneficiary. (Medicaid policy requires the MIHP provider to coordinate with the beneficiary's medical care provider at specified points throughout the MIHP service process, from intake to case closure, using standardized forms.)

MIHP providers are advised to meet with staff at medical care provider offices (e.g., "lunch & learn" sessions) to discuss MIHP services, how to refer to MIHP, and how communications regarding mutual beneficiaries will occur. If meetings are not feasible, the provider could provide brochures with a cover letter on how to make a referral to MIHP.

MIHP providers are especially encouraged to market their services to medical care providers serving large numbers of low-income pregnant women and infants, such as Federally Qualified Health Centers, community health centers, etc. It is suggested that providers also market their services to staff at local birthing hospitals, as they are in a position to refer women and infants to MIHP at the time of discharge.

MDHHS does not provide a standardized form for medical care providers to use to refer their patients to MIHP. MIHP providers may wish to develop their own form for this purpose.

## **MIHP Outreach to Potential Beneficiaries**

Outreach is another ongoing activity for MIHP providers. Outreach has two main components:

1. Broadly advertising the program to potential beneficiaries.
2. Identifying a particular pregnant woman, mother of an infant, or other primary caretaker of an infant, who may be eligible for MIHP and reaching out to her to explain the program and encourage her to participate.

### **Broadly Advertising MIHP**

MIHP providers have used one or more of the following methods to broadly advertise MIHP to potential beneficiaries:

1. Maintaining a web site.
2. Maintaining a Facebook page.
3. Talking about the program on a local TV or radio show.
4. Participating in community baby showers or health fairs.

5. Leaving brochures or posters at physician's offices, laundromats, grocery stores, dollar stores, food banks, places of worship and other locations throughout the community.

A standardized *MIHP Parent Information Sheet* has been developed for MIHP providers to distribute to potential MIHP beneficiaries statewide. It is available in English, Arabic and Spanish. The *MIHP Parent Information Sheet* is written at the 6th grade reading level. It can be downloaded and printed from the MIHP web site. Although it was designed in color, it also prints out well in black and white. Some providers develop their own brochures to distribute to potential MIHP beneficiaries.

If you are working with a population that does not speak English, Arabic or Spanish, and wish to translate the brochure into another language, you must contact MDHHS to request permission to do so.

### **Directly Contacting Potential MIHP Beneficiaries**

Most MIHP providers spend a great deal of time and effort identifying and personally contacting potential beneficiaries in order to "sell" them on the program. They use several different methods to do this.

One method is face-to-face outreach at a community agency. This requires an agreement between the MIHP provider and the agency, allowing the provider to visit the agency to approach potential beneficiaries (e.g., in the waiting room), and then take them to a private space to talk.

Direct contact is also done by phone, mail, or cold-call home visits. These methods are used when a referral source supplies the MIHP provider with the names of potential MIHP beneficiaries, along with their phone numbers and/or addresses. Unfortunately, many phone numbers and addresses are not current, and the MIHP provider is unable to locate a fair number of referred individuals. It is also unfortunate that referral sources don't always "talk up" the MIHP beforehand, so the individual being contacted has no idea about MIHP or that her contact information was given to the MIHP.

### **Outreach through Partnerships**

Generally speaking, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and MHPs generate a great number of MIHP referrals. MIHP providers should do everything possible to promote sound partnerships with WIC and MHPs, but in areas of the state where there are numerous MIHP providers, especially Southeast Michigan, you may need to develop alternative outreach partners.

Five common potential outreach partners are described below:

#### **Outreach through Partnerships with WIC**

WIC is an absolutely critical partner in identifying potential MIHP beneficiaries. Most WIC programs are operated by local health departments (LHDs), but some are operated by other community agencies. There are two different ways in which WIC can partner with an MIHP provider to identify potential MIHP beneficiaries:

1. A WIC agency may agree to allow an MIHP provider to conduct outreach activities on its premises during clinic hours.
2. A WIC agency may agree to fax or send written referrals to an MIHP provider.

It is easiest for WIC to partner with the MIHP provider when an LHD operates both the WIC and MIHP programs. However, private MIHP providers may also work out partnering agreements with LHDs that don't operate their own MIHPs or with LHDs that do operate their own MIHPs, but don't have the capacity to provide MIHP services for all of the women who come through their doors. Private providers may also work out partnering agreements with WIC agencies other than LHDs.

## **Outreach through Partnerships with LHDs Involving Programs Other than WIC**

It may be possible for an MIHP provider to partner with the LHD to conduct outreach activities through LHD maternal-child health programs besides WIC. LHDs don't all offer the same maternal-child health programs, but may offer Medicaid outreach and enrollment, prenatal clinics, immunization clinics, and home visiting programs other than MIHP.

## **Outreach through Partnerships with MHPs**

MHPs are required to assign their eligible pregnant and infant enrollees to MIHPs. Some MHPs rotate referrals among all of the MIHP providers in a given county and others refer only to MIHP providers with whom they have established good working relationships. It is their choice.

*The MIHP – MHP Collaboration Form* has been developed for use by both MIHPs and MHPs to share information about referred individuals. MHPs use it to refer pregnant women and infants to MIHP providers and MIHP providers use it to inform MHPs of members currently receiving MIHP services. The form and instructions for its use are available at the MIHP web site.

## **Outreach through Partnerships with Federally Qualified Health Centers (FQHCs) and Large-volume Prenatal Clinics**

FQHCs and large-volume prenatal clinics that do not operate their own MIHPs may also be willing to serve as MIHP outreach sites.

## **Outreach through Partnerships with Birthing Hospitals**

Some MIHP providers get most or all of their infant referrals through partnerships with birthing hospitals. MDHHS is in the process of working with birthing hospitals across the state to see that all Medicaid-eligible infants are referred to MIHP or Children's Special Health Care Services before discharge.

## **Locating MIHP Marketing and Outreach Partners**

MIHP providers need to be familiar with the particular entities in their respective service areas that frequently come into contact with low-income pregnant women and infants, as these entities are potential marketing and outreach partners.

Local United Way offices are a good source of information about community resources, including resources for low-income pregnant women and infants. To find the United Way in your area, go to [www.unitedway.org/find-your-united-way](http://www.unitedway.org/find-your-united-way).

The Michigan Association of United Ways web site includes information about 2-1-1, a health and human services telephone referral system that's available 24 hours a day, 7 days a week, 365 days a year in 180 different languages, covering 99% of Michigan's population.

Local agencies, such as the Local Health Department, local Department of Health and Human Services, or Community Action Agency, may have developed resource and referral guides and posted them online. An Internet search for "\_\_\_\_\_ County Community Resources" is likely to generate multiple resource guides.

Although every community is different, the following is a list of MIHP potential marketing and outreach partners common to most:

1. Supplemental Nutrition Program for Women, Infants and Children (WIC)  
MDHHS WIC Program  
[WIC](#)

MDHHS WIC Agency List (by County)  
[http://www.michigan.gov/documents/mdch/WIC\\_Agency\\_List\\_382084\\_7.pdf](http://www.michigan.gov/documents/mdch/WIC_Agency_List_382084_7.pdf)

To find local WIC agency: 1-800-26-BIRTH.

2. Medicaid Health Plans  
A list of MHPs by county is available at:  
[www.michigan.gov/MDHHS/0,1607,7-132-2943\\_4860\\_5047---,00.html](http://www.michigan.gov/MDHHS/0,1607,7-132-2943_4860_5047---,00.html)

A list titled, *Medicaid Health Plans: MIHP Contact Person*, may be accessed at  
[www.michigan.gov/mihp](http://www.michigan.gov/mihp).

3. Medical Care Providers  
Ask the Local Health Department or refer to phone book or Internet to identify medical care providers. Develop relationships with key staff at obstetric offices, prenatal clinics (especially high-volume clinics serving Medicaid beneficiaries), newborn nurseries, pediatric clinics and offices, Federally Qualified Health Centers, hospitals (especially discharge planners), and childbirth education programs. Make sure that social workers affiliated with prenatal clinics and hospitals know how to refer to your program. To identify Federally Qualified Health Centers in your locale, go to:  
[www.wheretofindcare.com/FederallyQualifiedHealthCenters/Michigan-MI/City.aspx](http://www.wheretofindcare.com/FederallyQualifiedHealthCenters/Michigan-MI/City.aspx)

4. Free and Low Cost Health Care in Michigan  
[www.michigan.gov/mihp](http://www.michigan.gov/mihp)  
[Migrant Health Centers in Michigan](#)

5. Local Health Departments (LHDs)  
Many LHDs are MIHP providers.  
Local Public Health Department Locator  
<http://www.malph.org/>

6. Department of Health and Human Services Local Offices  
<http://www.michigan.gov/dhs/0,1607,7-124-5461---,00.html>

7. *Early On* Michigan  
<http://www.1800earlyon.org/>

8. Great Start Collaboratives – Early Childhood Investment Corporation  
<http://www.greatstartforkids.org/content/great-start-your-community>

9. Michigan Domestic Violence Resource Directory  
[http://www.michigan.gov/som/0,1607,7-192-29941\\_30586\\_240---,00.html](http://www.michigan.gov/som/0,1607,7-192-29941_30586_240---,00.html)

10. Community Mental Health Services Programs  
Michigan Association of Community Mental Health Boards Members  
<http://www.macmhb.org/BoardList.html>

11. Office of Recovery Oriented Systems of Care (ROSC)  
Oversees prevention, treatment and recovery efforts related to substance use and mental health disorders and problem gambling additions in Michigan; provides links to community-based services [http://www.michigan.gov/MDHHS/0,1607,7-132-2945\\_5102-14983--,00.html](http://www.michigan.gov/MDHHS/0,1607,7-132-2945_5102-14983--,00.html)
12. Pregnancy Testing Centers (family planning clinics, crisis pregnancy centers)
13. Affordable Care Act Local Helpers  
<https://healthcare.gov>  
Click on “Find Local Help” at bottom of screen. Enter zip code for your service area to get a list of agencies that are assisting people to file Health Insurance Marketplace applications.
14. Community Action Agencies  
[www.mcaaa.org](http://www.mcaaa.org)
15. Emergency food, shelter, utility programs
16. Places of worship
17. Grocery stores
18. Dollar stores
19. Thrift stores (Goodwill, Salvation Army, Volunteers of America, etc.)
20. Laundromats
21. Beauty salons

Occasionally, a new MIHP provider will encounter difficulties in recruiting beneficiaries. In this case, contact your MIHP consultant.

## **MIHP Marketing and Outreach Development and Documentation**

MIHP providers must demonstrate a capacity to conduct outreach activities to the target population and to medical care providers in the geographic areas to be served. MIHP providers must develop and maintain on file a protocol which describes an outreach plan which specifies outreach activities, frequency of outreach activities and groups/agencies selected for outreach, including potential beneficiaries, medical care providers and other community providers who serve MIHP-eligible Medicaid beneficiaries. Documentation must be maintained to indicate that outreach activities are being conducted according to plan, unless beneficiary referrals are received from a single, regular source.

## **Responding to Referrals Promptly**

The MIHP provider must respond to all referrals promptly to identify the beneficiary’s needs as specified below:

1. The provider must contact a pregnant beneficiary within 14 calendar days from the date the referral is received.
2. When an infant referral is received from a hospital prior to the infant’s discharge, the provider is to complete the infant assessment visit within a maximum of two business days from the date of discharge.
3. When an infant referral is received from a source other than a hospital, the provider is to complete the infant assessment visit within seven calendar days from the date the referral is received.

If the MIHP provider is unable to visit the beneficiary within the stated time frames, documentation must clearly support all attempts to contact or visit the beneficiary.

## Replying to Referral Sources on the Disposition of Referrals

MIHP providers must report all new MIHP enrollees who are MHP members to the appropriate MHP on a monthly basis. The *MHP/MIHP Collaboration* form is used for this purpose. It is available at the MIHP web site. An alternative form may be used if both parties agree to it.

MIHP providers are encouraged to document and report disposition of a referral (i.e., initiation of services, inability to locate, or refusal of services) to other referral sources as well. The referral source may be a WIC office, medical care provider, community services agency, or other entity. Reporting the disposition of a referral assures the referral source that the beneficiary has not been lost in the system and is a basic professional courtesy. Providers who systematically report back to the referral source are seen as more efficient and reliable than those who do not.

There is no form for MIHP providers to use to report disposition of referrals to referral sources other than MHPs. However, it is suggested these reports be written rather than verbal.

## Conducting Outreach Activities Professionally and Fairly

While conducting outreach activities, the provider must be mindful that the needs and wants of the beneficiary always come first. Some MIHP providers, especially if they are operating in counties with many other MIHP providers, may feel they are competing for MIHP referrals. A few may go so far as to engage in questionable outreach activities that are not in keeping with policy and are not in the best interest of beneficiaries.

MDHHS expects all MIHP providers to conduct their outreach activities professionally, fairly, and ethically. This includes, but is not limited to, the following:

1. Not offering incentives (e.g., diapers, Pack N Plays, gift cards, etc.) to encourage beneficiaries to enroll in MIHP
2. Not using false advertising
3. Not promising more than can be delivered
4. Not entering a beneficiary's name in the MIHP database as a placeholder
5. Refraining from seeing beneficiaries who are already being seen by other MIHP providers
6. Sharing information with other providers as appropriate

MIHP providers are expected **not to advertise or use in promotional activity, a promise to provide any free items or services** to beneficiaries. Local organizations sometimes sponsor community baby showers or health fairs and ask participating agencies to bring gifts to raffle off to participants. You can participate in a community baby shower and donate gifts for the raffle, but you cannot administer *Risk Identifiers* there and you cannot use the baby shower as a vehicle for MIHP enrollment in any way.

Providers are expected to comply with requirements issued by the Office of Inspector General (OIG), USA Department of Health and Human Services in a special advisory bulletin titled *Offering Gifts and Other Inducements to Beneficiaries*, August 2002. Providers who do not comply with the requirements specified in this bulletin may be dis-enrolled from Medicaid/MDHHS program. The bulletin is available at [Special Advisory Bulletin: Offering Gifts and Other Incentives....](#)

## Respecting Outreach Relationships Developed by Other MIHP Providers

Many MIHPs have developed outreach relationships with particular community organizations. Some of these relationships are long-standing. If you approach an organization that already has a relationship with another MIHP and is allowing that MIHP to conduct outreach activities on its premises, respectfully move on to another organization.

MIHPs are asked to recognize the importance of continuity of care while performing outreach activities. It is expected that new providers who are leaving the employment of another MIHP to open their own MIHP will not encourage beneficiaries to transfer to their new agency. If a woman was served by an MIHP during her pregnancy, it is recommended that she continue with that MIHP after her infant is born. However, it is ultimately up to the beneficiary to decide whether or not to transfer to a new MIHP provider.

## Filing a Complaint against another MIHP Provider

If an MIHP provider feels that another MIHP provider is consistently conducting outreach activities in an unprofessional, unfair, or unethical manner, or is otherwise acting inappropriately, the provider is encouraged to complete an *MIHP Complaint Form* and submit to MDHHS. The form is at the MIHP web site. The complaint will be investigated by one of the state consultants. If it is found that a provider is, in fact, operating unprofessionally or unfairly, the provider will be required to implement a corrective action plan.

## Helping Potential MIHP Beneficiaries to Apply for Medicaid and Maternity Outpatient Medical Services (MOMS)

Many MIHP beneficiaries who are identified through outreach are not enrolled in Medicaid (and so are not in MHPs) when MIHP services are initiated. MIHP providers cannot be reimbursed for services provided to a woman until she has applied for Medicaid, been approved, and received a Medicaid ID number.

However, if the woman enrolls in the Maternity Outpatient Medical Services (MOMS) Program at the time she applies for Medicaid, she is given a *Guarantee of Payment* letter. This letter is intended to assure providers that MDHHS will reimburse for pregnancy related services, including MIHP services, provided to the beneficiary. This letter includes information on eligibility, covered services, billing instructions, etc. A sample letter is available in the Forms Appendix of the *Medicaid Provider Manual*.

Women applying for Healthy Kids for Pregnant Women Medicaid must request a presumptive eligibility determination if they want to receive prenatal services prior to receiving a Medicaid number. Healthy Kids for Pregnant Women applicants will receive prenatal services only under their presumptive eligibility. MIHP is considered a part of the prenatal services.

While MIHP providers are not paid for assisting women to apply for Medicaid and MOMS, it is clearly to their advantage to do what they can to facilitate the submission of these applications. They may do this by helping a woman to complete an online or paper Medicaid application or referring her to the Michigan Health Care Helpline at (1-855-789-5610) or [www.Michigan.gov/mibridges](http://www.Michigan.gov/mibridges) for application assistance.

## Filing a Medicaid Application

Medicaid applications are submitted to and processed by the Michigan Department of Health and Human Services (MDHHS). If a Medicaid application is filed online, a statement is issued verifying the application date and if requested, presumptive eligibility. This statement is proof of the date that MDHHS received the application. The MDHHS standard of promptness to approve or deny a Medicaid application for a pregnant woman is 15 calendar days. The beneficiary's Medicaid ID number is issued at the time her application is approved.

## Local Health Department Medicaid Outreach Activities

Assisting MIHP beneficiaries to enroll in Medicaid is not a covered MIHP service. However, local health departments (LHDs) are encouraged to conduct Medicaid outreach activities to assist Medicaid eligible individuals to access Medicaid-covered services and some LHDs perform this function. Medicaid outreach activities include informing families, parents and community members about the Medicaid program and assisting an individual or family to enroll. For more information, go to *Medicaid Provider Manual* at [Medicaid Provider Manual](#), click on “Local Health Departments” in the bookmarks column on the left, and then go to Section 3 of that chapter.

## Using the MIHP Logo for Outreach Purposes

MIHP agencies were notified that the MIHP logo was available for use in the #9 Coordinator Email FY 14.15. Three attachments were provided:

1. MIHP Logo (in color)
2. MIHP Logo Usage Guidelines
3. MIHP Logo Permission Request Form

The logo is now also available in black and white. These documents are also posted on the MIHP web site.

All MIHP materials to display the MIHP logo must be approved by your MIHP consultant before use. To assure proper use of the logo, review the *MIHP Logo Usage Guidelines* prior to requesting approval for using the MIHP logo. When requesting to use the MIHP logo, email the completed *MIHP Logo Permission Request Form*, along with draft copies of any materials you plan to use with the MIHP logo, to your MIHP consultant. Your consultant will notify you within two weeks as to the status of your request. Contact your consultant if you have questions.

## 8.0 MIHP SERVICE DELIVERY

### Conducting Professional Visits to Deliver Care Coordination and Health Education Services

MIHP provides care coordination and health education services for maternal-infant dyads. Care coordination services are provided or overseen by a registered nurse or a licensed social worker. Education services are provided by a registered nurse, a licensed social worker, a registered dietitian, or an infant mental health specialist. MIHP staff providing care coordination and education services use a supportive approach based on Motivational Interviewing principles.

Care coordination services are much the same for all beneficiaries, but education is tailored to each individual beneficiary subsequent to the risk identification process and as documented in the *Plan of Care*.

MIHP services (except for transportation, childbirth education classes, and parenting education classes) are provided through one-on-one/dyad, face-to-face meetings, lasting at least 30 minutes. These meetings are referred to as professional visits. Professional visits are never conducted with groups of beneficiaries. The specific purpose of professional visits is to implement the *Plan of Care*, which is based on the beneficiary's *Risk Identifier* and professional observation/judgment.

### Individualized Services to Meet the Needs of Each Beneficiary

The way in which MIHP services are provided must be individualized to meet the needs of each beneficiary. Some beneficiaries may have limited reading skills or information processing difficulties, some may not speak English, some may require accommodations due to physical or emotional challenges, some may require evening or weekend appointments due to work or school schedules. MIHP providers must do everything possible to meet these needs.

### Definitions of Case Management/Care Coordination

Before discussing MIHP care coordination services in depth, it may be helpful to take a quick look at how the practice of case management/care coordination is defined. There are many definitions of case management and many other names for case management, including "care coordination." MDHHS is choosing to use the terminology "care coordination." Definitions used by the Case Management Society of America, The National Academy of State Health Policy, and The Centers for Medicare and Medicaid (CMS) are given below:

#### Case Management Society of America

The Case Management Society of America defines case management as a collaborative process of assessing, planning, implementing, facilitating, coordinating, monitoring, and evaluating the options and services required to meet an individual's health and human service needs. It is characterized by advocacy, communication, and management of available resources, and promotes quality and cost-effective interventions and outcomes. Case management services are optimized if offered in a climate that allows direct communication among the case manager, the beneficiary, the payer, the primary care provider, and other service delivery professionals.

(Excerpted from <http://www.cmsa.org/PolicyMaker/ResourceKit/AboutCaseManagers/tabid/141/Default.aspx>)

## National Academy for State Health Policy

“Case coordination” and “case management” are terms used to describe an array of activities that help to link families to services, avoid duplication of effort, and improve communication between families and providers. While some sources make a distinction between the two terms, and some have advocated replacing the term case management with care coordination, the meaning of these terms varies, depending on the provider, program or payer. In practice today, the term care coordination and case management are used interchangeably without clear and distinct usage. For example, while most public health programs and pediatric primary care providers emphasize care coordination, Medicaid has traditionally paid only for services identified as case management. The federal Medicaid statute and implementing regulations do not contain a “care coordination services” category. (Excerpted from *Improving Care Coordination, Case Management, and Linkages to Service for Young Children: Opportunities for States* (Apr 2009), National Academy for State Health Policy)

## The Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services, US Department of Health and Human Services, defines case management as “services that assist individuals eligible under the Medicaid State Plan in gaining access to needed medical, social, education and other services.” Case management includes the following elements:

1. **Assessment** of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services, such as housing and transportation. Comprehensive assessment addresses all areas of need, the individual’s strengths and preferences, and the individual’s physical and social environments. Assessment activities are defined to include the following:
  - a. Taking beneficiary history.
  - b. Identifying the needs of the individual and completing related documentation.
  - c. Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.
2. **Development of a specific care plan** based on the information collected through the assessment described above. The care plan specifies the goals of providing case management to the eligible individual, and actions to address the medical, social, educational, and other services needed by the individual. This includes activities such as ensuring the individual’s active participation, and working with the individual and others to develop goals and identify a course of action to respond to the individual’s assessed needs. While the assessment and care plan must be comprehensive and address all of the individual’s needs, the individual may decline to receive services in a care plan to address those needs.
3. **Referral and related activities** to help an eligible individual obtain needed services, including activities that help link the individual with medical, social, education providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
4. **Monitoring and follow-up activities**, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring and follow-up activities may be with the individual, family members, providers, or other entities. These activities may be conducted as frequently as necessary to help determine such matters as whether:
  - a. Services are being furnished in accordance with the individual’s care plan.
  - b. Services in the care plan are adequate to meet the needs of the individual.

- c. There are changes in the needs or status of the individual, requiring adjustments to the care plan and service arrangements with providers. (Excepted from *Federal Register*, Dec. 4, 2007, Vol. 72, No. 232, 68077-68093; 42 CFR Parts 431, 440, and 441)

## **MIHP Care Coordination Services**

### **MIHP Care Coordinator**

After the registered nurse or licensed social worker administers the *Maternal Risk Identifier* or the *Infant Risk Identifier*, the beneficiary's *Plan of Care* is developed. This is done jointly by the registered nurse and the licensed social worker. At that time, either the registered nurse or the licensed social worker is designated as the beneficiary's care coordinator. The registered dietitian and the infant mental health specialist cannot function as the care coordinator.

The name of the care coordinator must be documented in the beneficiary's record. If there is a change in care coordinators during the beneficiary's participation in MIHP, this also must be documented in the record.

The care coordinator is responsible for monitoring and coordinating all care provided for the beneficiary. This means that the care coordinator follows up with the other professionals who are working with the beneficiary to assure that the team is doing all of the following things:

1. Ensuring that the beneficiary is involved in her own care plan development and service arrangements to the greatest possible extent.
2. Using Motivational Interviewing and promoting self-empowerment and self-management.
3. Facilitating implementation of the *Plan of Care (POC)*; coordinating services when multiple providers are involved.
4. Helping the beneficiary to locate resources; facilitating connections with providers of other services and supports; advocating on behalf of the beneficiary to obtain services, if needed.  
(NOTE: The team encourages the beneficiary to take as much responsibility as possible for arranging and accessing services for herself and her infant, in that learning to navigate the health care system is an important goal for all MIHP beneficiaries. Of course, the team offers hands-on support in arranging services for beneficiaries who clearly need it, for example, women with developmental challenges or who are immobilized with depression.)
5. Following up with the beneficiary to determine if she has connected with, and is actually receiving services from, a particular referral source; if not, assisting the beneficiary to address barriers.
6. Assisting the beneficiary with needs and problems as they arise.
7. Evaluating whether the *POC* is meeting the beneficiary's goals.
8. Modifying the *POC*, as needed.
9. Communicating with medical care provider and Medicaid Health Plan.
10. Determining if specified, desired service outcomes are achieved.

### **MIHP Care Coordination Process Overview**

The MIHP care coordination process includes eight components. Some of these components can only be done by certain disciplines. The chart below shows which of the components can be done by which disciplines.

