OPERATIONS GUIDE

Division of Maternal and Infant Health
Bureau of Family Health Services
Population Health Administration
Michigan Department of Health and Human Services

MDHHS MIHP 1.1.17 v.2

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)

The Maternal Infant Health Program (MIHP) is Michigan's largest, evidence-based home visitation program for Medicaid eligible pregnant women and infants. The purpose of MIHP is to promote healthy pregnancies, positive birth outcomes and healthy infant growth and development with the long-term goal of reducing infant mortality and morbidity as part Michigan's Infant Mortality Reduction and Prevention Plan.

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 MIHP 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.]*

MIHP has proven successful 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 the State of Michigan.

The latest published study further demonstrated that: (1) infants with any MIHP participation had reduced odds of death in the first year of life compared with matched nonparticipants (2) infant death odds were reduced both among black infants and infants of other races (3) neonatal death and post-neonatal death odds were also reduced and; (4) 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).]*

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 central and comprehensive source 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. MDHHS welcomes your feedback, please forward questions or comments about the *Guide* to one of the consultants listed below.

MDHHS MIHP Consultant Contact Information

For additional MIHP information, contact one of the MDHHS MIHP consultants listed below:

Ingrid Davis, MPA MIHP Program Consultant Division of Maternal and Infant Health Michigan Department of Health and Human Services Washington Square Building - 3rd Floor 109 W. Michigan Lansing, MI 48913 Mailing Address: PO Box 30195 Lansing, MI 48909 Ph: 517 335-9546 Fax: 517 335-8822 Email: Davisi1@michigan.gov	**Joni Detwiler, MSW** MIHP Program Consultant Division of Maternal and Infant Health Michigan Department of Health and Human Services Washington Square Building - 3rd Floor 109 W. Michigan Lansing, MI 48913 Mailing Address: PO Box 30195 Lansing, MI 48909 Ph: 517 335-6659 Fax: 517 335-8822 Email: Detwilerj@michigan.gov	**Cherie Ross-Jordan, LMSW** MIHP Program Consultant Division of Maternal and Infant Health Michigan Department of Health and Human Services Washington Square Building - 3rd Floor 109 W. Michigan Lansing, MI 48913 Mailing Address: PO Box 30195 Lansing, MI 48909 Ph: 517 373-2458 Fax: 517 335-8822 Email: rossjordanc@michigan.gov

MIHP Web Site

MDHHS maintains an MIHP web site at 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

The *MIHP Coordinators Directory* includes updated contact information for each MIHP provider, including the names of the coordinator and a secondary contact person. An email address and phone number is needed for the secondary contact person. The secondary contact may or may not be another staff person.

The *Directory* also lists the counties served by each MIHP. As a Medicaid provider, you may select the counties you wish to serve. In order to list a county in the *Directory*, you must be willing to serve the county in its entirety.

The *Directory* also indicates the name the agency's MDHHS MIHP assigned consultant, as well as MIHPs that offer childbirth education and/or parenting education for beneficiaries served by other MIHPs.

The *Directory* is posted on the MIHP website. 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.

It is important that you are diligent about reporting any changes to MDHHS so that your contact information is always current to ensure you receive important communications from MDHHS.

MIHP Specialty Providers

The *MIHP Coordinators Directory* also indicates which providers have been designated as specialty providers serving persons who speak Arabic, Chaldean or Spanish, are deaf or hard of hearing, are blind or visually impaired, are Native American/American Indian, are adolescents, refugees or Migrants. This information is useful to persons who are referring a particular individual to an MIHP and are looking for the best possible fit.

An attestation form which can be found on the MIHP website must be submitted to the MDHHS MIHP prior to being designated as an MIHP specialty provider. As of January 1, 2017, this applies to all MIHP providers new and existing. You must notify your MIHP consultant within 14 days if your agency is no longer meeting the designation criteria listed below.

Criteria to be designated as a specialty provider:

1. Provider's outreach activities are directed toward the population.
2. Persons served by the provider are in the specialty population group.
3. Outreach and educational materials are written in the language of the population (if applicable).
4. Provider has at least one staff who speaks the language of the population (if applicable).
5. Staff have participated in some form of training (e.g., online) on serving the population.

Maternal Infant Health Program (MIHP) Email Addresses

MDHHS MIHP has three different email addresses for sending and receiving MIHP documents. Please be careful to use the correct address when submitting the documents specified below:

NewProviderApplication@michigan.gov

- Inquiries about becoming a new MIHP provider

MIHP@michigan.gov

- Submission of *MIHP Personnel Rosters*
- Submission of changes to the *MIHP Coordinators Directory* (e.g., change of address, phone, fax, counties served, etc.)
- Submission of complaints; use encrypted software if beneficiary is named (complaints can also be submitted via fax or mail)

MDHHS-MIHPCertification@michigan.gov

- Communications related to certification review documents
- *Corrective Action Plans*

Please use the above e-mail addresses as directed. Always use the consultant's email address when communicating with your consultant. **Do not cc any of these mailboxes when you send an email to your MIHP consultant.**

MIHP Overview

Origins

In 2014, Medicaid paid for a total of 49,008 live births in Michigan. This constitutes 42.8% of all births in the state, down from 45.3% in 2010. 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) health 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 health risks and beneficiary priorities.
5. Measure specified outcomes.

For quality assurance purposes, MDHHS MIHP reviewers conduct onsite program certification reviews. MDHHS MIHP consultants provide consultation, technical assistance, and ongoing program monitoring of MIHP providers statewide.

Administration by MDHHS

MIHP is jointly administered by two areas within the Michigan Department of Health and Human Services: Medical Services Administration (MSA) and Population Health Administration. The MSA is responsible for promulgating Medicaid policies, assisting providers to implement Medicaid policies, monitoring contracts with Medicaid Health Plans, and making payments to Medicaid providers. Within the Population Health Administration, the Bureau of Family Health Services is responsible for developing MIHP procedures, providing technical assistance, monitoring and certifying program providers to ensure equitable, standard, quality services are provided statewide.

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 provider assists the woman to overcome 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.). MIHP 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 provider continues to support the mother and begins to monitor the infant's health, safety and development. The MIHP provider ensures that the infant has a medical care provider, encourages the mother to take the infant to see the medical care provider for regular well-child visits (and when medical attention is indicated), and helps the mother to follow through with the medical care provider's recommendations. The MIHP provider 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 MIHP provider refers the infant to *Early On Michigan* for a comprehensive developmental evaluation. The MIHP provider 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 MIHP provider must provide nutrition counseling services **or** refer beneficiaries to other local agencies that offer the services of a registered dietitian. The MIHP 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 the MIHP is to reduce infant mortality and morbidity among the Medicaid population. "Infant mortality is a critical indicator of the overall health and wellness of all Michiganders and is a complex problem that can be more effectively understood and addressed using the Life Course Model. This includes a framework for how *social determinants of health* impact health outcomes for individuals, as well as whole groups of people. Life course looks at health as an integrated continuum and suggests that a complex interplay of biological, behavioral, psychological, social, and environmental factors contribute to health outcomes across the course of a person's life." *[Excerpted from the State of Michigan Infant Mortality Reduction Plan February 2016]*

Social Determinants and Contributing Factors for Infant Mortality

"Social determinants of health—often defined as the circumstances in which people are born, grow up, live, work, play and pray—shape individual behavior and the choices that are available to individuals for improving health. Some individuals, and specific groups of people, do not have the same access to health care and have limited choices for improving health. Access to health care and healthy behaviors are important, but social determinants of health can have a greater impact on health and birth outcomes. These factors can adversely impact health when nutritious food, transportation, safe housing, education, livable and/or sustainable wages are not available or are very difficult to obtain. Persistent health inequities among people of color and/or those living in poverty are directly related to their living conditions and personal experiences, and these factors must be addressed in any plan designed to improve birth outcomes of all people.

To eliminate these inequities, experts in infant mortality across Michigan are working to understand the contributing health determinants from historical, social, and cultural perspectives for each population group where the rate of poor outcomes is higher than it is for more advantaged populations. Partnerships and strategies to address social determinants of health will take an interdisciplinary approach including partners in public health, housing, employment, and the court system to improve the support systems for those most adversely impacted by socioeconomic and racial disparities.

The Michigan 2016-2019 Infant Mortality Reduction Plan takes into consideration the role that racial disparities and the social determinants play in determining infant mortality rates. It focuses on strategies geared toward the highest risk families and communities. This will ensure that everyone who lives in Michigan has health care and that socioeconomic determinants of health are addressed to achieve and sustain health and wellness. To improve the number of Michigan infants who survive and thrive requires purposeful, measurable movement toward improved health equity, which is a key focus of the state's Plan." This is highlighted in Goal 6 of the Plan; expanding home visiting programs such as MIHP to promote healthy women and children. *[Excerpted from the State of Michigan Infant Mortality Reduction Plan February 2016]*

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."

Michigan Infant Mortality Reduction and Prevention Plan

In 2011, Michigan developed and released a comprehensive infant mortality reduction plan based on the Life Course Model and Perinatal Periods of Risk (PPOR) using a health equity lens in order to strategically impact infant mortality. The plan was updated and released in February 2016 with an expanded more comprehensive focus on infant mortality reduction efforts statewide.

Michigan's 2016-2019 Infant Mortality Reduction Plan Goals:

1. Achieve health equity and eliminate racial and ethnic disparities by addressing the social determinants of health in all infant mortality reduction goals and strategies
2. Implement a Perinatal Care System
3. Reduce premature births and low birth weight
4. Support increasing the number of infants who are born healthy and continue to thrive
5. Reduce sleep related infant deaths and disparities
6. Expand home-visiting and other support programs to promote healthy women and children
7. Support better health status of women and girls
8. Reduce unintended pregnancies
9. Promote behavioral health services and other programs to support vulnerable women and infants

Implementation of the plan is ongoing. Download a two-page summary of the goals and strategies here; the complete report is available here. Visit www.michigan.gov/infantmortality for more information on the MDHHS Infant Mortality Reduction Initiative.

Infant Mortality Rates in Michigan

Infant mortality rates in Michigan indicate significant health disparities among population groups. Michigan's overall infant mortality rate (provisional for 2015) was 6.9 deaths per 1000 live births. Racial and ethnic disparities persist; as shown below, the Black, Hispanic, and Arab rates remain higher than the White rate:
(Source: MDHHS Vital Records and Health Statistics)

- White: 5.3/1000
- Black: 13.7/1000
- Hispanic: 9.6/1000
- Arab: 5.7/1000
- Asian and Pacific Islander: 3.6/1000
- American Indian: fewer than ten deaths

Practices to Reduce Infant Mortality through Equity (PRIME)

Funded through the W.K. Kellogg Foundation, the MDHHS Bureau of Family Health Services 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 American Indians 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.

The Trauma-Informed Approach

In recent years the impact of trauma and toxic stress across the life course has been well documented with input from scientists in the fields of neuroscience, genetics, immunology, psychology and epidemiology. Children and adolescents are particularly vulnerable to individual traumatic events but even more so to chronic or toxic stress, which impacts physical, cognitive, emotional and social development. The developmental impact in turn affects health and mental health outcomes across the life course.

The terms trauma-informed care or trauma-informed approach are used to describe activities that seek to prevent and treat the impact of trauma and toxic stress and to support and build resilience. In maternal and child health programs, the focus on prevention and early intervention creates an opportunity to apply trauma-informed principles in a context that emphasizes protective factors and resilience as well as healing. The trauma-informed approach at its core is compassionate care that recognizes the prevalence of trauma and its impact and attempts to develop or restore a sense of safety, self-efficacy and empowerment for those that seek services. Although specific practices vary, all trauma-informed approaches should incorporate the six key principles described by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2014). The principles are - safety; trustworthiness & transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues. For more information visit: www.michigan.gov/traumatoxicstress

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, Reproductive and Preconception Health Program, Perinatal Care System, Breastfeeding Promotion Program, Fetal Alcohol Spectrum Disorders Program, Safe Delivery of Newborns Program, Infant Safe Sleep Initiative, Eliminating Non-Medically Indicated Elective Delivery before 39 Weeks Initiative, and the Maternal, Infant and Early Childhood Home Visiting Program.

MIHP Providers

There are about 175 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, tribal agencies, community-based organizations, and private entities such as hospitals, home health agencies, and individually-owned businesses.

MDHHS MIHP encourages grassroots community and faith-based organizations not affiliated with an existing health care delivery system to apply to become MIHP providers especially in communities that have difficulty engaging MIHP beneficiaries. To promote equity, MDHHS also encourages the start-up of small businesses that would provide MIHP in under-resourced neighborhoods where large numbers of MIHP-eligible individuals reside.

The goal is to increase the number of providers that are clearly present in neighborhoods and willing to conduct extensive outreach activities directed at Medicaid eligible hard-to-reach pregnant woman and infants.

In order to become an MDHHS 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)

Medicaid has consistently encouraged MIHPs and MHPs to collaborate and coordinate services for mutually-served beneficiaries, reimbursing all MIHP providers on a Fee-For-Service basis through the MDHHS Community Health Automated Medicaid Processing System (CHAMPS)**.** Effective January 1, 2017, MIHP services provided to individuals enrolled in a MHP will be administered by the MHP. This means that MHPs will contract with MIHPs and reimburse them for MIHP services provided to MHP enrollees. This MIHP transition into managed care is discussed further in *Chapter 3 - MIHP Goal and Primary Partners* and throughout this *MIHP Operations Guide*. Please review these new sections carefully.

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, MIHP services, transportation, and case management for Medicaid beneficiaries.

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.

Fundamentals of the MIHP

MIHP services promote healthy pregnancies, positive birth outcomes, and infant health and development. MIHP promotes health equity and provides care coordination and health education services targeting the psychosocial, nutritional, and health risks specific to each pregnant woman and infant Medicaid beneficiary.

MIHP services supplement prenatal and infant medical care and support the beneficiary in attaining health and well-being by identifying and addressing the impact of the social determinants of health.

The following are fundamentals of the MIHP:

1. MIHP is co-managed by the MDHHS Bureau of Medicaid Policy and Bureau of Family Health Services and incorporates participatory planning with key stakeholders, including program participants.
2. Interventions are delivered by providers operating within their professional scope of practice and following the program policy.
3. MDHHS requires and provides ongoing training and oversight of MIHP providers.
4. Resources are limited and MIHP cannot address all issues for all beneficiaries.
5. Systems of care vary across communities.
6. The MIHP focus is on motivating beneficiaries and coordinating services.
7. The MIHP is based on a population management model and health domains are determined systematically.
8. The MIHP has a statewide database that is used for population management purposes, including tracking, reporting, and outcomes measurement.

9. Interventions are prioritized to address (1) identified health domains, (2) anticipated service levels, and (3) specified domains/areas. Interventions are evidence-based or considered best-practices.
10. Plans of care are tailored to individual beneficiaries based on readiness for change in addition to identified health domains.

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 health domains. 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 MIHP 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/.

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. 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, or 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. 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. It provides direct links to information on a variety of topics including: 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. Click on "Policy and Forms." As a Medicaid provider, you are responsible for thoroughly reading all Medicaid bulletins pertaining to MIHP as you receive them. Often, the final policy has been changed from the proposed policy; it is important that you read the final policy very carefully.

If you would like to receive a copy of Notices of Proposed Policy, fill out the MSA-0209 Request to Participate in Policy Proposal Review. This form is provided to you in MS Word format. Please fax the completed form to (517) 335-5136 or email to MSADraftPolicy@michigan.gov

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. Click on "Billing and Reimbursement."

Provider Updates – Medicaid Alerts, including Biller "B" Aware notices, are available at 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.

MIHP billing codes and fee screens (reimbursement rates for various covered services) may be found at 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. 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. 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

CHAMPS Enrollment/Michigan Medicaid Provider Support

Providers with questions about Medicaid billing may call the toll-free number: **1-800-292-2550** or send an e-mail to: ProviderSupport@michigan.gov with "ATTN: Julie Withers" in the subject line. Write "MIHP Question" in the body of the email and include a brief explanation of your need. Provider Support will contact you.

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 under the "Providers", current providers, required forms tab on the left side of the web page.

Requests for Records from CMS/PERM

The Payment Error Rate Measurement (PERM) is The Centers for Medicare & Medicaid Services (CMS) program in which information is requested from providers to support appropriate billing practices. Information about PERM can be found at the MDHHS web site under (PERM Provider Education). Helpful information is also located at Payment Error Rate Measurement (PERM) - Centers for Medicare ...

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, HIPAA 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, U-19, MIChild, Maternity Outpatient Medical Services (MOMS), and Healthy Michigan Plan. 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). Most pregnant and infant MIHP beneficiaries are, or will soon become, 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. A 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, MIHP services, 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.

The State of Michigan is divided into ten Prosperity Regions. Each MHP serves one or more of these regions. Go to View a map of the recommended health plans listed by prosperity region >> for a list of MHPs serving each Prosperity Region.

MHPs may provide incentives to their members to encourage them to use prenatal and pediatric care. Once a MIHP beneficiary is enrolled in a 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 a MHP or to select Fee-For-Service coverage. Voluntary populations include: Migrants, 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 a 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

If a mother is enrolled in a MHP at the time of the birth of her baby, the baby will be enrolled in that same plan for at least the month of birth. The family could prospectively choose a different MHP for the infant. The infant's eligibility continues for 12 continuous months without any interruption or spend down. MHP responsibilities begin at the time of the child's birth. The mother must report the birth to the Michigan 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

MIHP providers collaborate with the Medicaid health plans, prenatal and pediatric providers, and community resource partners to systematically identify and provide equitable, quality, coordinated care for pregnant mothers, infants and their caregivers.

MHP Administers MIHP Services Provided to its Members

Effective January 1, 2017, MIHP services provided to individuals in a Medicaid Health Plan (MHP) are administered by the MHP. This means that all services provided to MIHP enrollees are coordinated and reimbursed by the MHP.