Care Coordination Process Component	Responsible Staff
1. Administration of <i>Risk Identifier</i> and completion of <i>Plan of Care, Part 1</i>	RN or SW; <i>POC 1</i> must be signed by both
2. Development of <i>Plan of Care, Parts 2 – 3</i>	RN and SW; <i>POC 3</i> must be signed by both
3. Implementation of <i>Plan of Care, Part 2</i>	Two or more of the four disciplines
4. Documentation of visits	Two or more of the four disciplines
5. Monitoring implementation of <i>Plan of Care, Part 2</i>	Care Coordinator: RN or SW
6. Coordination with Medicaid MHPs	Care Coordinator: RN or SW
7. Coordination with Medical Care Provider	Care Coordinator: RN or SW
8. Conclusion of MIHP services	Any one of the four disciplines; only the RN or SW can do the <i>Discharge Summary</i>

## Care Coordination Tracking Forms

MIHP care coordination requires attention to many different details. Three forms are used to ensure that the care coordination activities are tracked and documented:

1. The *Maternal or Infant Forms Checklist* (required) is used to track and document each component of the care coordination process from date of receipt of referral to the date the *Discharge Summary* is sent to the medical care provider.
2. The *MIHP Contact Log* or a contact log of your own design (required) is used to track and document attempts to contact the beneficiary (e.g., phone, text, email, letter, note on door, etc.) between professional visits and from the last professional visit to discharge. An agency may choose to use the MDHHS form or an alternative contact log form.
3. The *MIHP Referral Log* (optional) is used to track and document referrals to other services and supports. Although MDHHS developed this form, providers are not required to use it. However, it is recommended that providers use the MDHHS form or an alternative referral log form.

## MIHP Education Services

In addition to coordinating the beneficiary's care, the MIHP provider delivers or arranges for the delivery of a variety of education services. Education may be provided by a registered nurse, a licensed social worker, a registered dietitian or an infant mental health specialist. Education services are provided as part of the implementation of the *Plan of Care, Parts 1 - 2*.

Education is focused on the following domains for pregnant women and infants:

### **Maternal**

1. Family Planning
2. Asthma
3. Diabetes (Type 1, 2, and Gestational)
4. Hypertension
5. Pregnancy Health
6. Nutrition
7. Maternal Breastfeeding
8. Smoking & 2<sup>nd</sup> Hand Exposure
9. Alcohol
10. Drugs
11. Social Support
12. Abuse/Violence
13. Stress/Depression
14. Food
15. Housing
16. Transportation

### **Infant**

1. Infant Health Care
2. Infant Safety
3. Feeding and Nutrition
4. Infant Breastfeeding
5. General Infant Development
6. Family Social Support, Parenting and Child Care
7. Maternal Considerations
8. Substance-Exposed Infant
  - Positive at Birth
  - Primary Caregiver Use
  - Environmental Exposure

## **Psychosocial and Nutritional Assessment Tools: *MIHP Risk Identifiers***

### **Obtaining Consents Prior to Administering the *Risk Identifier***

A new, separate *MIHP Consent to Participate in Risk Identifier/MIHP Consent to Participate in MIHP* and a new, separate *MIHP Consent to Release Protected Health Information* is required for each individual beneficiary prior to administration of the *Risk Identifier*. Individual consents are required for multiples. Instructions on completion of both consent forms are posted on the MIHP web site.

If a potential beneficiary declines to sign both consent forms, the *Risk Identifier* is not administered and no MIHP services are provided. The woman is given program contact information, in case she changes her mind. She also should be given the *MIHP Parent Information Sheet* and the *MIHP Maternal and Infant Education Packet* or information about signing up for text4baby.

If the beneficiary signs the *Consent to Participate in the Risk Identifier/Consent to Participate in MIHP*, but declines to sign the *Consent to Release Protected Health Information*, you may still provide services for her. When she signs the *Consent to Participate in the Risk Identifier/Consent to Participate in MIHP*, the beneficiary is authorizing data entry into the SSO System because SSO is part of MDHHS. It is not a separate entity that would require a signed *Consent to Release Protected Health Information* form.

If your agency has an in-house release, you are still required to use the MIHP release forms. If you have an agency release form that lists different agencies and medical care providers, you will need to list them again on the *MIHP Consent to Release PHI* form. If you need more lines you may attach an additional page.

If a *Risk Identifier* is administered and the beneficiary initially declines to participate in MIHP (checks the “I do not wish to participate” box on the *Consent*), but then she changes her mind, use a new consent form.

### ***Risk Identifier* Required Prior to Providing MIHP Services**

Medicaid requires that a psychosocial and nutritional assessment is completed before the beneficiary's *POC* is developed and before she receives any type of MIHP service. The *Maternal and Infant Risk Identifiers* are the MIHP psychosocial and nutritional assessment tools.

The *Risk Identifier* must be administered, the *POC 1* must be completed, and the *Risk Identifier* data must be entered into the MDHHS database before the *Plan of Care (POC)*, *Parts 2-3* are developed and before any professional visits or other services are provided. The *Risk Identifier* must be administered and the *POC 1* needs to be completed before transportation services, childbirth education classes, or parenting education classes can be provided, unless there is a documented emergency.

There's a single exception to the requirement that the *Risk Identifier* must be administered before transportation services can be provided, other than in an emergency situation. This exception is for Nurse Family Partnership beneficiaries who may receive transportation services through MIHP. Additional information on MIHP transportation provided to NFP beneficiaries is provided in *Chapter 5 – Reimbursement for MIHP Services*.

The paper *Risk Identifier* functions as a worksheet only. The electronic version must be printed out and filed in the beneficiary's paper chart or scanned into the electronic record as soon as the data has been entered into the database.

### **When Multiple Providers are Working to Enroll the Same Beneficiary**

There may be times when multiple providers are working to enroll the same beneficiary in their respective MIHPs. When this happens, the provider that first enters the *Risk Identifier* data into the MIHP database and obtains a score sheet is the one that is authorized to serve the beneficiary and receive payment for the *Risk Identifier* visit.

### **Administering the *Risk Identifier* with Primary Caregiver**

Most often, the *Infant Risk Identifier* is done with the infant's biological mother. However, if the biological mother is not the infant's primary caregiver, the *Risk Identifier* is done with the individual who is functioning as the primary caregiver.

If the primary caregiver is not the mother, certain sections of the *Infant Risk Identifier* are not completed. *The Infant Risk Identifier - Maternal Component* has a checkbox to indicate that the primary caregiver is not the mother. When this box is checked, the fields that aren't pertinent are not asked. For example, a foster parent will not be asked questions that do not pertain to her.

### **When to Administer the *Infant Risk Identifier***

Administer the *Infant Risk Identifier* as soon after birth as possible. If you have been serving the infant's mother prenatally, do not wait until her postpartum visit is completed before you administer the *Infant Risk Identifier*.

### **Risk Domains Covered by *Risk Identifiers***

The *Maternal Risk Identifier* is the MIHP tool used to determine specific risks of pregnant women. It includes questions under the following headings: Demographics; Basics; Household Members; Health History: Pregnancy; Health History: Hypertension, Asthma, Diabetes; Health History: HIV Sexually Transmitted Infection; Health History: Other; Family Planning; Prenatal Care; Nutrition; Breastfeeding;

Smoking; Alcohol; Drug Use; Stress; Depression and Mental Health; Depression Follow-up Screening; Social Support; Abuse and Violence; Basic Needs – Housing; and Basic Needs – Food/Transportation.

The *Infant Risk Identifier* is the MIHP tool used to determine specific risks of infants and their primary caregivers. It includes questions under the following headings: Demographics, Maternal/Infant Basics, Maternal Family Planning, Maternal Smoking, Maternal Alcohol, Maternal Drugs, Maternal Stress, Maternal Depression & Mental Health, Depression Follow-up Screening, Maternal Abuse and Violence, Maternal Basic Needs, Parenting, Infant Family Support, Parenting and Childcare, Infant Birth Health Status, Infant Health Care, Infant Safety, Infant Feeding and Nutrition, Infant General Development.

The *Risk Identifiers* do **not** address every conceivable risk to maternal and infant health. When the literature review was conducted in the early stages of the MIHP re-design, the goal was to identify only those risks that were **clearly** linked to poor birth outcomes **and** for which there were interventions that had proven successful (or were at least very promising) in reducing those risks. Only risks that met both of these criteria were included in the *Maternal Risk Identifier*, as the intent of the re-design was to move toward making MIHP an evidence-based model.

The professional staff must ask each question on the *Risk Identifier*. The staff may complete the *Risk Identifier* either by writing the beneficiary's responses on a hard copy or by electronically entering her responses while asking the questions.

### **Establishing Rapport at *Risk Identifier* Visit**

During the enrollment visit with the pregnant beneficiary or primary caregiver, establishing rapport is imperative, as this will increase the likelihood that the beneficiary will want to stay in the program. Therefore, when soliciting a response, *Risk Identifier* questions should be asked in a caring and empathetic manner. The timing of asking sensitive questions, such as those pertaining to domestic violence or drug use, should be a consideration. If the beneficiary chooses not to respond to specific questions initially, the MIHP staff should ask the questions at a later visit and document the beneficiary's response on a *Professional Visit Progress Note*.

### **If a Woman Declines MIHP Services after *Maternal Risk Identifier* Administered**

If a woman declines MIHP services after the *Maternal Risk Identifier* has been administered, she should be asked if the provider may contact her again around the time that the baby is due to see if she would like services at that time. If she says yes, the provider should use a tickler file to ensure that a staff re-contacts the woman at that time. If a mother declines services for her infant after the *Infant Risk Identifier* has been administered, she should be asked if the provider may contact her a few months later to see if she would like MIHP services at that time.

### **Data Entry and Scoring Results Page**

After the *Risk Identifier* is administered, the responses are entered in the MDHHS MIHP database. All responses, except for the Medicaid ID number, must be entered into the database in order to get a *Score Summary* printout. The *Maternal Risk Identifier Score Summary* printout indicates the pregnant woman's level of risk for each maternal domain and her overall risk score. The *Infant Risk Identifier Score Summary* printout indicates the infant's level of risk for each infant domain and his overall risk score, as well as the mother's level of risk for each maternal domain and her overall risk score.

Each domain scores out at one of the following risk levels: no, low, moderate, high or unknown. Not all of these risk levels are available as options in all domains. "Unknown" is used when the potentially high risk questions regarding a specific domain are not answered by the beneficiary. These include specific questions regarding previous poor birth outcomes, alcohol or drug use, abuse/violence, stress/depression/mental health, and family planning. If a specific domain scores out as "unknown", implement the highest risk level interventions available for that domain, not including the emergency level interventions.

The overall score is determined as follows:

- No Risk:** If no domain has a high, moderate or low score and no unknown or refused responses were given
- Low Risk:** If no domain has a high or moderate score and no unknown or refused responses were given
- Moderate Risk:** If no domain has a high score and at least one domain has a moderate score and no unknown or refused responses were given
- High Risk:** If any domain has a high score
- Unknown Risk:** If no domain has a high score and at least one unknown or refused response was given to the high-risk questions

## **Step-by-Step Implementation of the MIHP Care Coordination and Health Education Services**

MIHP providers strive to identify and enroll women in MIHP as early in their pregnancies as possible. Research has shown that outcomes are better if a pregnant woman enrolls in MIHP in her first or second trimester. However, some women are not identified and enrolled in MIHP while they are pregnant. Their infants may be enrolled in MIHP after hospital discharge or at any other time during infancy up to 12 months of age. After the birth of the infant, the MIHP provider works with the infant's primary caregiver. Most often, this is the infant's mother. However, if the mother is not the infant's primary caregiver, the MIHP provider may visit with another individual who is serving in this capacity.

### **Differences between MIHP Prenatal and Infant Services**

The provider can render services to the pregnant woman or mother-infant dyad in order to complete the beneficiary's *Plan of Care* until all available visits are used. There are 9 visits available during the prenatal and postpartum period and 9 visits available during infancy. In infancy however, after the first 9 visits are completed, an additional 9 visits may be provided in order to meet the *POC* objectives, if authorized by the infant's medical care provider or standing order. A total of 36 visits may be provided for drug-exposed infants, if authorized by the infant's medical care provider or standing order. During the entire time that the pregnant or infant beneficiary is receiving MIHP services, appropriate referrals should be made and all beneficiary questions should be answered.

MIHP care coordination and health education services activities during the pregnancy and infancy phases are essentially the same, but there are some differences. For example, the required forms, while similar, do not contain all of the same information and questions, and educational interventions vary somewhat.

Another difference is that during the infancy phase, developmental screening is provided for all infant beneficiaries. This is because infancy is a time of dynamic change across developmental domains (communication, gross motor, fine motor, problem-solving, social and emotional) and an infant's status may change in a surprisingly short period of time. Unless ongoing developmental screenings are conducted, early identification of concerns may not occur, and necessary referrals, support and treatment may not be provided for the infant. This is why MIHP conducts repeated developmental screenings throughout the infant's first year of life. The care coordinator provides support, as the infant's primary caregiver is helped to closely monitor her infant's health, safety and development.

## MIHP Service Delivery Tasks by Care Coordination Component

Below is an outline of tasks that are to be performed by the MIHP provider when a woman enrolls in MIHP while she is pregnant or after her baby is born, whether or not she participated in MIHP during her pregnancy. These tasks are classified under the following headings:

1. Risk Identification (Psychosocial and Nutritional Assessment)
2. *Plan of Care (POC)* Development
3. *Plan of Care* Implementation
4. Documentation of Visits
5. *Plan of Care* Implementation Monitoring
6. Coordination with Medicaid Health Plans
7. Coordination with Medical Care Provider
8. Conclusion of MIHP Services

### **1. Risk Identification (Psychosocial and Nutritional Assessment)**

- a. Upon receipt of a referral to your MIHP, verify the correct spelling of the beneficiary's name in CHAMPS, if she is enrolled in Medicaid.
- b. Determine if another provider has already done a *Risk Identifier* for the referred individual. Do this by using the "check for existing screens" function of the MDHHS MIHP electronic database. When you select this function, instructions are provided. If another provider has done a *Risk Identifier*, do not do another one. Never open a maternal or an infant case without checking to see if beneficiary is already being served by another provider.

If the potential maternal or infant MIHP beneficiary is identified through outreach (e.g., at WIC office, MDHHS office, OB clinic, hospital, pediatric clinic, etc.), you still need to determine if beneficiary is already involved with another MIHP provider by using the database "check for existing screens" function.

If you find that a beneficiary is enrolled in another MIHP, encourage her to stay with her current MIHP provider, if possible. If she chooses to transfer to your program, ask her to sign a *Consent to Transfer MIHP Record to a Different Provider (Consent to Release Protected Health Information)* and obtain her information from the other provider. Do not administer another *Risk Identifier*.

- c. Never enter a beneficiary's name into the database as a placeholder; you are NOT allowed to claim that you are serving a potential beneficiary before you obtain consents and administer the *Risk Identifier*.
- d. Meet individually, face-to-face with the potential MIHP beneficiary or beneficiary's primary caregiver.
  - 1) Carefully explain MIHP. You may give the beneficiary the *MIHP Parent Information Sheet*, but don't expect that it will provide a sufficient explanation. One of the reasons women give for dropping out of home visiting programs is that they didn't understand why the home visitor was really there or didn't see how the home visitor could actually help them. You may need to explain MIHP more than once at the *Risk Identifier* visit.
  - 2) Carefully explain the *Consent to Participate in MIHP Risk Identifier Interview/Consent to Participate in MIHP* form and obtain beneficiary's signature. The potential beneficiary, or the

primary caregiver if the beneficiary is an infant, must print and sign her name on this form before you can administer the *Risk Identifier* and enroll her in MIHP.

- 3) If the potential beneficiary **declines** to sign the *Consent to Participate in the MIHP Risk Identifier Interview/Consent to Participate in MIHP* you do not administer the *Risk Identifier* and she is not eligible to receive any MIHP services, including child birth education classes, parenting classes or transportation. Proceed as follows:
  - a) Give her your program contact information in case she changes her mind. Provide her with the *MIHP Parent Information Sheet* and *MIHP Maternal and Infant Education Packet* and/or tell her how to sign up for *text4baby*. Ask if you may contact her near her due date to see if services are needed at that point. If the potential beneficiary is an infant, ask the primary caregiver if you may contact her in a few months to see if services are needed at that point.
  - b) If a pregnant woman is not a Medicaid beneficiary, help her to apply for Medicaid and MOMS online or to complete the paper application form. Alternatively, you may refer her to [www.Michigan.gov/mibridges](http://www.Michigan.gov/mibridges) or the Michigan Health Care Helpline at (1-855-789-5610) for application assistance. Encourage her to select a Medicaid Health Plan (MHP) as soon as she receives notice that her Medicaid application has been approved (rather than wait an additional 30 days to be automatically assigned). The legal standard of promptness requires MDHHS to process a pregnant woman's Medicaid application within 15 days from the date of submission.
  - c) If a woman with an infant was a Medicaid beneficiary while she was pregnant (coverage continues during the month her pregnancy ends and during the two calendar months following the month her pregnancy ends), encourage her to inform MDHHS of the baby's birth immediately, so that MDHHS can issue the infant a Medicaid ID number and enroll the infant in the MHP.
  - d) If a woman with an infant was not a Medicaid beneficiary while she was pregnant and her infant is not a Medicaid beneficiary, help her to complete an online or paper Medicaid application on behalf of her infant. Alternatively, you may refer her to [www.Michigan.gov/mibridges](http://www.Michigan.gov/mibridges) or the Michigan Health Care Helpline at (1-855-789-5610) for application assistance. Encourage the mother to enroll the infant in an MHP as soon as she receives notice that the infant's Medicaid application has been approved (rather than wait the 30 days to be automatically assigned). Do not open a case, as no billable service has been provided.
  - e) If a potential beneficiary who declines to participate in MIHP is enrolled in an MHP, you must notify her MHP that she has declined MIHP, using the *MHP/MIHP Collaboration Form* or other mutually-agreed-upon form.
- 4) If the beneficiary **agrees** to sign the *Consent to Participate in MIHP Risk Identifier Interview/Consent to Participate in MIHP*, proceed as follows:
  - a) Explain the *MIHP Consent to Release Protected Health Information*. Complete the form with her, and ask her to print and sign her name on the form.
  - b) Administer either the *Maternal Risk Identifier* or the *Infant Risk Identifier*. The *Risk Identifier* is the MIHP psychosocial and nutritional assessment form.
  - c) After completing the *Risk Identifier*, give the beneficiary or the beneficiary's primary caregiver the entire *MIHP Maternal and Infant Education Packet* (do not

split it into maternal and infant packets and hand them out separately) and/or assist her to sign up for *text4baby*. Providing the *Education Packet* and/or *text4baby* is part of the *Risk Identifier* visit. At future visits, you will review the packet materials with her, as needed. Of course there is the possibility that you will need to replace the packet or components that you find necessary, if she doesn't keep the packet. You need to document that she signed up for *text4baby*, if that was her choice, on the *POC 1*.

- d) Complete each of the tasks listed on the *Plan of Care, Part 1*, which is discussed below (2. *Plan of Care Development*). If the beneficiary has an emergency situation, you can assist her to deal with the crisis before doing the *POC, Part 1*.
- e) If you have time after you administer the *Risk Identifier*, you may address some of the domain topics from the *POC 1*, using the *Education Packet*.
- f) Assist beneficiary to apply for Medicaid for herself or infant if not already covered, as described below:
  - 1) If a pregnant woman is not a Medicaid beneficiary, help her to apply for Medicaid and MOMS online or to complete the paper application form. Alternatively, you may refer her to [www.Michigan.gov/mibridges](http://www.Michigan.gov/mibridges) or the Michigan Health Care Helpline at (1-855-789-5610) for application assistance. Encourage her to select a Medicaid Health Plan (MHP) as soon as she receives notice that her Medicaid application has been approved (rather than wait an additional 30 days to be automatically assigned). The legal standard of promptness requires MDHHS to process a pregnant woman's Medicaid application within 15 days from the date of submission.
  - 2) If a woman with an infant was a Medicaid beneficiary while she was pregnant (coverage continues during the month her pregnancy ends and during the two calendar months following the month her pregnancy ends), encourage her to inform MDHHS of the baby's birth immediately, so that MDHHS can issue the infant a Medicaid ID number and enroll the infant in the MHP selected by the mother.
  - 3) If the woman was not a Medicaid beneficiary while she was pregnant and her infant is not a Medicaid beneficiary, help her to complete an online or paper Medicaid application on behalf of her infant. Alternatively, you may refer her to [www.Michigan.gov/mibridges](http://www.Michigan.gov/mibridges) or the Michigan Health Care Helpline at (1-855-789-5610) for application assistance. Encourage the mother to enroll the infant in an MHP as soon as she receives notice that the infant's Medicaid application has been approved (rather than wait the 30 days to be automatically assigned).

It may take up to two months for MDHHS to provide the infant's Medicaid ID number. Presumptive eligibility letters are not issued for infants, as they are for pregnant women. However, if the mother was an enrolled Medicaid beneficiary at the time of the infant's birth, it is likely that the infant will be Medicaid eligible. If the infant does qualify, claims may be submitted retroactively to birth.

- g) If the woman declines MIHP services after the *Risk Identifier* has been administered, give her your program contact information in case she changes her mind. Provide her with the *MIHP Parent Information Sheet* and *MIHP*

*Maternal and Infant Education Packet* and/or tell her how to sign up for text4baby. Ask if you may contact her near her due date to see if services are needed at that point. If the potential beneficiary is an infant, ask the primary caregiver if you may call back in a few months to see if services are needed at that point.

- h) Enter *Risk Identifier* data into the MIHP electronic database. (NOTE: Do not enter **any** data into the database until the beneficiary has signed the *Consent to Participate in Risk Identifier Interview/Consent to Participate in MIHP* and the *Consent to Release Protected Health Information* and the *Risk Identifier* has been administered.)

Upon completion of data entry, a computer-scored *Score Summary* is provided. All responses, except for Medicaid ID number, must be entered into the database in order to get the *Score Summary* printout. The maternal *Score Summary* includes: 1) the beneficiary's risk factors, stratified into no, low, moderate, high or unknown risk levels, and 2) a determination of overall risk level. The infant *Score Summary* includes: 1) the infant's and mother's risk factors, stratified into no, low, moderate, high or unknown risk-levels, and 2) a determination of overall risk level for each beneficiary. If a specific domain scores out as "unknown", implement the highest risk level interventions available for that domain, not including the emergency level interventions.

- i) You can enter the *Maternal or Infant Risk Identifier* data and get the *Score Summary* printout before you have the beneficiary's Medicaid ID number. However, in order to complete the *Risk Identifier*, you must go back and enter the ID number when you get it. You may not bill for the *Risk Identifier* until you have completed the *Risk Identifier*, entered the *Risk Identifier* data into the database (with the Medicaid ID number), and developed the *POC Parts 1, 2, and 3*. The *Risk Identifier* is considered complete when data has been entered into all required fields, including the Medicaid ID number.
- j) It is essential that you enter the beneficiary's Medicaid ID number as soon as you receive it.
- k) On occasion, you may need to make a correction to a record in the MIHP database (*Risk Identifier* or *Discharge Summary*). Instructions on how to do this are posted on the MIHP web site.
- l) File the electronic *Risk Identifier* and the *Risk Identifier Score Summary* in the beneficiary's chart. It's expected that all professional staff have access to the total chart and will read the entire *Risk Identifier* printout, not just the *Score Summary*, in order to get a comprehensive understanding of the beneficiary's risks and circumstances.
- m) You may not bill for the *Risk Identifier* until you have administered the *Risk Identifier*, entered the *Risk Identifier* data into the database (with the Medicaid ID number), and developed the *POC Parts 1 - 3*.
- n) You may bill for administering the *Risk Identifier*, even if the beneficiary declines services. If a potential beneficiary agrees to participate in the *Risk Identifier* interview but does not agree to participate in MIHP, you complete the *Risk Identifier* interview, enter her data into the MIHP electronic database, develop the *POC Parts 1 - 3* (which will contain minimal documentation, including that she completed the *Risk Identifier* and *POC Part 1*, but declined services), and complete a *Discharge Summary*. You can bill for the completed *Risk Identifier*

only after her *Risk Identifier* data has been entered into the MIHP electronic database.

- o) If you complete a *Risk Identifier* for a pregnant woman but she is not approved for Medicaid, delete it from the database if it's within 120 days from the date you printed out the *Risk Identifier Score Summary*. If you experience any difficulties, contact MDHHS.
- p) If you implement one or more *POC 2* interventions at the time of the *Risk Identifier* visit, document this on the appropriate *POC 2* domain, noting the "Date Achieved". If the domain subsequently doesn't score out as a risk on the *Risk Identifier* summary, you can identify it as a risk based on professional observation and judgment, if the criteria in Column 2 are met. If you make a referral during this visit, document it on the *Professional Visit Progress Note* or on the optional *MIHP Referral Follow-up Form*.
- q) There is a not a specific box or space on the *Risk Identifier* to enter the location of the beneficiary's medical care provider. You can add this information to the comment section of the *Risk Identifier* or to your own form.

## **2. Plan of Care (POC) Development**

The foundation of MIHP care coordination is the *Plan of Care (POC)*. The *POC* consists of three standardized forms:

- Maternal or Infant Plan of Care Part 1 (POC 1)*
- Maternal or Infant Plan of Care Part 2, Interventions by Risk Level (POC 2)*
- Plan of Care Part 3, Signature Page for Interventions by Risk Level (POC 3)*

### **Plan of Care, Part One (POC 1)**

The *Maternal POC 1* or the *Infant POC 1* is completed for all beneficiaries after the *Risk Identifier* is administered. The *POC 1* documents that the professional (RN or SW) has completed the following tasks at the time of the *Risk Identifier* visit:

1. Provided the beneficiary (pregnant woman or infant's primary caregiver) with the standardized *MIHP Maternal and Infant Education Packet*, which includes information about each of the MIHP risk domains, or assisted the beneficiary to sign up for *text4baby*, or both. NOTE: If the beneficiary chooses *text4baby* rather than the packet, the professional must follow-up at subsequent visits to ensure that beneficiary is receiving *text4baby* messages.
2. Provided an opportunity for the beneficiary to ask questions.
3. Provided the beneficiary with written information about the Healthy Michigan Plan.
4. Made a referral to WIC, if needed.
5. Prepared the beneficiary for further MIHP visits.
6. Provided the beneficiary with the MIHP agency's contact information and information about how to contact the agency if assistance is needed between scheduled appointments.
7. Provided the beneficiary with the following:

<b>Pregnant beneficiary</b>	<b>Infant beneficiary's primary caregiver</b>
Advice on how to access community-based no and low cost food programs.	Information about parenting classes and support groups available in the community.
Assistance with identifying an emergency transportation plan.	Information about developmental screening using ASQ-3 and ASQ: SE-2 Questionnaires corresponding to the infant's age.
Assistance with identifying at least one	

individual to call when needed.	
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8. Schedule a follow-up appointment, if applicable.

The *POC 1* must be completed, signed and dated by both RN and SW within 10 business days of each other. It is expected that in most instances, the professional who administers the *Risk Identifier* will sign the *POC 1* on the date of the *Risk Identifier* visit. The second required professional signature must be dated within 10 business days of the date of the first signature.

### **Plan of Care, Part Two (POC 2)**

MDHHS has developed a standardized set of *POC 2* interventions for pregnant beneficiaries and a standardized set of *POC 2* interventions for infant beneficiaries. The interventions are built on evidence-based, promising, and emerging practices identified in the literature, as well as best-practices. Various MIHP stakeholders, including MIHP providers and Medicaid, provided input as the interventions were developed.

MIHP providers are required to implement the standardized interventions, but it is expected that they will use professional observation and judgment as they do so. These are considered to be minimum interventions; providers can do more if they are in a position to do so.

### **Maternal Beneficiary with No Identified Risks**

Once the *Risk Identifier* data are entered into the MIHP database and the *Score Summary* printout becomes available, the nurse and social worker determine whether or not a *POC 2* is needed. If a woman's *Maternal Risk Identifier* overall score is "no" risk, and no other risks are identified based on information obtained through interviews or professional observation, a *POC 2* is not completed and no intervention is provided. Staff asks the woman if MIHP may contact her again around the time that her baby is due to ask if she would like to participate in the program at that time.

However, if the beneficiary states that she wants you to visit her even though zero risks have been identified, you may do so. In this case, you must carefully document why she wants you to visit. As you discuss this with her, you may find that she actually does meet risk criteria in one or more *POC 2* domains (e.g., social support, transportation, etc.) and then you would develop a *POC 2*. As the beneficiary begins to trust you, she may reveal other information indicating that she is at risk in additional domains.

If you do not determine that she meets risk criteria in one or more *POC 2* domains, service would involve the provision of education per the *POC 1*, but not implementation of *POC 2* interventions, and your activities would be documented on the *Professional Visit Progress Note* under "other visit information."

### **Developing the POC 2 for Beneficiaries with Identified Risks**

The *POC 2* is developed for all beneficiaries with identified risks. If a woman's *Maternal Risk Identifier* overall score is "moderate," "high" or "unknown" risk, or her score is "no" risk but additional risks are identified based on information obtained through interview or professional observation, staff completes a *POC, Part 2* and intervention is provided. Before the *POC 2* is drafted, the professional who administers the *Risk Identifier* should talk with the beneficiary to get her input on her own problems, needs, goals, and objectives, so they can be clearly reflected in the *POC*.

The registered nurse and licensed social worker must develop the *POC 2* together. The registered dietitian and infant mental health specialist may provide input into the *POC 2* development process.

A face-to-face conference is recommended, but not required, when developing the *POC 2*. Care conferencing by phone is acceptable. It is also acceptable for one party to draft the *POC 2* and leave it for another party to review and sign. The care coordinator is identified and documented as the *POC 2* is developed.

## **POC 2 Domains**

To develop the *POC 2*, the nurse and social worker use the standardized *Maternal or Infant Plan of Care Part 2, Interventions by Risk Level* forms to document the interventions that will be implemented with a particular beneficiary. Separate interventions are provided for risk domains covered in the *Maternal and Infant Risk Identifiers*. There are 16 maternal risk domains and 8 infant risk domains. This means that a maternal beneficiary's *POC 2* will consist of one to 16 domains and an infant beneficiary's *POC 2* will consist of one to eight domains.

*Plan of Care Part 2, Interventions by Risk Level* forms are available at [www.michigan.gov/mihp](http://www.michigan.gov/mihp) for each of the following domains:

### **Maternal**

1. Family Planning
2. Asthma
3. Diabetes (Type 1, 2, and Gestational)
4. Hypertension
5. Pregnancy Health
6. Nutrition
7. Maternal Breastfeeding
8. Smoking & 2<sup>nd</sup> Hand Exposure
9. Alcohol
10. Drugs
11. Social Support
12. Abuse/Violence
13. Stress/Depression
14. Food
15. Housing
16. Transportation

### **Infant**

1. Infant Health Care
2. Infant Safety
3. Feeding and Nutrition
4. Infant Breastfeeding
5. General Infant Development
6. Family Social Support, Parenting and Child Care
7. Maternal Considerations
8. Substance-Exposed Infant
  - Positive at Birth
  - Primary Caregiver Use
  - Environmental Exposure

There is no infant *POC 2* domain for birth health, although questions about it are included in the *Infant Risk Identifier*. Birth health is a static, one-time assessment and there are no interventions for it because we don't have the ability to change the status of an event that occurred in the past.

Most *POC 2* domains have moderate, high and emergency interventions. Some domains have low, moderate and emergency interventions. Some domains have only moderate and high level interventions. This is because of the nature of a particular domain.

There are several domains that score out "unknown" if the beneficiary does not answer certain questions. These include specific questions regarding previous poor birth outcomes, alcohol or drug use, abuse/violence, stress/depression/mental health, and family planning. If a specific domain scores out as

"unknown", implement the highest risk level interventions available for that domain, not including the emergency level interventions.

There is no requirement that the *POC 2* address a particular number of domains. Rather, a beneficiary's *POC 2* must incorporate all of the domains that correspond to her individual risks, as identified by the *Risk Identifier* or by the registered nurse or licensed social worker, based on observation and information gathered during the initial interview.

However, *POC* implementation is client-focused, meaning that the beneficiary selects the domains that are priorities for her and that she wishes to address. The beneficiary's record must state why interventions addressing the other risks are not being provided.

## **Pulling the *POC 2* Domains and Completing the Forms**

To compile the *POC 2*, the nurse and social worker pull a *POC 2* risk domain form (*Interventions by Risk Level*) for each of the beneficiary's identified risks, including those identified by the *Risk Identifier* and those identified by professional observation and judgment. The *Maternal Plan of Care, Part 2 Interventions by Risk Level* and the *Infant Plan of Care, Part 2, Interventions by Risk Level* forms are divided into three columns: intervention level based on risk identifier; risk information; and intervention. Detail on completing these three columns is provided below:

**Column 1: Intervention level based on risk identifier.** Check the box in this column to reflect the risk level that is generated by the *Maternal Risk Identifier* or *Infant Risk Identifier* algorithm for a given domain. This is the level of service that can be anticipated based on the beneficiary's responses to specific questions on the *Risk Identifier*. For example, if the beneficiary scores moderate risk in the Abuse/Violence domain, check the moderate box in this column. You are not required to fill in the date in the space provided below the checkbox when you initially develop the *POC* and the risk was generated by the *Risk Identifier*, but you are not prohibited from doing so. (NOTE: There is also an emergency level of service for several domains which does not score out, as it is based on professional judgment rather than the algorithm.)

You cannot electronically override the computerized assessment results (*Risk Identifier* scores). In other words, you cannot change the risk level for any domain that scored out as a risk on the *Risk Identifier* as you develop the initial *POC 2*. However, you can add a domain based on professional judgment if the beneficiary meets the criteria designated in Column 2 (Risk Information). If you do add a domain before the initial *POC 3* is signed, document the date that it was added on the *POC 2* in the space provided in Column 1.

**Column 2: Risk information.** The second column has descriptions of the risks that are anticipated at each intervention level. Some of the risks are identified on the *Maternal Risk Identifier* or *Infant Risk Identifier* per the algorithm. Other risks are based on professional observation and judgment.

The purpose of Column 2 is to assist you if you are considering adding a domain or changing the risk level for an existing domain based on professional observation and judgment. If, and only if, the beneficiary's risk information matches the criteria in Column 2, you can add a domain or change the risk level.

The *Risk Identifier* algorithms are posted on the MIHP web site. *POC 2s* are not designed to include all of the items from the algorithm. Column 2 does not include every item from the algorithm or every observation you possibly could make as a professional. NOTE: An algorithm is a formula or precise step-by-step plan for a computational procedure to solve a particular problem, especially by a computer. To be an algorithm, a set of rules must be unambiguous and have a clear stopping point (Definition adapted from online sources).

**Column 3: Intervention.** The third column specifies the standardized interventions for a given domain. Interventions are minimum expectations of service delivery and are developed based on best practices and available evidence. Interventions are to be implemented using motivational interviewing techniques. Interventions are stratified by risk level. Risk levels may include low risk, moderate risk, high risk and emergency, but all domains don't have all of these risk levels.

Each intervention is numbered. The number is documented on a *Professional Visit Progress Note* each time the intervention is implemented. There is also a *Date Achieved* space after each intervention. The date is inserted when the intervention is first implemented. If the intervention is re-implemented at a later visit, do not change the *Date Achieved*. You may choose to add additional dates each time the intervention is re-implemented, but this is not required.

There is a checkbox at the top of the interventions column which is used to document that the beneficiary has refused all domain interventions.

Not all interventions are applicable to every beneficiary who scores out at a particular level in a particular domain. For example, two women may score out as high risk in the depression domain but one may require a mental health referral and the other may not, as she is already in treatment.

Detailed instructions for completing the *POC 2* are on the MIHP web site.

### **Plan of Care, Part Three (POC 3)**

*The Plan of Care, Part 3, Signature Page for Interventions by Risk Level* is a form used to document that the licensed social worker and registered nurse have jointly developed the *POC 2*, concur on the interventions to be implemented, and are responsible for implementation. The RN and SW must sign and date the *POC 3* within 10 business days of each other. This means that the *POC 3* can have different signature dates, but these dates must be within the 10-day limit. An additional signature line is provided for other disciplines contributing to *POC 2* development.

The *POC 2* and the *POC 3* must be completed and signed by the RN and SW before any professional visits are conducted, unless there is a documented emergency. There is no requirement that the *POC 2* and the *POC 3* must be completed within a certain number of days from the date that the *Risk Identifier* was administered.

### **Changing the Risk Level after the *POC 2* is Developed and the *POC 3* is Signed**

After the *POC 2* is developed and signed, you may increase or decrease the risk level for a particular domain, but only if the beneficiary meets the criteria designated in Column 2 (Risk Information) of the *POC 2* for that domain. For example, if the beneficiary scored moderate risk in a particular domain on the *Risk Identifier*, but you use professional judgment to determine that she meets the Column 2 criteria for high-risk, you would increase the risk level to high and use the high-risk interventions.

You can only document a risk level that has corresponding interventions for a particular *POC* domain. Document the date that you change the risk level in the *Date* space provided in Column 1 of the *POC 2*, and document the reason for the change in risk level on the *Professional Visit Progress Note* or *Contact Log*.

You cannot change the risk level during the case conference when the initial *POC 2* is developed. You must conduct at least one professional visit after the *Risk Identifier* visit to be able to change the risk level.

## **Adding a New Risk Domain after the POC 2 is Developed and the POC 3 is Signed**

After the POC 2 has been developed and the POC 3 has been signed by the RN and SW, you may add a risk domain based on professional observation and judgment, but only if the beneficiary meets the criteria designated in Column 2 (Risk Information) of the POC 2 for that domain. If you add a domain, document the date that it was added on the POC 2 in the space provided in Column 1 and place it in the beneficiary's chart. The RN and SW must update and sign the POC 3, documenting that a domain has been added. You must use the *Prenatal or Infant Care Communication/Notification of Change in Risk Factors Form* and *Cover Letter Form B* to inform the medical care provider of this change.

### **3. Plan of Care, Part 2 (POC 2) Implementation**

POC 2 implementation typically begins with the first professional visit after the *Risk Identifier* visit. However, at times you may provide POC 2 interventions at the *Risk Identifier* visit. If you do, document the *Risk Identifier* visit date in the "Date Achieved" space in Column 3 on the appropriate POC 2 domain page. You may also document interventions provided before the official development of the POC 2 on a *Professional Visit Progress Note* or *Contact Log*.

Always check CHAMPS before you go out on a visit to determine if the beneficiary is currently enrolled in Medicaid. This can alert you to the fact that you may not be paid for the visit. It is also good practice to check CHAMPS to see if the beneficiary has been assigned to a MHP or Integrated Care Organization before you go out on a visit.

Discussion of the POC 2 with the beneficiary at the first professional visit should cover the *Risk Identifier* results and which domains the beneficiary chooses as her priorities. It is critical for her to see how her priority needs and goals are being incorporated in the POC 2. If she can't see "what's in it for me", she may drop out very quickly. Help the beneficiary to identify what will make a positive difference in her life. You may use *The Difference Game* (available from the MIHP state team) for this purpose.

Although the beneficiary selects her own high-priority domains, this doesn't mean that you ignore her low-priority risk domains; in fact, you are required to bring up all of her risk domains at some point or to document why you did not do so on the *Professional Visit Progress Note* or *Contact Log*. Use Motivational Interviewing techniques, respect the beneficiary's preferences, and gently encourage her to look at risk domains she is reluctant to address.

If the *Maternal Risk Identifier* indicates that the woman is at no risk overall, give her your program contact information, should she need assistance later in her pregnancy. Also ask if you may contact her as she nears the end of her pregnancy to discuss preparedness for the infant, and again after her infant is born, to assess her infant for MIHP services.

If the woman has no identified risks but sees the benefit of MIHP, or in your professional judgment it would be appropriate to serve her, you may initiate services, but you must clearly document the need for MIHP education and other supportive services in the *Risk Identifier* comment section or under "other visit information" on the *Professional Visit Progress Note*. In this case, you would have no POC 2 domain interventions to implement, so you would be providing education using the *MIHP Maternal and Infant Education Packet* or *text4baby* and documenting your activities under "other visit information" on the *Professional Visit Progress Note*. You would also complete a *Discharge Summary* at the end of service.

If the *Infant Risk Identifier* indicates that the infant is at no risk overall, you serve the infant anyway, in order to be able to conduct developmental screenings.

As you conduct visits to implement the *POC 2*, be sure to:

- a. Be prepared for every visit. Staff must review the individual beneficiary's *POC 2* and should review *Professional Visit Progress Notes* before each visit.
- b. Implement the interventions as specified in the *POC 2* for each domain. These are standardized interventions upon which the statewide MIHP evaluation is based; all MIHPs must essentially be implementing the same model in order for MIHP to be designated as evidence based. However, not all interventions will be applicable to all beneficiaries. For example, if an intervention is to refer the beneficiary to a particular service, but she already accessing that service, you would not make the referral. Date only the interventions that you actually provide on the *POC 2*.
- c. Implement *POC 2* interventions only for risk domains that are included in the *POC 2*.
- d. Provide interventions during visits that reflect the *POC 1* and/or *POC 2*.
- e. Provide interventions at or below the beneficiary's current documented level of risk. If you provide interventions above the beneficiary's documented level of risk for any domain, the electronic *Discharge Summary* will not record them in the "Interventions Provided" section. This means that the information will not be captured in the MIHP database at this time.

In order to provide the most appropriate care, you should increase the risk level when the beneficiary's situation matches the risk information in Column 2 of the *POC 2*, so you can implement a higher level of interventions.

- f. Address all risk domains included in the *POC 2* or provide documentation as to why a risk domain is not being addressed on the *Professional Visit Progress Note*.
- g. If the beneficiary signed up for text4baby, determine at subsequent visits whether or not she is actually receiving text4baby messages and document this on the *Progress Note*. If not, give her the *Maternal & Infant Education Packet*. Professional staff should always have an *Education Packet* with them, to be used in this instance or to supplement the information that the beneficiary is receiving from text4baby.
- h. Address all domains that score out as high risk within the first three visits or document why this has not been done on a *Professional Visit Progress Note*. For example, if the beneficiary is in an emergency situation such as imminent eviction, it's appropriate to address the emergency first. Be sure to document the reason why you did not address the high risk (e.g., depression) at one of the first three visits. Even If the beneficiary is already seeing a therapist for depression, you still need to address depression within the first three visits. MIHP is a care coordination model, a critical element of which is to support the beneficiary to follow through with treatment. You would encourage her to continue to address her issues with her therapist and support her as she does so.
- i. Help the beneficiary develop a written or verbal safety plan when she scores out as high risk on the depression, domestic violence, or substance abuse domain (infants only) or provide documentation that the beneficiary did not wish to develop a safety plan. See "Implementing Plans of Care 2 with Safety Plans" later in this chapter.
- j. Refer beneficiary to other services and supports as specified in the *Plan of Care, Part 2, Interventions by Risk Level*. See *Referral Resources for MIHP Families* at [www.michigan.gov/mihp](http://www.michigan.gov/mihp). In MIHP, what it means to make a referral is specifically defined. See *Making and Following Up on Referrals* later in this chapter or on the MIHP web site.

- k. Use Motivational Interviewing techniques throughout *POC 2* implementation.
- l. Coach the beneficiary to promote self-empowerment and self-management throughout *POC 2* implementation.

#### **4.Documentation of Visits**

Documentation of MIHP services provided is required by Medicaid. Standardized forms must be used. Written instructions are available to assist staff in completing the required data elements on all forms to assure that program services are appropriately recorded. For additional information on MIHP forms, see *Chapter 14 – Required MIHP Forms*.

The *Professional Visit Progress Note* is a critical MIHP form, as it is used to document what transpired at each visit. It includes fields for: whether or not visit was blended, trimester, beneficiary name and Medicaid number, type and location of visit, date of visit, time in and out, topics reviewed from the MIHP *Maternal and Infant Education Packet* or *text4baby*, whether or not beneficiary is a first time mother, whether or not RD standing order is in place, domain and risk level addressed, interventions provided (listed by number), mother/caregiver’s reaction to interventions, other visit information, outcome of previous referrals, items tracked at every visit, plan for next visit, new referrals made, signature of home visitor, and date of signature.

The *Professional Visit Progress Note* was carefully designed to make documenting a visit as simple and quick possible. It consists of fill-in-the-blank fields, check-boxes and narrative sections. The narrative sections include:

- Mother/caregiver’s reaction to interventions provided
- Other visit information
- Outcome of previous referrals
- Plan for next visit

Some MIHP professionals, who are used to writing extensive case notes, find it challenging to convert to the briefer format. See forms instructions and specific guidelines for completing the narrative sections of the *Professional Visit Progress Note* on the MIHP website.

#### **5.Plan of Care, Part 2 (POC 2) Implementation Monitoring**

The goal of implementation monitoring is to assure that the *POC 2* is being implemented appropriately and that the beneficiary’s needs are being met. Monitoring spans the length of time the pregnant or infant beneficiary is in the program.

The care coordinator is responsible for monitoring *POC* implementation thoroughly and systematically at regular intervals. It is recommended to do this at least quarterly. Implementation monitoring consists of carefully reviewing the beneficiary’s chart and checking with the beneficiary to determine the extent to which she feels MIHP is meeting her needs. The care coordinator is responsible for making sure the individual beneficiary is receiving the best possible care. This is different from the QA that the program coordinator conducts, which is focused on improving quality of the MIHP overall to assure compliance with certification requirements.

As the care coordinator reviews the beneficiary’s chart, he or she is looking for documentation that the team’s activities are in keeping with the *POC 2*. The care coordinator identifies any task that has “fallen through the cracks”, determines if barriers to achieving goals are being addressed, decides if the beneficiary should be discharged, and identifies the team’s next steps. The following forms are particularly helpful for monitoring *POC 2* implementation:

1. *Professional Visit Progress Notes*
2. *Maternal Forms Checklist (M001) or Infant Forms Checklist (I001)*
3. *Referral Log* (MDHHS form or own form)
4. *Contact Log* (MDHHS form or own form)

The *Forms Checklist* is a one-page summary of the beneficiary's progression of care. It includes dates that various services are provided. It is required for QA purposes to assure all forms are complete.

The *Contact Log* documents attempts to contact the beneficiary (e.g., phone, text, email, letter, note on door, etc.) between professional visits and from the last professional visit to discharge. It is important that every attempt is documented so team members are aware of each other's efforts in this regard. It is also critical for risk management purposes, as this documentation may help to limit your legal liability in case the beneficiary is harmed relative to a risk that has been identified in her chart (e.g., domestic violence, depression, child abuse, etc.) and your actions are questioned in an investigation or malpractice suit. Remember: *If it isn't documented, it didn't happen.*

As you monitor the *POC 2*, keep the following considerations in mind:

- a. Modify the *POC 2* at any time by adding a new domain based on professional judgment in light of new information obtained through interviews or observation, but only if the risk criteria in Column 2 are met. Add the domain to the chart, document the date that you added the domain in the *Date* space provided in Column 1 of the *POC 2*, and have the RN and SW update and sign the *POC 3*, documenting that a domain has been added. You may then implement the interventions for the new domain.

If you add a new domain, complete the *Prenatal Communication/Notification of Change in Risk Factors Cover Letter Form B* or the *Infant Communication/Notification of Change in Risk Factors Cover Letter Form B* and forward it to the medical care provider. This is because the addition of a domain to the *POC 2* constitutes a significant change in beneficiary status.

- b. In order to provide the most appropriate care, you should increase the risk level when the beneficiary's situation matches the risk information in Column 2 of the *POC 2*, so you can implement a higher level of interventions. You may change the risk level for a particular domain at any time, except prior to the first professional visit.

The change in risk level must be based on professional judgment in light of new information obtained through interviews or observation, but only if the risk criteria in Column 2 are met. This means that the risk level cannot be changed based on how a beneficiary presents on a given day. For example, if a beneficiary scored high for depression on the *Risk Identifier*, but at a subsequent visit she appears to be in a good mood, this is not a sufficient reason to change the risk level on the *POC*. You would change the risk level only when the beneficiary's situation changes so as to meet the criteria in Column 2.

When you do increase or decrease the risk level, note the change on the *POC 2* and enter the date of the change in the "Date" space in Column 1. You can change the risk level on *the POC 2* on the discharge date, as long as the beneficiary meets the risk criteria in Column 2. A change in risk level is not a significant change in the *POC 2* and need not be communicated to the medical care provider.

- c. There is no requirement that a particular number of disciplines must implement the interventions, as this will depend on the particular domains that the beneficiary has selected. However, it is expected that both required disciplines will participate in implementing the interventions for most beneficiaries.

## **6.Coordination with Medicaid Health Plans (MHPs)**

- a. Communicate with MHP as specified in *MIHP Provider – MHP Care Coordination Agreement (CCA)*. The CCA, titled *Sample 3 (Sample of Care Coordination Agreement)*, is available at [Medicaid Provider Manual](#) in the *Forms Appendix*. The signed CCA agreement with a particular MHP may include provisions not included in the *Care Coordination Agreement* template, if both parties are in agreement.
- b. Use the *MHP/MIHP Collaboration Form* to inform MHPs when their members enroll in in your MIHP. This must be done on a monthly basis. MHPs use the same form to refer pregnant women and infants to MIHP providers. An equivalent form may be used if both parties are in agreement. (See *MHP/MIHP Collaboration Form Instructions* on the MIHP web site.)
- c. Contact the MHP contact person who is designated to work with MIHPs in order to coordinate transportation for mutual beneficiaries. If you are unable to resolve an issue with the MHP contact person, ask your consultant for assistance.
- d. When you implement the emergency interventions, you must notify the MHP, using the *Prenatal or Infant Care Communications* form. You must fax this form to the MHP within 24 hours.