MHP administration of MIHP is described in the following documents:

1. *Changes in Benefit Administration of Maternal Infant Health Program Services for Individuals Enrolled in a Medicaid Health Plan* MSA-16-33
2. *MIHP and MHP Care Coordination Agreement*, MIHP website
3. *MIHP to Managed Care Frequently Asked Questions*, MIHP website
4. *MHP Single Point of Contact List for MIHP*, MIHP website

MIHPs may be required to establish and maintain contractual agreements with MHPs in their service area in order to receive payment for claims for services provided to MHP enrollees. MHPs are not required to contract with all of the MIHP providers operating within their service area.

Contracts will be directly negotiated between the MHP and MIHP agency. See the *MHP Single Point of Contact List for MIHP* at the MIHP web site to determine where to direct inquiries about contracting with the MHPs. This list also provides contact information for the MIHP Care Coordination Liaison at each MHP.

MIHP providers and MHPs establish and maintain a Care Coordination Agreement (CCA) for both in-network and out-of-network services. The intent of the CCA is to describe the services to be coordinated and the essential aspects of collaboration between the MHP and the MIHP provider.

Medicaid Health Plans will determine which MIHP providers they will contract based on several factors including service area, quality, responsiveness, specialty and network adequacy. Volume may be one consideration but it is not the only consideration. Existing CCAs will be honored. Contact your MHP liaison if you have any questions

about obtaining a CCA or need assistance in obtaining a CCA. The MIHP reviewer will ask for CCAs as part of the certification review process.

MIHP services for Fee-For-Service (FFS) beneficiaries are reimbursed through CHAMPS. A MIHP that provides services to a FFS beneficiary may continue to provide services after the beneficiary enrolls in a MHP. The MHP is required to reimburse the MIHP until case closure, even if the MHP does not have a contract with the MIHP.

Non-contracted MIHP providers are required to contact the enrollee's MHP before providing out-of-network services. MHPs must support their enrollees in their choice of MIHP provider and support current service relationships between MIHP provider and enrollee, including extending services to the infant with the same provider who rendered maternal services.

The MIHP is required to notify the MHP that their member has been discharged using the MIHP *Notice of Beneficiary Discharge* within 14 calendar days of entering the *Discharge Summary* into the MIHP database.

a. When you are serving a FFS beneficiary and she subsequently is enrolled in a MHP, send the *MIHP Prenatal or Infant Care Communication* form to notify the MHP contact that she is participating in your MIHP. At that time, initiate contact with the MHP to inquire about entering into a CCA if your MIHP agency does not have a current contract with the MHP.

b. When you are doing outreach (not on a MHP referral) and you encounter a beneficiary who is in a MHP to which you are contracted, enroll her in your MIHP and send the *MIHP Prenatal or Infant Care Communication* form to notify the MHP contact that she is participating in your MIHP.

c. When you are doing outreach (not on a MHP referral) and you encounter a beneficiary who is in a MHP to which you are non-contracted, tell her to contact her MHP to be referred to an in-network MIHP.

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.

As with all Medicaid enrolled providers, MIHP providers are able to define the service area that best accommodates their professional operations. Medicaid Health Plans, however, operate in their approved Prosperity Regions.

MHP Prior Authorization of Services Not Required in Most Situations

Medicaid Health Plans will not require prior authorization for the Initial Risk Assessment visit, professional visits, drug-exposed infant visits, MIHP lactation support visits, childbirth education classes, or parenting education classes when provided within the criteria and limits established in Medicaid policy.

Prior Authorization May be Required by the MHP in the Following Situations:

1. *Risk Identifier* indicates no scored risks for beneficiary. If the *MIHP Risk Identifier* does not indicate scored risks for MIHP services yet professional observation suggests otherwise, the MIHP provider must contact the MHP. Prior authorization from the MHP may be required to proceed with MIHP services**.**

2. Infant is older than 12 months at time of MIHP enrollment or reaches the age of 18 months while enrolled in the MIHP program. *Risk Identifiers* and educational materials utilized by the MIHP are designed for use with infants. Prior authorization from the MHP may be required to initiate services for a child older than 12 months of age, or for MIHP services beyond 18 months of age.

3. MIHP services in excess of limits established in Medicaid policy.

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 receive both Medicare and Medicaid coverage, including Part D prescription drugs, through new managed care entities called **Integrated Care Organizations (ICOs).** ICOs 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 generally 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 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-centered planning process. Membership will include the enrollee and the enrollee's chosen allies, primary care physician and, as applicable, Long Term Services and Supports (LTSS) 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 with 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. MIHP agencies that serve MI Health Link participants need to contract with each beneficiary's ICO in order to be reimbursed for MIHP services.

On July 1, 2016, MDHHS instituted a new process for beneficiary enrollment in the MI Health Link program. This change has billing implications for MIHP providers serving MI Health Link enrollees. See L 16-42.pdf for additional information.

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 or see Bulletin MSA 14-57, distribution date December 29, 2014, at http://www.michigan.gov/documents/mdch/MSA_14-57_477754_7.pdf

Submit MI Health Link questions or billing concerns that are not resolved by the ICO to:

Email: integratedcare@michigan.gov

Mail: MI Health Link
Medical Services Administration
PO Box 30479
Lansing, MI 48909-7979

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 listed above. A standing order must include the following elements: printed MIHP agency name, printed medical provider name, medical provider signature and credentials (MD, DO, FNP, PA), and date of signature. A standing order written on a medical provider's prescription pad is also acceptable if the elements listed above are included. A sample template titled Key Elements of a MIHP Standing Order, which covers all three standing order situations may be found on the MIHP website.

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 and the updated order must be placed in the chart. It is acceptable to place the standing order in the chart of every beneficiary, even though it may not be activated at any point throughout the course of care.

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 48 hours.
4. If the medical care provider does not return the signed order within 48 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.
5. If the written order is not received from the medical care provider, the agency cannot bill for the professional visit.

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
Health Education 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.
Post-Partum Lactation Support and Counseling	Provision of individual, comprehensive lactation support and counseling services for post-partum women up to and through 60 days post-delivery. Includes assessment and the following interventions, at a minimum: positioning techniques,

Registered Nurse or Licensed Social Worker who is an International Board Certified Lactation Consultant (IBCLC)	proper latch on, frequency of feeding, recognizing hunger cues, expression of milk, how to tell when baby is getting enough, and when to call a health care professional. Covers: • One-on-one/dyad visits
Nutrition Education Registered Nurse or Licensed Social Worker or Registered Dietitian (requires medical provider order)	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. Covers: • One-on-one/dyad visits only
Service Coordination Licensed Social Worker or Registered Nurse	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. Covers: • One-on-one/dyad visits only
Nutrition Counseling Registered Dietitian (NOTE: Requires medical care provider order.)	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.) Covers: • One-on-one/dyad visits only
Infant Mental Health (IMH) Services IMH Specialist	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: 1. Assess need for infant mental health services, using recommended objective tools that measure: infant social-emotional development (Ages and Stages Questionnaires: Social/Emotional-2, Devereux Infant-Toddler Assessment); parent-infant attachment (Massie/Campbell Scale of Mother Infant Attachment during Stress); and parental depression (Edinburgh Postnatal Depression Scale). 2. If assessed need is low-moderate, provide brief, direct parent-infant intervention and/or referral to other parenting support program. 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. Covers: • One-on-one/dyad visits only

Childbirth Education Group Classes (CBE)	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 *Medicaid Provider Manual Chapter, MIHP, Section Childbirth Education*).
Parenting Education Group Classes (PE)	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 *Medicaid Provider Manual Chapter, MIHP, Section Parenting Education*).

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 be employed by 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).

The provider may provide post-partum lactation support counseling services if there is an RN or SW on the *MIHP Personnel Roster* who has been certified by the IBCLC. If the provider chooses not to offer IBCLC services directly, they are encouraged to refer a beneficiary who needs breastfeeding support to breastfeeding resources in the community.

Both Required Disciplines Must Regularly Conduct Visits

Both required disciplines must regularly conduct professional visits. Both required disciplines must conduct at least one visit with each beneficiary during the course of service. If both disciplines do not conduct at least one visit, the reason must be documented in the chart, i.e., the beneficiary declined the visit with the other required discipline.

Aside from the required RN visit and the required SW visit, the remaining visits should be conducted by the MIHP discipline or disciplines whose expertise is most relevant to the particular beneficiary, based on her unique health risks, strengths and goals.

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.

MDHHS expects that all MIHP agencies have the staffing capacity to provide quality services. This means that the staffing level must be sufficient to ensure that each beneficiary can be seen at least monthly.

Back-up Staffing Plan

In their agency staffing protocol, providers must describe a back-up staffing plan that would be activated whenever the MIHP is totally void of one of the required disciplines (RN or SW) 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 anticipate or they do not have at least one nurse and one social worker on staff for more than six consecutive weeks. At that time, the MIHP consultant will discuss the actual implementation of the plan with the provider. The consultant will reply in writing, confirming that notification was received. 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 MIHP 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 is at the discretion of MDHHS. Ongoing contact must be maintained with the 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.

You are not required to update the back-up staffing plan annually, however, you are encouraged to review the plan to ensure it remains applicable/ current.

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 documentation in the chart 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 to cover a MIHP beneficiary 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 the 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 chart. 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. MDHHS MIHP encourages 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, productivity analyses, consumer satisfaction analyses, and analyses of 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

MIHP RD and SW staff qualifications were revised effective May 1, 2016. While licensure is still required, a social work degree is no longer specified for social workers. This means social workers who were "grandfathered in" in Michigan in 2005 when licensure was established are qualified to provide MIHP services. Although they do not have social work degrees, they have degrees in related fields, such as counseling or psychology. Qualifications for the MIHP RN, SW, RD, and IMHS are detailed 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.

There is also a description of IBCLC qualifications in Medicaid policy.

Licensure and Verification

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

RN	Licensed 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
IBCLC	International Board Certified Lactation Consultant (also must be a licensed RN or SW in order to bill for MIHP lactation support and counseling services)

Michigan professional licenses may be verified by the Department of Licensing and Regulatory Affairs (LARA) at www.michigan.gov/lara. Click on "Verify a License" in the "Quick Links" column on the right.

There should be a copy of each of the following in the personnel file of every MIHP professional on staff:

- Current license, registration and certification
- Verification of current license, registration and certification
- Resume

The MIHP coordinator must carefully track the license, registration and certification expiration dates for all professional staff. A professional with an expired credential must not provide any MIHP services as of the date of expiration. Per Medicaid policy, services provided by a professional with an expired credential 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 authorized to use the State of Michigan MILogin System for purposes of entering MIHP 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). It is your responsibility to submit each *Personnel Roster* by the deadline; MDHHS does not issue reminders every quarter.

MIHP Personnel Roster Due Dates

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

You are also required to submit an updated *Personnel Roster* to authorize a new staff member to use the MILogin System or to deactivate a user when a staff member leaves prior to the end of the quarter. This must be done within 10 business days of any agency personnel change.

If you have made any changes to your agency's contact information (address, phone number, fax number, etc.) on the *Personnel Roster*, please indicate this in the body of your *Personnel Roster* submission email. This will ensure that your contact information changes are updated in the *MIHP Coordinator Directory*.

Staffing Waiver Requests

At times, a provider may be unable to find a fully qualified licensed RN or SW to fill a particular position. In this case, the provider can request that certain personnel requirements be waived. Education and licensing/registration/endorsement 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. MDHHS does not grant waivers for registered dietitians, infant mental health specialists, or International Board Certified Lactation Consultants.

A provider who is unable to find a licensed RN or SW 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 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 a professional 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. The *Notice of Waiver Completion* must be maintained in the individual's personnel file. It must also be sent to MDHHS. 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 may be found at 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. 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.

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, if applicable. However, agencies that are part of a local health department, FQHC, hospital system, or home health agency that issues identification badges to all of its employees are not required to alter their badges to include "MIHP."

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

MIHP services are a Medicaid-only benefit. As a Medicaid beneficiary, individuals enrolled in Fee-for-Service or in one of the following programs may be eligible to receive MIHP services:

- Healthy Kids for Pregnant Women and Children
- Group 2 Pregnant Women Program
- U-19
- MIChild
- The Healthy Michigan Plan
- Maternal Outpatient Medical Services (MOMS)

Maternal MIHP Eligibility

Healthy Kids for Pregnant Women
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 MDHHS worker to determine the reason. If the reason does not appear to be in keeping with Medicaid policy, contact your consultant.

Group 2 Pregnant Women Program
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.

U-19
U-19 is a Medicaid health care program for low-income children under age 19. There is only an income test. There is no monthly premium for this Medicaid program. Most children who are eligible for U-19 Medicaid are enrolled in a Medicaid health plan. This program provides a comprehensive package of health care benefits including vision, dental, and mental health services. Contact the local MDHHS office in your county to apply for this program or apply online at www.michigan.gov/mibridges.

MIChild
MIChild is a health care program for children who are under age 19, low income and uninsured children of Michigan's working families. MIChild has a higher income limit than U-19 Medicaid. There is only an income test. There is a $10 per family monthly premium for MIChild. The $10 monthly premium is for all of the children in one family. The child must be enrolled in a MIChild health and dental plan in order to receive services. Beneficiaries receive a comprehensive package of health care benefits including vision, dental, and mental health services. For more information and to apply, contact MIChild at 1-888-988-6300 or visit the MIChild Information website at www.michigan.gov/michild. (If a MIChild beneficiary becomes pregnant, she may remain in MIChild and she is eligible for MIHP.)

Healthy Michigan Plan
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 MIHP provider must observe the infant during every visit with the primary caregiver (i.e. mother, father, foster parent etc.).

Infants are eligible for MIHP from birth to 12 months of age, as long as they are covered by Medicaid.

MIHP was specifically designed to serve infants from birth to 12 months of age. The *Infant Risk Identifier* and infant interventions were not originally designed to meet the developmental needs of toddlers. Although an infant who is 12 months of age or older should not be regularly enrolled in MIHP, when on rare occasions, MIHP providers encounter a child over the age of 12 months who is in a situation that warrants an exception to this requirement,

the MIHP provider must submit a statement in writing to their consultant or to the beneficiary's MHP requesting approval to enroll the infant in your MIHP. If the consultant or the MHP approves the request, the provider will receive authorization in writing. Authorization from the MIHP consultant or the MHP must be maintained in the beneficiary's medical record along with documentation of how the beneficiary is benefitting from MIHP services.

When an infant being served by MIHP reaches 12 months of age, you should begin transition planning and 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 for approval to your consultant or to the beneficiary's MHP to allow you to continue serving the beneficiary. If the MIHP consultant or MHP approves the request, the MIHP provider will receive authorization in writing. Documentation of authorization from the MIHP consultant or MHP, must be maintained in the beneficiary record.

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 addressed with both the mother and the foster family on the *Discharge Summary* and note in the comments section of the *Discharge Summary* that you have been working with the foster parent and unaware of the mother's status at DS.

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.

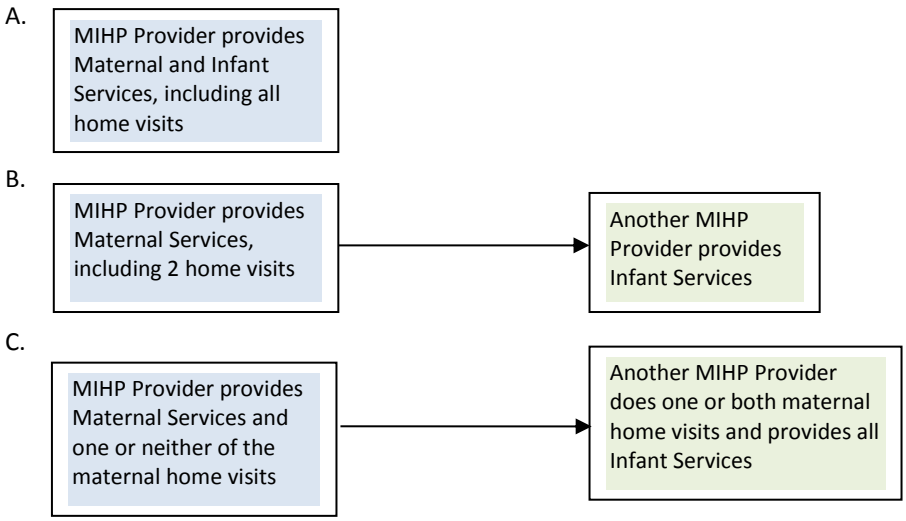
Mother-Infant Dyad Service Options

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

Maternal only MIHP providers are required to serve the mother-infant dyad as follows:

1. Provide all maternal services, including the two required home visits, and after the baby is born, transfer infant to a second certified provider, per written agreement; or jointly provide maternal services with a second certified MIHP provider who would conduct at least one of the two required home visits, and after the baby is born, transfer the infant to the second provider, per a written agreement.
2. Contact the infant services provider with maternal referral information within one month of maternal enrollment in MIHP to prepare for postpartum transition (*for beneficiaries with MRI dated after 7/31/16*).
3. Document in the chart that you followed your specified process for transitioning the beneficiary to the infant services provider-and note if the
   a. Infant has been enrolled in infant services, infant services were refused, or it was not possible to locate the infant.

Below is a diagram of the three options for providing maternal and infant visits in MIHP:



For more information, see *Mother-Infant Dyad Guidelines for Maternal-Only MIHP Providers* 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 a contract, including payment methodology, directly with the beneficiary's ICO.

Billing for MIHP Services Provided to Individuals Enrolled in MHPs

It is incumbent upon MIHP providers to check eligibility and MHP enrollment before providing a MIHP service. MHPs are responsible for authorizing and paying for MIHP services provided to individuals enrolled in MHPs. Billing for these services may include:

- In network MIHP providers: MIHP and MHP negotiated contracts and CCAs will define procedures and rates for reimbursement. These may vary across MHPs.
- Out of network MIHP providers: Non-contracted MIHP providers are required to contact the enrollee's MHP before providing out-of-network services and discuss reimbursement details. Any questions related to providing out-of-network services will need to be discussed directly with the individual MHP prior to providing services. If services are MHP approved and provided by an out-of-network MIHP, those services will be reimbursed, at a minimum, at FFS rates.

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

Medicaid beneficiaries who are not enrolled in a MHP have Fee-for-Service (FFS) Medicaid coverage, often referred to as "straight Medicaid." Providers must use appropriate procedure and diagnosis codes when billing for MIHP services. Services provided to FFS beneficiaries are paid by MDHHS according to the MIHP database and fee schedule provided on the MDHHS website. In these cases, the MIHP provider submits FFS claims to MDHHS electronically through the Community Health Automated Medicaid Processing System (CHAMPS). This requires the agency to have a National Provider Identifier (NPI) and to complete the CHAMPS enrollment process. The provider must have proof that they are an approved Medicaid provider with an MIHP B356 specialty designation before attending a New Provider Orientation. NPI numbers are in the public domain.

If the beneficiary also has commercial health insurance, a denial from the primary insurance is not required before billing for MIHP services as MIHP services are a Medicaid only benefit.

An online training titled *Overview of the Maternal Infant Health Program Training Course* 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*.

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 primary caregiver.

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. Post-partum lactation support and counseling in home or office
5. Childbirth and parenting education classes
6. 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 six service categories are discussed below.

1. Assessment

The assessment visit is the first visit with the beneficiary. It is conducted in person by either a licensed registered nurse or a licensed social worker.

Assessment involves the administration of the *MIHP Maternal Risk Identifier* or the *MIHP Infant Risk Identifier.* These are mandatory 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.

The *Risk Identifier* assures that all appropriate services are identified prior to the initiation of professional visits, substance-exposed infant visits, lactation support and counseling visits, childbirth education, parenting education or transportation services.

Before a MIHP provider can provide any other MIHP services or bill for the *Risk Identifier*, the provider must administer the *Risk Identifier*, enter the *Risk Identifier* data into the MDHHS MIHP database, obtain a score result, and develop the *Plan of Care, Parts 1-3*. A complete assessment includes the *Risk Identifier* and the complete *POC, Parts 1-3*.

If no scored risks are identified by the *Risk Identifier*, but the providers are authorized by the MIHP consultant (for FFS beneficiaries) or by the beneficiary's MHP to serve the beneficiary based on needs identified by professional judgment, the MIHP provider must complete the *POC Part 1*. The only situation in which a *POC* is not required, is when the beneficiary declines services either before or after the *Risk Identifier* is administered.

Even if the provider does not yet have the beneficiary's Medicaid ID number, the provider can enter the *Risk Identifier* into the MIHP database, print it out with the *Score Summary*, develop the *POC*, and provide MIHP services for the beneficiary. However, providers cannot bill for the *Risk Identifier* until the Medicaid ID number is entered into the database. Each agency must decide whether or not they will provide services before a beneficiary's ID number is issued.

Most often, the *Infant Risk Identifier* is administered with the infant's biological mother. However, if the biological mother is not the infant's primary caregiver, the *Risk Identifier* is administered 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*.

Even if it takes two visits to fully administer the *Risk Identifier*, you can only bill for one *Risk Identifie*r visit. You may not bill until the *Risk Identifier* is fully administered. If it takes two visits to complete a risk identifier, the 2nd visit is required within 14 calendar days from the date of the first visit. The date of the second visit is the date that the *Risk Identifier* was administered for documentation and billing purposes; in other words, it is the date of MIHP enrollment.

The *Risk Identifier* data must be entered into the database and placed in the beneficiary's chart with the *Score Summary* before the first professional visit is conducted.

Even if the beneficiary declines MIHP services either before or after the *Risk Identifier* is fully administered, you may bill for the *Risk Identifier* visit.

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 the appropriate 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, face-to-face meetings with the pregnant woman or dyad, 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.

A minimum of two home visits are required for maternal beneficiaries. At least one home visit must be conducted within one month of enrollment in the MIHP (for beneficiaries with a MRI conducted after 1/1/17) and at least one maternal visit must be conducted postpartum (after the infant is born) unless there is a documented reason or the beneficiary refused services within this timeframe. The *Maternal Risk Identifier* visit may count as one of the two required home visits. The 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.

Fetal Loss or Infant Death

To enroll in MIHP, the Medicaid beneficiary must be pregnant. If the MIHP maternal beneficiary 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 number is issued, the provider may continue to serve the beneficiary until her 9 maternal visits are used or her Medicaid coverage ends, whichever comes first. A MIHP provider may continue to provide MIHP maternal services to a Medicaid eligible woman for up to 60 days after a fetal loss or infant death.

If the infant is enrolled in MIHP and the infant dies after the mother's MIHP coverage has ended, MIHP services are immediately terminated for the mother. The mother is then referred to bereavement support services. Contact the MDHHS Infant Health Unit at 517 335-8955 to make a bereavement services referral for families who have experienced a miscarriage, stillbirth or infant loss. Alternatively, you may call Maximum Living, Inc. at 248 814-0706 to make the referral. Bereavement support services are free for families. The MDHHS Grief Support Services Referral form is posted on the MIHP web site.

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 must be written, although a verbal order is acceptable if there is an urgent concern. The reason for and purpose of additional visits must be well documented in the medical record.

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.
4. 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.
5. If the written order is not received from the medical care provider, the agency cannot bill for the professional visit.

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.*

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 (or any other MIHP services) 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.

Medicaid reimbursement for a professional visit includes related care coordination activities. When beneficiary needs arise, the MIHP provider is required to coordinate all necessary MIHP-related services with the appropriate community agency. Visits beyond the established limit may not be billed to Medicaid or the beneficiary.

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 why 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 (96154) for purposes of implementing the *Plan of Care*. It is important to bill for two (2) units with 96154, 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 96154 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 must be written, although a verbal order is allowable in an urgent situation when the beneficiary must be seen that day. See section tilted *Infant Professional Visits* earlier in this chapter.

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. The standing order must have been reviewed and signed by the medical care provider within the last 12 months. Additional information on obtaining medical care provider authorization for MIHP services is provided in *Chapter 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. Post-Partum Lactation Support and Counseling

Individual, comprehensive lactation support and counseling services may be provided for post-partum MIHP beneficiaries through 60 days post-delivery. Beneficiaries in the MOMS program are not eligible for these services. Lactation support and counseling services may be provided by a MIHP RN or SW with a valid certification issued by the International Board Certified Lactation Consultants (IBCLC). Lactation support and counseling services provided by an IBCLC Registered Dietician (RD) are not billable under MIHP as RDs are not licensed in Michigan. The IBCLC must complete all of the MIHP required trainings and be listed on the *MIHP Personnel Roster*.

The MIHP IBCLC provides evidence-based interventions that, at a minimum, include: instruction in positioning techniques and proper latching to the breast; counseling in nutritive suckling and swallowing; milk production and release; frequency of feedings and recognizing hunger cues; expression of milk and use of pump if indicated; assessment of infant nourishment; and reasons to contact a health care professional. The IBCLC also provides community support referrals, such as the Women, Infants and Children (WIC) program, as indicated.

Before initiating MIHP IBCLC services:

- Initial MIHP assessment/*Risk Identifier* (infant or maternal) visit must be completed and entered into the MIHP database.
- *Plan of Care* (infant or maternal) must be developed and signed.

The *IBCLC Post-Partum Lactation Support and Counseling Professional Visit Progress Note Code S9443* is used to document the provision of MIHP IBCLC services and the evaluation of outcomes from the interventions. The form and instructions are located on the MIHP web site.

There must be documentation of the need for maternal lactation support in the beneficiary's chart. MIHP IBCLC services must be provided through a face-to-face encounter lasting at least 30 minutes. There is a limit of two lactation support and counseling visits per beneficiary per pregnancy. These two visits may be conducted in addition to the nine maternal professional visits. Claims are submitted using the mother's Medicaid beneficiary ID with the Healthcare Common Procedure Coding System (HCPCS) code S9443. Documentation must support a separately identifiable visit.

An MIHP agency can bill under both 99402 and S9443 codes for services provided on the same day. When two visits are made on the same date of service, there must be two separate progress notes, a standard *MIHP Professional Visit Progress Note* (99402) and a *MIHP IBCLC Post-Partum Lactation Support and Counseling Professional Visit Progress Note (S9443).*The maternal beneficiary would need to have two postpartum professional visits left in order bill this way for two lactation visits.

5. 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 ½ of the classes or cover at least ½ 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 ½ 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 ½ of the classes or cover at least ½ 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*.

6. 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.

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.

Transportation Provided by the MHP for MHP-Enrollees

MHPs are responsible for providing transportation (including bus tokens) to MHP covered services. Beginning January 1, 2017, MIHP services will become an MHP covered service. As a result of this transition, MHPs will be responsible for providing transportation for pregnancy-related appointments for MIHP and Nurse-Family Partnership participants. These pregnancy-related appointments include those for oral health services, WIC services, behavioral health and substance use disorder services, and child birth education classes, regardless of who provides the child birth education services. The MIHP should work with the MHP to coordinate transportation services.

Beginning January 1, 2017, MIHPs must follow each health plan's internal processes to coordinate transportation services for MIHP enrollees. Codes and associated fees located on the MIHP database will no longer be applicable for claims for transportation services provided by MIHP providers to MHP enrollees (relative to both in network and out-of-network providers) and MIHP providers will no longer be eligible for the administrative fee for MHP enrollees.

There are no special restrictions during the first 30 days of MHP enrollment; transportation should be arranged through the MHP.

Each MHP has procedures and timeframes for requesting transportation. However, all MHPs are required to have a process to request emergency transportation which would include same-day services. MIHP providers should discuss those details with the MHPs.

There will be no impact to MIHP transportation services provided to FFS beneficiaries.

MIHP Options for Becoming MHP Transportation Providers

MIHP providers are encouraged to discuss with the Medicaid Health Plans, or their transportation vendor, the options for enrollment as a transportation contractor. Individual MIHP staff members (not the agency) may also provide transportation and use the health plan gas mileage reimbursement process in place for volunteer or

family/friend drivers (complete the health plan mileage reimbursement forms) to receive payment for mileage. MIHP providers should discuss those details with the MHPs.

Transportation Provided by the MIHP for Fee-For-Service Beneficiaries

There are no changes to MIHP benefit administration to FFS beneficiaries, including transportation services. For women and infants who are enrolled in fee-for-service (FFS) Medicaid, the MIHP may provide transportation services for medical/health care (including pharmacy), mental health services, substance abuse treatment, WIC visits, childbirth education classes, parenting education classes, and for visiting the infant in the hospital.

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 MHP Care Coordination Liaison at every MHP in the service area in order to coordinate transportation. See the *MHP Single Point of Contact List for MIHP* at the MIHP web site to obtain contact information for the MHP Care Coordination Liaisons.

If you have a beneficiary whose transportation needs are not being met by MDHHS or her MHP, work directly with the local MDHHS office or MHP 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 risk 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 the total maternal visits must be conducted in the home. The Maternal Risk Identifier visit may count as one of the two required home visits. At least 80% of all professional infant visits 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), MIHP providers 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 the 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 (more than one beneficiary has a *Risk Identifier* but not a *Discharge Summary)*. 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.

It's up to you to decide which Medicaid ID to use, based on the situation and needs of the beneficiaries involved. For example, if the mother has unused visits during the postpartum period, you could use her Medicaid ID until all of her visits have been used and then bill under the infant's Medicaid ID. You cannot go back and forth, billing each visit under a different Medicaid ID.

When you bill under the mother's Medicaid ID, you address both the mother's and infant's risk domains during the blended visits. Likewise, when you bill under the infant's Medicaid ID, you address both the infant's and mother's risk domains during blended visits. When you bill under one infant's Medicaid ID in a family with multiples, you address risk domains for more than one infant and for the mother during blended visits.

Blended visits are documented as follows:

1. There is a checkbox at the top of the standard *Professional Visit Progress Note (*PVPN) to document that a visit was blended.

2. *POC 2* interventions provided for the beneficiary whose Medicaid ID is being used to bill are documented in the *Domain/Risk Addressed* section of the standard PVPN.

3. *POC 2* interventions provided for all other family members are documented on an addendum to the standard PVPN titled *Professional Visit Progress Note for Beneficiary Whose Medicaid ID is Not Used to Bill Blended Visits.*

Activities other than the provision of *POC 2* interventions that are done with or on behalf of **any** of the family members are documented under *Other Visit Information* on the standard PVPN. This includes referrals that are made for a beneficiary whose Medicaid ID is not used to bill blended visits.

The standard PVPN along with the addendum is filed in the chart of the beneficiary whose Medicaid ID is used to bill blended visits or in the family chart.

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 Medicaid ID and additional maternal risks are identified by the *Infant Risk Identifier* that weren't included in the mother's POC, plan to address these risks.

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 *Infant Care Communication* to the medical care provider and MHP 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, and all services billed under one infant's Medicaid ID number.
With multiples, you cannot bill one infant's Medicaid ID for the initial 9 visits and then bill another infant's Medicaid ID 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 choose to bill under the ID of any of the infants. With multiples, it is often the case that the healthiest infant with the fewest needs is the first one discharged from the hospital. This infant becomes the first one for whom a *Risk Identifier* is done and the one whose Medicaid ID is billed for the blended visits after the other infants come home.

Additional blended visits beyond the initial 9 infant visits for the sibling group may only be provided if a physician's order authorizing additional visits is found in the chart. Developmental screening for multiples is critical; a developmental concern identified by the *ASQ* for one infant is an acceptable rationale for the medical care provider to authorize additional blended visits for the sibling group.

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* at the MIHP website for details. Different MIHP agencies may not serve different children in a set of 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 <u>before</u> any professional visits can be provided. Bill the *Maternal Risk Identifier* visit under the mother's Medicaid ID.

You may choose to continue to bill visits under the infant's Medicaid ID <u>or</u> to start billing under the mother's Medicaid ID. 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.

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.

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.

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 website.
2. Prospective provider sends name, phone number, email address and request to attend an MIHP provider inquiry meeting to 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 - 3rd Edition* and *User's Guide,*
    c. Proof of purchase of the *ASQ-3 Learning Activities* book
    d. Proof of purchase of the *Ages and Stages Questionnaire: Social Emotional - 2nd Edition* and *User's Guide*
    e. *MIHP Personnel Roster* indicating that both required disciplines 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.
    a. Provider is designated as MIHP specialty provider, if applicable as approved by the MDHHS.
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 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 *Chapter 9 – MIHP Quality Assurance and Improvement.*

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. 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.

The acceptable browsers for MIHP MILogin use are IE 8 or IE 11. <u>You cannot use IE 9 or 10.</u> 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.

To check your browser on Internet Explorer:

1. Open Internet Explorer.
2. Click on the "tools" button in the top far right corner of your screen.
3. Go to "About Internet Explorer" to verify which version you are operating.
4. Uncheck/Disable the box (if need be) that asks "Install new versions automatically."
5. If your operating system is Windows 10, and you are utilizing Microsoft Edge, its browser is the current version of Explorer which is Internet Explorer 11.

Provider Authorization of MIHP Electronic Database Users

The MIHP provider must authorize staff members to use the State of Michigan MILogin 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 MILogin System may enter *Risk Identifier* and *Discharge Summary* data into the MDHHS database. This includes support staff.

The MILogin System 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 **MILogin/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 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 MILogin must be listed on the current *MIHP Personnel Roster.*

3. If you wish to authorize a new staff member to use MILogin 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* within 10 days of any agency personnel 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 MILogin System

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

1. Individual (s) goes to the state's MILogin System web site at https://milogintp.michigan.gov
2. The individual follows the instructions on the MILogin System 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 MILogin 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 MILogin 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 MILogin authorization and password for each agency, given that access is based on the agency's NPI number.

Official Agency Telephone

The telephone number listed in the *MIHP Coordinator Directory* is the agency's official telephone number. It may be a land line or cell phone number.

The official telephone number should be used for agency business only. Calls coming into this number should be answered professionally with a statement that includes the name of the MIHP. This phone must not be accessible to family members or others who are not authorized to handle PHI.

The agency phone number must have a voice mail message that includes:

1. The name of the MIHP.

2. Directions on what the caller should do if she is in an emergency situation during the work day, after hours, or on the weekend. Directions should including calling 9-1-1 or going to the ER.

3. Directions for leaving a call-back number with a statement indicating when the caller may expect a return call.

Voice mail messages must be checked and deleted frequently. The caller should never be denied the opportunity to leave a message because the voice mail box is full.

MIHP state-level staff or MHP staff may call the agency number periodically to determine if the phone is being answered professionally and in keeping with the requirements listed above.

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.

   Refrain from sharing beneficiary protected health information when using various methods of online and electronic communication (e.g., fax, e-mail, and text) unless they have been verified as secure to ensure you are not violating Health Insurance Portability and Accountability Act (HIPAA) or confidentiality guidelines. To learn more about Health Information Privacy, visit http://www.hhs.gov/hipaa/for-professionals/index.html

   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.*

2. All staff with access to protected health information must sign confidentiality statements. This includes the coordinator, the owner, professional staff, administrative staff, data entry staff and anyone else who has access to PHI. The agency must keep these statements on file.

3. A double-locking system is required when staff take beneficiary records into their homes. This means that records must be stored two locks away from anyone who is not authorized to see the beneficiary's PHI in order to prevent inadvertent exposure. If no one else has access to the home, records can be stored in a locked office in the locked house. If other people, including family and friends, have access to the house, records can be stored in a locked cabinet in a locked office or in a locked briefcase in a locked cabinet. A double-locking system must also be used when transporting records.

4. 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.

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. Internet Protocol (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 smaller than a zip code.

Agencies are required to become familiar with HIPAA and understand how the law affects MIHP program operations. See http://www.hhs.gov/ocr/privacy/index.html for additional information. Also see Indicators #13, #14 and #16 in the *MIHP Certification Tool* for MIHP confidentiality requirements.