## **7.Coordination with Medical Care Provider**

You communicate with the medical care provider at three points: MIHP enrollment, when a significant change occurs, and at the conclusion of MIHP services. There are two exceptions to this requirement. Do not send communications to the medical care provider if:

- a) The beneficiary has not consented to release PHI to her medical care provider.
- b) The medical care provider is a clinic-based MIHP provider and there is documentation in the chart that the medical care provider does not wish to receive these communications.

In either of these instances, you are not required to complete, send, and file copies of the communication forms and associated cover letters.

In all other instances, use the following forms to communicate with the medical care provider:

### **Maternal**

- 1) At MIHP enrollment:

*Prenatal Communication/Notification of MIHP Enrollment with Cover Letter Form A*

On the *Prenatal Communication* form, indicate each risk for which there is a developed domain in the *POC 2*, including those identified by the *Risk Identifier* and those identified by professional judgment. This form must be sent within 14 days after the *Risk Identifier* visit is completed.

- 2) When there's a significant change in beneficiary status:

*Prenatal Communication/Notification of Change in Risk Factors with Cover Letter Form B.*

This form must be sent whenever:

- a. A new POC 2 domain is added (but not when the risk level is changed for a particular domain).
- b. The beneficiary changes medical care providers. When a beneficiary informs you that she has a new medical care provider, ask her to update her *MIHP Consent to Release Protected Health Information* by adding the new medical care provider's name, initialing and dating it. After you have obtained her authorization, send the new provider a copy of the initial *Prenatal or Infant Care Communication* form with a note explaining that it was originally sent to a previous medical care provider when the beneficiary first enrolled in MIHP. Send subsequent medical care provider communications to the new provider.
- c. You have implemented the emergency interventions. In this case, you must notify the medical care provider using the *Prenatal or Infant Care Communications* form. You must fax this form to the medical care provider within 24 hours.

You are also required to notify the medical care provider if the beneficiary transfers to your MIHP, but you are not required to use the form for this purpose. You may choose to write a note or call the medical care provider. If you call, it must be documented in the chart on the *Contact Log*.

- 3) At end of service or after birth of baby:  
*Maternal Discharge Summary with Cover Letter Form C*

## Infant

- 1) At MIHP enrollment:  
*Infant Care Communication/Notification of MIHP Enrollment with Cover Letter Form A*

On the *Infant Care Communication* form, indicate each risk for which there is a developed domain in the POC 2, including those identified by the *Risk Identifier* and those identified by professional judgment.

- 2) When there's a significant change in beneficiary status:  
*Infant Communication/Notification of Change in Risk Factors Cover Letter Form B*

This form must be sent whenever:

- a. A new POC 2 domain is added (but not when the risk level is changed for a particular domain).
- b. The beneficiary changes medical care providers. When a caregiver informs you that her infant has a new medical care provider, ask her to update the *MIHP Consent to Release Protected Health Information* by adding the new medical care provider's name and initialing it. After you have obtained her authorization, send the new provider a copy of the initial *Prenatal or Infant Care Communication* form with a note explaining that it was originally sent to a previous medical care provider when the beneficiary first enrolled in MIHP. Send subsequent medical care provider communications to the new provider.
- c. You have implemented the emergency interventions. In this case, you must notify the medical care provider and Medicaid Health Plan using the *Prenatal or Infant Care Communication* form. You must fax this form to both entities within 24 hours.

You are also required to notify the medical care provider if the beneficiary transfers to your MIHP, but you are not required to use the form for this purpose. You may choose to write a note or call the medical care provider. If you call, it must be documented in the chart on the *Contact Log*.

When there is a change in maternal risk and you add a new domain to Maternal Considerations, you must update and sign the POC 3, but you are not required to send the

update to the infant's medical care provider. However, if the newly-identified risk is one that may affect the infant's care (e.g., substance use, domestic violence, etc.), it is recommended that the medical care provider be alerted, if the mother has consented. Some MIHP providers have policies that expressly prohibit the sharing of maternal information with the infant's medical care provider.

3) At end of service:

*Infant Discharge Summary with Cover Letter Form C*

There are three parts to the *Infant Discharge Summary*. At a minimum, you must send part one (Infant) to the medical care provider. You may also decide to send part 2 (Maternal Considerations) and/or part 3 (Substance-Exposed Infant), based on your internal policy.

#### **Other considerations for coordinating with the medical care provider:**

- a) Note that the *Prenatal/Infant Care Communication* forms and the *Discharge Summary* must be signed by an RN or SW. *Cover Letters* may be signed by any staff.
- b) Forward a copy of the *Maternal Plan of Care* or *Infant Plan of Care* to the medical provider upon request.
- c) Do not release information to the beneficiary's medical care provider if you do not have a signed *Consent to Release PHI* to him or her. Be sure to document that communications were not sent for this reason.

### **8. Conclusion of MIHP Services**

Conclusion of MIHP services includes four steps:

- a. Conducting the final visit with the beneficiary (unless beneficiary is lost to service)
- b. Referring maternal beneficiary to the Healthy Michigan Plan, if applicable
- c. Completing the electronic *Maternal or Infant Discharge Summary*
- d. Notifying the medical care provider that the case has been closed

#### **Conducting the Final Visit: Maternal**

The final maternal visit will be the postpartum visit, unless the beneficiary is lost to service before her 9<sup>th</sup> visit. If the beneficiary has not been lost to service, the final visit will most likely focus on completing one or more interventions, celebrating the beneficiary's successes while in MIHP, encouraging her to enroll in other services and supports if indicated, getting her feedback on MIHP, transitioning the family to the infant portion of the program or, if services are no longer desired, ending the beneficiary-worker relationship.

To solicit feedback on how the beneficiary experienced MIHP, ask two simple questions:

1. What did you like best about MIHP?
2. How could MIHP have been better for you?

Explain to her that what she says is important because you will use her feedback to improve MIHP for other pregnant women and new mothers. This will assist you as a provider to improve the quality of your program.

#### **Refer Maternal Beneficiary to the Healthy Michigan Plan when Healthy Kids for Pregnant Women Medicaid Ends**

When a mother's Healthy Kids for Pregnant Women Medicaid coverage is ending and she will not have other health care insurance, help her find out if she is eligible for the Healthy Michigan Plan (Medicaid expansion under the Affordable Care Act). The Healthy Michigan Plan is another Medicaid program that covers adults with income at or below 133% of the federal poverty level. (NOTE: Healthy Kids for Pregnant Women Medicaid covers women at or below 185% of the federal poverty level, so not all MIHP beneficiaries will qualify for the Healthy Michigan Plan.)

Individuals are eligible for this program if they:

- Are 19-64 years
- Have income at or below 133% of the federal poverty level (\$16,000 for a single person or \$33,000 for a family of four).
- Do not qualify or are not enrolled in Medicare
- Do not qualify or are not enrolled in other Medicaid programs
- Are not pregnant at the time of application
- Are residents of the State of Michigan

An application can be filed at any time in one of the following ways:

- Online at [www.michigan.gov/mibridges](http://www.michigan.gov/mibridges)
- Over the phone at 1 855-789-5610
- In-person at a local MDHHS office

Applicants will need to have the following information:

- Birthdates and Social Security Numbers of everyone included on the application, including dependents
- Employer and income information for everyone in the family, such as a W-2 form or wage statement
- Policy numbers for current insurance plan, if there is one
- Information on any job-related insurance that's available to the family
- Citizenship and immigration status

Healthy Michigan Plan enrollees with annual incomes between 100 - 133% of the federal poverty level are required to contribute two percent of their annual income for premiums. They will also have copays for some services. However, if they engage in healthy behaviors, they may have their cost-sharing reduced.

The following publications are available at [MDHHS - Healthy Michigan Plan Provider Information](#)

1. *Healthy Michigan Plan Brochure*

This is a tri-fold brochure with basic information.

2. *Healthy Michigan Plan Handbook*

This is a 16-page handbook with more information about the program.

3. *Healthy Michigan Plan Flyer*

Email [healthymichiganplan@michigan.gov](mailto:healthymichiganplan@michigan.gov) to request copies of the brochure or handbook.

Additional resources for providers: [www.michigan.gov/healthymichiganplan](http://www.michigan.gov/healthymichiganplan)

Additional resources for families: [www.healthymichiganplan.org](http://www.healthymichiganplan.org)

If a beneficiary does not qualify for the Healthy Michigan Plan, she may qualify to purchase subsidized health insurance coverage through the federal Health Insurance Marketplace (health insurance exchange).

In addition to assisting the beneficiary to obtain health insurance before she leaves MIHP, be sure to give her information on Title X family planning clinics in her area. A list is available at [MDHHS Title X Family Planning Clinic Directory](#).

## Conducting the Final Visit: Infant

If other supports and services are indicated, bring the relevant brochures and contact information with you to the final visit. If primary caregiver still appears to be dealing with depression, alcohol or substance use, domestic violence, or a chronic disease and has not sought treatment, make another attempt to help her to do so.

## Encourage Enrollment in another Family Support Program

Encourage families, especially those who are at high risk at discharge, to enroll in another home visiting program so they will have continuing support. If no other home visiting program is available, suggest learn and play groups, parenting classes, family resource centers and any other family support programs that are offered locally. Your Great Start Collaborative (GSC) Coordinator should be able to provide you with this information. The GSC may publish a *Parent Resource Guide* or have one posted online. Ideally, you would hand every beneficiary a list of local resources for families with young children at the final visit, encouraging her to keep it for future reference as her infant gets older.

## Encourage Enrollment in Imagination Library

If you have an Imagination Library in your area, help the beneficiary sign up for it. Imagination Library provides a free, age-appropriate book every month to enrolled children from birth to age five. Books are mailed directly to the child's home. There is no income eligibility requirement and the program is free, regardless of ability to pay. There are Imagination Libraries serving many Michigan counties and cities, although some limit eligibility to children whose parents are participating in a particular parenting program. To find out if there is one in your area and if there are any eligibility restrictions, ask your GSC Coordinator or go to [http://usa.imaginationlibrary.com/find\\_my\\_affiliate.php](http://usa.imaginationlibrary.com/find_my_affiliate.php).

## Discuss How to Access Child Development Resources

Explain to the primary caregiver that although you will not be there to conduct any more ASQ-3 and ASQ: SE-2 screenings, there are ways that she can continue to learn about her child's ongoing development. She can do this by talking to her pediatrician, participating in a family support program, or looking at one or more of the following web sites:

### *General Child Development*

- Bright Futures Parent Handouts (American Academy of Pediatrics) <https://brightfutures.aap.org/families/Pages/Resources-for-Families.aspx> (English and Spanish)  
Handouts with information about children at 12-months, 15-months, 18-months, 2-years, 2½ years, 3 years and 4 years.
- PBSparents at <http://www.pbs.org/parents/child-development/>
- CDC Parent Information <http://www.cdc.gov/parents/index.html>
- CDC Child Development at <http://www.cdc.gov/ncbddd/childdevelopment/index.html>

### *Social and Emotional Development*

- ZERO TO THREE at <http://zerotothree.org/child-development>

- Center on the Social and Emotional Foundations for Early Learning – Resources: Family Tools at <http://csefel.vanderbilt.edu/resources/family.html>

Your GSC may be able to provide you with some parenting materials that you could give to your beneficiaries at the final visit.

## Completing the Discharge Summary

The *Maternal Discharge Summary* and the *Infant Discharge Summary* are comprehensive electronic forms that capture demographic data, risk levels, interventions provided, progress during maternal or infant interventions, and referrals made. Some beneficiary outcomes are captured under “progress during maternal or infant interventions.”

### Discharge Summary Required for Every Beneficiary Enrolled in MIHP

If you enroll a beneficiary in MIHP, you must complete a *Discharge Summary*. This is true even if the beneficiary is lost to service after the *Risk Identifier* visit and no other services are provided. If you implement interventions during the *Risk Identifier* visit and that is your only contact with the beneficiary, document the interventions on the *POC 2* and the *Discharge Summary*.

### Discharge Summaries for Family Served with Blended Visits

At times, you will have *Risk Identifiers* and open cases on more than one family member at the same time, serving them with blended visits. You will need to do a separate *Discharge Summary* for each family member.

When you discharge multiples, you must complete a separate *Discharge Summary* for each infant. However, only the *Discharge Summary* for the infant whose Medicaid ID number is being used for billing purposes is completed in its entirety, and only the interventions provided for the infant being billed are reflected on this *Discharge Summary*. For the other infants, an abbreviated *Discharge Summary* is done, indicating that they had an *Infant Risk Identifier*, but no visits. A chart reviewer would need to look at “other visit information” on the *Professional Visit Progress Notes* in the first infant’s chart to see what interventions were provided for the other infants. See *Discharge Summary Instructions* for detail on completing *Discharge Summaries* for multiples.

### Discharge Summary for Infant in Foster Care

If the infant is in foster care at the time of discharge, indicate the intervention numbers that were achieved with both the mother and the foster family on the *Discharge Summary*. Note in the comments section of the *Discharge Summary* that you have been working with the foster parent and do not know mother’s status at discharge.

### Date of Discharge

The *Discharge Summary* must be entered into the MDHHS database within 30 calendar days after:

- a. The pregnant woman’s MIHP eligibility period ends
- b. Infant services are concluded (e.g., infant ages out of program; all available visits have been used; services are no longer required; parent or caregiver requests discontinuation of services; the family moves, etc.) or there are four consecutive months of inactivity, unless there is documentation in the chart that the case is being kept open for a specific purpose and the purpose is stated.

The discharge date is the date that the completed *Discharge Summary* is entered into the MIHP database. This must be done within 30 calendar days of your determination that services have ended, eligibility has ended, or the family has been lost to follow-up.

If a *Discharge Summary* is not entered within 30 calendar days after the pregnant woman's MIHP eligibility ends or infant services are concluded, there must be a documented explanation in the chart. For example, "Migrant worker family is planning to return to the area within the service delivery period."

## **Notifying the Medical Care Provider that the Case Has Been Closed**

The *Discharge Summary* must be sent to the medical care provider within 14 days from the date that the *Discharge Summary* data is entered into the MIHP database. You do not need to send the *Discharge Summary* to the medical care provider if your MIHP is part of an OB or pediatric practice and the medical care provider has signed a statement indicating that notification is not necessary.

## **Sending the *Maternal Discharge Summary* to the Medical Care Provider**

To notify the medical care provider that a maternal case has been closed, complete the *Maternal Discharge Summary/Cover Letter Form C*. Mail or fax the printout of the electronic *Discharge Summary* to the medical care provider. Do not send the worksheet to the medical care provider.

## **Sending the *Infant Discharge Summary* to the Medical Care Provider**

To notify the medical care provider that an infant case has been closed, use the *Infant Discharge Summary/Cover Letter Form C*. There are three parts to the *Infant Discharge Summary*. At a minimum, you must mail or fax part one (Infant) to the medical care provider. You may also decide to send part 2 (Maternal Considerations) and/or part 3 (Substance-Exposed Infant).

The *Infant Discharge Summary* includes information about the mother. You are not required to share maternal information with the infant's medical care provider. Different agencies have different internal policies about this. It is possible to print out one, two or three sections of the *Infant Discharge Summary*, which means you can send the infant's information to the medical care provider without including the maternal information, if that is your agency's policy.

## **Linking to *Early On* and the Great Start Collaborative**

Each MIHP is required to be linked to, or serve as a member of, the Part C/*Early On* Interagency Coordinating Council and the Great Start Collaborative Council (GSC) in each of the counties it serves. If the MIHP serves five counties, it needs to be linked to *Early On* and the GSC in all five counties.

### ***Early On***

The MIHP needs to have a working relationship with *Early On* through which referrals may be facilitated (both ways) and care is coordinated for mutual clients. This relationship is critical because MIHP screens infant beneficiaries for potential developmental delays resulting in a significant number of referrals to *Early On*.

When an MIHP infant is involved with another program such as *Early On* or Children's Protective Services, the MIHP provider is encouraged to participate in care coordination meetings facilitated by the other program (not a separately reimbursable activity under MIHP) in order to reduce duplication of services and better serve the family.

### **Great Start Collaborative**

The MIHP needs to be linked to the GSC because it is responsible for assuring a coordinated system of community resources and supports to ensure that every Michigan child is:

1. Born healthy
2. Developmentally on track from birth through third grade
3. Ready to succeed in school at school entry
4. Reading proficiently by the end of third grade

GSCs focus on promoting: pediatric and family health; social and emotional health; family support; parenting leadership; and child care and early learning. The MIHP should know about this coordinated system of resources and supports since one of MIHP's key functions is to refer pregnant women and infants to needed services. It is also important that the MIHP is visible to and has a relationship with the GSC, so the GSC can promote your services to parents and other early childhood providers in the community. At a minimum, you must receive regular communications from the GSC in each county served by your MIHP.

## **Making Referrals to Child Protective Services**

Monitoring the health and development of the infant is an important aspect of MIHP, and providers are required to observe the infant during every professional visit. When providers see signs of suspected abuse or neglect, they are obligated by law to make a referral to Children's Protective Services (CPS).

MIHP must report possible child abuse or neglect to CPS in compliance with the Michigan Child Protection Law (Public Act 238 of 1975) by immediately calling Centralized Intake for Abuse and Neglect at 855-444-3911 and submitting a written report (DHS 3200) within 72 hours of the call. Information about how to report suspected child abuse or neglect to CPS is available at the Michigan Department of Health and Human Services web site at [http://www.michigan.gov/dhs/0,1607,7-124-5452\\_7119---,00.html](http://www.michigan.gov/dhs/0,1607,7-124-5452_7119---,00.html).

Families that become involved with CPS may become eligible to receive a wide variety of services intended to improve their ability to care for their children, such as parenting classes, counseling, substance abuse treatment, medical services, anger management education, and other services designed to meet the family's specific needs, including MIHP.

The MIHP provider should maintain a relationship with CPS in every county they serve. All MIHP staff must be familiar with the provider's CPS reporting protocol.

## **CPS Online Training for Mandated Reporters**

Click here to view a 14-minute video on [Mandated Reporters: Helping Protect Michigan's Most ...](#). If you have a question about reporting a particular situation to CPS, you may call the Mandated Reporter Hotline at 877-277-2585.

## **When Consent Is and Isn't Needed to Communicate with CPS**

The Michigan Child Protection Law requires mandated reporters to immediately report suspected abuse or neglect of a child to MDHHS CPS Centralized Intake. Consent is not required in order to report suspected abuse or neglect to CPS **or** while a CPS investigation is either being conducted, or when a case is open for services. During an investigation, only share information that is valid to the current investigation. CPS will not subpoena you for information while the investigation is underway. CPS has 30 days to complete the investigation and make a disposition of the case.

If the case involves a CPS case or a foster care case (requiring ongoing MDHHS case management), MDHHS caseworkers may be asked for and should provide a copy of the MDHHS Authorization to Release Confidential Information (DHS-1555-CS) signed by the beneficiary, before the MIHP provides information to CPS.

## Participant Retention in Home Visiting Programs

***The biggest hurdle to success in in-home visit programs is parents' reluctance to participate, and continue participating. It is very hard to keep families in programs. The drop-out rate for most programs is 50 to 60 percent.*** Deborah Daro, Chapin Hall at the University of Chicago

Studies indicate that what keeps a parent participating in a home visiting program depends on the particular combination of participant characteristics, home visitor characteristics, program and agency characteristics, and community characteristics. The parent doesn't just make a "yes" decision at the time of enrollment; she makes an ongoing cost-benefit analysis at every visit – is this really worth it to me? She will remain engaged over time only if she feels encouraged to stay with the program or if she receives tangible benefits and meaningful assistance.

A string of no-show appointments often indicates that a parent has disengaged and is dropping out. Some MIHP providers have succeeded in decreasing the number of no-show appointments by collecting baseline data, implementing one or more of the strategies listed below, and collecting follow-up data to see if the strategy made a difference.

1. Remind the beneficiary about each upcoming MIHP appointment, as other providers do:
  - a. Text a reminder message the day before the appointment.
  - b. Have staff make reminder phone calls the day before the appointment. Research shows this is more effective than automated reminder phone calls.
2. Update contact info at every visit.
3. Thank beneficiaries for being available when they said they would be.
4. Thank beneficiaries for giving advance notice when they need to cancel.
5. Hold a gift card drawing for all beneficiaries who show up on time or keep appointments in a given month.
6. At the end of every visit, ask: *How is MIHP working for you? How can we do a better job of meeting your needs?* See *Assessing Beneficiary Satisfaction with MIHP Services* at the MIHP web site for a brief set of optional questions that may be used for this purpose.

## Building Trusting Relationships with MIHP Beneficiaries

Research confirms what MIHP providers know from experience: if the beneficiary doesn't trust the home visitor, it's unlikely that she will even continue with MIHP, much less act on the suggestions offered by the home visitor. Some research findings that emphasize the importance of trusting relationships in home visiting programs are given below:

The relationship the new parent has with the home visitor may prove more important than the quality of the curriculum used during home visits.

(Home Visiting Services for Adolescent Parents in Massachusetts, RWJF, July 2008)

Given the importance that mothers place on the development of interpersonal relationships, it is important for home visitors to continually assess the quality of their relationships with clients.

(Jack SM, DiCenso A & Lohfeld L (2005). A theory of maternal engagement with public health nurses and family visitors *Journal of Advanced Nursing* 49(2) 182-190)

Factors related to greater trust specific to patient-provider relationships in a population of low-income and minority women receiving perinatal care were:

- Effective communication
- Demonstration of caring
- Perceived competence

(Providing Health Care to Low-Income Women: A Matter of Trust, Family practice Vol. 21. No5@Oxford University Press, 2004)

Trusting relationships are the underpinning of MIHP. The beneficiary must trust the professional in order for learning and behavior change to occur. Trust is also the basis of Motivational Interviewing, a key approach in MIHP services.

MIHP provides comprehensive services for pregnant women and infants, drawing upon the expertise of professionals from four different disciplines. This breadth of expertise is a major strength of MIHP. However, it also means that when a beneficiary needs the expertise of more than one discipline, she must develop trusting relationships with two to four different MIHP staff. This poses a challenge, especially in light of the fact that the number of MIHP visits is limited.

MIHP providers are encouraged to do everything possible to promote the development of trusting relationships between MIHP professionals and a given beneficiary. This means limiting, to the greatest possible extent, the number of individuals of the same discipline who visit with the beneficiary. In other words, it is inappropriate for two or more licensed social workers or two or more registered nurses to visit the same woman unless there is no other choice (e.g., the first licensed social worker or registered nurse is ill, is on maternity leave, has changed jobs, etc.). It is not the intent of this program to have a different professional within a given discipline conduct each visit; the intent is to promote same-staff consistency within disciplines so that trusting relationships can be developed.

## Elements of Trusting Relationships

Much has been written about the importance of building trusting professional-client relationships in health, education and human services settings. Frequently cited elements of trusting relationships include the following:

- Mutual respect
- Empathy (ability to put oneself in another person's place using effective listening and to convey compassion vs. sympathy)
- Partnership
- Shared power
- Shared vision
- Collaborative goal setting
- Reciprocal communication
- Support
- Cultural sensitivity

Some professionals seem to be "naturals" at developing trusting relationships. However, educational activities to teach skills that promote trusting relationships are widely available for persons who are not "naturals" or who did not have much coursework in this area in their degree programs. Training on effective listening is paramount, as listening skills are particularly important in general and as a prerequisite to using Motivational Interviewing appropriately.

## What Do Women Want from Home Visitors?

Developing a trusting relationship in an office or clinic setting is one thing; developing a trusting relationship in the sanctity of the client's home is another. Minnesota Healthy Beginnings, a universal

home visiting program for expectant parents and families with new babies, was funded by the Minnesota Dept. of Health (MDH) from 1999-2003. MDH conducted focus groups to ascertain how Healthy Beginnings clients perceived home visiting. Here are some of the focus group findings, many of which pertain to the home visitor-client relationship:

What women want to know about home visits:

- Who is this person who makes the visits? Will I feel comfortable with her? What expertise does she have?
- Why is it better to have a home visit than to just call my doctor?
- Will it be worth getting dressed for?
- Why am I being called? Invited?
- What do other women who participated say about it?
- What should I expect during the home visit?
- Is it free? Is there a cost?
- Why women hesitate to have home visitors:
  - Fear of being judged.
  - Not wanting to deal with a stranger.
  - Feeling like they have to get ready for a visit and not wanting to get ready.
  - Feeling like a home visit isn't "part of the package" or typical or normal.
  - Feeling that if they get called for a home visit that they did something wrong.
  - Not really understanding the purpose of the visit or how they can benefit.

Women want home visitors who:

- Make them feel comfortable.
- Are knowledgeable and experienced.
- Offer options for different ways to do things.

What a home visitor should do to help make women feel comfortable:

- Be down to earth, kind, gentle with the baby, and have a sense of humor.
- Don't expect them to do anything special to prepare (like cleaning).
- Tell them dads and siblings are welcome to participate.
- Offer options for things to do, ways to do things, things to talk about.
- Don't overwhelm them with too much information.
- Don't be judgmental.
- Refer to your own kids at times.
- Don't say you're a mandated reporter unless you have to.
- Don't write stuff down if you don't have to. If you do have to, let women know what you are writing down and why you are writing it down.
- Know when to leave.
- Reassure them. For example, tell them they are doing a good job; that they are a good mother or father; that the baby is doing great; or that they look good.
- Give them your number to call if they need help.