Required Infant Developmental Screening Tools

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

1. *Ages and Stages Questionnaires, 3rd Edition (ASQ-3)*
2. *ASQ-3 User's Guide*
3. *ASQ-3 Learning Activities (book with CD)*
   Available in English and Spanish
   http://www.brookespublishing.com/store/books/squires-asq/index.htm
4. *Ages and Stages Questionnaires: Social-Emotional (ASQ: SE-2)*
5. *ASQ: SE-2 User's Guide*
   Available in English and Spanish
   http://www.brookespublishing.com/store/books/squires-asqse/index.htm

Requirements for Serving Persons with Limited English Proficiency

On Aug. 11, 2000, President William J. Clinton signed 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 by 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, 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 Michigan, 42.9 % speak Spanish and 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, 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 Pediatric and Family Health, Social-Emotional Health, Parenting Leadership, Family Support, and Child Care and Early Education)
    c. Fetal-Infant Mortality (FIMR) Teams
    d. *Early On* Local Interagency Coordinating Councils
6. Maintaining a web site and/or social media tools

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, especially new providers, need to repeatedly market their services to potential referral sources due to staff turnover. This will ensure health and human services workers have access to current information about the availability of MIHP services in their community. 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

MDHHS requires MHPs to refer their pregnant and infant enrollees to an MIHP. MHPs will determine which MIHP providers they will contract with based on several factors including service area, quality, responsiveness, specialty and network adequacy.

It is the MIHP provider's responsibility to ensure that every MHP operating in their service area is familiar with the MIHP agency. The provider should develop good working relationships with each MHP so that the MHP will feel confident in referring its members to the provider's program.

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 in-network medical care 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 will refer 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. MHPs may refer to the MIHPs of their choice, but they cannot dictate that a beneficiary must enroll in a particular MIHP. The beneficiary may choose from among all of the MIHPs contracted with the MHP.

The *MIHP-MHP Referral Status Report* has been developed for use by both MHPs and MIHPs to share information about pregnant women and infants referred to an MIHP by an MHP. The form and instructions for its use are available at the MIHP web site. This form replaces the *MIHP-MHP Collaboration Form*. MIHP are encouraged to communicate with the MHPs about any specialty services they are able to provide (e.g., culturally or linguistically appropriate services) and assure the *MIHP Coordinator Directory* accurately reflects specialty services.

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 serve as MIHP referral sources.

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.

The Birthing Hospital Projects are ongoing. To date, 41 of the 83 Michigan birthing hospitals have created **and** implemented quality improvement projects with the following focus areas:

1. Refer Medicaid infant beneficiaries to the MIHP, if not currently enrolled in a Michigan evidence-based Home Visiting Program
2. Refer potentially eligible infants to the Children Special Health Care Services local health department program
3. Increase breastfeeding initiation rates
4. Create and/or enhance current Infant Safe Sleep policy and/or procedures to comply with Public Act 122 of 2014
5. Increase the making of and follow through with postpartum appointments by postpartum mothers
6. Collaborate with the Home Visiting HUBs located in counties serving their patient populations

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.

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

   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

   The *MHP Single Point of Contact List for MIHP* provides contact information for the Contracts/Provider Services Representative and the Care Coordination Liaison for each MHP.

3. Medical Care Providers
   Ask the Local Health Department or refer to the 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

4. Free and Low Cost Health Care in Michigan
   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

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 addictions in Michigan; provides links to community-based services 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

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 Status of Referrals Made to MIHP

The MHP uses the *MIHP-MHP Referral Status Report* to send referrals to the MIHP. The MHP populates the form with the name, Medicaid ID, DOB and contact information for multiple beneficiaries. The MIHP attempts to contact everyone on the list and then sends the *Referral Status Report* back to the MHP, indicating if each beneficiary was enrolled in the MIHP, declined to enroll, was already enrolled in another MIHP, or if the MIHP was unable to contact the beneficiary. The completed report is returned to the MHP within 30 days of receipt. The form and instructions are available at the MIHP web site.

MIHP providers are encouraged to document and report the status 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. 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.

Replying to Referrals from Children's Protective Services

When a provider receives a referral from Children's Protective Services (CPS), they must determine if the beneficiary is already enrolled in another MIHP. If so, they must inform CPS that the beneficiary is currently being served by another MIHP agency and provide contact information for that agency. CPS may not decide that a beneficiary must enroll in a particular MIHP. The beneficiary always has the right to decide whether or not to enroll in MIHP and to be served by the MIHP agency of her choice within her MHP network.

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) US 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 programs. 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 within her MHP network.

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 it to MDHHS. The form is at the MIHP web site. In consultation with the MDHHS Maternal Health Unit Manager, the complaint will be investigated by the MIHP Quality Improvement Coordinator. 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.

Employee Complaints against MIHP Providers

The MDHHS Maternal Health Unit does not investigate complaints made by MIHP employees against their employers. Employees with personnel issues (e.g., wage disputes, alleged discrimination, abusive practices, etc.) that are not resolved through the MIHP's internal employee grievance procedure, are encouraged to view the Michigan Department of Licensing and Regulatory Affairs (LARA) website at www.michigan.gov/lara for information on possible courses of action. Employees with concerns other than personnel practices are referred to *Chapter 13 – Reporting Medicaid Billing Fraud, HIPAA Violations, and Quality of Care Concerns*.

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 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, and then go to Section 3 of that chapter.

Using the MIHP Logo for Outreach Purposes

Samples of variations of the MIHP logo, the MIHP Logo Usage Guidelines and the MIHP Logo Permission Request Forms are available on the website.

All MIHP materials which display the MIHP logo must be approved by your MIHP consultant prior to use. To assure proper use of the logo, please review the MIHP Logo Usage Guidelines prior to requesting approval for using the MIHP logo.

The MIHP logo is available in black and white and in the original teal color, and it comes in various sizes. When submitting your permission request to your consultant, indicate which variations you would like and they will be sent to you via email. Along with the permission request, include draft copies of any materials you plan to use with the MIHP logo.

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, an International Board Certified Lactation Consultant (who is also a licensed RN or SW), 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. However, 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 and 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. (Excerpted 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 Risk Identifier* and completion of *Plan of Care, Part 1*	RN or SW; *POC 1* must be signed by both
2. Development of *Plan of Care, Parts 2 – 3*	RN and SW; *POC 3* 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 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 complete the *Discharge Summary*

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* is required to track and document each component of the care coordination process from the date of receipt of referral to the date the *Notice of Notice of MIHP Beneficiary Discharge* is sent to the medical care provider and MHP.

2. The *MIHP Contact Log* (or an alternative contact log of your own design) is required to:

    a. Track and document attempts to contact the beneficiary (e.g., phone, text, email, letter, note on door, etc.) if there's a gap in service between professional visits and from the last professional visit to discharge.

    b. Document the reason why visits are not conducted on a monthly basis.

    c. Document the specific purpose that an infant case is being kept open after four consecutive months of inactivity.

3. The *Contact Log* used for other purposes as well. See *Plan of Care, Part 2 (POC 2) Implementation Monitoring* later in this chapter. Also see the *MIHP Contact Log Forms Instructions* at the MIHP web site.

4. The *MIHP Referral Log* may be used to track and document referrals to other services and supports. MDHHS developed this form for providers to use as a worksheet. If MIHP providers use the optional MIHP referral log those referrals must be transferred to the PVPN. It is required that all referrals are tracked on the PVPN.

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, an International Board Certified Lactation Consultant (who is also a licensed RN or SW), a registered dietitian or an infant mental health specialist. Education services are provided as part of the implementation of the *POC 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 & 2nd 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 MILogin System because MILogin 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 (transportation, childbirth education classes, 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 entered into the beneficiary's paper or electronic chart before the first professional visit is conducted or any other MIHP services are provided.

You are not required to have developed the *POC Parts 2 and 3* before notifying the medical care provider and MHP that the beneficiary has enrolled in MIHP. You must notify the medical care provider and MHP of enrollment within 14 days of the *Risk Identifier* being fully administered.

If it takes two visits to fully administer the *Risk Identifier*, the second visit must take place within 14 calendar days from the date of the first visit.

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 Summary* 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 MIHP postpartum visit is completed before you administer the *Infant Risk Identifier.*

Health Risk Domains Covered by *Risk Identifiers*

The *Maternal Risk Identifier* is the MIHP tool used to determine specific determinants of health and 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 determinants of health and 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, and 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 health factors and risks that were **clearly** linked to poor birth outcomes **and** for which there were interventions that had proven successful (or considered promising practices) 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 before or after *Maternal Risk Identifier* Administered

If a woman declines MIHP services before or 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 before or 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**.** In the comments section of the *Risk Identifier*, document that you gave the woman the *MIHP Maternal and Infant Education Packet*.

When a woman declines services after the *Risk Identifier* is administered, do not develop the *POC Parts 1, 2 and 3*. However, be sure to complete the *Discharge Summary*.

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

The first professional visit should take place within 30 days of MIHP enrollment (date that the *Risk Identifie*r was fully administered).

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 or MIHP eligibility ends. 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 MIHP- enrolled 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. Always search by name and date of birth first, and then by Medicaid number. Search for an existing *Maternal Risk Identifier* and *Infant Risk Identifier* under the mother's name and date of birth when you get an infant referral. When you select the "check for existing screens" 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, local 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* 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 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. If the mother is in a MHP at the time of the birth of her baby, the baby will be enrolled in that plan for at least the birth month. The family could prospectively choose a different MHP for the infant.

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 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 an MIHP case, as no billable service has been provided.

e) If a potential beneficiary who declines to participate in MIHP was referred by her MHP, you must notify her MHP that she has declined MIHP, using the *MIHP-MHP*

Referral Status Report. If she was not referred by her MHP, you are not required to inform the MHP, but you may choose to do so.

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.

5) If the beneficiary **agrees** to participate in MIHP services after the *Risk Identifier* has been administered:

   a) After completing the *Risk Identifier*, give the beneficiary or the beneficiary's primary caregiver the *MIHP Parent Information Sheet* and 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 t*ext4baby*. 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*.

   b) Give the beneficiary or the beneficiary's primary caregiver a copy of your internal beneficiary grievance procedure and a copy of *Your Rights and Responsibilities as a Maternal Infant Health Program Participant*. Keep these two documents entirely separate. Do not merge them in any way and do not copy one document on the front of a page with the other document on the back.

   c) 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*.

   d) 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*.

   e) 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 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. If the mother is in a MHP at the time of the birth of her baby, the baby will be enrolled in that plan for at least the birth month. The family could prospectively choose a different MHP for the infant.

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 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.

6) If the beneficiary **declines** MIHP services after the *Risk Identifier* has been administered,

   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 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. If the mother is in a MHP at the time of the birth of her baby, the baby will be enrolled in that plan for at least the birth month. The family could prospectively choose a different MHP for the infant.

   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 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 an MIHP case, as no billable service has been provided.

f) If a potential beneficiary who declines to participate in MIHP was referred by her MHP, you must notify her MHP that she has declined MIHP, using the *MIHP-MHP Referral Status Report.* If she was not referred by her MHP, you are not required to inform the MHP, but you may choose to do so.

7) If a woman **declines** or **accepts** services after the *Risk Identifier* is administered:

a) 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.

b) 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.

The only exception to this when the beneficiary declines MIHP services after the *Risk Identifier* is administered. In this case, do not develop the *POC Parts 1-3*. However, you must complete the *Discharge Summary*.

If no risks are scored on the *Risk Identifier*, but you have received written approval to serve the beneficiary for needs you identified based on professional judgment, you must develop the *POC Parts 1-3.*

c) 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, 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.

d) It is essential that you enter the beneficiary's Medicaid ID number as soon as you receive it.

e) 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.

f) File the electronic *Risk Identifier* and the *Risk Identifier Score Summary* in the beneficiary's chart before the first professional visit is conducted or any other MIHP services are provided. 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.

g) 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.

h) 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 1st Addressed". 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 risk assessment visit, document it in the risk identifier within the comments section.

i) 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 written information on how and when to contact the agency.

7. Provided the beneficiary with *Your Rights and Responsibilities as a Maternal Infant Health Program Participant.*

8. Provided the beneficiary with the following:

Pregnant beneficiary	Infant beneficiary's primary caregiver
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.	

9. 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.

Beneficiary with No Scored 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 beneficiary's *Risk Identifier* has no scored risk, a *POC 2* is not completed. Staff asks the beneficiary or legal representative if MIHP may contact her again around the time that her baby is due or later in infancy to ask if she would like to participate in the program at that time.

Since all of the *MIHP Risk Identifier* questions (e.g., those pertaining to breastfeeding) are not included in the scoring algorithm, professional observation is essential to beneficiary assessment. On the rare occasion that there is no scored risk following the administration of the *Risk Identifier,* yet professional observation suggests the beneficiary would benefit from MIHP services, contact your MIHP consultant (for FFS beneficiaries) or the beneficiary's MHP for authorization to provide MIHP services. If the consultant or MHP approves your request to serve the beneficiary, you will receive written authorization.

The written authorization will outline expectations for the MIHP agency, such as the following:

- Refer to another age-appropriate program as soon as possible.
- Refer to CSHCS or another specified program.
- Understand that this permission is time-limited.

The written authorization must be maintained in the beneficiary's chart and support how the beneficiary may benefit from MIHP services. Once approval is received, you must develop the *POC 1* before providing any additional MIHP services to the beneficiary.

If the infant or mother has at least one risk identified on the *Infant Risk Identifier*, you do not need to request written authorization from your consultant in order to serve the dyad.

If the beneficiary states that she wants you to visit her even though no scored risks have been identified, contact your MIHP consultant or the beneficiary's MHP and describe how the beneficiary may benefit from MIHP participation. Carefully document the reason and need for the visit. Once services are initiated, you may find that she meets risk criteria in one or more *POC 2* domains (e.g., social support, transportation, etc.) and you would then develop a *POC 2*. As you build rapport with the beneficiary, she may reveal other information indicating that she is at risk in additional domains as well.

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

In this situation, you need only develop the *POC 1.* The *Risk Identifier* and the *POC 1* must be completed and the *Risk Identifier* entered into the MIHP database before further MIHP services are initiated. Document your activities on the *Professional Visit Progress Note* under "other visit information."

Written approval from the consultant or MHP also is required when an agency requests permission to enroll an infant older than 12 months, zero days of age or to continue to serve an infant who has reached 18 months, zero days of age.

Developing the *POC 2* for Beneficiaries with Scored Risks

The *POC 2* is developed for all beneficiaries with identified risks. If a beneficiary's *Risk Identifier* overall score is "low," "moderate," "high" or "unknown" risk, staff completes the *POC, Part 2*.

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*. This is a crucial component of *POC 2* development. You may use *The Difference Game* (available from the MIHP state team) for this purpose.

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, plus any applicable maternal domains, which are referred to as Maternal Considerations.

Plan of Care Part 2, Interventions by Risk Level forms are available at 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 & 2nd 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 1st Addressed* 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 1st Addressed.* 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 or any other MIHP services are provided, unless there is a documented emergency.

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. Also, document the reason for adding the domain on the *Contact Log* or the *Professional Visit Progress Note*.

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 1st Addressed" 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.

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. Only date 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* or *Contact Log*.

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. 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.

m. Ask the beneficiary for feedback on services provided at the end of every visit.

5. **Documentation of Visits**

Documentation of MIHP services provided is required by Medicaid. Standardized forms must be used. Written instructions are available at the MIHP web site 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, whether or not the beneficiary was asked if satisfied with MIHP services/ needs being met (should be asked at every visit), outcome of previous referrals, items tracked at every visit, plan for next visit, new referrals made, signature of home visitor, and date of signature.

Most *Professional Visit Progress Notes* will document that *POC 2* domain interventions were provided (in the "Domain/Risk Addressed" section) and/or that *POC 1* education was provided (under "Other visit information"). However, it is also possible that neither the *POC 1* nor the *POC 2* was addressed at a visit because of the beneficiary's life situation on that particular day. For example, the beneficiary may have just learned about the death of a loved one and cannot focus on *POC 1* educational topics or *POC 2* risk domains. In this circumstance, document the beneficiary's situation and how you addressed it under "Other visit information."

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.

Documenting Emergencies

There are several situations in which you are directed to document that the beneficiary had an emergency. For example, in order to see a beneficiary who is transferring into your MIHP but whose records you have not yet received, you must document that the beneficiary had an emergency. Emergencies are defined on the *Plan of Care* 2 risk domains corresponding to the emergency risk-level interventions. In this transfer example, another factor that would qualify as an emergency is receipt of a CPS request to see the beneficiary immediately. The need to deliver formula or diapers generally does not qualify as an emergency, although it may be in some cases.

6. ***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 making sure the individual beneficiary is receiving the best possible care by monitoring *POC* implementation thoroughly and systematically-on a quarterly basis, at a minimum. This is done by conducting care coordination chart reviews.

Care coordination chart reviews are different from internal quality assurance chart reviews. Care coordination chart reviews are intended to ensure a particular beneficiary is being appropriately served, whereas internal quality assurance chart reviews are intended to ensure compliance with certification requirements in order to improve the quality of the overall MIHP.

It is suggested that care coordination chart reviews are conducted on at least 10% of charts at least quarterly in order to determine:

a. Whether or not the beneficiary has been seen within the last 30 days. If not, there must be documentation explaining the gap in service.

b. The extent to which the POC is being implemented as developed and whether it needs modification.

c. The extent to which the appropriate interventions are being implemented.

d. Whether or not appropriate referrals have been made and followed up on.

e. Whether or not the POC is meeting the beneficiary's needs.

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.

You can choose the months in which you will conduct the quarterly care coordination chart reviews and the percentage of charts you will review. The MIHP Quality Improvement Coordinator suggests that you review at least 10% of your open charts, but this is not a requirement.

You may document your quarterly reviews in whatever manner you choose. You are not required to provide this documentation to your reviewer in Cycle 6. However, the reviewer will be asking staff about your agency's protocol on care coordination chart reviews during the staff interview portion of your certification review. The intent of focusing on this is to gradually improve quality related to ensuring the beneficiary's needs are being met clinically and in the view of the beneficiary. It is recommended that care coordinators review their own charts, as

well as participate in peer review of each other's charts. An important part of the chart review is to establish a protocol and practice of asking the beneficiary if MIHP is meeting her needs.

The following four forms are particularly helpful for monitoring *POC 2* implementation:

1. *Professional Visit Progress Notes.* See Section 4 above.

2. *Maternal Forms Checklist (M001)* or *Infant Forms Checklist (I001) and Maternal Transfers Checklist (M701) or Infant Transfers Checklist (I701)* received. This is a one-page summary of the beneficiary's progression of care. It includes dates that various MIHP services are provided. It is required for QA purposes to assure that all MIHP are forms are included in the chart.

3. *Referral Log* (MDHHS form or own form). This is an optional form that is used to track referrals to various services and supports, dates that referrals are made, and dates that staff follow-up on referrals.

4. The *MIHP Contact Log* (or an alternative contact log) is required to:

   A contact log is required in every MIHP chart opened as of October 1, 2014. You may use the *MIHP Contact Log* or design your own form. The *MIHP Contact Log* is a very basic form. It provides spaces for the date, notes, and the initials of the professional or administrative staff person making an entry.

   Entries Required on Contact Log

   You are required to use the *Contact Log* to document:

   1. Attempts to contact the beneficiary (e.g., phone, text, email, letter, note on door, etc.) if there's a gap in service between professional visits and from the last MIHP billable service to discharge. However, you are not required to log routine contacts, such as calling the beneficiary to confirm an upcoming appointment or to ask for directions to the beneficiary's home.

   2. Reason why the beneficiary has not been seen whenever there is a one-month gap in service.

   3. The specific purpose that an infant case is being kept open after four consecutive months of inactivity.

   Entries Required on *Contact Log* or *in the Comments Section of the Risk Identifier*

   You are required to use the *Contact Log* or *Professional Visit Progress Note* to document:

   1. The reason why you added a risk domain to the *POC 2*, based on the risk criteria listed in Column 2 of the *POC 2*.

   2. The reason why you changed the risk level for a particular domain, based on the risk criteria listed in Column 2 of the *POC 2*.

   3. Interventions provided at the *Risk Identifier* visit.

   4. Reason why a particular *POC 2* risk domain is not addressed.

   5. A verbal order taken from a medical care provider over the phone.

   6. A referral you make when talking with the beneficiary over the telephone.

Entries Required on *Contact Log*, *Prenatal or Infant Care Communication Form*, or Written Message to Medical Care Provider

Phone discussion notifying the medical care provider that beneficiary has transferred to your MIHP.

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 impacted based on what is 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*.

Using the *Contact Log* for Other Purposes (Not Required)

You are encouraged to use the log for other purposes as well. For example, you may use it to document:

1. Contacts with other service providers on behalf of the beneficiary.
2. Contacts among team members.
3. Decisions made among team members.
4. Any other information that would be useful for team members to have.

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

a. Make sure the appropriate interventions are being implemented, especially in the stress/depression, domestic violence, and substance-exposed infant domains, in which safety must be considered. Beneficiaries who score moderate or high on stress/depression must be referred to mental health services (may include infant mental health) or there must be documentation that the referral was discussed.

b. 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 necessary because the addition of a domain to the *POC* 2 constitutes a significant change in beneficiary status.

c. 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 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.

6. Coordination with Medicaid Health Plans (MHPs)

a. Communicate with MHP as specified in *MIHP Provider – MHP Care Coordination Agreement (CCA),* if you have one. 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 revised *Prenatal and Infant Care Communication* forms to notify the MHP that one of their members has enrolled in your MIHP. These are the same forms you use to notify the medical care provider about beneficiary enrollment.

c. Use the *MIHP-MHP Referral Status Report* to communicate with the MHP about the status of maternal and infant referrals that they send to your agency. This form replaces the *MHP-MIHP Collaboration Form* effective 01-01-17. The new form is generated by the MHP, rather than by the MIHP, on a monthly basis.

The MHP populates the name, Medicaid ID number, DOB, phone number, and address for multiple beneficiaries. The MIHP attempts to contact everyone on the list and then sends the *Referral Status Report* back to the MHP, indicating if each beneficiary:

1. Was enrolled in the MIHP (with date)
2. Declined to enroll (with reason, if known)
3. Was already enrolled in another MIHP (with name of the other MIHP)
4. Was not contacted (with explanation of attempts to contact and number of attempts to contact; e.g., "Attempted to contact via phone (000-123-4567) 3 times. Left voice mail and did not receive a return phone call.")

It is the responsibility of the MHP to determine how to proceed with each beneficiary with whom no contact was made; in other words, whether or not to roll the beneficiary over to the *MIHP-MHP Referral Status Report* for the following month.

The form must be completed and returned by the MIHP to the MHP within 30 days of receipt. MIHPs do not use this form to report contacts with any beneficiaries who were not referred by the MHP.

d. 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.

e. 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.

f. When the beneficiary is discharged, send the *Notice of Beneficiary Discharge* to the MHP, as well as to the medical care provider. This must be done within 14 calendar days of entering the *Discharge Summary* into the MIHP database. Do not send the *Discharge Summary* with the notice.

g. You are not required to notify the MHP when:

   a. A domain is added to the *POC 2*
   b. Beneficiary transfers to your MIHP
   c. Beneficiary changes medical care provider

h. If you have a contract with an MHP, there may be additional coordination and reporting requirements. These additional requirements may vary across MHPs.

7. Coordination with Medical Care Provider

You are required to communicate with the medical care provider at four points: MIHP enrollment, when a significant change occurs, if an emergency intervention is utilized 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 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 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:

Notice of MIHP Beneficiary Discharge

Do not send the *Discharge Summary* to the medical care provider or the MHP.

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:
I*nfant 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 *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 *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:

Notice of MIHP Beneficiary Discharge

Do not send any part of the *Discharge Summary* to the medical care provider or the MHP.

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* A and B, as well as the *Notice of MIHP Beneficiary Discharge*, may be signed by any staff.

b) Forward a copy of the M*aternal 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 9th 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.

During this final visit you should solicit feedback on how the beneficiary experienced MIHP. Two simple questions may assist.

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 MIHP provider to improve the quality of your program. You may document her feedback on the discharge summary in the comments section.

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
- 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 to request copies of the brochure or handbook.
Additional resources for providers: www.michigan.gov/healthymichiganplan
Additional resources for families: 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.

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."

Both paper *Discharge Summary Worksheets* are retired as of January 1, 2017 and are no longer available at the MIHP web site. This is to reduce potential errors in transferring the information from the *Worksheet* to the electronic *Discharge Summary.* It is recommended that you have the chart in front of you as you complete the electronic *Discharge Summary*.

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 declines MIHP services or is lost to service either 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* at the MIHP web site 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 on the *Contact Log* 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 and MHP that the Case Has Been Closed

The *Notice of MIHP Beneficiary Discharge* must be mailed or faxed to the medical care provider and MHP within 14 calendar days from the date that the *Discharge Summary* data is entered into the MIHP database. Do not send the *Discharge Summary* (or any part of the *Infant Discharge Summary)* to the medical care provider or the MHP.

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 Great Start Collaborative (GSC) because the GSC is responsible for assuring a coordinated system of community resources and supports to ensure that every Michigan child is:

1. Born healthy
2. Healthy, thriving and developmentally on track from birth through third grade
3. Developmentally ready to succeed in school at time of school entry
4. Prepared to succeed in fourth grade and beyond by 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.

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 may also mean that when a beneficiary needs the expertise of more than one discipline, she must develop trusting relationships with more than two different MIHP staff. This may pose a challenge, especially in light of the fact that the number of MIHP visits are 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 (The 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 humility (The ability to maintain an interpersonal stance that is other-oriented [open to the other] in relation to aspects of cultural identity that are most important to the person. Cultural humility was introduced as an alternative to cultural competence, which has negative connotations. Competence assumes that one can learn or know enough, that cultures are monolithic, and that one can actually reach a full understanding of a culture to which they do not belong. Cultural humility is associated with cultural sensitivity, which encourages individuals to be thoughtful when considering culture. However, sensitivity does not touch on the necessity of learning, reflection, or growth. Cultural humility requires a lifelong commitment to self-evaluation and self-critique, a desire to fix power imbalances where none ought to exist, and aspiring to develop partnerships with people and groups who advocate for others.)

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.

What do Men Want from Home Visitors?

Written by Colbert Williams – Father and Parenting Consultant

It is important to engage, support and involve men when providing home visiting services when the provider first enters the home. This can be done in the following ways:

1. Invite dads to the conversation
2. Make equal eye contact with both mom and dad during meetings
3. Ask dad specific questions that positively reinforces his role and involvement
4. Provide dad with material that highlights all the benefits that children gain when fathers are involved
5. Have paperwork that asks for father's information
6. Ask fathers what they want/need

7. If a dad is not present. Ask mom about him and encourage her to include dad's participation

Home visiting programs have to build a trusting connection with fathers. In order to do so home visiting coordinators must:

1. Start from the assumption that dads want to be involved in their children's health
2. Build off the strengths of men
3. Treat each dad as an individual
4. Suspend judgment – Males share the other half of the story
5. Empower dads by meeting them where they are
6. Be open, transparent and straight forward when it comes to addressing men and their needs as fathers
7. Share the "Good News". Men need to hear all the benefits that their presence can have on the lives of their children

When fathers are involved in home visiting services, fathers gain a sense of value in their contributions to their children's overall well-being and can create a positive and supportive environment for the whole family.

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 <u>all</u> 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.

Motivation 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

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
  This training is required for all MIHP professionals. Continuing education credits are not available.
- *Introduction to Motivational Interviewing* 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.

Engaging Fathers in MIHP Services

Since MIHP was originally conceptualized in 1987, the goal of the program has been to promote healthy pregnancies, positive birth outcomes, and infant health and development. Programming has been tailored to the needs of mothers and infants and there have been more recent efforts to better engage fathers and promote male involvement.

Over the last several decades, a great deal of research has demonstrated that fathers have a unique and essential role in promoting the health and development of children. In recent years, MIHP has been more deliberate in efforts to engage and support fathers and males, especially when they are involved or may share a home with a mother and infant who are being served by MIHP or when they are the primary caregiver of an infant enrolled in the program.

Surveys of MIHP providers were conducted in 2016 to assess the MIHPs process for engaging and supporting fathers and males in home visiting, as well as what fatherhood resources are currently available statewide. Additionally, coordinator trainings and resources on engaging fathers in home visiting were provided. Efforts are ongoing. See the MIHP website for links to fatherhood resources.

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 three trainings on the MIHP web site:

1. Implementing the MIHP Depression Interventions
2. Interpersonal Violence and MIHP
3. Intimate Partner Violence: More than Meets the Eye

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 or MHP to request approval to continue to serve the infant.

If you bill for an SEI visit (visits 19-36), you **must** address an SEI domain at that visit.

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.

Michigan Safe Delivery

Safe Delivery allows parents to safely surrender their newborn child no more than 72 hours old to an employee who is inside and on duty at any hospital, fire department, policy station, or by calling 911. This program is a safe, legal and anonymous alternative to abandonment or infanticide and releases the newborn for placement with an adoptive family.

Safe Delivery Hotline: 866-733-7733 MDHHS - Safe Delivery - State of Michigan

Family Planning

Michigan's Infant Mortality Reduction Plan (2016-2019) includes the following goal:

> Goal 8d: To promote reproductive planning for all childbearing-age adults as a component of primary care and promote access to reproductive health services.

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.

Medicaid MIHP policy states that: *Family planning options should be discussed throughout the course of care, giving the woman time to consider her options. (Section 2.7 Professional Visits, MIHP, Medicaid Provider Manual).*

Operationally, this means that:

1. Family planning will be discussed at every maternal visit with referrals to family planning services as needed. 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).
2. Every effort will be made to assist the maternal beneficiary to make and keep her postpartum medical care provider appointment, at which time family planning will be addressed (e.g., help her make the appointment, arrange transportation if necessary, help her prepare questions for her medical care provider, etc.).

3. Family planning will be discussed at every infant visit with the mother (or father, if he is the primary caregiver), with referrals to family planning services as needed. Family planning need not be discussed if:

    a. The mother has become pregnant again.
    b. The mother has undergone operative or non-operative permanent sterilization.
    c. The mother or father (if he is the primary caregiver) refuses to discuss family planning.

All staff should be familiar with the document, *Discussing Family Planning,* at the MIHP web site.

Referrals to family planning must be made, if indicated. Family planning resources, which may be shared with beneficiaries, are available at the MIHP web site.

<u>Family Planning Services when Beneficiary Loses Healthy Kids for Pregnant Women Medicaid</u>

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.

Oral Health for Pregnant Women and Infants

Dental caries (also commonly referred to as cavities) is a transmissible, infectious disease. Mothers or even other caregivers may unknowingly transfer caries causing bacteria to their children through the exchange of saliva, even before the first tooth develops. Michigan PRAMS data indicates that nearly half of Michigan women with an immediate dental need did not receive oral health care during their pregnancy, with minorities and low income women struggling the most[2].

The Department of Health and Human Services (DHHS) is dedicated to addressing these oral health disparity issues. It is estimated that children of mothers with untreated decay have four times the risk of decay compared with children of mothers without untreated decay[1]. In addition, there is mounting research which indicates a potential link between preterm birth, low birth weight and poor oral health. Since pregnancy is a critical time in which women may be more likely to adopt healthy behaviors as well as gain needed dental health insurance coverage, it is imperative that oral health is prioritized during the perinatal period by medical and dental professionals, as well as the public health community at large.

A Perinatal Oral Health Plan has been developed as part of Michigan's Infant Mortality Reduction Plan to ensure optimal oral health for pregnant women and infants in Michigan. The 2020 Michigan State Oral Health Plan looks to improve dental health, access to oral health care among underserved populations, awareness of the importance of oral health as it relates to overall health, and integration among oral health, medical and social service providers. For more information, you can access the plan at the following link: 2020 State of Michigan Oral Health Plan.

It is critical for mothers in the perinatal period to prioritize the future oral health needs of her child, including the age one dental visit. The Michigan Department of Health and Human Services - the Perinatal Oral Health Program and the Maternal Infant Health Program (MIHP) are dedicated to partnering with a multitude of national, state, and local entities to spread this messages as well as developing and sharing tools, resources, and disseminating best practices that improve the oral health of some of Michigan's most vulnerable women.

Visit the MIHP website to obtain information on oral health for pregnant women and infants. Both written and video materials are available. Resource materials may be viewed, printed or copied. Materials are available in English and Spanish. You may obtain additional oral health resources at the following link: MDHHS Oral Health Website

Infant Sleep Safety

Every two to three days in Michigan, an infant dies due to being placed to sleep in an unsafe environment. Sleep-related infant deaths are the third leading cause of all infant death in Michigan and the leading cause of death among infants 1 month to 12 months old. They are considered the most preventable type of infant death. It is critical that MIHP beneficiaries are educated on infant sleep safety and are supported in providing a safe sleep environment for their infant throughout their participation in MIHP.

Infant sleep safety should be discussed at every MIHP visit. Having an appropriate sleep environment prepared for the infant prior to arrival home from the hospital is essential. The majority of infant deaths due to unsafe sleep occur while the baby is under 4 months old, so safe sleep must begin the first day home from the hospital. All staff should be familiar with the most recent American Academy of Pediatrics guidelines for infant sleep safety (below) and providers should review these with the beneficiary and family members.

- Infants should sleep in the same bedroom as their parents – but on a separate surface, such as a crib or bassinet, and never on a couch, armchair or soft surface. Based on the latest evidence, infants should share their parents' bedroom for at least the first six months and, optimally, for the first year of life.

- Always place baby on his or her back for every sleep time.
- Always use a firm sleep surface. Car seats and other sitting devices are not recommended for routine sleep.
- Keep soft objects or loose bedding out of the crib, including pillows, blankets or bumper pads.
- Wedges and positioners should not be used.
- Don't smoke during pregnancy or after birth.
- Breastfeeding is recommended and is associated with a reduced risk of sudden infant death.
- Offer a pacifier at nap time and bedtime (make sure that it is not coated with any substance and that it is not attached to anything such as a string or stuffed animal).
- Avoid covering the infant's head or overheating.
- Do not use commercial devices marketed to reduce the risk of SIDS.
- Supervised, awake tummy time is recommended daily to facilitate development and minimize the occurrence of positional plagiocephaly (flat heads).

The guidelines can be accessed at http://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Expands-Guidelines-for-Infant-Sleep-Safety-and-SIDS-Risk-Reduction.aspx. For additional education, a free online training course can be accessed at: https://courses.mihealth.org/PUBLIC/home.html. Nurses and Social Workers can receive continuing education credit for course completion.

Anticipate areas where beneficiary may have difficulty in following the infant safe sleep guidelines and assist her in developing a plan for success. Guide her in enlisting support from family members and help to educate all caregivers in the home on infant sleep safety. Common myths and barriers should be discussed. Provider should assess the infant's sleep setting, position, clothing and environment. This needs to be done frequently as parent's adherence to safe sleep guidelines typically varies due to what is happening in the home, i.e. if parent is very exhausted, she may not lay baby to sleep in crib, but instead bring baby to bed with her, or if parent is living at a different location and there is not space for a crib or pack and play in the new location, etc. Videos and other resources can be accessed at: http://www.michigan.gov/safesleep. Free brochures, posters, decals and DVDS can be ordered at: http://www.healthymichigan.com.

Zika Virus Toolkit

MDHHS top priority for the public health response to Zika is to protect pregnant women because of the risks associated with Zika virus infection during pregnancy. On an individual level, pregnant women can take actions to protect their pregnancy. It's important to remember that everyone can take action to protect their community from viruses spread by mosquitoes, like Zika. This toolkit offers social media messaging, tools, and resources to support your agency's efforts in promoting Zika prevention. To learn more visit: www.cdc.gov/zikavirus

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 MIHP 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

- Methods of contraception
- Spacing pregnancies
- Family planning resources

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

MIHP providers are expected to know about the CBE programs in their service area. This information may be available from the Great Start Collaborative or from 2-1-1. In some service areas, face-to-face CBE classes are unavailable. Even if they are available, some beneficiaries may choose not to enroll in them. In these situations, online CBE may be helpful.

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. BabyCenter also has a free online childbirth class consisting of 51 short videos at Childbirth class: Free video series | BabyCenter.

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
- Breastfeeding 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 illnesses
- 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

Michigan's Infant Mortality Reduction Plan (2016-2019) includes the following goals:

Goal 7d: Promote immunizations for adolescents and pregnant women.
Goal 4d: Promote family centered medical homes and well-child visits including immunizations.