## **Basic Strategies for Building Trusting Relationships**

MIHP professionals must be adept at forming trusting relationships as quickly as possible, given program limitations on the number of allowable visits. The focus group results reported by Minnesota Healthy

Beginnings in the section above provide a springboard for formulating basic trust-building strategies, such as the following:

Initial contacts:

Beneficiaries may not be clear about why the home visitor is there and may not feel emotionally safe with the home visitor. Therefore, it's important to:

- Be friendly, relaxed, open, accepting, respectful and genuine.
- Tell the beneficiary about yourself and your experience providing support for pregnant women and infants.
- Clearly explain (repeatedly, if necessary) that MIHP is a benefit of Medicaid health insurance for all pregnant women and infants.
- Clearly explain how you see your role, how you see her role, and how you anticipate working together in partnership.
- Ask her about her expectations of MIHP and if what you have explained about roles and working together sounds acceptable to her.
- Try to identify any concerns or fears she may have related to home visiting and address them.
- Offer to explain the role of the home visitor to other family members if she would like.
- Find common ground and talk about it (e.g., "I had a December baby too," etc.).
- Watch and listen for positive attributes, behaviors, interactions, statements, etc., and comment about them to the beneficiary.
- "Be down to earth, kind, gentle with the baby (if applicable), and have a sense of humor."
- At the end of the visit, ask if she thought the visit went okay, and what you can do so that she is comfortable with you coming back again.

Throughout relationship:

- Be friendly, relaxed, open, accepting, respectful and genuine.
- Find common ground and talk about it (e.g., "I had a December baby too," etc.).
- "Be down to earth, kind, gentle with the baby (if applicable), and have a sense of humor."
- Never miss an opportunity to comment on a positive attribute, behavior, interaction, statement, etc.; one of the most important things you can do is serve as a mirror for the beneficiary's strengths.
- Focus on the beneficiary's strengths as you implement the interventions – keep a running list and refer to her strengths often, especially as you and she talk about the next steps she is going to take (e.g., "You're being so good to your baby by keeping all of your prenatal care appointments, but you said your OB doesn't always explain things; do you want to practice what to say to him if it happens again?") or "I know you're great at holding your baby when you feed her; do you think you can build on this and talk to her as you feed her – just describe what you see her doing or what you see as you look out the window? It doesn't really matter what you say – it's making eye contact with you and hearing your soft, loving voice as she eats that matters at this stage.")
- When the beneficiary says or does something that you think is particularly noteworthy, ask her if you can share that idea or practice with other women in the future.
- Whenever possible, present your suggestions as options with alternatives.
- If you say you're going to do something, do it. Follow through, follow through, follow through.

- If you are truly concerned about something the beneficiary is doing (or not doing) or about some aspect of her current situation, talk with her about it in a direct, but non-accusatory way, using an I message (“I’m concerned that…”).
- Refrain from judgment.
- If you are having a hard time refraining from judgment or you are experiencing strong emotional reactions to working with the beneficiary, talk it out with your supervisor or another colleague. In the best of all worlds, all home visitors would have access to ongoing reflective supervision to work through concerns and increase self-awareness about how personal values, beliefs, and emotions affect interactions with clients.

## Motivational Interviewing

Ideally, MIHP providers are skilled person/family-centered practitioners (person-centered when the beneficiary is an adult; family-centered when the beneficiary is a child). Person/family-centered practice is different from the traditional helping model in which the expert tells the client what to do and the client complies (or doesn’t). In the person/family-centered model, the practitioner and the client operate as partners who work together and learn from each other, with the clear understanding that the client holds the ultimate decision-making power.

Client-centered practice is based on the six principles of partnership: everyone desires respect, everyone deserves to be heard, everyone has strengths, judgments can wait, partners share power, and partnership is a process (Appalachian Family Innovations). Client-centered practitioners build strong partnerships, foster mutual respect and honesty, respect the client’s culture, build on the client’s strengths, promote individualized planning and flexible supports, and build the client’s confidence.

Motivational Interviewing (MI) is a client-centered method used by MIHP providers as they talk with beneficiaries about setting and working toward meeting their behavior change goals. The goal of MI is to enhance the beneficiary’s motivation to change behavior by helping her to see the difference between her stated goals and her current behavior, and exploring and resolving her ambivalence. This evidence-based approach is fundamentally collaborative and respectful, rather than confrontational and directive.

MI was developed in 1983 by clinical psychologists William R. Miller and Stephen Rollnick, to treat persons with alcohol problems. It has since been used and tested with a broad range of populations including: persons with other addictive behaviors (e.g., drugs and tobacco); persons with dual diagnoses (mental illness/substance abuse); persons with depression, anxiety, eating disorders, and risky sexual behaviors; homeless persons; adolescents treated in the ER for injuries related to carrying weapons, driving while drinking, not wearing seat belts or helmets, etc., and others. Increasingly, MI is being used in health care settings to address health-related lifestyle behaviors and to improve treatment adherence. Encouraging results have been reported on the use of MI with persons with chronic medical illnesses, including diabetes, obesity, hypertension, pain, and cardiovascular disease.

## Four Generic Motivational Interviewing Communications Strategies

MI requires that practitioners become skilled at using four generic communications strategies. These strategies are as follows:

1. Expressing empathy (important for the client to feel understood and to develop the therapeutic alliance)
2. Supporting self-efficacy (focusing the client’s effort to believe that change is possible, which is a significant motivator in being able to create change)
3. Rolling with resistance (not challenging resistance, but assisting client to identify solutions to her identified barriers to change)
4. Developing discrepancy (exploring with the client the difference between her identified goals and her current behavior) (Excerpted from Harvard Pilgrim Health Care, January 2008)  
[https://www.harvardpilgrim.org/portal/page?\\_pageid=253.251590&\\_dad=portal&\\_schema=PORTAL](https://www.harvardpilgrim.org/portal/page?_pageid=253.251590&_dad=portal&_schema=PORTAL)

MI is not a "bag of tricks" to get someone to do something they don't want to do. Rather, MI is a "way of being" with people.

Empathy is fundamental in cultivating the MI spirit of collaboration in a health care setting. Empathy is the practitioner's sensitive ability and willingness to understand (and experience) the patient's thoughts, feelings, and struggles from the patient's point of view. Simple phrases, such as "So you are pretty frustrated with trying to lose weight," or "Many of my patients also have difficulty fitting exercise into their lives," can help build solid relationships with patients. Motivational enhancement strategies are less likely to be effective without the foundation of empathy.

## **OARS: The Pillars of Motivational Interviewing**

The pillars of MI are referred to as OARS, which stands for open-ended questions; affirmations; reflective listening; and summaries. OARS strategies help engender the MI spirit of collaboration and build a solid foundation of practitioner-patient communication. The four OARS strategies are briefly described below:

### **1. Open-ended Questions**

Open-ended questions can't be answered with a "yes" or "no." Rather, they invite patients to tell their stories. Practitioners who use open-ended questions receive less biased data from patients because open-ended questions allow patients to give spontaneous and unguided responses, which helps build rapport and trust. These responses enable practitioners to find out information they otherwise would not have thought to ask about, but that is nevertheless pertinent to the situation. Open ended questions usually begin with the phrase, "Tell me about... (How your exercise plan is going?)" or "To what extent... (Have you been able to take your medication as we had discussed?)" vs. closed-ended questions, which usually begin with "Did you... (take your medications as prescribed?). Closed-ended questions focus on the practitioner's agenda and thus place the patient in a passive and less engaged role.

### **2. Affirmations**

Statements of appreciation and understanding are important for building and maintaining rapport. Practitioners can affirm patients by acknowledging their efforts to make changes, no matter how large or small. Some examples are, "You took a big step by coming here today"; or, "That is great that you were able to quit smoking for 2 weeks"; or, "You've overcome a lot."

### **3. Reflective Listening**

Reflective listening involves taking a guess at what the patient means and reflecting it back in a short statement. The purpose of reflective listening is to keep the patient thinking and talking about change. Reflective listening can be used (1) to understand the patient's perspectives and convey you are listening; (2) to emphasize the patient's positive statements about changing so she hears her positive statements about changing twice -- once from herself and once from the practitioner; and (3) to diffuse resistance. Several types of reflections are useful; all of these should be crafted as statements rather than as questions, which allows the patient to elaborate on her own ideas.

### **4. Summaries**

A summary is longer than a reflection. Use summaries mid-consultation in order to transition to another topic, or to highlight both sides of the patient's ambivalence. Example: "You have several reasons for wanting to take your asthma medication consistently; you say that your mom will stop nagging you about it and you will be able to play basketball more consistently. On the other hand, you say the medications are a hassle to take, and they taste bad. Is that about right?" Use summaries at the end of the consultation to recap major points.

(Excerpted from Using Motivational Interviewing to Promote Patient Behavior Change and Enhance Health - Medscape Today Online Course)

## **Online Motivational Interviewing Training**

Online Motivational Interviewing training is available as follows:

- *Motivational Interviewing and the Theory Behind MIHP Interventions* [www.michigan.gov/mihp](http://www.michigan.gov/mihp)  
This training is required for all MIHP professionals. Continuing education credits are not available.
- *Introduction to Motivational Interviewing* [www.michigan.gov/mihp](http://www.michigan.gov/mihp)  
This training is optional for MIHP professionals, but continuing education credits are available for four of the modules.

It is highly recommended that MIHP professionals are equipped with basic counseling skills, especially empathy skills, as these are fundamental to using the Motivational Interviewing approach.

## Coaching Beneficiaries to Promote Self-Empowerment and Self-Management

Helping the beneficiary learn how to address her own needs, as well as the needs of her infant, is one of the most important objectives of the MIHP. It's crucial that she gains the confidence and necessary skills to function as her own and her infant's "care coordinator," because her MIHP team is only available to assist her for a brief period of time.

To the greatest possible extent, the MIHP team strives to help the beneficiary develop the personal mindset and requisite tools to rely on herself to navigate complex health and human services systems. This includes teaching her how to:

- Seek out and acquire the information and resources she needs for herself and her baby
- Make her own appointments (physician, lab, WIC, etc.)
- Make her own transportation arrangements
- Make a list of the questions she has for her health care provider
- Talk with health care and human services providers without feeling intimidated; keep asking questions until she understands what actions she needs to take, when and how follow-up care will be provided, etc.
- Advocate for developmental screening for her child over time
- Access practical and emotional support
- Access emergency services

Of course, some MIHP beneficiaries are quite comfortable with and skilled at seeking and arranging for their own supports and services. Others, however, may need a great deal of coaching in this area, due to depression, comprehension difficulties, language barriers, or other factors. Providers need to assess if it's most appropriate for them to "do for," "do with," or "cheer on" a particular beneficiary at any given point.

All beneficiaries should be given clear information on calling 2-1-1, a comprehensive health and human services information and referral service available 24/7/365 through the United Way. Ninety-nine percent of Michigan's population has 2-1-1 service. Information is provided in over 180 languages.

## Implementing *Plans of Care 2* with Safety Plans

Five different *Plans of Care 2* include the development of a safety plan as an intervention:

1. Stress/Depression Maternal  
High Risk #13: Develop and document emergency safety plan.
2. Abuse/Violence Maternal  
High Risk #14: Assist beneficiary with development of a personalized safety plan.
3. Substance Exposed Infant: Positive at Birth

Moderate Risk #9: Assist with development of a safety plan to protect infant if /when Mom/Primary Caregiver is using drugs or alcohol.

4. Substance Exposed Infant: Primary Caregiver Use

Moderate Risk #11: Encourage Caregiver to develop a Safety Plan.

5. Substance Exposed Infant: Environment

High Risk #9: Assist with development of a safety plan to protect infant when others are using substances in the environment.

## Learning to Develop Safety Plans

MIHP does not require a standardized format for safety plans. However, sample safety plan templates for abuse/violence and depression are posted on the MIHP web site.

Safety plans are discussed in two trainings on the MIHP web site:

1. Implementing the MIHP Depression Interventions
2. Family Violence and MIHP

There are also many online resources for creating safety plans at other web sites. These resources may be useful for staff who are not experienced with safety planning and would like more in-depth information about it.

## Documenting Safety Plan Development

It is required that you document that you assisted the beneficiary to develop a written or verbal safety plan since injury or death is a possible outcome for anyone dealing with significant depression, abuse/violence or substance use when an infant is involved. You can document that a safety plan was developed by simply inserting the intervention number in the "Interventions Provided" field and describing the beneficiary's response in the "Narrative about Mother/Care Giver's Reaction to Intervention Provided" field on the *Professional Visit Progress Note*. If the beneficiary states that she does not wish to develop a safety plan, be sure to clearly document this.

The beneficiary determines whether or not she wants to keep a written safety plan for herself. If the plan addresses depression or substance use, ideally she would keep it. However, it may not be safe for a women living with domestic violence to have a written safety plan in her home. You are not required to file a copy of the plan in the chart, but do so, if possible, so that that everyone on the team knows what it says.

## Safety Plans for Women with Depression

Development of a safety plan is one of the depression domain interventions. Developing a safety plan is a sound practice with any woman at high-risk for depression, because even if she has not experienced suicidal ideation, she could experience it at a later date. Also, suicidal ideation is not the only safety consideration related to depression. Child safety is an issue for a woman who feels too immobilized at times to attend to her infant's needs or who is self-medicating due to depression, especially if she is isolated. If you determine that there is no safety risk for a particular beneficiary or that a beneficiary does not wish to develop a safety plan, be sure to document this.

## Implementing the Substance-Exposed Infant Interventions

MIHP professional staff may use the substance-exposed infant (SEI) interventions and the substance-exposed infant progress note when a substance use risk is identified. You do not have to be billing under the drug-exposed infant procedure code, required for visits 19-36, to be able to use the SEI interventions and accompanying progress note. If you choose to use the SEI interventions for visits 1-18 billing under the professional visit procedure code, you are still required to use the substance-exposed infant progress note for documentation purposes.

The additional 18 visits that are available to a substance-exposed infant are to be used before the infant turns 18 months of age. The intent is to visit the family more often, not to extend the period of MIHP services well into toddlerhood. Toddlers are not the expertise of the MIHP. When an infant turns 18 months of age, you must contact your consultant to request approval to continue to serve the infant.

For additional information:

- Refer to *Section 2.8 Drug Exposed Infant, MIHP Chapter, Medicaid Provider Manual*.
- See the MIHP web site for the three *Substance Exposed Infant Plans of Care: Positive at Birth, Primary Caregiver Use, and Environmental Exposure*, along with instructions for completing them, and the *Substance Exposed Code Professional Visit Progress Note*.
- See *Chapter 5 – Reimbursement for MIHP Services, MIHP Operations Guide*

## **Implementing Interventions in the Maternal Drugs and Substance-Exposed Infant Domains: Prescribed and Non-prescribed Medications**

For purposes of implementing the MIHP interventions related to drug use, drug use includes both prescribed and non-prescribed medications, including suboxone, methadone, subutex and marijuana. These medications have effects on fetal growth and development and could result in a positive drug screen and/or neonatal abstinence syndrome. Any infant exposed to these drugs is eligible for 18 additional substance-exposed infant visits, if authorized by the medical care provider.

## **Family Planning**

MDHHS places a high priority on assisting women to avoid unintended pregnancies and to space pregnancies at least 18 months apart, given that short birth intervals are associated with adverse outcomes. This means that family planning interventions are crucial in MIHP.

Family planning options must be discussed throughout the course of care (at least once). The literature shows that discussing family planning with a woman during the first trimester and throughout her pregnancy is more effective than waiting until after she delivers. (Guidelines for Prenatal Care, Sixth Edition 2007. American Academy of Pediatrics, American College of Obstetricians and Gynecologists).

Referrals to family planning must be made, if indicated. All staff should be familiar with the document, *Discussing Family Planning*, at the MIHP web site.

After the infant is born, address family planning if it has been identified as a risk or the beneficiary inquires about it.

Many MIHP beneficiaries lose their Medicaid coverage at the end of two calendar months following the month the pregnancy ends. At that point, they have no way to pay for family planning services.

A beneficiary who is losing her Healthy Kids for Pregnant Women Medicaid coverage should be encouraged to apply for the Healthy Michigan Plan (Medicaid expansion under the Affordable Care Act). See section titled *Refer Maternal Beneficiary to the Healthy Michigan Plan* when *Healthy Kids for Pregnant Women Medicaid Ends* earlier in this chapter.

Also make sure that the beneficiary is aware that family planning services are offered at Title X family planning clinics. A list of family planning clinics is posted on the MIHP web site.

## **Childbirth Education Group Classes**

MIHP providers are required to encourage every first-time mother to complete a childbirth education (CBE) course. Referrals of first-time mothers to CBE must be documented in the beneficiary's record. However, in some communities, there are few or no affordable CBE options for MIHP beneficiaries. If your MIHP serves an area where there are absolutely no CBE resources, contact your consultant to determine the best way to provide CBE for your beneficiaries.

The MIHP provider may choose to teach and bill Medicaid for childbirth education (CBE) classes. CBE can be billed one time per beneficiary per pregnancy. The pregnant woman must attend at least ½ of the classes or cover at least ½ of curriculum described in the course outline before Medicaid is billed. There are no requirements as to how many classes must be provided or how long each class must be. However, there are content requirements.

Required content for MIHP-reimbursable childbirth education classes is indicated by the major headings listed below, while bullets indicate suggested content:

### **Pregnancy**

- Health care during pregnancy
- Physical and emotional changes during pregnancy
- Nutrition

### **Labor and Delivery**

- Signs and symptoms of labor, including information regarding pre-term labor
- Breathing and relaxation exercises
- Analgesia and anesthesia
- Avoiding complications
- Coping skills
- Types of deliveries
- Episiotomy
- Support techniques
- Hospital tour

### **Infant Care**

- Preparation for breastfeeding
- Infant feeding
- Newborn immunizations
- Infant car seat use
- Newborn attachment

### **Postpartum Care**

- Postpartum physical and emotional changes, including depression
- Feelings of partner
- Potential stress within the family
- Sexual needs
- Exercise

## Importance of Family Planning

If one MIHP provider chooses to offer CBE classes, it is acceptable for beneficiaries from other MIHPs to participate in the classes. The MIHP providing the classes is responsible for billing for reimbursement for the beneficiaries in attendance, including those from other MIHPs.

If a beneficiary is homebound because of a medical condition or some other unusual circumstance, CBE may be provided in her home as a separately billable service. There must be written documentation from the medical provider in the chart stating why one-on-one CBE was needed and where it took place. There must also be documentation that at least ½ of the curriculum was covered. Alternatively, the MIHP provider may provide one-on-one CBE under the *POC 1 - Prenatal Care* or *POC 2 - Prenatal Care* domain and bill it as a regular professional visit.

## Childbirth Education Resources

The March of Dimes has excellent current and visually appealing CBE resources geared to low-level readers. For example, they have developed a free iPad app titled “My 9 Months” that birth professionals can use to educate expecting moms and their families. They also have brief videos of a small diverse group of pregnant women learning about signs of labor, signs of premature labor, and stages of labor available at [Childbirth education classes | March of Dimes](#), along with other resources.

## Parenting Education Group Classes

The MIHP provider may choose to teach and bill Medicaid for parenting education classes, but only if no other community-based organization is providing no-cost parenting classes in the area. MIHP parenting education classes can be billed one time per infant or per family in the case of multiple infants. The parent must attend at least ½ of the classes or cover at least ½ of the curriculum described in the course outline before Medicaid is billed. There are no requirements as to how many classes must be provided or how long each class must be. However, there are content requirements.

Required content for MIHP-reimbursable parenting education classes is indicated by the major headings listed below, while bullets indicate suggested content:

### Feeding Recommendations throughout the First Year of Life

- Nutritional requirements
- Developmental issues related to feeding children
- Breast feeding advantages
- Formula preparation and breastfeeding

### Normal and Abnormal Patterns of Elimination

- Normal range of elimination patterns and changes throughout childhood
- Toilet training issues and developmental readiness

### Common Signs and Symptoms of Infant Illness

- Appropriate care for common illness
- Danger signs and when to call the health care provider
- Emergency numbers (i.e., poison control, emergency room, etc.)

### Common Childhood Injuries and How to Care for Them

- Signs and symptoms – when to seek medical care
- Basic first aid

- Accident prevention and safety

### **Normal Range of Sleep, Rest, Activity and Crying Patterns**

- How to assist an infant in settling to sleep
- Normal patterns of sleep and activity and developmental changes
- Information on safe sleep environment
- Signs and symptoms of over-stimulation and under-stimulation
- How to quiet a crying baby
- How to play with a baby to encourage optimum developmental skills

### **Hygiene**

- Hygiene needs of infants
- Appropriate care of routine problems (e.g., diaper rash, seborrhea, circumcision, etc.)

### **Normal Developmental Milestones of Infants Throughout the First Year**

- Developmental issues relating to providing care, feeding, and stimulation
- Realistic expectations of infants in relationship to their developmental level

### **Emotional Needs**

- Parent-infant interactions and attachment
- Normal changes that occur throughout the first year of life and their impact on the infant-parent interaction
- Discussion and modeling of parenting behaviors that positively impact the emotional well-being of the infant

### **Protection from Toxic/Hazardous Wastes**

- Paint
- Lead
- Water

### **Immunizations and Health Maintenance**

- Well baby visits
- American Academy of Pediatrics recommended schedule
- Care of the infant after immunization

### **Day-to-day Living with Infants and Young Children**

- Appropriate methods for managing activities and stress when living with infants and children
- Secondhand smoking
- Appropriate ways of handling infant behavior

## **Immunizations**

Immunization status must be discussed throughout the course of care (at least once). MIHP providers are expected to ask the beneficiary or primary caregiver if her own and her infant's immunizations are up to date. If she does not know, she should be encouraged to find out if she and her infant have all of the

immunizations her medical provider recommends. She should be encouraged to obtain immunizations and be assisted with appointments and transportation as needed.

To see the child immunization schedule recommended by the Centers for Disease Control and Prevention, US Department of Health and Human Services, go to [www.michigan.gov/mihp](http://www.michigan.gov/mihp) and click on "Families," then "Education & Information for Parents," then "Infant Health and Safety," and then "Immunization Schedule for Babies and Young Children."

## Developmental Screening

### Introduction to the *Ages and Stages Questionnaires-3 (ASQ-3)* and the *Ages & Stages Questionnaires: Social/Emotional (ASQ: SE-2)*

Infancy is a dynamic time of change across multiple developmental domains. An infant's status may change in a surprisingly short period of time. Unless ongoing developmental screening is conducted, early identification of potential concerns may not occur, and the necessary referral, support and treatment may not be provided for the infant. Therefore, developmental screening must be provided for all MIHP infant beneficiaries.

MIHP providers are required to purchase and use the following two developmental screening tools:

1. *The Ages and Stages Questionnaires-3 (ASQ-3) and User's Guide*
2. *The Ages & Stages Questionnaires: Social/Emotional (ASQ: SE-2) and User's Guide*

### ASQ Developmental Domains

The ASQ-3 is used to monitor and identify issues in general infant development in the communication, gross motor, fine motor, problem-solving, and personal-social domains. *The ASQ: SE-2* is used to monitor and identify issues in infant development in the social-emotional domain.

The ASQ: SE-2 focuses deeply and exclusively on children's social and emotional behavior. Children who are exposed to risk factors such as poverty or toxic stress are more likely to experience depression, anxiety, and anti-social behavior. With the typical ups and downs of young children's emotions and behavior, delays or problems can be easily missed. The ASQ: SE-2 is intended to help home visiting programs, early intervention programs, Early Head Start, Head Start, child welfare agencies, and other early childhood programs accurately screen infants and young children to determine who would benefit from an in-depth evaluation in the area of social-emotional development.

### ASQ Questionnaires Were Developed to be Completed by Parents

ASQ questionnaires were developed to be **completed by parents** and scored by professionals, paraprofessionals or clerical staff. The parent tries activities with the child and/or answers quick questions about the child's abilities. It takes about 15 minutes for a parent to complete the questionnaire. Having parents complete the ASQ is not only cost effective, but also *enhances the accuracy* of screening - regardless of socioeconomic status, location, or well-being - by tapping into parents' in-depth knowledge about their children.

You can mail or give the ASQ to a parent and ask her to complete it before your next visit. Or, you can help a parent complete the ASQ during a visit if she is unable to read or has other difficulties completing it

independently. (There is also an online completion option, but programs must purchase a subscription to this service.)

MIHP uses the ASQ screening tools to determine if a child should be referred to *Early On* for a comprehensive developmental evaluation. The tools are also useful in helping parents learn about and promote infant development.