Medicaid MIHP policy states that: *Immunization status must be discussed throughout the course of care. Providers must determine the status of the MIHP beneficiary's (i.e., mother and/or child) immunizations. The parent(s) should be encouraged to obtain immunizations and be assisted with appointments and transportation as needed. (Section 2.14 Immunizations, MIHP, Medicaid Provider Manual).* Operationally, this means that:

1. The mother's immunization status will be discussed at least once during pregnancy.

2. Infant immunizations will be discussed at least once during pregnancy.

3. The infant's immunization status will be discussed at every infant visit.

4. Every effort will be made to assist the maternal beneficiary and the primary caregiver of the infant beneficiary to obtain immunizations (e.g., help make the appointment, arrange transportation if necessary, help prepare questions for the medical care provider, etc.).

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 and click on "Families," then "Education & Information for Parents," then "Infant Health and Safety," and then "Immunization Schedule for Babies and Young Children."

To see information on maternal vaccines before, during and after pregnancy, go to Pregnancy and Vaccination | Vaccines for Pregnant Women | CDC

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 use the following two tools for ongoing developmental screening:

1. *The Ages and Stages Questionnaires-3 (ASQ-3)*
2. *The Ages & Stages Questionnaires: Social/Emotional (ASQ: SE-2)*

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, including self-regulation, compliance, adaptive functioning, autonomy, affect, social-communication, and interaction with people. 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 how to 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 following *ASQ* materials, available in both English and Spanish, from Brookes Publishing:

1. Ages and Stages Questionnaires, 3rd Edition (ASQ-3)
   http://www.brookespublishing.com/resource-center/screening-and-assessment/asq/asq-3/

2. ASQ-3 User's Guide
   http://www.brookespublishing.com/resource-center/screening-and-assessment/asq/asq-3/

3. ASQ-3 Learning Activities book
   http://www.brookespublishing.com/resource-center/screening-and-assessment/asq/asq-3/

4. Ages and Stages Questionnaires: Social-Emotional, 2nd Edition (ASQ: SE-2)
   http://www.brookespublishing.com/store/books/squires-asqse/index.htm

5. ASQ: SE-2 User's Guide (included in *ASQ: SE-2 Starter Kit)*
   http://www.brookespublishing.com/store/books/squires-asqse/index.htm

If your MIHP does not provide infant services, you are not required to purchase the *ASQ* materials. 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.

Please note, sharing copies of *ASQ* materials among MIHP agencies to help defray the administrative costs associated with opening a new MIHP is prohibited under copyright law.

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. Please assure that household items are evaluated for safety and pass "the choke test."

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. Staff who conduct *ASQ* screenings must view the no-cost online training titled *ASQ-3 and ASQ: SE-2 Developmental Screening in MIHP* at the MIHP web site. The training explains how to administer and score the *ASQ-3* and *ASQ: SE-2*. Staff must also become very familiar with the *ASQ-3 User's Guide,* the *ASQ-3 Learning Activities* book and the *ASQ: SE-2 User's Guide.*

ASQ Training Videos Produced by Brookes Publishing

Three training DVDs are available from Brookes Publishing at a cost of @ $50 each (2016). 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)

Brookes also has archived three webinars addressing changes in the *Ages and Stages Questionnaires* and discussing ways to best utilize both the *ASQ: SE-2* and the *ASQ-3*. The links are available on YouTube. Links are also available on the Brookes Publishing website at http://agesandstages.com/

1. What's New for ASQ: SE-2
Taped by developers Jane Squires and Diane Bricker
https://www.youtube.com/watch?v=L8t9DAPKgLA
The *ASQ: SE-2* is different from the previous edition in the following ways:

- A two-month questionnaire has been added that screens infants 1 month 0 days to 2 months, 30 days.
- New items have been added that evaluate early communication, regulatory and autism spectrum disorders.
- New design and format, which is easier to read and use.
- Now age adjusts at 37 weeks gestation from birth until infant reaches age 2.
- Ages have been extended to cover the entire preschool age range (1-72 months).

2. **Using the ASQ-3 and the ASQ: SE-2 together**
   Taped by developer Jane Squires and team members
   https://www.youtube.com/watch?v=0NC14OoDesg

3. **Promoting Family Engagement with the ASQ: SE-2**
   Taped by Elizabeth Twombly and Kimberly Murphy
   https://www.youtube.com/watch?v=ccZ0bw8QQro

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, use the ***ASQ* Calculator** at www.agesandstages.com/free-resources/asq-calculator to determine which questionnaire interval to use. For example, the calculator 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, the age must be adjusted if the child is younger than 24 months at the time of screening and was born 3 or more weeks prematurely. The *ASQ* Calculator quickly and easily adjusts 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 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. However, if the *ASQ: SE-2* score is close to the cutoff, screening must be repeated in 2 months.

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 **below** the cutoff; further assessment with a professional may be needed.	Discuss with family, refer the infant to *Early On* for a comprehensive developmental evaluation, document in record.
Score is close to the cutoff; provide learning activities and monitor.	Repeat the screening in **two** months.
Score is above the cutoff; development appears to be on schedule.	Repeat the screening in **four** months.

The infant's total *ASQ: SE-2* 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: SE-2* Score Category	Take This Action
Score is **above** the cutoff; further assessment with a professional may be needed.	Discuss with family, refer the infant to *Early On* for a comprehensive developmental evaluation, document in record. Alternatively, refer to Infant Mental Health.
Score is close to the cutoff; provide learning activities and monitor.	Repeat the screening in **two** months.
Score is below the cutoff; development appears to be on schedule.	Repeat the screening at the next MIHP - required age interval.

Although you only are required to provide learning activities when an infant scores close to the cutoff (gray zone) in a particular domain, it is strongly suggested that you provide learning activities to each family during or after each *ASQ-3* and *ASQ: SE-2* screening.

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 developmental concern is in the social-emotional domain, you many refer to infant mental health services instead of *Early On*.

If the family declines an *Early On* or infant mental health services referral, document this in the chart. At a minimum, simply state: The family declined to accept an *Early On* or infant mental health services referral. If the infant is referred to *Early On*, but does not qualify for *Early On* or infant mental health services, document this in the chart. In either of these situations, share the *ASQ-3* and *ASQ: SE-2* learning activities with the family.

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

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. There is one exception, however; the *ASQ-3* is not administered with an infant who is younger than one month of age, per the publisher's instructions.

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:

<u>Positive *Bright Futures* Screen (concern is triggered)</u>:

1. If the infant is <u>less than two months old and at least one *Bright Futures* "not yet" box is checked</u>, 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 <u>is two months or older and at least two *Bright Futures* "not yet" boxes are checked</u>, 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.

<u>Negative *Bright Futures* Screen (no concern is triggered)</u>

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 MIHP consultant or the infant's MHP if enrolled in a health plan for approval 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.

Do not administer the *ASQ: SE-2* at the *Risk Identifier* visit or before the infant is one month old. 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.

It is not expected that the *ASQ-3* and the *ASQ: SE-2* will be administered 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 and services are initiated, it increases the probability of a better outcome long term. These early interventions could positively change the trajectory of their lives.

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

The field called *Administering Program/Provider* that does not need to be completed, however all five numbered sections including Sections #4 and #5, even if the score is below the cutoff (development appears to be on track) must be completed.

There are five items under Section #4 – Follow-Up Referral Considerations. Mark each one as Yes, No, or Unsure (Y, N, U). Note that the questions in parentheses are "for example" questions; they aren't all-inclusive and don't necessarily have to be addressed for a particular infant. See pages 98-103 in the *ASQ: SE-2 User's Guide* for additional information.

There are nine items in Section #5 – Follow-Up Action. Check all that apply. If the score is below the cut-off, check "Other:" and write "None."

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 Infants with No Scored Risks

You must have written permission from your MIHP consultant or the beneficiary's MHP, in order to serve an infant with no scored risks per the *Infant Risk Identifier*. In this situation, 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.

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 zone) 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 document why you did not do so.

You may pull the *POC 2* whenever you have a concern about an infant's development. If you add a domain to the *POC 2*, follow the regular procedure, including updating and signing the *POC 3* and notifying the medical care provider of this significant change.

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 zone) in a particular developmental domain.

Brookes describes the160-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.

Use the following process for introducing the learning activities to families:

1. Give the family the appropriate Learning Activities sheet, based on the chosen domain and infant's age.
2. If older children are present, ask if they would like to learn more about activities they can do with their new brother or sister.
3. Explain that these are activities they could do with their infant to help him or her develop.
4. Ask if they are already doing some of the activities. If so, provide positive feedback.
5. Ask them if they would like you to demonstrate any of the activities for them.
6. Ask them if they would like to try doing a learning activity with their infant while you are there.
7. Ask them if they would like to try doing a learning activity with their infant in the coming week.
8. If so, ask which activity and if they have any questions about it.
9. Remind them that infants have to do the same thing over and over and over again to master each little developmental step.
10. Provide positive feedback on their willingness to try new things with their infant.
11. Make a strength-based comment to the family about what you saw on the visit between the parent and infant.
12. At the next visit, follow-up on how the learning activities are going.

The *ASQ-3 User's Guide* also includes Developmental Guide sheets for various age ranges. Developmental Guide sheets provide information about what typically developing infants may be expected to do at each age range. You are not required to share these with families, but it is recommended that you do so.

Although you only are required to provide leaning activities when an infant scores close to the cutoff (gray zone) in a particular developmental domain, it is strongly suggested that you provide learning activities to all families after each *ASQ-3* screening, ideally for all five domains. There are several reasons for doing so:

1. Parents may not have access to well-researched infant development information.
2. Parents may use the learning activities to promote their infant's development, strengthening the parent – infant relationship.
3. Parents may appreciate receiving the information which could strengthen your relationship with them and lead them to perceive MIHP as having added value.
4. You would have increased opportunities to provide positive feedback when parents demonstrated or talked about using the learning activities.

Learning Activities When *ASQ: SE-2* Score is Close to the Cutoff

MIHP agencies are expected to teach families how to implement learning activities when an infant scores close to the cutoff (gray zone) on an *ASQ: SE-2* screening. The *ASQ: SE-2 User's Guide* includes one-page Social Emotional Activities for infants at various age ranges (2, 6, 12, 18, 24 months, and beyond). There is not a separate book of learning activities for the *ASQ: SE-2,* as there is for the *ASQ-3*.

The process for introducing the social and emotional learning activities to families is very similar to the process described in the previous section titled *Learning Activities When ASQ-3 Score is Close to the Cutoff.*

Although you only are required to provide learning activities when an infant scores close to the cutoff (gray zone), it is strongly suggested that you provide learning activities to all families after each *ASQ: SE-2* screening. The reasons for doing so are given in the last paragraph of the previous section.

The *ASQ: SE-2 User's Guide* also includes one-page Social Emotional Development Guides for infants at various age ranges (2, 6, 12, 18, 24 months, and beyond). Social Emotional Development Guides provide information about what typically developing infants may be expected to do at each age range. You are not required to share these with families, but it is recommended that you do so.

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 prematurely. Use the **ASQ Calculator** at 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.

When you are serving multiples, you track *ASQ-3* and *ASQ: SE-2* screening dates on the *Infant Forms Checklist* for the infant whose Medicaid ID is used to bill blended visits. The *ASQ-3 and ASQ: SE-2 Tracking for Multiples* form is used to track screening dates for the other multiples in the family. File the *Tracking for Multiples* form in the chart of the infant whose Medicaid ID is not used to bill blended visits or in the family chart.

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. There is an increasing emphasis on tracking referrals and following up on referrals in home visiting initiatives in Michigan and across the country.

Agency Referral List

MIHP agencies must maintain a current list of other agencies that may have appropriate services to offer the beneficiary. This list must be readily available to all MIHP staff.

Handing Out Community Referral Information to the Beneficiary

It is recommended that MIHP providers hand out a community referral list and/or brochures or other written materials to every beneficiary as she enters the program, encouraging her to call the appropriate provider agency if she should require assistance at any point.

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 and under what conditions 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 and under what conditions 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 whether the beneficiary wishes to seek services from the referral source. The beneficiary may indicate they have an alternate resource they would like to access.
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* This serves as documentation of the referral and alerts other team members to follow up on it at a subsequent visit.

You now are required to track all referrals, including referrals made over the phone, on the *MIHP Professional Visit Progress Note (PVPN)*. You may still track referrals on the optional *MIHP Referral Follow-Up Form,* but you will need to transfer the information to the PVPN. The *Referral Follow-Up Form* is now titled the *MIHP Referral Follow-Up Worksheet*. You may choose to use it to easily track all referrals provided during the course of care on one page if you wish to do so, in addition to tracking referrals on the *PVPN*.
If you make a referral during the enrollment visit, be sure to document it on the *POC 2* in the "Date 1st Addressed" space in Column 3 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".

Agencies that provide referrals to their beneficiaries over the phone should document each referral on the *Contact Log* in the beneficiary's chart. Follow-up on the referral must be documented on the *Professional Visit Progress Note* in the "Outcome of previous referrals" section. Referrals made over the phone must be included on the *Discharge Summary*.

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 two 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 IMH)
2. Using Community Mental Health Contacts to Navigate Mental Health Services for MIHP Infants and their Families

These two documents are in the process of being updated. They will be shared via coordinator e-mail.

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
3. MIHP Depression Safety Plan (example)
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 Fact Sheet
   Depression during and after pregnancy fact sheet | womenshealth.gov

   (Replaces Depression During and after Pregnancy: A Resource for Women, Their Families, & Friends (booklet),which was the actual brochure referenced in the webcast but is no longer available.)

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 for Depression Assessment

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, is a comprehensive list of resources for consumers and professionals who wish to learn more about perinatal depression and treatment.

The following resources are particularly noteworthy:

Michigan Statewide Perinatal Mood Disorder Coalition
www.mipmdcoalition.org/get-help/

The coalition maintains an ever-expanding list of PMD treatment specialists and support groups at the URL above. This list is broken out by 10 regions (State of Michigan Prosperity regions). Many of the specialists listed have indicated which insurances they accept. Find your community on the map of Michigan to identify your region, click on "Get Help" at the top of the page, and click on your region.
You can join with others in Michigan and in your region to support women and families experiencing perinatal mood disorders including, depression, anxiety and others. Coalition membership is free. Mini-grants are available to Coalition members to help start support groups, promote public awareness of PMD, etc.

MedEdPPD.org
www.mededppd.org

A professional education, peer-reviewed web site developed with the support of the National Institute of Mental Health (NIMH) to further the education of primary care providers who treat women who have or are at risk for postpartum depression (PPD), and to provide information for women with PPD and their friends and family members. English and Spanish.

Depression in Mothers: More Than the Blues - A Toolkit for Family Service Providers
http://store.samhsa.gov

HHS Publication No. (SMA) 14-4878. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. This free publication, available in English and Spanish, may be downloaded or ordered by phone 1-877-726-4727.

Moms' Mental Health Matters
https://www.nichd.nih.gov/ncmhep/MMHM/Pages/index.aspx

National Child & Maternal Health Education Program, Eunice Kennedy Shriver National Institute of Child Health and Human Development. Excellent materials for distribution.

It's not just postpartum, and it's not just depression. Historically, much of the research on women's mental health related to pregnancy has been on depression that occurs after the birth of a baby. But, we know now—it's not just the postpartum period, and it's not just depression. Women experience depression and anxiety, as well as other mental health conditions, during pregnancy and after the baby is born. These conditions can have significant effects on the health of the mother and her child. This initiative is designed to educate consumers and health care providers about who is at risk for depression and anxiety during and after pregnancy, the signs of these problems, and how to get help.

Depression in Adults: Screening Recommendation

On January 26, 2016, The U.S Preventive Services Task Force (USPSTF) updated its 2009 recommendation on depression screening for adults. Their previous recommendation did not address pregnant and postpartum women. However, the USPSTF now recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

To view the full recommendation: Depression in Adults: Screening - US Preventive Services ....

The clinical summary includes the following statement:

> Effective treatment of depression in adults generally includes antidepressants or specific psychotherapy approaches, alone or in combination. Given the potential harms to the fetus and newborn child from certain pharmacologic agents, clinicians are encouraged to consider evidence-based counseling interventions when managing depression in pregnant or breastfeeding women.

To see a one-page clinical summary: View Clinical Summary.

Assisting a New Mother to Keep Her Postpartum Care Appointment with Medical Care Provider

Maternal and child health funders, policy makers, health plans and providers are promoting efforts to increase the postpartum care visit rate and improve the content of postpartum visits among states' Medicaid and CHIP

populations. The Centers for Medicare & Medicaid Services is funding initiatives toward this end and this goal is incorporated in the *State of Michigan 2016-2019 Infant Mortality Reduction Plan* (Goal 7d*i*).

The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists both recommend that women schedule a standard postpartum care visit four to six weeks after delivery. This visit allows the medical care provider to assess the physical and psychosocial health of the mother, to counsel her on infant care and family planning, and to address preexisting or developing conditions such as diabetes, hypertension, obesity, asthma and depression.

Documented barriers to completion of the postpartum visit include the following:

1. Adjusting to being a new mother
2. Lack of child care during appointment time
3. Conflict of work schedule with appointment
4. Lack of transportation
5. Discontinuation of insurance coverage
6. Dissatisfaction with care
7. Perception of poor continuity of care (e.g., seeing a different member of OB team at every visit)
8. Fear of negative prognosis
9. Perception of having good health so the visit is unnecessary
10. Focus is on infant's health rather than her own

MIHP home visitors should systematically encourage every new mother to make and keep her postpartum care appointment. Steps include the following:

1. Talk with the mother about the importance of the postpartum visit from the beginning of MIHP service; don't wait until infant is born.
2. Help prepare her for the visit so she knows what to expect. Explain what is likely to be covered. Inquire how she will respond when her medical care provider asks about the family planning method she has decided to use.
3. Help her schedule the appointment (if she needs help with this).
4. Ask her to identify potential barriers to keeping her appointment.
5. Help her strategize ways to help circumvent the barriers.
6. Help her take steps to circumvent the barriers.