### **Why MIHP Uses the ASQ-3 and ASQ: SE-2**

The decision to require all MIHP providers to use the same screening tools is based on three reasons:

1. The ASQ-3 and ASQ: SE-2 are reliable, cost-effective, culturally-sensitive, and easy for parents to use (written at 4th - 5th grade reading level).
2. Using the same screening tools for all infants is important for MIHP evaluation purposes in the future.
3. By using these tools, we are helping to build a statewide developmental monitoring system, as an increasing number of early childhood programs and providers are utilizing the ASQ-3 and ASQ: SE-2 as their screening tools of choice.

### **Purchasing and Learning to Use the ASQ Tools**

MIHP providers must purchase the ASQ tools, both of which are available in English and Spanish. Purchasing information is available at the following web sites:

1. *Ages and Stages Questionnaires, 3<sup>rd</sup> Edition*  
Purchase from Brookes Publishing at  
<http://www.brookespublishing.com/resource-center/screening-and-assessment/asq/asq-3/>
2. *Ages and Stages Questionnaires: Social-Emotional, 2<sup>nd</sup> Edition*  
Purchase from Brookes Publishing at  
<http://www.brookespublishing.com/store/books/squires-asqse/index.htm>

MDHHS also requires purchase of the *ASQ-3* and *ASQ: SE-2 User's Guides* and the *ASQ-3 Learning Activities* book with CD-ROM. These materials can also be obtained via the Brookes Publishing web site.

If your MIHP does not provide infant services, you are not required to purchase the ASQ tools. However, the MIHP agency to which you transition your beneficiaries after the baby is born must purchase and use them. You must ensure that your partnering transition agency is using the ASQ developmental screening tools.

### **ASQ-3 Materials Kit**

You may choose to purchase the *ASQ-3 Materials Kit*, which includes approximately 20 toys, books and other items designed to encourage a child's participation and support effective, accurate administration of the questionnaires. The *Materials Kit* is available from Brookes Publishing at <http://agesandstages.com/>.

Alternatively, you can use materials that are available in the parent's home to administer the ASQ-3. The advantage to using materials in the home is that you can show parents how everyday items can be used to promote child development.

### **ASQ Training**

The MIHP Coordinator should make sure that professional staff are very familiar with this section of the *MIHP Operations* Guide and that they are well-trained on using the ASQ tools.

There is a no-cost training on the *Ages and Stages Questionnaires* at the MIHP web site that explains how to administer and score the ASQ-3 and ASQ: SE-2. This training is required for all MIHP staff who conduct developmental screening. Staff who conduct ASQ screenings also should be familiar with ASQ-3 *User's Guide* and the ASQ: SE-2 *User's Guide*.

Three training DVDs are available from Brookes Publishing at a cost of @ \$50 each (2014). These DVDs are titled:

1. *The Ages and Stages Questionnaires on a Home Visit*
2. *ASQ-3 Scoring and Referral*
3. *ASQ: SE-2 in Practice* (26 minutes)

## **ASQ Questionnaire Intervals: Selecting the Right Questionnaire Based on Age**

It's important to distinguish between ASQ questionnaire intervals and ASQ administration intervals. ASQ questionnaire intervals pertain to selecting the correct questionnaire based on the child's age; ASQ administration intervals are the points in time that a particular program decides to administer the ASQ.

Questionnaire intervals are the different versions of the questionnaire based on the child's age in months. The ASQ-3 has 21 questionnaire intervals (2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, and 60 months). The ASQ: SE-2 has nine questionnaire intervals (2, 6, 12, 18, 24, 30, 36, 48, and 60 months). Each questionnaire interval covers a range of months.

If an infant is not the exact age of one of the questionnaire intervals listed above, refer to **Selecting the Correct ASQ-3 Based on the Child's Age** chart or **Selecting the Correct ASQ: SE-2 Based on the Child's Age** chart at [www.michigan.gov/mihp](http://www.michigan.gov/mihp). These charts indicate which questionnaire to use with an infant who is not the exact age of one of the questionnaire intervals. For example, the ASQ-3 chart indicates that if an infant is 3 months 0 days through 4 months 30 days, use the 4 month questionnaire.

When selecting the ASQ-3 or ASQ: SE-2 questionnaire to match the child's age, calculate an adjusted age if the child is younger than 24 months at the time of screening and was born 3 or more weeks premature. Use the **ASQ Calculator** at [www.agesandstages.com/free-resources/asq-calculator](http://www.agesandstages.com/free-resources/asq-calculator) to quickly and easily adjust for prematurity in order to select the right tool. Use of the ASQ Calculator is recommended, as it reduces the odds of calculation errors.

The ASQ authors have determined that infant must be at least one month old before it's appropriate to administer the ASQ-3. Likewise, the infant must be at least one month old before it's appropriate to administer the ASQ: SE-2.

The *Selecting the Correct ASQ-3 Based on the Child's Age* and *Selecting the Correct ASQ: SE-2 Based on the Child's Age* charts are only for purposes of helping you to select the right questionnaire to use with a particular child based on the child's age. *These charts DO NOT indicate when to conduct the first screening or repeated screenings with an MIHP infant beneficiary. The timing of MIHP developmental screenings using the ASQ-3 and ASQ: SE-2 is discussed below.*

## **ASQ Administration Intervals: When MIHP Administers the ASQ-3 and ASQ: SE-2**

Administration intervals are the points at which the ASQ-3 and ASQ: SE-2 are repeatedly administered in MIHP. MDHHS requires that MIHP providers administer the ASQ-3 every 4 months if development appears to be on schedule. However, if the ASQ-3 score is close to the cutoff, screening must be repeated in 2 months.

MDHHS requires that MIHP providers administer the ASQ: SE-2 at the following points in time: before the infant reaches 3 months; before the infant reaches 9 months; before the infant reaches 15 months, and before the infant reaches 21 months, if development appears to be on schedule.

## Using ASQ Scores to Determine What Action the MIHP Provider Should Take

The infant's total ASQ-3 score will fall under one of three categories. The categories are listed in the table below with the specific action that the MIHP provider should take with respect to each category.

Total ASQ-3 Score Category	Take This Action
Score is <b>below</b> the cutoff; further assessment with a professional may be needed	Discuss with family, refer the infant to <i>Early On</i> for a comprehensive developmental evaluation, document in record.
Score is close to the cutoff; provide learning activities and monitoring	Repeat the screening in <b>two</b> months.
Score is above the cutoff; development appears to be on schedule	Repeat the screening in <b>four</b> months.

The infant's total ASQ: SE-2 score will fall under one of two categories. The categories are listed in the table below with the specific action that the MIHP provider should take with respect to each category.

Total ASQ: SE-2 Score Category	Take This Action
Score is <b>above</b> the cutoff; further assessment with a professional may be needed	Discuss with family, refer the infant to <i>Early On</i> for a comprehensive developmental evaluation, document in record. Also refer to Infant Mental Health.
Score is at or below the cutoff; development appears to be on schedule	Repeat the screening at the next MIHP - required age interval.

Remember that you may refer an infant to *Early On* for a comprehensive developmental evaluation, based solely on your professional opinion, when the infant is too young for the ASQ-3 or ASQ: SE-2 to be administered, or when you or the parent suspect there is a developmental concern that is not reflected in the infant's ASQ scores.

If the family declines an *Early On* referral, document this in the chart. At a minimum, simply state: The family declined to accept an *Early On* referral.

The total number of ASQ-3s and ASQ: SE-2s administered over the course of MIHP service will vary from infant to infant, depending on a variety of factors, including the following:

1. The age of the infant at MIHP entry
2. How long the infant is in MIHP
3. The infant's ASQ score at each administration
4. Whether or not ASQs are being administered by another program serving the infant
5. Whether or not the infant is referred to *Early On* for a comprehensive developmental evaluation at some point

## MIHP Developmental Screening Begins with the *Infant Risk Identifier*

MIHP developmental screening actually begins at program enrollment, when the *Infant Risk Identifier* is administered. The *Infant Risk Identifier* includes developmental screening questions from *Bright Futures*, an initiative of the American Academy of Pediatrics. *Bright Futures* screening questions are included for each of the following age ranges:

- Less than 3 weeks
- 3 to 4 weeks
- 1 month 0 days to 2 months 30 days
- 3 months 0 days to 4 months 30 days
- 5 months 0 days to 7 months 30 days
- 8 months 0 days to 10 months 30 days
- 11 months 0 days to 12 months 30 days
- 13 months 0 days to 15 months 30 days

There are 5 to 11 screening questions for each *Bright Futures* age range. The individual who is administering the *Infant Risk Identifier* selects the age-appropriate set of questions, adjusting for prematurity, as needed. See “Adjusting for Prematurity across MIHP Developmental Screening Tools” later in this chapter.

Once the *Infant Risk Identifier* has been administered and *Bright Futures* screening has been repeated, if necessary, all follow-up developmental screening is conducted using the ASQ tools. The timing of the initial follow-up screening using the ASQ tools depends on the primary caregiver’s responses to the *Bright Futures* questions, as detailed below:

Positive *Bright Futures* Screen (concern is triggered):

1. If the infant is less than two months old and at least one *Bright Futures* “not yet” box is checked, administer the ASQ-3 within two weeks. (The infant must be at least one month old before it’s appropriate to administer the ASQ-3. If the infant is less than one month old, use the age-appropriate *Bright Futures* questions from the *Infant Risk Identifier*.)
2. 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. If the infant is at least three months old, also use the ASQ: SE-2. (The infant must be at least one month old before it’s appropriate to administer the ASQ: SE-2.) You are not required to administer both the ASQ-3 and the ASQ: SE-2 at the same visit.

Negative *Bright Futures* Screen (no concern is triggered)

If no concerns are triggered by the *Bright Futures* screen in the *Infant Risk Identifier*:

Administer the initial ASQ-3 at the first professional visit (not the *Risk Identifier* visit) unless the infant is not yet two months old. In this case, administer the ASQ-3 at the first visit conducted after the infant turns two months old. Repeat ASQ-3 screenings at the time intervals specified in the grid in the previous section titled *Using ASQ Scores to Determine What Action the MIHP Provider Should Take*.

Administer the ASQ: SE-2 using the following questionnaire intervals at the times specified below:

- 2 month questionnaire before the infant reaches 3 months old (but not before 1 month of age per the ASQ authors).
- 6 month questionnaire before the infant reaches 9 months old.
- 12 month questionnaire before the infant reaches 15 months old.
- 18 month questionnaire before the toddler reaches 21 months old. (NOTE: You must contact your consultant for permission to serve a child who reaches 18 months of age.)

If the infant is older than the age limit for a particular questionnaire at the time of enrollment, use the age-appropriate questionnaire and administer it within the first 3 professional visits.

If it is not possible to administer the ASQ-3 or ASQ: SE at the specified points in time, document the reason in the chart.

Generally speaking, the *Infant Risk Identifier* (which includes developmental screening questions from *Bright Futures*) and the ASQ are **not** administered during the same visit. The *Infant Risk Identifier* is billed as an assessment visit and the ASQ is billed as a professional visit which must be documented on a

*Professional Visit Progress Note.* Only under unusual circumstances can these two visits be billed on the same day.

## **Why It's Important to Administer the Initial ASQ-3 and ASQ: SE-2 as Early as Possible in MIHP**

It is important to conduct the initial ASQ-3 and the initial ASQ: SE-2 as early as possible for the following reasons:

1. Many infants are lost to MIHP care after only a few visits. Screening early ensures that these infants will be screened at least once.
2. Many MIHP families, like other families, deeply appreciate the information they get from developmental screening and see it as a real benefit of MIHP participation. Screening appears to be a way to engage some families that would otherwise drop out of MIHP.
3. Children living in poverty are at higher risk for developmental delays than other children. The sooner a developmental delay is identified, the sooner we can intervene, increasing the probability of a better outcome. Many children in poverty enter kindergarten having never been screened; those with developmental delays miss out on years of early intervention that could have changed the trajectory of their lives. MIHP may provide the only opportunity for some children to be screened early in life.

## **Why It's Important to Conduct Repeated Administrations of the ASQ-3 and ASQ: SE-2 in MIHP**

It is important to conduct repeated administrations of the ASQ-3 and ASQ: SE-2 for the following reasons:

1. Child development is dynamic (rapidly changing) in nature.
2. Some developmental delays are not detectable at all stages of development.
3. Repeated developmental screening provides a more accurate assessment of development than a one-time evaluation, and developmental screening at multiple ages allows for monitoring of developmental progress (or regression) over time.
4. Repeated developmental screening promotes and supports a parent's understanding of her child's development.

It is important to screen all children for developmental delays, but especially those who are at a higher risk for developmental problems due to preterm birth, low birth weight, or having a brother or sister with an autism spectrum disorder. (*Centers for Disease Control and Prevention*)

## **Completing and Filing the ASQ-3 and ASQ: SE-2 Information Summaries**

You must complete an *ASQ Information Summary* every time you administer the ASQ-3 or ASQ: SE-2. Note that the *ASQ-3 Information Summary* form is somewhat different from the *ASQ: SE-2 Information Summary* form.

When you complete the *ASQ-3 Information Summary*, you are not required to complete the following fields:

1. Child's ID number
2. The total score column, as long as the total score circles are filled in. (NOTE: As a QA practice, complete both the total score column and the total score circles; but this is not required.)
3. Section 5 Optional

When you complete the *ASQ: SE-2 Information Summary*, you are not required to complete the following fields:

1. Mailing address
2. City
3. State
4. Zip
5. Telephone
6. Assisting in *ASQ: SE-2* completion

At a minimum, the scored *ASQ Information Summary* must be kept in the infant's record for each *ASQ-3* and *ASQ: SE-2* administered. The completed questionnaire (without the *Information Summary*) should be given to the parent, although a copy of the *ASQ Information Summary* must be provided to the parent upon request.

If the parent doesn't want the completed questionnaire, it may be filed in the chart. This way all home visitors can easily see the specific developmental questions or issues that need to be addressed. However, it is not required that copies of completed questionnaires be kept in charts, as staff may not have portable copy machines for use in the field. Staff who cannot make copies in the field can cross-reference the scored *Information Summary* to the questionnaire when visiting with the parent, if the parent has kept it.

## **Administering ASQ Tools with Low-Risk Infants**

When administering the *ASQ* tools with a "low-risk" infant (for whom there is no *POC 2*), use the *POC 1* to set up *ASQ* appointments. Document the *ASQ* visits under "other visit information" on the *Professional Visit Progress Note*.

## **Pulling Infant POC – General Development Based on Bright Futures or ASQ Scores**

The general infant development domain is not required for every infant. It should not be pulled for every infant.

### Bright Futures Scores

General infant development will score out if a concern is identified by the *Bright Futures* questions in the *Infant Risk Identifier (IRI)*. In this case, you must pull the *Infant Plan of Care – General Development* domain. If no concern is identified by the *IRI Bright Futures* questions, you may pull this domain.

### ASQ-3 and ASQ: SE-2 Scores

If an infant's *ASQ-3* score is below the cutoff or *ASQ: SE-2* score is above the cutoff, pull the *Infant Plan of Care - General Development* and add it to the *POC, Part 2*. Also pull *General Development* if there are two consecutive *ASQ-3* screenings scoring close to the cutoff (in the gray area) in the same developmental domain. If the *ASQ-3* or *ASQ: SE-2* scores out in the gray zone, you may pull *General Development*.

If there are two consecutive *ASQ-3* screenings scoring close to the cutoff (in the gray area) in two different developmental domains, and there is no concern on the part of the caregiver or MIHP staff, you need not pull *General Development*. However, be sure to but document why you did not do so.

In Column 2 of the *POC 2*, the following risk criteria are included:

ASQ-3 result (s) in gray zone  
ASQ: SE-2 result (s) in gray zone

These statements refer to screening conducted at any time during the course of care, not just to the most recent screening.

## Learning Activities When ASQ-3 Score is Close to the Cutoff

Effective November 1, 2015, new MIHP agencies are expected to purchase the *ASQ-3 Learning Activities* book with CD-ROM from the Brookes Publishing Company. Agencies will use this resource to teach families how to implement learning activities when an infant scores close to the cutoff (gray area) in a particular developmental domain. Brookes describes the 160-page paperback book as follows:

*Enhance the growth and development of infants and young children with more than 400 fun, fast, and easy-to-use learning activities—now in a **new edition** specially developed to complement ASQ-3™. Perfect for sharing with parents of children who are developing typically or need non-intensive support in one or more developmental areas. These playful, developmentally appropriate activities:*

- *Encourage progress in the same five developmental areas as ASQ-3™ - communication, gross motor, fine motor, problem solving, and personal-social*
- *Use safe, age-appropriate materials that most families have at home*
- *Help even the youngest children develop crucial early language and literacy skills*
- *Promote closer parent-child interactions*
- *Serve as a natural follow-up for children who score in the ASQ-3™ monitoring zone*

*New additions include a new set of activities for 0-2 months; more activities—30+ per age range; more language and literacy activities; more language modeling for parents; easy to email PDF format to share with parents; more differentiation of activities by age; and activities are now in color on the CD-ROM.*

*Now packaged as a book and CD-ROM together so you can photocopy or print them as needed, these creative, cost-effective activities are the perfect way for parents and children to learn and have fun together.*

### **Infants Being Screened by Other Early Childhood Providers**

If another early childhood provider is conducting ASQ-3 and ASQ: SE-2 screenings for an infant, the MIHP provider need not duplicate them. Just be sure to document that developmental screening is being provided by another entity and obtain copies of the *ASQ Information Summary* for the infant's record.

If you are unable to secure the *Information Summaries* from the other early childhood program, note the attempts made to do so. You must then conduct the ASQ-3 and ASQ: SE-2 as appropriate from that point forward.

If the infant drops out of the program that has been conducting the screenings, then screening becomes your responsibility. Document that you have asked the caregiver and that the infant is or is not continuing with the program.

When an infant is referred to *Early On*, he or she will receive a developmental evaluation, which is much more comprehensive than ASQ screening, and which will be used to determine eligibility for *Early On* services. If the infant is found to be eligible for *Early On*, an *Individualized Family Service Plan (IFSP)* will be developed and services will be provided. In this case, the MIHP provider need not continue to conduct ASQ screenings, but should document that the infant is receiving services through *Early On*.

If the infant is not enrolled in *Early On* because he is found to be ineligible or the family decides against enrollment, or the infant is enrolled but then drops out of *Early On*, it is your responsibility to resume developmental screening.

## Adjusting for Prematurity across MIHP Developmental Screening Tools

**All three of the developmental screening tools used in MIHP require adjustment for prematurity:**

- When selecting the appropriate *Bright Futures* questions, you need to adjust for prematurity if the infant was born before 40 weeks gestation. Adjusted age is calculated by subtracting the number of weeks born before 40 weeks of gestation from the chronological age. This adjustment is made automatically when the data is entered electronically into the MDHHS database. However, if you select the wrong questions when you administer the *Infant Risk Identifier*, the screening results won't be valid.
- When selecting the ASQ-3 or ASQ: SE-2 questionnaire to match the child's age, calculate an adjusted age if the child is younger than 24 months at the time of screening and was born 3 or more weeks premature. Use the **ASQ Calculator** at [www.agesandstages.com/free-resources/asq-calculator](http://www.agesandstages.com/free-resources/asq-calculator) to quickly and easily adjust for prematurity in order to select the right tool. Use of the **ASQ Calculator** is recommended as it reduces the odds of calculation errors.

## Developmental Screening with Multiples

It may not be feasible to complete, score, and discuss the results of ASQ screenings for more than one infant at one visit, especially if developmental guidance is provided. Therefore, in the case of multiples, the MIHP provider may need to conduct developmental screening for each infant at a separate visit.

Since developmental screening is conducted periodically during infancy and screening multiples could take a significant number of visits, the MIHP provider may need to ask the medical care provider to authorize an additional 9 visits. The MIHP provider can only bill under one infant's Medicaid ID number per family for the first 9 visits and for any additional visits authorized by the medical care provider.

## Making and Following-up on Referrals to Other Supports and Services

MIHP professionals are required to refer beneficiaries to other community service providers as detailed in the interventions for each domain. Professionals are also required to follow-up on referrals to determine whether or not a beneficiary accessed the services to which she was referred.

## Handing Out a Community Referral List

It is recommended that MIHP providers hand out a community referral list to every beneficiary as she enters the program, encouraging her to call the appropriate provider agency if she should require assistance at any point. Before handing out this list, the MIHP provider may want to contact each listed agency, explaining MIHP services and indicating that some MIHP beneficiaries will be seeking their services. Handing out a community referral list does not constitute an MIHP referral, and no follow up is required.

## Developing Relationships with Key Referral Sources

There are key referral sources with whom you need to cultivate good working relationships, given the nature of the services they provide and the fact that many beneficiaries need their services. For example, if you do not have a registered dietitian (RD) on staff, your staffing protocol must describe how you arrange for RD services, identify the RD services provider, and specify how the referral is made. Likewise, if you do not have an infant mental health (IMH) specialist on staff, your staffing protocol must describe how you arrange for IMH services, identify the IMH provider, and specify how the referral is made.

You also need good relationships with *Early On*, CMH, MHP behavioral health care managers, substance use disorder programs and domestic violence programs, as beneficiaries may be reluctant to use these services and need help to access them. It's not possible to provide quality care coordination in the absence of strong relationships with key referral sources.

## **Making Referrals**

An MIHP referral takes place when a professional:

1. Discusses a particular referral source with the beneficiary, so she clearly knows what to expect.
2. Encourages the beneficiary to seek services from the referral source.
3. Determines that the beneficiary wishes to seek services from the referral source.
4. Provides specific information about contacting the referral source in writing.
5. Determines if the beneficiary needs assistance to contact the referral source due to limited English proficiency, low literacy, comprehension difficulties, immobilization stemming from depression, fear or stigma related to using certain services (e.g., *Early On*, mental health services, substance abuse services, domestic violence services, etc.), or other concerns.
6. Provides assistance in contacting the referral source, if needed.

If the beneficiary does not wish to seek services, ask her about her reasons. If appropriate, gently encourage her to continue to think about it, explaining the potential benefits.

MIHP encourages the use of warm transfers when making referrals in some situations. For information on warm transfers, see *Chapter 11 - Maintenance, Retention and Transfer of MIHP Records*.

## **Documenting Referrals**

Whenever an MIHP professional makes a referral, the appropriate box must be checked under "New referrals" on page 2 of the *Professional Visit Progress Note* or on the optional *MIHP Referral Follow-Up Form*. This serves as documentation of the referral and alerts other team members to follow up on it at a subsequent visit.

If you make a referral during the enrollment visit, be sure to document it on the *POC 2* in the "Date Achieved" space in Column 3 or on the *MIHP Referral Follow-Up Form* so that it is captured for the *Discharge Summary*.

If the beneficiary declines the attempt at referral, document her refusal of the referral under "Other visit information".

## **Following Up on a Referral and Documenting the Outcome**

Follow-up on a given referral must take place within three professional visits from the date of the referral. Anyone on the team can follow up on a referral; it does not have to be the professional who originally made the referral. The care coordinator is responsible for monitoring the chart to assure that follow up takes place as required.

An MIHP referral follow-up takes place when a professional:

1. Asks the beneficiary if she has accessed the service to which she was referred.
2. If she has accessed the service:

- a. Supports her actions in this regard.
  - b. Asks if the service seems to be meeting her needs.
  - c. If it is not, offers any help that may be indicated.
3. If she has not accessed the service:
- a. Talks with her about why she didn't access the service (e.g., "baby was sick and I didn't get to it" or "I ran out of phone minutes" or "I called and they gave me the run-around" or "I changed my mind – I don't want this service.")
  - b. If she decided not to seek services, asks about her decision.
  - c. If appropriate, gently encourages her to continue to think about it, explaining the potential benefits.
  - d. If she tried to seek the service, but was unsuccessful, offers to help, if appropriate.

Whenever an MIHP professional follows up on a referral, the beneficiary's response must be documented under "Outcome of previous referrals" on page 2 of the *Professional Visit Progress Note*. Follow up referral documentation should include which referral is being addressed and the status of the referral.

## Referrals for Mental Health Services

### Perinatal Depression

There are three types of depression women may experience during the perinatal period (from start of pregnancy to 12 months after giving birth):

#### 1. The Baby Blues

- Common reaction the first few days after delivery
- Crying, worrying, sadness, anxiety, mood swings
- Usually lifts in about 2 or 3 weeks
- Experienced by 50 – 80% of women

#### 2. Perinatal Depression

- Major and minor episodes of clinical depression during pregnancy or within first year after delivery
- More than the Baby Blues - lasts longer and is more severe
- Symptoms:
  - Sad, anxious, irritable
  - Trouble concentrating, making decisions
  - Sleeping or eating too much or too little
  - Frequent crying and worrying
  - Loss of interest in self care
  - Loss of interest in things that used to be pleasurable
  - Shows too much or too little concern for baby
  - Not up to doing everyday tasks
  - Feelings of inadequacy
  - Intrusive thoughts
  - Suicidal thoughts
- Symptoms last more than 2 weeks
- Co-occurs with anxiety disorder for 2/3 of women:
  - Generalized Anxiety Disorder
  - Panic Disorder
  - Obsessive-compulsive Disorder
  - Other
- Often co-occurs with substance use disorder
- Experienced by 10-20% of all women but prevalence is much higher for low-income and minority women (30 – 60% in various studies)

### 3. Postpartum Psychosis

- A rare disorder (one or two in 1,000 women)
- A severe form of perinatal depression that can be life-threatening
- Symptoms: extreme confusion, hopelessness, can't sleep or eat, distrusts others, sees or hears things that aren't there, thoughts of harming self, baby or others
- A medical emergency requiring urgent care

For much more information on perinatal depression, see the *Implementing the MIHP Depression Interventions* webcast at the MIHP web site.

#### **Developing Relationships with CMHSPs and MHPs to Clarify Referral Process**

A significant number of MIHP beneficiaries require referrals for mental health services. MIHP providers need current, accurate information about mental health services available from MHPs, Community Mental Health Services Programs (CMHSPs), and other community agencies that serve Medicaid beneficiaries, including pregnant women and mother-infant dyads. MIHP providers are encouraged to meet with MHPs and CMHSPs in their respective service areas to develop relationships and document the referral process to be used by MIHP providers when referring MIHP beneficiaries to MHPs and CMHSPs for mental health assessment and services.

#### **Implementing the MIHP Depression Interventions Webcast**

Information on making mental health services referrals is included in the *Implementing the MIHP Depression Interventions* webcast. This training, available at the MIHP web site, is required for all MIHP professionals. The training covers the following topics:

1. Perinatal depression and its impact on the mother and her infant
2. Role of MIHP staff in addressing perinatal depression
3. How to access mental health treatment and support services in the community for women suffering from perinatal depression

In addition to the MIHP Stress/Depression domain interventions, six important documents are referenced in the web cast. Professional staff should be very familiar with these documents. Two of the documents, which are intended for MIHPs only, were emailed directly to MIHP Coordinators in November 2013:

1. CMH Contacts for Mental Health Services for Infants and Their Families (Including Infant Mental Health)
2. Using Community Mental Health Contacts to Navigate Mental Health Services for MIHP Infants and their Families

The other four documents are available at the MIHP website:

1. Possible Reasons for Referral to an MIHP Infant Mental Health Specialist or to CMH for an Assessment (at webcast)
2. Weekly Self-Care Action Plan for Pregnant Women and Mothers with Young Children) webcast
3. MIHP Safety Plan
4. MIHP Perinatal Depression Resources for Consumers and Health Care Providers

Two other resources that are referenced in the webcast are recommended for sharing with beneficiaries:

1. Depression During and after Pregnancy: A Resource for Women, Their Families, & Friends (booklet) [Depression During and After Pregnancy: A Resource for Women](#)
2. PostPartum Depression Education Video - New Jersey – You Tube (5.13) (video) [Post Partum Depression Educational Video \(New Jersey\) - YouTube](#)

## Referring to the Medical Care Provider

MDHHS recognizes that although some communities do have perinatal depression treatment programs and/or support groups, the reality is that it is still difficult for many MIHP beneficiaries with depression to access mental health therapy. MHPs provide up to 20 outpatient visits for beneficiaries with mild to moderate mental illness. However, many women are not enrolled in MHPs until fairly late in their pregnancies and their Medicaid coverage ends about 60 days postpartum. Also, in some areas of the state, it is difficult for MHPs to find mental health therapists who will accept Medicaid. Community Mental Health Services Programs (CMHSPs) provide services for Medicaid beneficiaries, but only if they meet criteria for severe mental illness.

The third intervention in the MIHP *Stress/Depression POC 2* is: “Educate on symptoms of depression and/or anxiety to report to health care provider.” Mental health issues are widely prevalent in this country and the vast majority of adults with mental health disorders rely on their primary care providers to make a diagnosis and manage their medications. Approximately 1 in 10 adults are treated with an antidepressant annually, and nearly three quarters of antidepressants are prescribed by general medical providers (Mojtabai R. & Olfson M. (2008) National patterns in antidepressant treatment by psychiatrists and general medical providers: Results from the national comorbidity survey replication. *The Journal of Clinical Psychiatry*, 69(7), 1064-1074). Because of the stigma of mental illness, many people will not see a mental health provider, but will discuss mental health concerns with their primary care provider, so this option may be acceptable to some MIHP beneficiaries.

## MIHP Perinatal Depression Resources for Consumers and Health Care Providers

*MIHP Perinatal Depression Resources for Consumers and Health Care Providers*, available on the MIHP web site, includes resources for consumers and professionals who wish to learn more about perinatal depression and treatment. One of the resources included in this list is <http://www.motherscenter.org/item/mededppd-org.html>, a professional education, peer-reviewed web site developed with the support of the National Institute of Mental Health (NIMH).

## 9.0 MHHP QUALITY ASSURANCE AND IMPROVEMENT

### MIHP Provider Certification for Quality Assurance

Medicaid policy requires MDHHS to monitor and certify Maternal Infant Health Program (MIHP) providers to assure that they are operating in compliance with Medicaid policies (*Medicaid Provider Manual*) and procedures (*MIHP Operations Guide*). Certification is the culmination of a comprehensive review process, in which the reviewer assesses compliance with both program and billing requirements.

MIHP state consultants are available to provide consultation to assist new and existing MIHP providers to achieve and maintain certification. MIHP providers are strongly encouraged to make use of the consultation services that are available to them.

MDHHS conducts the initial certification review approximately six months after a new MIHP provider has begun to serve MIHP beneficiaries. If the new provider achieves full certification at their 6-month review, their next review is conducted 12 months later. If they achieve full certification at their 12 month review, their next review is conducted 18 months later. If they continue to achieve full certification, they are reviewed every 18 months for as long as they operate the program.

The certification review is conducted in two parts:

1. The first part is a review of documents submitted by the provider to the reviewer at least 14 calendar days prior to the scheduled onsite review. These documents include the *MIHP Personnel Roster*, staff licenses and registrations, course completion certificates for required trainings, signed confidentiality agreements for staff with access to Protected Health Information, and program protocols.
2. The second part is a two-day onsite visit, during which the reviewer conducts staff and coordinator interviews, inspects the facility, and examines beneficiary charts, billing documentation and personnel files.

Reviews are conducted by registered nurses who have worked, or are currently working, as MIHP Coordinators or professional staff.

In order to be reviewed, new and existing agencies (as of August 1, 2014) must have at least 40 charts. This may be any combination of open and closed charts that were active for some period of time since program start-up or since the last review. If closed charts are included in the 40, they must have been closed during this period of time. A new agency can only count 10 transfers toward the 40 charts required for their initial review.

Cases that are ready for discharge should not be kept open. The only MIHP agencies that are not required to have 40 charts at the time of certification review are tribal agencies and agencies serving specialty populations.

### Overview of the Certification Process

For an overview of the certification process, see the following documents at the MIHP web site:

1. MIHP Certification Process
2. MIHP Certification Review Process Flow – Existing Agency
3. MIHP Certification Review Process Flow – New Agency

There are five types of certification: provisional certification (first six months), full certification, conditional certification, decertification and emergency decertification. Each is described in *MIHP Certification Process* (referenced above).

Note that emergency decertification may or may not be the result of a certification review. It may also result from a complaint investigation that reveals serious action or inaction or a pattern of activity that threatens the health, well-being and safety of MIHP beneficiaries.

## **Certification Review Scheduling**

When a provider receives a notice of certification letter, it indicates the number of months (6, 12, or 18) that their certification is valid. This means that the provider knows the month/year that their next review will be conducted well in advance.

Two to three months prior to the review month, the reviewer contacts the provider to schedule the actual dates for the onsite review. Onsite reviews are conducted on two consecutive dates. In rare circumstances, reviews may be rescheduled at the mutual agreement of the MIHP provider and MDHHS. However, they can only be moved up or back two weeks from the originally scheduled dates.

After the review is scheduled, the provider receives the *MIHP Certification Review Scheduling Letter – New Provider* or the *MIHP Certification Review Scheduling Letter – Existing Provider*. These letters describe in specific detail what the provider needs to do to prepare for the review, including what materials are required to be submitted to the reviewer prior to the onsite review. The deadline for submission of these materials is indicated on the letter (14 calendar days before the onsite review).

The scheduling letter has several attachments including the following:

1. Certification Tool (revised every 18 months)
2. Review Agenda
3. MIHP Certification Protocols
4. Forms to be used to submit beneficiary names so reviewer can select charts

The provider is encouraged to use the *Certification Tool* and *Chart Review Tools* (discussed below) to review their own program prior to the certification review visit, so they are as prepared as possible for the onsite review.

## **Review of Documents before the Onsite Review**

**Prior to the review, the reviewer will examine the following documents submitted by the provider:**

1. *MIHP Personnel Roster*.
2. Certificates of attendance from all coordinator meetings held since your last review.
3. MIHP staff licenses and registrations.
4. Course completion certificates (or group training sign-in sheets) for all required trainings.
5. For all staff hired since 10-01-12, copies of *Notice of New Professional Staff Training Completion* and any waiver documents.
6. Signed confidentiality agreements for staff that have access to Protected Health Information.
7. Your program protocols.
8. For the billing review, a list of the names of 20 closed maternal beneficiaries and a list of the names of 20 closed infant beneficiaries since your last review, who have had at least 5 visits in addition to an *MIHP Risk Identifier* visit.
9. If you do not have 20 closed charts for one or both of the lists, then also list the names of beneficiaries with open charts since your last review, who have had at least 5 visits, in addition to an *MIHP Risk Identifier* visit, in order to bring the total number of charts to 20.
10. Your MIHP web site address, if you have one.
11. Directions to your agency, once in your community, and specific directions to your office, once in your building.

The reviewer will also conduct an Internet search using your program/agency name to see if your agency is advertising enrollment incentives on other web sites.

## Onsite Review

The onsite review includes the following components:

1. Coordinator interview
2. Professional staff group interview (except at a six-month follow-up review). The interview takes approximately one hour. The number of staff who must be present (in addition to the Coordinator) depends on the size of the staff, as noted below:
  - Up to three professional staff: All must participate
  - Four to five professional staff: At least three must participate
  - Six or more professional staff: At least 50% must participateIf professional staff cannot participate in the group interview in person, they may participate via conference call.
3. Billing review of closed charts since last review (may include open charts if there aren't enough closed charts)
4. Discussion of findings from pre-review of submitted documents
5. Program review of open and closed charts (since last review)
6. Follow-up on any Not Met indicators from last review
7. Inspection of the facility
8. Exit Meeting on Preliminary Findings

## Standardized Chart Review Tools

During the onsite review, the reviewer uses standardized chart review tools to document their findings. The provider is encouraged to use these tools as they conduct their own internal quality assurance chart reviews. The tools are all available at the web site.

1. [Maternal Chart Review Tool](#)
2. [Maternal Billing Review Tool](#)
3. [Infant Chart Review Tool](#)
4. [Infant Billing Review Tool](#)
5. [Professional Visit Progress Note Review](#)

## Notification of Review Results

Within 30 days after the review is completed, the provider receives the following certification documents (templates at MIHP web site):

1. Certification Notification Letter
2. Certification Tool (with ratings and comments)
3. Follow-Up on Not-Met Indicators from Previous Certification Review
4. Preliminary Findings of Not Met Indicators
5. [Corrective Action Plan \(CAP\) and Instructions](#) (if applicable)

If one or more indicators are rated as Not Met, the provider must submit a *Corrective Action Plan (CAP)* to MDHHS within 21 days, using a standardized form and set of instructions. Upon receipt of the CAP, MDHHS has 14 days to notify the provider that it has been approved or that modifications are required. The provider receives written notice when the CAP has been approved.

## Billing Concerns Referred to OIG

When a certification review identifies potential billing concerns, the certification documents are forwarded to the MDHHS Office of Inspector General (OIG). The OIG audits and investigates suspected misuse of Michigan's Medicaid Program to ensure that funds are used for the best care of beneficiaries. The OIG recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation and prosecution.

## Review Cycles

A new MIHP certification review cycle begins every 18 months. Several months before the new cycle starts, the *Certification Tool* is updated to reflect the changes in policy and procedures that occurred over the previous 18-month cycle and to make any needed clarifications.

If an agency receives a conditional certification and their six-month follow-up review falls under the next cycle, the new *Certification Tool* is used for the follow-up review. MIHP providers must operate with respect to current requirements; it would not be productive to assess providers on obsolete requirements. However, providers are given advance notice of the changes in the *Certification Tool* and new criteria are not applied prior to the effective date designated by MDHHS.

## Confirmation Emails Required throughout Certification Process

Providers receive numerous documents from MDHHS throughout the certification review process, including the review scheduling letter, certification documents and Corrective Action Plan approval letter. Providers must confirm receipt of each of these documents by sending an email to the following mailbox: [newproviderapplication@michigan.gov](mailto:newproviderapplication@michigan.gov).

## Internal Quality Assurance

It is required that MIHP providers do not rely solely on MDHHS certification reviews in order to assure program quality. MIHP Coordinators are expected to routinely conduct their own internal quality assurance activities, including chart reviews and billing audits.

The purpose of internal quality assurance activities is to assure that: documentation is complete; *POCs* are being implemented; appropriate referrals are being made and followed-up on; and all staff are following the program requirements specified in the *Medicaid Provider Manual* and the *MIHP Operations Guide*.

MIHP providers must have an internal quality assurance protocol that:

1. Describes internal quality assurance activities
2. Specifies that chart reviews and billing audits are conducted quarterly, or more frequently
3. Indicates the minimum number of charts reviewed per chart review and per billing audit
4. Describes how staff are trained and supported to ensure that the *Risk Identifier*, *POC*, *Professional Visit Progress Notes*, and *Discharge Summaries* are linked
5. Describes how staff works with the beneficiary to identify her needs at program entry and periodically asks beneficiary if services being provided are meeting her needs

The coordinator is responsible for implementing the internal quality assurance protocol. If deficiencies are identified through this process, the coordinator is also responsible for developing a quality improvement plan, overseeing implementation of the plan, and evaluating whether or not the plan worked.

The *Maternal and Infant Forms Checklists* are intended to assist you with internal monitoring. They are the only place to document some activities, and they provide the recommended flow format for charts. It is not acceptable to prepare the *Forms Checklists* only for the charts that will be reviewed by MDHHS.

## Addressing Potential Deficiencies between Reviews

Whenever the MIHP Coordinator experiences difficulties in delivering services to a beneficiary or encounters significant barriers to implementing a particular policy or protocol, the coordinator is encouraged to contact an MIHP consultant to discuss the situation. The consultant will carefully evaluate all of the factors involved and assist the coordinator to resolve the situation if at all possible so that the program is not cited with a deficiency.

## Unannounced Site Visits

On rare occasions, MDHHS staff will make an unannounced site visit to an MIHP agency. The Office of the Inspector (OIG) also makes unannounced visits. Unannounced visits typically take place for one or more of the following reasons:

- A whistleblower reports possible fraud/abuse
- A beneficiary lodges a complaint of a serious nature about the quality of services received
- Another entity lodges a complaint of a serious nature, including unethical behavior
- There are unusual or questionable findings in a certification review
- Questionable financial activity is identified through a MDHHS in-house billing audit, which is separate from certification review
- Concerns are identified by an MDHHS employee and the MDHHS Maternal Health Unit Manager determines that they are of a serious nature

Medicaid providers must, upon request from MDHHS, make available for examination and photocopying, any record that they are required to maintain. This means that MIHP documents must be appropriately filed in the beneficiary's chart at all times, not just in preparation for a certification review.

## MIHP Quality Improvement

Coordinators are encouraged to learn as much as possible about Continuous Quality Improvement (CQI), which is spreading rapidly in healthcare. CQI is a process-based, data-driven approach to improving the quality of a service or product. The federal government's, Health Resources and Services Administration (HRSA) has a quality improvement toolkit online that is helpful when implementing the QI process and can be accessed at <http://www.hrsa.gov/quality/toolbox/methodology/index.html>

Proven processes, such as Plan, Do, Check, Act, (figure 1), can be utilized to assist with quality improvement projects in MIHP agencies. There is always room for improving operations, processes, and activities so that the best and highest quality of care is provided to mothers, their infants and families enrolled in the MIHP.

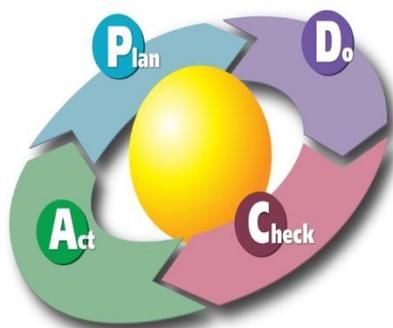


Figure 1

**Plan** – Recognize and analyze the problem needing improvement  
**Do** – Develop and test the solution  
**Check** – Review the test and study the results  
**Act** – Take action based on what you learned in the study step: Adopt, adapt, or abandon

Modified from Demming's PDSA

Accessed at <http://asq.org/learn-about-quality/project-planning-tools/overview/pdca-cycle.html>

PDCA picture – Wikipedia, the free encyclopedia, accessed at <https://en.wikipedia.org/wiki/PCDA>

## **10.0 MIHP PROVIDER CONSULTATION, TECHNICAL ASSISTANCE AND TRAINING**

MIHP is a complex, comprehensive program. In order to promote program fidelity and to keep providers updated on new developments, MDHHS offers a range of consultation, technical assistance and training activities.

### **MDHHS Consultation**

MDHHS MIHP consultants have specialized expertise and knowledge about MIHP and are available to provide you with assistance and advice. Consultation activities for agencies include but are not limited to:

#### **1. Individual Calls or Meetings with MDHHS MIHP Consultants**

MDHHS MIHP consultants are available to respond to providers' individual questions and to assist them with problem solving on an as-needed basis. Consultants make every effort to respond to inquiries as soon as possible and welcome dialogue with providers. It is expected that the MIHP Coordinator is the only one who communicates agency needs and concerns to the MDHHS Consultants. Communications should not come from multiple staff.

#### **2. Direct Mail and Email Communications**

MDHHS periodically provides written program updates, policy and procedure clarifications, and resource information to MIHP Coordinators via email or direct mail.

Email messages are dated and numbered for reference purposes. When asking an MIHP consultant for clarification on a particular email message, it's helpful if the provider can give the date and number of the message in question, although it is not required.

Coordinator emails are sent on a monthly basis. Copies of previous coordinator emails may be accessed through the MDHHS-MIHP File Transfer areas of the Single Sign-On (SSO) System. File Transfer allows MIHP providers to secure web-based access to vital program related communications 24 hours per day, seven days per week. A maximum of two staff members per agency may request subscriptions to File Transfer areas.

### **MDHHS Technical Assistance**

MDHHS staff offers technical assistance with data, electronic forms, and navigating MDHHS technology including but not limited to:

#### **1. Data**

The MDHHS vision is to promote better health outcomes, reduce health risks and support stable and safe families while encouraging self-sufficiency. The MIHP assists in the success of this mission through supporting Medicaid beneficiaries in order to promote healthy pregnancies, positive birth outcomes, and infant health and development. Statewide and agency-specific data informs the program to accomplish this goal.

Data is gathered from various sources including Medicaid paid claims, *MIHP Risk Identifiers* and Discharge Summaries. MIHP data is analyzed to assure proper utilization of services, and provide objective information that informs MIHP providers, MDHHS, Legislators, and stakeholders.

MIHP has established data standards and processes to ensure data integrity, confidentiality, and security. Our goal is to maintain accurate, standardized data while protecting the data from inappropriate use.

## 2. MIHP Provider Quarterly Data Reports

MDHHS provides each MIHP provider with quarterly reports based on data that the provider has entered into the MIHP electronic database. The MIHP provider can use these reports to plan program changes to improve service quality.

Effective July, 2015, the data reports for MIHP provider agencies are generated quarterly and pushed electronically to each provider's inbox within the CHAMPS billing system. Any MIHP provider who has access to CHAMPS can view, save, and/or print their MIHP agency quarterly data reports from the "Archived Documents" area of their CHAMPS inbox. MIHP reports are auto-generated and become available mid-month in the month following the end of each quarter (mid-January, mid-April, mid-July, and mid-October). MIHP quarterly data has a six month claims lag time to allow for data completion in the Michigan Data warehouse system.

Quarterly Data Report Schedule:

<u>Report Available in CHAMPS</u>	<u>Report Time Period</u>
Mid-July Q1	Oct 1 – Dec 31
Mid-October Q2	Jan 1 – Mar 31
Mid-January Q3	Apr 1 – Jun 30
Mid-May Q4	Jul 1 – Sep 30

To locate your agency's quarterly data reports in CHAMPS:

- a. Login to SSO: <https://sso.state.mi.us/>
- b. Click on the CHAMPS application link.
- c. Select your profile (in order to query documents you must select CHAMPS Full Access or CHAMPS Limited Access) > click Go.
- d. Once at the main CHAMPS screen, click My Inbox > click Archived Documents.
- e. Click on the Go button to retrieve results.
- f. You can narrow your search by selecting an item (i.e., Received Date, Payroll Date) from the "Filter By" drop-down list(s) and then enter the specific criteria in the field(s). For date selections you will need to enter a "from" and "to date" (both red boxes) in a MM/DD/YYYY format > then click the Go button.
- g. In order to view a document, double-click on the Document Name.
- h. A File Download window may appear depending on what format (i.e., PDF, Excel, Word) of file you are opening. Click Open to open the file and click Save to save the file.
- i. Note: columns with up and down arrows allow you to sort ascending or descending.

FY 2013-2014 MIHP quarterly data reports are archived in the SSO File Transfer System.

## 3. Certification Data Reports

MIHP utilizes standardized data reports as part of the MIHP agency certification process. Prior to the agency certification review, standardized data reports are generated for each agency scheduled for review. The data reports contain an 18-month historical review of the agency's MIHP Medicaid claims prior to the agency's upcoming certification review. A desk audit is performed by the MIHP Quality Improvement Coordinator and the MIHP Reviewer prior to the agency's certification review.

#### 4. MIHP Evaluation

MDHHS uses multiple strategies to evaluate the Maternal Infant Health Program. One important evaluation strategy is the independent, evidence-based evaluation conducted by Michigan State University (MSU) researcher partners. This evaluation utilizes administrative data located in the MDHHS data warehouse. More information about these research results can be found on the MIHP website under “Research”.

#### 5. Acceptable Browsers for MIHP Single Sign-On (SSO) System

The acceptable browsers for MIHP SSO use is IE 8 or IE11, Firefox and Chrome. You cannot use IE 9 or 10. Occasionally, Internet Explorer (IE) will auto-update to another level (IE 8 increases to 9 or 10), and you may not know if you have not disabled the auto-update function. You should always check the printed version of your *Risk Identifier* and *Discharge Summary* for accuracy.

#### 6. MIHP Single Sign-On (SSO) System File Transfer Areas

The MDHHS - File Transfer application is a web-based application accessed via internet browser through the State of Michigan Single Sign-On System. The name of the file at present is listed as DCH-File Transfer.

The DCH-MIHP File Transfer area houses official MIHP communications generated by the State of Michigan Maternal Infant Health Program. Current and historical records are available for download. When new documents are posted by State MIHP to the MIHP File Transfer area(s), an email is automatically generated by the File Transfer system announcing that a File is available for download.

A User ID and Password for the Single Sign-On System is required to access the DCH-MIHP File Transfer areas and MIHP Providers must request a subscription through the Single Sign-On System to access the MIHP File Transfer areas. A maximum of two staff members per agency may request a subscription to each of the MIHP File Transfer areas.

There are two MIHP File Transfer areas:

1. One houses the MIHP Coordinator Emails titled, MIHP Coord Emails.
2. The other houses the MIHP Provider Quarterly Reports titled, MIHP Quarterly Reports.

Single Sign-On Login Issues:

- If you have any problems accessing your Single Sign-On (SSO) account, please contact the State of Michigan Client Service Center at 517-241-9700 or 1-800-968-2644.

DCH-File Transfer Application Issues:

- If you have problems accessing the SSO DCH-File Transfer link, please contact the State of Michigan Client Service Center at 517-241-9700 or 1-800-968-2644.

MIHP File Transfer Area Issues:

- If you have problems subscribing to or downloading from the MIHP File Transfer Areas, please contact your MIHP Consultant.

## 7. MIHP Agency NPI Issues

MIHP agencies are required to use only one NPI number for all MIHP business since the agency's NPI number affects MIHP data results. An MIHP agency that has been using one NPI number to enter MIHP risk identifiers into the SSO/MIHP application and another NPI to perform their MIHP billing via CHAMPS claims must contact MDHHS to rectify this issue.

## Training

### 1. Conference Calls and Webinars

MDHHS MIHP staff may facilitate conference calls or webinars for MIHP Coordinators on critical topics, as needed.

### 2. MDHHS Online Trainings

MDHHS has developed a series of online trainings for MIHP providers. These trainings are for all MIHP Coordinators and all professional staff paid with MIHP funds to work directly with beneficiaries. Trainings can be accessed at the MIHP website under the heading *MIHP Provider Training*.