If the mother is enrolled in an MHP, find out if her MHP provides incentives for completing the postpartum visit. If so, tell the mother what the incentive is and what she needs to do in order to receive it.

9.0 MIHP QUALITY ASSURANCE AND IMPROVEMENT

MIHP Provider Certification for Quality Assurance

The Maternal Infant Health Program (MIHP) monitors and certifies MIHP providers to assure they are operating in compliance with MDHHS 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. Certification reviews are a critical quality component of the MIHP which allows for ongoing performance monitoring, continuous quality improvement and quality assurance.

MIHP state consultants provide consultation to assist new and existing MIHP providers to achieve and maintain certification. MIHP providers are strongly encouraged to make use of these consultation services to ensure successful MIHP implementation is maintained and certification is achieved. New provider onsite consultation visits are scheduled 6 weeks after program start-up and again at 3 months after program start-up. Consultation is also available for existing providers upon request.

Review Timeline for New Providers

MDHHS grants a new provider a six-month provisional certification upon completion of all application requirements. The initial certification review is conducted approximately six months after the provisional certification is granted. A new provider who receives full certification at their first review is reviewed again in twelve months. A new provider who obtains full certification but who had few infants or had discharged few beneficiaries at the time of the review, will have a six month consultation visit so that the consultant can provide guidance in these areas as needed. A new provider who receives conditional certification is reviewed again in six months.

Review Timeline for Existing Providers

An existing provider who receives full certification is reviewed again approximately eighteen months after this review. If the provider maintains full certification, they are reviewed every 18 months during program operation. An existing provider who receives conditional certification is reviewed again in six months.

Minimum Caseload Requirements in order to be Reviewed

In order to be reviewed, new and existing agencies 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.

The only MIHP agencies that are not required to have 40 charts at the time of certification review are agencies that have been designated as exempt by MDHHS. These include tribal agencies and agencies serving persons who are deaf or hard of hearing, or persons who are blind or visually impaired.

To ensure that a new provider will have 40 cases by the time of the first review, it is recommended the provider meet minimum caseload expectations at two points in time prior to the review. The assigned MIHP state consultant contacts the new provider at the times specified below to inquire about the number of beneficiaries enrolled in the MIHP to date and, if applicable, discharged since the day of MIHP new provider orientation.

It is expected that a new provider have:

At least ten beneficiaries one month before review
At least 35 beneficiaries two weeks before review

* Please note: No more than 10 beneficiary transfers can be counted toward the 40 cases required for a new provider's initial review.

The state consultant will ask the new provider to submit beneficiary counts in writing at these points in time. The information documented by the provider may be cross-checked through administrative data on an as-needed basis.

Existing providers must have at least 40 beneficiaries in the eighteen months before the review.

All providers must have at least 40 beneficiaries one week before the review* or the review will be canceled, resulting in decertification.

Cases that are ready for discharge should not be kept open.

Overview of the Certification Process

The certification review is conducted in two parts:

1. Pre-review. The first part is a review of documents submitted by the provider and received by the reviewer at least 14 calendar days prior to the scheduled onsite review. Timely submission of pre-review documents is measured in indicator #38 of the Cycle 6 *Certification Tool*. The required pre-review documents are listed below in the section titled *Pre-review of Documents before the Onsite Review*.

2. Onsite review. The second part is a two-day onsite visit, during which the reviewer conducts staff and coordinator interviews; observes the agency; examines open and closed beneficiary charts, billing documentation and personnel files; discusses pre-review findings; follows up on *Not Met* indicators from the previous review (if applicable); and conducts an exit meeting to discuss preliminary review findings.

Reviews are conducted by registered nurses or a licensed social worker who have worked, or are currently working, as MIHP coordinators or professional staff.

For an overview of the certification process with timeframes, see the following documents:

1. MIHP Certification Review Process Flow – Existing Agency
2. MIHP Certification Review Process Flow – New Agency

Types of Certification

Subsequent to a review, the reviewer and MIHP state staff determine the provider's certification status based on the number of *Not Met* indicators, the number of *Not Met* critical indicators, and the provider's previous certification status, if applicable. The provider receives one of five possible certifications:

1. Provisional certification
2. Full certification
3. Conditional certification
4. Decertification
5. Emergency decertification

The options and implications of each are described below.

Provisional Certification

All new MIHP agencies receive a six-month provisional certification once they have met all application requirements specified in the *MIHP Application Process*. These requirements include approval of the application, completion of MIHP orientation, proofs of purchase of required materials, and enrollment in the Community Health Automated Medicaid Processing System (CHAMPS). Provisional certification allows the new agency to begin to serve beneficiaries and submit billings.

Approximately three months after the agency receives its provisional certification, the assigned MIHP state consultant conducts an onsite consultation visit. This visit is to assure that program implementation is on track, the agency is implementing the program as designed, and to provide technical assistance as needed. At this visit, the consultant inquires as to the agency's outreach activities and progress in recruiting program participants. If indicated, the consultant assists the agency to strengthen recruiting efforts.

The first certification review is conducted six months after the provisional certification is granted. The outcome of the first review is either full certification or conditional certification.

Full Certification

Full certification is obtained when:

- A complete certification review has been conducted.
- The agency has received 6 or fewer *Not Met* indicators, two or fewer of which are *Not Met* critical indicators.
- The agency has submitted a Corrective Action Plan (CAP) for the *Not Met* indicators and MDHHS has approved it. The CAP must be received by MDHHS within 21 calendar days of the official notification of the results of the review. MDDHS responds approximately two weeks from the date of receipt of the CAP, approving the CAP or requesting modifications.

Full certification is effective for a minimum of 12 months for a new agency. Full certification is effective for a minimum of 18 eighteen months for an existing agency.

Conditional Certification

Conditional certification is obtained when:

- A complete certification review has been conducted.
- An existing agency has received 7 or more *Not Met* indicators or three or more *Not Met* critical indicators.
- A new agency has received 7 to 17 *Not Met* indicators or three or more *Not Met* critical indicators.
- The agency has submitted a Corrective Action Plan for the *Not Met* indicators and MDHHS has approved it. The CAP must be received by MDHHS within 21 calendar days of the official notification of the results of the review. MDHHS responds approximately two weeks from the date of receipt of the CAP, approving the CAP or requesting modifications.

Conditional certification is effective for six months, during which time the agency must correct all *Not Met* indicators. Conditional certification requires a follow-up consultation visit at approximately three months. Depending on the number, complexity and critical nature of the *Not Met* indicators, this visit may be scheduled earlier than three months post review. It is also possible that more than one consultation visit will be made.

Six months after the first conditional review, a second review is conducted. The outcome of the second review is either full certification or decertification.

Decertification

Decertification takes place under one of the following circumstances:

1. A new agency receives 18 or more *Not Met* indicators in their first review.
2. An existing agency receives 7 or more *Not Met* indicators or 3 or more *Not Met* critical indicators at two successive reviews.

Decertification requires the agency to cease providing MIHP services. When an agency is decertified by MDHHS, the agency's certification to provide or be reimbursed for MIHP services is revoked and upon notification the agency must immediately cease enrolling beneficiaries. A written notice is sent to the agency via certified mail.

The certified letter includes the following: the date of decertification; the requirement to stop enrolling beneficiaries in the MIHP; the requirement to close or transfer the active caseload to another MIHP provider within 14 business days of receipt of the letter; suspension of any future billings for services from the date of decertification on; and notice of removal from the MDDHS *MIHP Coordinator Directory*.

Written notification to the MDHHS MIHP Consultant that the termination plan was successfully implemented is required no later than 30 days after the agency's termination date.

An agency that is decertified may file an appeal via the Medicaid Administrative Tribunal and Appeals Division. The Medicaid Policy Consultant, Medicaid Managed Care and Medicaid Claims are informed when an agency is decertified.

The *MIHP Decertification Termination Protocol* is available at the MIHP website.

Emergency Decertification

An emergency decertification may be authorized if a certification review or a complaint investigation reveals a serious action/inaction or a pattern of activity that threatens the health, well-being or safety of Maternal Infant and Health Program beneficiaries. Emergency decertification can be invoked in conjunction with the MDHHS Office of Inspector General (OIG), which is responsible for investigating alleged Medicaid fraud, waste, and abuse. In this situation, the agency may be shut down immediately, rather than within 30 days after a specified termination date.

An agency that is decertified on an emergency basis may file an appeal via the Medicaid Administrative Tribunal and Appeals Division.

MIHP Review Cycles

A new MIHP certification review cycle begins approximately every 18 months. Several months before the new cycle begins, 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. The current review cycle is Cycle 6, which covers the time period from August 1, 2016 through January 31, 2018.

All providers are reviewed at least once per cycle. 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.

Certification Review Scheduling

The MIHP certification reviewer is assigned 6-8 weeks before a review and will contact the agency at that time to schedule the actual dates of the onsite review. Onsite reviews are conducted on two consecutive week-day dates. However, in rare instances an onsite review may be conducted on the weekend, at the discretion of MDHHS.

The MIHP agency will know the approximate month of their review based on the type of certification attained at the previous review. The certification review is scheduled by the assigned reviewer approximately 6, 12, or 18 months **after** your previous review.

> Example: If your review was conducted on November 26 and 27, 2015, and you received a full certification, your review will be scheduled after May 27, 2017.

The MIHP coordinator must be available for the entire review. Your agency must have a back-up person who is prepared to substitute for the MIHP coordinator in the event that the MIHP coordinator has an emergency on the days of the review and cannot participate. A review will not be re-scheduled in case of coordinator emergency due to cost considerations. Please have additional staff on hand to assist (e.g., answer questions, locate charts and other documents, etc.), if needed.

Shortly 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 receipt 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. Personnel Roster Report
5. MILogin User List

The provider is encouraged to use the *Certification Tool* and *Chart Review Tools* (discussed in *Standardized Chart Review Tools* section later in this chapter) to review their own program prior to the certification review visit, so they are as prepared as possible for the onsite review.

Note that conducting internal chart reviews is a criterion for Indicator #66 on the *Certification Tool.* Although it is not mandatory that you use the *MIHP Chart Review Tools* for internal reviews, you are required to keep a file of the completed chart review tools that you have used within the last quarter to present to your reviewer.

Pre-review of Documents before the Onsite Review

Prior to the review, the reviewer will examine the following documents submitted by the provider:

1. A current copy of your *MIHP Personnel Roster*.

2. Copies of certificates of attendance (coordinator or coordinator's delegate) from all coordinator meetings and live webcasts held since your last review.

3. Copies of current licenses, registrations, and certifications (including, if applicable, International Board of Certified Lactation Consultants) for all professional staff; verification of staff licenses, registrations and certifications; and staff resumes.

4. Copies of course completion certificates (or group training sign-in sheets) for the coordinator and all professional staff for the following online trainings:

    a. Overview of the MIHP Training Course (formerly titled MIHP Billing and Overview)
    b. Motivational Interviewing and the Theory behind MIHP Interventions
    c. Smoke Free for Baby and Me
    d. Alcohol Free Baby and Me
    e. Ages and Stages Questionnaires (3rd Edition) and Ages and Stages Questionnaires: Social-Emotional
    f. Breastfeeding and MIHP
    g. Prevention of Early Elective Delivery
    h. Interpersonal Violence and MIHP
    i. Intimate Partner Violence: More Than Meets the Eye
    j. Implementing the MIHP Depression Interventions
    k. Reaching the Most Difficult to Reach Families: An Attachment Perspective
    l. Infant Mental Health in MIHP (This training is under development; you will be notified when it is posted on the web site.)
    m. Infant Safe Sleep for Health Care Providers

5. For all staff hired since your previous review, copies of *Notice of New Professional Staff Training Completion* and any *staff waiver* documents.

6. Signed confidentiality agreements for all staff that have access to Protected Health Information, including the coordinator and owner.

7. A copy of the beneficiary grievance procedure you give to each beneficiary upon enrollment.

8. A copy of each of the 15 protocols listed in *MIHP Cycle 6 Certification Protocols*, tailored to your agency.

9. Your back-up staffing plan, if you have been void of one of the required disciplines since your previous review.

10. Your MIHP web site address, if you have a web site.

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.

Indicator #38 measures timeliness and completeness of the pre-review materials. Be sure to double-check that you have compiled all of the pre-review materials before you send them to the reviewer. It is not the reviewer's job to track them for you and let you know if something is missing.

Selection of Charts for Review

The MIHP Quality Improvement Coordinator selects the charts for both the program and billing portions of the certification review for new and existing agencies. A desk audit is performed prior to the review to identify which charts are to be reviewed.

For billing review charts, claims data are examined. Charts with identified billing discrepancies are selected first, and then random selection is used for the remaining charts. Examples of billing discrepancies include, but are not limited to, the following:

- More than one *Risk Identifier* was billed per beneficiary
- Professional visits were billed before the *Risk Identifier* was billed
- More than 9 maternal visits were billed
- More than 9 infant visits were billed without authorization of the medical care provider
- *Infant Risk Identifier* was administered on an infant over 12 months of age without consultant's or MHP's written approval
- Infant over 18 months of age was served without consultant's or MHP's written approval

For program review charts, random selection is used.

This means that:

1. Your agency will not be required to submit lists of beneficiary names prior to the onsite review.
2. Your agency will not have advance notice of the charts that have been selected for the billing review.
3. The reviewer will not randomly select charts for the program review when she gets to your office. When the reviewer arrives at your office, she will hand you a list of the beneficiary names whose charts you will pull for the billing component and for the program component of the review. The list of names will also include Medicaid ID numbers and dates of birth. The billing chart review consists of 6 maternal charts and 6 infant charts. The program chart review consists of 7 maternal charts (4 open and 3 closed) and 7 infant charts (4 open and 3 closed).
4. All charts and billing records must be presented upon request by the reviewer.
5. If your existing agency has more than one MIHP office, your review will not be conducted at the main office; it will be conducted at the satellite office serving the greatest number of MIHP beneficiaries. Only charts from this satellite office will be reviewed. Prior to your review, you will be asked to submit a list of all beneficiaries served at this office since your last review. The MDHHS MIHP Quality Improvement Coordinator will randomly select the charts and provide the list to your reviewer. The reviewer will present this list to you at the onset of your review.

Onsite Review

The MIHP agency must have a back-up person prepared for the review in case the coordinator has an emergency and cannot participate in the review. A review will not be re-scheduled in case of coordinator emergency because of cost considerations.

The onsite review includes the following components:

1. Coordinator interview
2. Professional staff group interview (except at a six-month follow-up review)
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 (if applicable)
7. Agency observation
8. Exit meeting on preliminary findings

If the provider has an electronic health records system, the coordinator indicates if they will print out paper copies of the selected charts or if they will assign a staff to assist the reviewer to review the charts electronically.

Professional Staff Group Interview

The group staff interview is conducted at every review, except for 6-month follow-up reviews. The interview takes approximately one hour. The number of professional staff who must be present (in addition to the coordinator) depends on the size of the staff as noted below:

1. Agency employing 2-3 professional staff: All must participate.
2. Agency employing 4-5 professional staff: At least three must participate.
3. Agency employing 6 or more professional staff: At least 50% must participate.

If professional staff cannot participate in the group interview in person, they may participate via conference call. Failure to have the required number of professional staff participate in the interview will result in a *Not Met* rating for Cycle 6 *Certification Tool* Indicator #39.

Administrators and other program staff are welcome to observe the staff interview. Only persons who are listed on the *MIHP Personnel Roster* may actively participate in the staff interview.

Standardized Chart Review Tools

During the onsite review, the reviewer uses standardized chart review tools to document her 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. Program Chart Review Tool
2. Sample of the "unpopulated" Billing Review Tool

You will not need to provide the CHAMPS Summary Report or remittance advices.

Post-Review Preparation of Certification Documents

After the onsite review is concluded, the reviewer drafts the following three documents:

1. *Certification Tool*, which includes a rating for each indicator ("Met", "Not-Met," "Met with Conditions," or "Not Applicable") and an explanation of the rating.

2. Certification notification letter, which identifies the *Not Met* and *Met with Conditions* indicators and gives the certification status.

    a. Certification status for new providers is based on the number of *Not Met* indicators and the number of *Not Met* critical indicators. The options are full certification (next review 12 months later), conditional certification (next review 6 months later), or decertification (based on receiving 18 or more *Not Mets* at first review).

b. Certification status for existing providers is based on the number of *Not Met* indicators, the number of *Not Met* critical indicators, and the previous certification status. The options are full certification (next review 18 months later), conditional certification (next review 6 months later, or decertification (based on two successive conditional certifications).

3. *Follow-up on Not Met Indicators from Previous* Certification Review

The reviewer submits these three documents, along with the *Preliminary Findings of Not Met Indicators*, to MDHHS. When MDHHS receives the documents, they are reviewed by the MIHP quality assurance coordinator, MIHP quality improvement coordinator, the state consultant and Maternal Health Manager. This team may or may not entirely concur with the reviewer's findings, which is why the findings at exit interview are considered to be preliminary.

Notification of Review Results

Within 45 days after the review is completed, the provider receives the following certification documents (templates available 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)

In Cycle 6, the *MIHP Certification Tool* includes 66 indicators. Four of these indicators are place holders for the next review cycle, meaning that 62 indicators are actually rated. Each indicator in the *MIHP Certification Tool* includes a reference to the current *Medicaid Provider Manual* or *MIHP Operations Guide*. Four of the indicators are designated as *critical indicators* because they are fundamental to the implementation of MIHP. These are: #2 (sufficiently detailed clinical record), #26 (conducting developmental screening using the *ASQ*), #27 (correct completion of the *Plan of Care*), and #56 (correct completion of *Discharge Summaries*).

Subsequent to the review, the reviewer assigns one of the four ratings to each indicator:
Met, Not Met, *Met with Conditions*, or *Not Applicable*. A *Not Met* rating means that you are out of compliance on that indicator and must submit a *Corrective Action Plan*. The *Certification Tool* explains each *Not Met* rating and identifies the concerns that must be addressed in the *Corrective Action Plan.*

Certification (full, conditional or decertification) is based on:

1. The number of *Not Met indicator* ratings you received
2. The number of *Not Met critical indicator* ratings you received
3. Your previous certification (unless this was your first review)

If an agency has more than 6 *Not Met* indicators, or more than two *Not Met* critical indicators, a conditional certification is granted. If a new agency has 18 or more *Not Met* indicators on its first review, the agency's MIHP will be terminated.

A *Met with Conditions* rating means that the indicator was essentially met; however, there is an issue that could use refinement. The *Certification Tool* explains the issue and provides recommendations for improvement. A *Met with Conditions* rating does not require a *Corrective Action Plan*.

Corrective Action Plans

If one or more indicators are rated as *Not Met*, the provider must submit a *Corrective Action Plan (CAP)* to MDHHS within 21 days of receipt of the certification notification letter, using a standardized form and set of instructions. Upon receipt of the *CAP*, MDHHS has 14 days to respond.

When MDHHS receives the *CAP*, it is reviewed by the MIHP quality assurance coordinator, MIHP quality improvement coordinator, the state consultant and Maternal Health Manager. This team approves the CAP or determines that modifications are needed. If modifications are needed, the consultant informs the agency. The agency then must resubmit the CAP within 2 business days. The provider receives written notice when the CAP has been approved.

Ensuring All Consents and Plans of Care are Complete and Accurate Post Review

If Indicator #3 (consents) or Indicator #27 (*Plan of Care, Part 2*) were rated Not Met, the first team member to visit a beneficiary subsequent to the review, must check to make sure that the consents or the *POC 2* are complete and accurate before conducting the visit. For example, if #27 was rated *Not Met* because chart review indicated that some domains that scored out as risks on the *Risk Identifier* did not have corresponding *POC 2* domains in the chart, the team member needs to add the missing domains to the *POC 2* to ensure the beneficiary will get the appropriate care. In this case, the team member also needs to notify the medical care provider that additional risks have been identified.

Billing Concerns Referred to MDHHS Office of Inspector General

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.

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: MDHHS-MIHPCertification@michigan.gov

Tips for Agencies Preparing for Certification Review

1. Become very knowledgeable about the *MIHP Certification Tool* NOW. Don't wait until your review is imminent. The *Certification Tool* will help you understand what you need to do in order to be fully certified at your next review.

    a. Carefully study every single indicator and criterion.
    b. Ask your MIHP consultant to clarify anything you don't understand.
    c. Ask your MIHP consultant for ideas on how to meet the criteria; consultants have knowledge and experience working with various MIHP providers who've set up good systems. Don't waste time wondering what you're supposed to do or reinventing the wheel.

2. Pay special attention to the *Top 10 Not Mets,* especially the MIHP critical indicators. At every MIHP coordinator meeting, we provide you with an updated list of the top 10 Not Met indicators based on certification review results. The *Top 10 Not Met Indicators* from November 2014 through May 2016 are listed below, with critical indicator numbers in bold.

   #56 Discharge Summary (69%)
   #3 Signed Consents (66%)
   #26 Use of ASQ-3 and ASQ: SE (51%)
   #27 Plan of Care, Parts 1-3 (47%)
   #33 Professional Visits to Implement Plan of Care (44%)
   #2 Progress note sufficiently detailed (37%)
   #22 Medical Care Provider Notification of Beneficiary Enrollment (33%)
   #29 Care Coordination (19%)
   #12 Care Coordination Agreements (19%)
   #44 Required training completed (17%)

   Also, see *Top 6 MIHP Not-Met Indicators: Most Frequent Reasons for Getting Dinged (November 1, 2014 through December 31, 2015)* at the MIHP web site. This document specifically identifies the most frequent reasons why agencies were dinged on the top 6 Not Met indicators. We narrowed it down to the top 6, using 35% as the cutoff (at least 35% of agencies reviewed were dinged on these indicators).

3. Conduct your own practice certification review. The tools used by the reviewers are on the web site:

   A. Program Chart Review Tool
   B. Sample of the "unpopulated" Billing Review Tool

4. Ask your MIHP consultant. Your consultant is available to answer your questions and help you understand the program and its ever-changing requirements, so that your MIHP will succeed.

5. Whenever the MDHHS Maternal Health Unit Technician sends you an email asking that you confirm receipt, be sure to reply immediately.

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. Specifies which staff position(s) performs chart reviews and billing audits
4. Indicates the minimum number of charts reviewed per chart review and per billing audit
5. Describes how staff are trained and supported to ensure that the *Risk Identifier*, *POC*, *Professional Visit Progress Notes*, and *Discharge Summaries* are linked
6. 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 MIHP activities, and they provide the recommended order of document placement in 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 MIHP staff will make an unannounced site visit to an MIHP agency. The MDHHS Office of the Inspector (OIG) also makes unannounced visits. Unannounced visits typically take place for one or more of the following reasons:

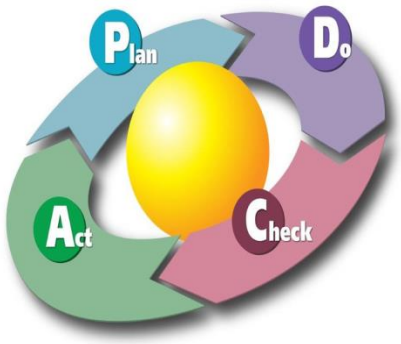
- A whistleblower reports possible fraud/abuse
- A beneficiary lodges a complaint of a serious nature about the quality of services received
- Another entity lodges a complaint of a serious nature, including unethical behavior
- There are unusual or questionable findings in a certification review
- Questionable financial activity is identified through a MDHHS in-house billing audit, which is separate from certification billing 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.



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

Figure 1

PDCA picture – Wikipedia, the free encyclopedia, accessed at https://en.wikipedia.org/wiki/PDCA

Meeting Beneficiary Needs and Expectations Matters

An important measure of quality is the extent to which patients' needs and expectations are met.
(Health Resources and Services Administration, US Department of Health and Human Services)
In MIHP, we are always striving to improve our ability to meet beneficiary needs and expectations. We do this by:

- Supporting beneficiary engagement
- Practicing with cultural humility
- Assessing health literacy
- Engaging in beneficiary-centered communication
- Providing linguistically appropriate care
- Providing evidence-based care
- Coordinating care other parts of the larger health care system

MIHP Quality Improvement Over Time

As our understanding and practice of continual quality improvement matures, so will MIHP program fidelity. Fidelity is vital to the survival of the MIHP program because it provides accountability to stakeholders. Improved quality improves the health and well-being of Medicaid eligible pregnant women and infants.

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 consultant. Communications should not come from multiple staff.

While MIHP providers are encouraged to network with each other and grow together as a community, providers are cautioned against relying on other provides for answers to their questions. When you have questions about Medicaid policy, the *MIHP Operations Guide*, or MIHP forms and forms instructions, it is best to direct them to your consultant.

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.

Coordinator emails generally are sent on a monthly basis. They 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.

Copies of previous coordinator emails may be accessed through the MDHHS-MIHP File Transfer areas of the MILogin 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.

IT Alerts are email messages that are sent to MIHP coordinators to inform them that IT issues affecting the State of Michigan MIHP computer applications have been identified or resolved. The alerts are usually time-sensitive, so they are sent separately from the monthly coordinator emails.

MDHHS Technical Assistance

MDHHS staff offers technical assistance with data, electronic forms, and navigating MDHHS technology including but not limited to the following:

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 *MIHP Discharge Summaries*. MIHP data is analyzed to assure proper utilization of services and provide objective information for MIHP providers, MDHHS, legislators, and other 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. Reports include: Demographics, *Risk Identifiers* completed; *Discharge Summaries* completed; *Risk Identifier* domain scores; referrals made; education provided; and breastfeeding data.

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 the first week of 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:

Data Period	Distribution Period
Q1 (Oct – Dec)	Distributed to CHAMPS agency inboxes **1st week in July**
Q2 (Jan – Mar)	Distributed to CHAMPS agency inboxes **1st week in October**
Q3 (Apr – June)	Distributed to CHAMPS agency inboxes **1st week in January**
Q4 (Jul – Sept)	Distributed to CHAMPS agency inboxes **1st week in April**

To locate your agency's quarterly data reports in CHAMPS:

a. Login to MILogin: https://milogintp.michigan.gov
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 MILogin File Transfer System.

3. Certification Data Reports

MIHP utilizes standardized data reports as part of the MIHP agency certification process. Prior to agency certification review, data reports are generated to obtain an 18-month historical record of the agency's MIHP Medicaid claims. This information is used in the desk audits performed by the MIHP Quality Improvement Coordinator and the MIHP Reviewer prior to the agency's onsite review.

4. Data Requests

From time to time, an agency will request additional data from the MDHHS MIHP database to address a particular question. Contact your consultant when you have a data request. You may be asked to complete and submit a data request form, depending on the complexity of your request. The completed data request form will be reviewed and approved or denied, based on the following factors:

- Date the data is needed
- Reason the data is being requested
- Availability of the data requested
- MIHP staff availability to complete the request

5. 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".

6. Acceptable Browsers for MIHP MILogin System

The acceptable browsers for MIHP MILogin use are IE 8 or IE 11. <u>You cannot use IE 9 or 10.</u> 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.

7. MIHP MILogin System File Transfer Areas

The MDHHS - File Transfer application is a web-based application accessed via internet browser through the State of Michigan MILogin 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 staff 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 MILogin System are required to access the DCH-MIHP File Transfer areas and MIHP providers must request a subscription through the MILogin 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 is titled, *MIHP Coordinator Emails*. This area houses all MIHP coordinator emails from the following fiscal years:

   FY 2013/14 Entire Year of Reports #01 - #21
   FY 2014/15 Entire Year of Reports #01 - #11
   FY 2015/16 Partial Year to Current

2. The other is titled, *MIHP Quarterly Reports*. This area houses historical Quarterly Data Reports from FY 2013 and FY 2014. Beginning with the first quarter of 2015, Quarterly Data Reports are made available for all providers in the CHAMPS system under the provider inbox.

MILogin System Issues:

- If you have any problems accessing your MILogin System account, please contact 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 MILogin System 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.

8. 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 MILogin System 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. It may take several weeks to receive the CEs.

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 it must be 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 *Chapter 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 twice a year in the spring and fall 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.

Coordinator meeting participants who are present for the entire day receive training certificates. The coordinator or the coordinator's alternate must maintain proof of participation in all MIHP required regional face-to-face coordinator meetings. It is important to carefully file each training certificate. If you lose a training certificate, there may be a fee to replace it.

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.

PowerPoint presentations and other resources from the required face-to-face coordinator meetings are available at https://events.mphi.org/mihp-webcast-resources/

6. Required Webcasts

One live MIHP webcast is provided each year. This webcast is required for coordinators, but is open to all staff. Coordinators are strongly encouraged to require all of their staff to participate. The webcast is about 4 hours long, providing Medicaid and MIHP updates, as well as training activities. The coordinator or the coordinator's alternate must maintain proof of participation in all MIHP webcasts. It is important to carefully file each webcast certificate. If you lose a webcast certificate, there may be a fee to replace it.

CEs are not available for live webcasts. PowerPoint presentations and other resources from the required webcasts are available at https://events.mphi.org/mihp-webcast-resources/

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 encourages providers to participate in these networks, if possible. Contact your consultant to find out if there is a network in your region.

9. Home Visiting Collaboratives

In a few 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 across 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.

MIHP information dissemination to staff as described above is critical to ensure the agency does not receive a *Not Met* rating for Cycle 6 *Certification Tool* Indicator #43.

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.

The MIHP agency should have a single, complete chart for each beneficiary that contains all applicable MIHP forms. The chart must be accessible to all agency staff who are serving the beneficiary and to agents of the State and federal government upon request at any time, not only at the time of certification review. For this reason, and in order to reduce the likelihood that the beneficiary's chart will be lost or stolen, the chart should not be taken from the office. Agencies may choose to have a working chart with copies of forms, but the official chart should be complete and remain in the office.

It is highly recommended, not required, that all open charts be maintained in a single format (paper or electronic). All closed charts should be in one format or the other.

Handwritten documentation in charts must be legible.

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 MILogin 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, including MIHP program staff, Medicaid staff and Office of the Inspector General 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

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 may not refuse to transfer the beneficiary. Furthermore, the transferring 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.

Effective August 1, 2016, when sending a request for transfer, the receiving agency must keep the fax transmission confirmation form, verifying that the fax was sent. When sending the required beneficiary documentation to the receiving agency, the transferring agency must keep the fax transmission confirmation form, verifying that the documentation was sent. Fax transmission confirmation forms may be filed in the beneficiary's chart or be filed together in a binder.

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 <u>not</u>:

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 the *Maternal and Infant Forms Checklist for Transfers Received*, 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 (MILogin System) will continue to be noted as the agency that completed that specific document in the database. Although the name of the transferring MIHP agency is noted on the *Risk Identifier*, this does not prohibit the receiving MIHP agency from serving the beneficiary, billing for visits and completing the *Discharge Summary.*

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 the complete set of 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 Manua*l. 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.

Transferring the Beneficiary after the Discharge Summary Has Been Entered

There are times when a provider will receive a transfer request on a maternal or infant beneficiary who has already been discharged, but had unused visits. For example, an infant is discharged after the initial 9 visits were conducted and the *Discharge Summary* is entered into the database, but then the mother finds out that her infant may be eligible for an additional 9 visits with medical care provider authorization.

This is a valid request to transfer and it must be honored by the first agency. The first agency must comply with all of the requirements related to transfer. Records must be sent within 10 working days of receipt of the transfer request and the *Discharge Summary* must be deleted within 10 working days of the receipt of the transfer request.

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. Services 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 notify MDHHS in writing the following:

- Details their intent to follow the MIHP termination protocol.
- Cites a termination date not less than thirty days in advance of the date of notification.
- Includes the agency's MIHP NPI number.

The provider must also submit a plan describing:

- How and when beneficiaries, MHPs and other MIHP providers will be notified.
- How beneficiaries will be transferred to other MIHP providers.
- 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 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

Only an MIHP agency with current full certification status may opt to become voluntarily inactive. This means that an MIHP agency in good certification standing and in business for a minimum of six months may choose to temporarily discontinue MIHP services for a minimum of six months and a maximum of 12 months up to 12 months 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 Termination Protocol* and is approved at the discretion of the MDHHS. 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." The numbers that may be of most use to MIHP providers are given below.

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

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 Maternal and Infant 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/lara/0,4601,7-154-72600_73836---,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.

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.

MIHP forms are revised as a group annually. At that time, the date is changed on **all** of the forms, even those that were not modified in any other way.

If a single form must be revised before the next annual release, the same document name and date is used, but the revision number and date is added**.** As long as you are using the forms with the correct original date, regardless of the version date, you will be in compliance at your certification review.

Whenever one or more forms are revised or a new form is introduced, you will be notified via a coordinator email message.

You must use the appropriately dated versions of the required standardized forms. You are not required to use newly-issued forms in charts that are currently open; you are only required to use them in charts that are opened on or after the date of the forms.

Assuring that Staff Are Using the Forms Correctly

All staff must be trained to use the forms as required by MDHHS. Documentation on all forms must be complete and accurate. 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. 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 you must initial data entries that are crossed out or added. You also may date the correction if that is your preference, but it is not required.

8. Only the professional who conducts a professional visit can sign the *Professional Visit Progress Note (*PVPN*)* or edit the PVPN after the fact. It is not appropriate for another individual, such as the MIHP coordinator or a QA coordinator, to delete or add entries to the PVPN.

9. The professional who conducts a professional visit may dictate the PVPN entries to another staff who completes the form, but the professional must review the note carefully before signing it.

10. When signing MIHP forms, it is acceptable to use the first initial and full last name.

11. When documenting your professional credentials on MIHP forms, your licensure should be indicated as one or more 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
    IBCLC International Board Certified Lactation Consultant

12. You can use a signature stamp on letters, but not on other MIHP forms.

13. Different MIHP forms must be completed by specified deadlines. See the MIHP web site for a chart titled *MIHP Required Timelines for Forms Completion*.

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.

Entering Electronic *Risk Identifiers* and *Discharge Summaries* into the Chart after Data is Completely Entered into the MIHP Database

After the *Risk Identifier* is administered and the data has been entered into the MIHP database, you are required to file both the *Risk Identifier* and *Score Summary* in the beneficiary's chart. This must be done before the first professional visit is conducted or any other MIHP services are provided. This is required whether or not the beneficiary has obtained a Medicaid ID number at the time of enrollment. All staff must have immediate access to the *Risk Identifier* and *Score Summary* in order to best serve the beneficiary.

You are also required to enter the *Discharge Summary* in the beneficiary's chart before you send the *Notice of MIHP Beneficiary Discharge* to the medical care provider and the MHP. This notice must be sent within 14 days from the date the *Discharge Summary* is entered into the database. Do not send the *Discharge Summary* to the medical care provider or to the MHP with the notice.

The *Risk Identifier* and *Score Summary* must be entered in the chart before the first professional visit is conducted and the *Discharge Summary* must be entered in chart the before the *Notice of MIHP Beneficiary Discharge* is sent to the medical care provider and the MHP. All of these documents (if applicable) must be in the chart when the chart is pulled at the time of certification review.

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. The form to request access to MIHP forms in an unlocked format may be found on the MIHP web site under Policy and Operations. It is titled *Request for Unprotected 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, Professional Visit Progress Note*) into the individual EMR, you can shred the original. You don't need to keep paper copies of signed consent forms if you have an EMR system.

6. If a staff faxes in chart documentation (e.g., *Professional Visit Progress Note*) while in the field, the original must be in the chart within 14 days of the date of the visit.

7. All EMRs should be backed-up.

8. 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.

9. 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.

10. Charts must be available upon request by any agent of the state.

11. You need to scan and save the entire electronic *Risk Identifier, Risk Identifier Score Summary,* as well as the entire *Discharge Summary*, in your EMR system.

12. If you want to obtain your agency's data from the MDHHS database for your EMR system, contact your MIHP consultant to inquire about the file transfer process and Data Use Agreement. You must complete the *MIHP Provider Data Transfer File Request Form* in order to request permission to electronically upload your MIHP data. 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 the of 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