Some of the trainings are required and some are optional. The required trainings are clearly designated as such on the website. There are four categories of training:

- a. Required Training for All MIHP Provider Applicants
- b. Required Training for All MIHP Staff
- c. Additional MIHP Provider Trainings
- d. MIHP Domains/Risks and Provider Education

MIHP providers should strongly encourage their staff to complete the optional trainings, as well as the required trainings. Completion of trainings should be documented in personnel files.

Upon completion of an online training, a training certificate may be printed out. Training certificates for the required trainings must be submitted at the time of certification review. The coordinator may choose to have the staff view an online training as a group in order to discuss it. In this case, the sign-in sheet will serve as documentation of completion for certification review purposes.

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, repeating one or more trainings may be part of an agency's *Corrective Action Plan* subsequent to a certification review. All staff persons are encouraged to review the trainings whenever they feel they need a refresher.

Continuing education contact hours for registered nurses and licensed social workers are available for some of the MDHHS online trainings. Completion of a survey is required.

### 3. Required Training for New Professional Staff

All new MIHP staff hired or contracted after September 1, 2012 are required to complete the training activities specified on the first page of [New and Waived Employee Training](#). The new staff and supervisor must both sign the [Notice of New Professional Staff Training Completion](#) and placed in the staff's personal file. Documents that are referenced in the required training activities for new professional staff include the following:

[Topics Relevant to MIHP Practice](#)  
[Root Causes of Infant Mortality](#)  
[Health Disparities Definitions](#)

### 4. Required Training for Waiver Staff

For information on training requirements for waiver staff, see *Section 6 - Becoming an MIHP Provider*. Go to the *sub-section* titled, *Staffing Waiver Requests*.

### 5. Required Regional Face-to-face Coordinator Meetings

Regional face-to-face coordinator meetings are held annually in June at four different locations around the state. The coordinator or designated alternate **must** attend this meeting at their location of choice. Two persons from each MIHP can participate. Meetings generally cover program updates, Medicaid updates, and training on one or more critical topics. They also offer useful networking opportunities for participants. CEs are offered for some of the trainings. The decision to conduct regional meetings rather than one statewide meeting was made to save travel time and costs for coordinators and to allow for more interaction among participants.

Certificates documenting participation of at least one staff (coordinator or alternate) are required at the time of certification review. If these certificates are not presented to the reviewer, the training indicator (#44) will be rated as Not Met. Participants must stay for the entire day in order to receive the certificate. There are no exceptions. For this reason, it is best to have two staff participate in each meeting in case one becomes ill or has an emergency. If only one staff plans to attend, there should be a back-up staff who can participate in case of an emergency.

### 6. Required Webcasts

Two live MIHP webcasts are provided in February and September each year. These web casts are required for coordinators, but are open to all staff. Coordinators are strongly encouraged to require all of their staff to participate. The web casts are about 4 hours long. They cover Medicaid and MIHP updates, as well as training activities.

### 7. Special Meetings and Trainings

Special meetings are sometimes held with key partners, such as Medicaid Health Plans, to better collaborate in serving our mutual target population. Arrangements are made to allow for participation via conference call, if possible, for these types of meetings.

At times, providers are invited to attend special events sponsored by other initiatives, such the Infant Mortality Summit or the Michigan Home Visiting Conference. These are optional, but providers are encouraged to participate, if possible.

## **8. MIHP Provider Network Regional Meetings**

In several regions of the state, MIHP providers meet together on their own to develop relationships, coordinate referrals, and share mutually beneficial information. MDHHS MIHP consultants may participate in these meetings to provide state updates, if invited and time permits. MDHHS encourages providers to participate in these networks, if possible.

## **9. Home Visiting Collaboratives**

In some areas of the state, representatives from different home visiting programs (e.g., MIHP, Nurse-Family Partnership, Healthy Families America, Early Head Start Home-Based Option, Parents as Teachers, Healthy Start, etc.) meet together to create local home visiting systems, sometimes referred to as “hubs.” The goal is to better serve the needs of families across programs and avoid duplication of services. MDHHS encourages participation in these efforts, if possible, as MIHP has a clear stake in home visiting systems-building at the state and local levels.

## **Coordinator Responsibility for Disseminating MIHP Information to Staff**

The coordinator is responsible for disseminating information received from the MIHP state team to their professional and administrative staff. All staff working cross the state must access and use this information in order to promote fidelity to the model and improve the quality of MIHP services. This is a critical responsibility that the coordinator must take very seriously. At a minimum, the coordinator must:

1. Forward every coordinator email, in its entirety, to all professional staff upon receipt.
2. Share with staff the updates and training content information received at regional coordinator meetings. This means supplying staff with copies of the handouts, reviewing PPT slides with staff, and addressing staff questions about the information.
3. Inform staff of any other special communications, webinar announcements, etc.

# 11.0 MAINTENANCE, RETENTION AND TRANSFER OF MIHP RECORDS

## Maintenance of Records

In the *Medicaid Provider Manual Chapter General Information for Providers (15.4 Availability of Records and 15.7 Clinical Records)*, there is discussion of the expectations for maintenance of clinical records. *15.4 Availability of Records*, discusses making records available to authorized agents of the state (consultants, reviewers, Office of Inspector General, etc.) for examination through the method determined by the agent. When MDHHS personnel or authorized agents want to see the chart, the agency must provide the entire chart. MIHP providers are expected to adhere to policy.

Agencies should have a single, complete chart that is accessible to all agency and State staff. The chart should be all electronic or all paper forms. Agencies may choose to have a working chart with copies of forms, but the official chart should be complete and remain in the office.

The state database is not an acceptable form of storage for beneficiary records. Agencies are required to store their own electronic *Risk Identifiers* and *Discharge Summaries*. An agency with an EMR system must do a file transfer from the SSO system back into their electronic record, or print these documents off and scan them into their record.

## Retention of Records

State law requires closed health records (including MIHP records) to be kept in their entirety for seven years after the last date of service. MIHP providers must keep all closed records in a HIPAA-compliant secure area for seven years, even if they are no longer operating as an MIHP. All accounting records relating to health records must be identified and kept with health records. Health and accounting records must be available for inspection and/or audit by MDHHS and/or Medicaid staff.

The *Medicaid Provider Manual Chapter General Information for Providers* discusses the maintenance of health records. The Michigan Public Health Code 368 of 1978 Sec. 333.16213 outlines Michigan law pertaining to medical record retention, transfer of medical records, destruction of records, and the process for handling record requests.

Providers should be very familiar with these requirements. To access Section 333.16213 of the Michigan Public Health Code, go to:  
[http://www.legislature.mi.gov/\(S\(cc3ll0exiqr5ch2gt42o4rjo\)\)/mileg.aspx?page=GetObject&objectname=mcl-333-16213](http://www.legislature.mi.gov/(S(cc3ll0exiqr5ch2gt42o4rjo))/mileg.aspx?page=GetObject&objectname=mcl-333-16213)

## Transfer of Care/Records

On occasion, a beneficiary will ask to be transferred from one MIHP agency to another. When this happens, it is expected that both the transferring and receiving agencies will talk with her about the request and encourage her to stay with the program of origin, if appropriate. It also is expected that the transferring and receiving agencies will communicate with each other appropriately and professionally in order to expedite the transfer in the beneficiary's best interest.

When an agency receives a transfer request, they must not refuse to transfer the beneficiary. Furthermore, the agency must not bill for any visits conducted after the date that the transfer request was received.

When the beneficiary requests a transfer, she must sign the *Consent to Transfer MIHP Record to a Different Provider (Consent to Release Protected Health Information)*. The transferring agency must keep

this signed form on file after the beneficiary information is sent to the receiving agency. The receiving agency must also keep a copy of the signed *Consent to Transfer* form on file. If the beneficiary does not sign this form, her MIHP records will not be transferred to the new provider and she will not receive MIHP services.

## Transferring Agency

When a request for transfer is received, the transferring agency has 10 working days to send or fax copies of all appropriate documents to the receiving MIHP agency. At a minimum, the following documents must be transferred:

1. *Risk Identifier*
2. *Risk Identifier Score Summary*
3. *POC, Parts 1-3*
4. *Professional Visit Progress Notes*

If a mother consents to transfer “my infant’s health information” but not “my health information,” the transferring agency is still expected to transfer both the maternal and infant components of the *Infant Risk Identifier* in their entirety, along with the corresponding *POCs*, to the receiving agency. If the mother objects to this, she will not be served by the new agency.

The transferring agency does not:

1. Copy its consent forms and send them to the receiving agency, as the opening date remains the date that the *Risk Identifier* was administered by the transferring agency.
2. Complete a *Discharge Summary*, as it would have to be deleted in order for the receiving agency to continue services.

## Receiving Agency

The receiving agency must obtain the beneficiary’s information from the transferring agency before providing services to the beneficiary, except in an emergency situation (e.g., family is homeless, has no food, etc.). This emergency must be documented in the chart.

If the receiving agency does not obtain the beneficiary’s information within 10 working days, they must document their efforts to get the information from the transferring provider and contact their consultant. The consultant will instruct the transferring provider to release the documents. If the transferring agency does not comply immediately, the consultant may be able to get the *Risk Identifier* and *Score Summary* from the database and send copies to the receiving agency. As long as there is documentation that the consultant has been contacted, the receiving agency will not be penalized by the certification reviewer because the documents, which should have been transferred, are not on file.

The receiving agency:

1. Must obtain a new signed *Consent to Participate in Risk Identifier Interview/Consent to Participate in MIHP* and a new signed *Consent to Release Protected Health Information* from the beneficiary.
2. Must use a new *Forms Checklist*, identifying the new care coordinator.
3. Must notify the medical care provider that they are now serving the beneficiary, as this constitutes a significant change in beneficiary status.
4. Is not required to sign the *POC 1* or *POC 3*.

The agency that originally entered the *Risk Identifier* into the state database (SSO) will continue to be noted as the agency that completed that specific document in the database. Assignment of the

transferring MIHP agency's name to the completed *Risk Identifier* does not prohibit the receiving MIHP from serving the beneficiary and billing for visits.

When a beneficiary has signed a transfer but then declines to transfer, the original agency must secure a statement in writing from the beneficiary indicating that she has rescinded her transfer request.

## **Failure to Transfer Records within 10 Working Days**

Providers that fail to transfer records within 10 working days, or that provide any additional billable services after a transfer request has been received, are monitored at the state level. If a provider demonstrates a pattern of failing to transfer records or providing services after a request has been received, it may be determined that the provider is not providing acceptable services as defined by Medicaid.

Service acceptability is discussed in *Section 8.5 Service Acceptability, General Information for Providers Chapter, Medicaid Provider Manual*. This section outlines situations in which service is not acceptable. If Medicaid determines that the provider is not in compliance with service acceptability requirements, it may result in the provider's disenrollment from Medicaid.

## **Warm Transfer**

It's expected that agencies will implement a warm transfer with beneficiaries who transfer from one MIHP agency to another. A warm transfer can be defined as a situation in which MIHP staff transfers a beneficiary to a new MIHP, but assists with introduction and sharing of information about the beneficiary's needs during the transfer process.

Warm transfer techniques may also be used when making a referral to another social service or medical agency for assistance. In that case, the MIHP staff may either conference the call to facilitate a three-way discussion or instead the MIHP staff may choose to initiate the call then "drop off" the line allowing the beneficiary to discuss his or her situations with the third party individual privately.

The warm transfer process is designed to streamline intake, referral and assistance. The initial agency performs a warm transfer to ensure the beneficiary receives the most appropriate information to meet their needs. This process allows the initial agency to stay on the line to ensure the second entity can help the consumer. Also, the referring agency can assist the consumer by helping them explain their needs to the second entity.

For additional information on making referrals, see *Chapter 8 – MIHP Service Delivery*.

## 12.0 MIHP TERMINATION OF SERVICES

### Termination

There are two ways that MIHP services are terminated. They can be terminated voluntarily by the provider or as a result of decertification by MDHHS:

#### MIHP Provider Voluntary Termination

When an agency no longer wishes to provide MIHP services and decides to terminate their program, the agency must follow the steps outlined in the *MIHP Termination Protocol*. The protocol is posted on the MIHP web site.

The agency must send a letter to MDHHS which:

- 1) Details their intent to follow the MIHP termination protocol.
- 2) Cites a termination date not less than thirty days in advance of the date of notification.
- 3) Includes the agency's MIHP NPI number.

The provider must also submit a plan addressing how and when beneficiaries, MHPs and other MIHP providers will be notified, how beneficiaries will be transferred to other MIHP providers, and how the provider will maintain beneficiary records in keeping with HIPAA requirements.

MDHHS may make a site visit to observe the termination process and provide consultation on problems that may arise. Within thirty days after the termination date, the former provider must send a communication to MDHHS detailing compliance with the termination protocol.

Terminated providers may bill CHAMPs for up to one year from each beneficiary's last date of service if the date of service occurred prior to termination date.

#### MIHP Provider Decertification

An agency that is decertified and terminated by MDHHS also must follow the *MIHP Decertification Termination Protocol*. In this case, the termination date is determined by MDHHS, not by the agency. The protocol is posted on the MIHP web site.

#### MIHP Provider Voluntary Inactive Status

An agency with full certification status may choose to temporarily discontinue MIHP services for a minimum of six months and a maximum of one year when extenuating circumstances arise and the agency is unable to provide professional visits. An agency with conditional certification status is not allowed to choose this option. An agency that chooses voluntary inactive status must follow the *MIHP Provider Inactive Status Protocol*. The protocol is posted on the MIHP web site.

## 13.0 REPORTING MEDICAID BILLING FRAUD, HIPAA VIOLATIONS, AND QUALITY OF CARE CONCERNS

Any provider, employee, or beneficiary who suspects Medicaid billing fraud, patient abuse, or violation of HIPAA privacy regulations is encouraged to contact MDHHS. The phone numbers to use for reporting are given at the end of the [Medicaid Provider Manual](#) in the Directory Appendix under, "Reporting Fraud, Abuse or Misuse of Services."

### To report suspected Medicaid provider fraud and/or abuse:

Office of Inspector General  
1-855-MI-FRAUD (643-7283) Toll free  
[http://www.michigan.gov/MDHHS/0,1607,7-132-2945\\_42542\\_42543\\_42546\\_42551-220188--,00.html](http://www.michigan.gov/MDHHS/0,1607,7-132-2945_42542_42543_42546_42551-220188--,00.html)

### Examples of Medicaid Provider Fraud

- Billing for medical services not actually performed
- Providing unnecessary services
- Billing for more expensive services
- Billing for services separately that should legitimately be one billing
- Billing more than once for the same medical service
- Dispensing generic drugs but billing for brand-name drugs
- Giving or accepting something of value (cash, gifts, services) in return for medical services, (i. e., kickbacks)
- Falsifying cost reports
- Falsely charging for:
  - Missed appointments
  - Unnecessary medical tests
  - Telephoned services

### To report quality of care concerns or suspected HIPAA violations regarding an MIHP provider:

MDHHS MIHP Consultant, MDHHS Division of Family and Community Health. Consultant contact information is provided in *Chapter 1 – Introduction to MIHP Services*. The MDHHS MIHP consultant will explore the situation and take action, as indicated.

### To report complaints about a licensed healthcare professional (e.g., registered nurse, licensed social worker, etc.):

Bureau of Health Services, Allegations Section  
517 373-9196  
[http://www.michigan.gov/MDHHS/0,1607,7-132-27417\\_27647---,00.html](http://www.michigan.gov/MDHHS/0,1607,7-132-27417_27647---,00.html)

A publication titled *Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians* (July 2014), is pertinent to Medicare and other federal health care providers. To access the document, click here: [Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians](#).

## 14.0 REQUIRED MIHP FORMS

MIHP providers are required to use standardized forms which were designed to increase efficiency and promote consistency across the state. All of the required and optional MIHP forms are available at [www.michigan.gov/mihp](http://www.michigan.gov/mihp).

Because the forms were developed to prompt concise, systematic record-keeping, check-boxes are provided wherever possible and space for narrative comments is limited. By checking a box, the professional who signs the form is stating that he or she took a specific action.

When a form is revised, the date on the form will be changed. You will be notified via a coordinator email message whenever a form is revised. When there are major changes to the forms, they generally are issued three months prior to the effective date to allow for transition and staff training.

### Assuring that Staff Are Using the Forms Correctly

All staff must be trained to use the forms as required by MDHHS. It is the coordinator's responsibility to ensure that all staff:

1. Have ready access to the forms instructions, which are posted at the web site
2. Receive ongoing feedback on completing the forms subsequent to internal QA activities

### General Instructions for Using the MIHP Forms

General instructions for using the MIHP forms are as follows:

1. Forms are available in protected Word format only. The intent is that all MIHP agencies are using standardized forms.
2. You can add your agency name, address and patient ID labels to paper forms without asking for MDHHS approval. This may be done in any non-electronic way (e.g., typing, handwriting, affixing labels, stamping, etc.). Any other proposed additions must be submitted to MDHHS for review and approval. MDHHS may allow you to add content to a standardized form in some unique situations, but not if it deviates from the intent of the form.
3. Any and all proposed additions to electronic forms must be approved by the MDHHS. Generally speaking, you cannot subtract a data field from a form and data fields must be in same order as on the standardized form. MDHHS may allow you to add content to a standardized form in some unique situations, but not if it deviates from the intent of the form.
4. Although you may not add to or change MIHP required or optional forms electronically, you may develop and use your own supplementary forms, or forms developed by others.
5. There is no standardized demographic sheet (beneficiary name, address, phone, FOB's name, etc.), but you can develop your own.
6. The Social Security Number (SSN) box on some forms is there as a means of identifying Medicaid beneficiaries.
7. Data entries on forms cannot be inappropriately altered. This means that you may not use white-out and must initial data entries that are crossed out.

8. When signing MIHP forms, it is acceptable to use the first initial and full last name.
9. When documenting your professional credentials on MIHP forms, your licensure should be indicated as one of the following:

RN	Registered Nurse
LLBSW	Limited Licensed Bachelor's Social Worker
LLMSW	Limited License Master's Social Worker
LBSW	Licensed Bachelor's Social Worker
LMSW	Licensed Master's Social Worker

10. You can use a signature stamp on letters, but not on other MIHP forms.

## Entering Data into the MIHP Database to Complete Electronic Forms

At this time, you must enter data into the MIHP database in order to complete four electronic forms: *Maternal Risk Identifier*, *Infant Risk Identifier*, *Maternal Discharge Summary*, and *Infant Discharge Summary*. When you discover that data entry errors have been made on one of these forms after it has been submitted to MDHHS, you may need to delete the completed form and start over. This is a time-consuming process. It is strongly recommended that you establish an internal QA process to prevent having to re-enter a completed form. For example, some agencies have another staff person review the form before the person who entered the data submits it to MDHHS.

It is planned that over time, other MIHP forms will be converted to the electronic format to be entered directly into the MIHP database. This means that internal QA processes to assure correct data entry will become increasingly important to your operations.

## Agencies Using Electronic Medical Records

MDHHS is supportive of MIHP agencies that convert to Electronic Medical Record (EMR) systems. An agency may incorporate MIHP forms within an EMR system as follows:

1. You may request access to a set of unprotected/unlocked MIHP required forms so that your agency can upload them into your EMR system. All of the MIHP required and optional forms are included in the set of unprotected/unlocked forms. Your MIHP consultant can provide you with a form to request a set of unprotected/unlocked forms. The request form must be completed by an authorized agency representative.

By signing the request form, your agency agrees not to change the MDHHS forms in any way unless MDHHS has approved the change. Your agency also agrees to accept responsibility for modifying the forms whenever they are revised by MDHHS. Upon receipt of your request, MDHHS will determine whether or not to approve it based on your agency's particular situation.

2. You can use any software package to duplicate the forms, but the forms must contain all required data fields in the order given on the current MIHP forms.
3. You may use electronic letterhead on MIHP documents, but you must maintain the document titles.
4. You may use electronic signatures, as long as they are password protected.

5. After scanning signed forms (e.g., *Consent to Participate in MIHP Risk Identifier Interview/Consent to Participate in MIHP, Consent to Release Protected Health Information*) into the individual EMR, you can shred the original.
6. All EMRs should be backed-up.
7. It is required that you maintain the *Infant Forms Checklist* and the *Maternal Forms Checklist* when you have an EMR system. You can complete the *Forms Checklists* electronically if the EMR report contains all of the data elements and the MDHHS reviewer can follow it. It is acceptable to run a report which gives the dates of the encounters for the beneficiary and staple it to the back of the *Forms Checklist* form.
8. You have two options when asked to provide beneficiary charts for your onsite certification review. You can print out paper copies of the requested charts or assign a staff person to assist the reviewer to read the charts on a computer monitor. This staff would need to be available throughout the two-day review, as needed.
9. Charts must be available upon request by any agent of the state.
10. You don't need to have paper copies of signed consent forms if you have an EMR system.
11. You need to save the entire electronic *Risk Identifier* and *Score Summary* in your EMR system.
12. If you want to obtain your agency's data from the MDHHS database for your EMR system, contact the MDHHS Maternal Health Unit Manager for more information about the file transfer process and Data Use Agreement. The file transfer process will work with any EMR platform. The individual agency's IT staff will have to adjust their programming to accept data from MDHHS.
13. The MDHHS 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.

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

## 15.0 MICHIGAN'S HOME VISITING PROGRAMS

MIHP is one of several early childhood home visiting models being implemented in Michigan. Home visiting programs provide voluntary, in-home services to expectant parents and families with infants and young children. Home visiting services include education, support and care coordination. They are intended to prevent a wide range of negative child outcomes by promoting maternal and child health, school success, positive parenting practices, safe home environments and access to services.

Home visiting programs vary with respect to the age of the child, the risk status of the family, the program goals, the range of services offered, the intensity of the home visits, the content of the curriculum or interventions delivered, the professionals or paraprofessionals who provide services, how effectively the program is implemented, and the range of outcomes observed. Quality home visiting programs have been shown to lead to outcomes such as improved prenatal health, increased intervals between births, reduced child maltreatment, improved school readiness, and increased family self-sufficiency.

### Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)

A new focus on home visiting transpired in 2010, when the federal Patient Protection and Affordable Care Act (2010) was signed into law. Section 511 of this law amended Title V of the Social Security Act to authorize the creation of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), which allows collaboration and partnership at the federal, state, tribal, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

MIECHV funds the states to implement home visiting programs that the federal Department of Health and Human Services has reviewed and designated as evidence-based. To date, 19 home visiting models have been so designated. For information on these models, go to the Home Visiting Evidence of Effectiveness (HomVEE) web site at <http://homvee.acf.hhs.gov/programs.aspx>. As additional evaluation results become available, the State of Michigan may submit MIHP for HomVEE review.

The overall goal of Michigan's MIECHV initiative is to improve child and family outcomes by implementing evidence-based home visiting within the Great Start System that provides programs for pregnant women, parents and caregivers, and children from birth to 8 years of age. The benchmarks/goals of MIECHV are:

1. Improvements in maternal and newborn health
2. Improvements in school readiness and achievement
3. Improvements in family economic self-sufficiency
4. Reduction of child injuries, child abuse, neglect or maltreatment and reduction of emergency department visits
5. Reduction of domestic violence
6. Improvement in coordination and referrals

Michigan has chosen to use MIECHV funds to support the following evidence-based models:

1. Healthy Families America
2. Nurse-Family Partnership
3. Early Head Start – Home-based Option

For information on these models, go to the MDHHS MIECHV web site at [Home Visiting – MIECHV Projects - State of Michigan](#) or to the HomVEE site at <http://homvee.acf.hhs.gov/programs.aspx>.

## Michigan Public Act 291 of 2012

In 2012, Michigan enacted a law (Public Act 291) requiring the Michigan Departments of Community Health, Human Services and Education to only support home visiting programs that are evidence based. MIHP and the MIECHV-funded models meet the evidence-based criteria specified in the law for designation as an evidence-based program. Infant Mental Health and Healthy Start meet the criteria for promising programs.

### Key Elements of Effective Home Visiting Programs

Deborah Daro, Chapin Hall at the University of Chicago, is one of the eminent researchers on home visitation in the US. The info below is taken from her presentation titled, Home Visitation: The Cornerstone for Effective Early Intervention. [Home Visitation: The Cornerstone for Effective Early Intervention](#)

#### Promising service characteristics

- Solid internal consistency linking program elements (curriculum) to desired outcomes
- Begin at birth or sooner (for CAN outcome)
- Engage families in services and sustain involvement long enough to achieve outcomes
- Provide direct assessment and services to children as well as parents
- Solid organizational capacity
- Build strong linkages among local providers

#### Promising staffing patterns

- Prevention is about building relationships, not delivering a product – hire relationship builders
- For the most intensive services, maintain low caseloads (15 per worker)
- Provide staff comprehensive initial and inservice training opportunities
- Provide staff multiple opportunities for individual and group supervision

#### What elements remain unclear?

- The appropriate target population
- The importance of curriculum consistency
- The optimal service duration and intensity
- The critical qualifications for home visitors
- The appropriate locus of administrative control

Another summary of key elements of effective programs was prepared by the Minnesota Department of Health:  
Home Visiting Program Design Elements of Effective Programs  
[Home Visiting Program Design Elements of Effective ... - LPHA](#)

