

Q & A
Regional Coordinator Meetings – March 2012

Scheduling Next Appointment on POC 1

1. Scheduling first appointment? Tried scheduling in Outlook calendar of each nurse and it NEVER worked out. Now social worker goes out first, then RN – gives them time to get appointment scheduled. I do most enrollments – I write nurse’s name whether they want office visit or home visit and message for RN to call client.
2. Regarding scheduling next appointment after risk assessment, we are clinic-based and next visit is dependent on OB scheduling. New ACOG guidelines recommend OB visits every 4-6 weeks in first and second trimesters. (PS This has really affected our number of visits.)
3. POC 1: Next visit date? The form asks if you plan a next visit.
4. POC 1 - #4: Where to put next visit date? No plan to put a date on the form? A specific date? Time- frame?

You will not be required to give the date of the next visit on the POC 1.

Discipline Completing Risk Identifier

1. For the Maternal Risk Identifier, if not having a discipline is a concern, why don’t you make it a required field that will not allow the scoring results until that field is completed? Also limit choices – no RD or unknown or other as choices.

We will take this under consideration.

2. Why is RD a choice on the electronic risk screener if it is forbidden?

When the Maternal Risk Identifier was created, RDs were authorized to complete it. This is no longer true and DCH wants know if any RDs are still completing it. Providers are expected to follow this policy.

SSO Database

1. Is there a way that SSO can be modified so that you can check to see if a client has had a completed screener without entering a service date (expand inquiry)?

We will follow up with Information Technology (IT) staff to see if this is possible.

2. Regarding consultants needing to delete a screener when a provider has an input error – any chance MIHP coordinators can do this? Seems cumbersome for everyone.

You have 120 days to complete the Risk Identifier. During that period, you can delete the Risk Identifier if there is an input error. If the Risk Identifier has been completed, or it is after the 120-day limit, your consultant must delete the Risk Identifier.

3. Can SSO be modified for providers to see all screeners entered by that provider without entering specific Medicaid numbers?

To see all screens entered under your NPI, press the search button without putting in any beneficiary information.

4. If we screen a pregnant woman and she is never approved for Medicaid, should we delete that screen out of the SSO database?

Yes, if it's within 120 days. After 120 days, ask your consultant to do it.

5. What EMR or electronic platforms will the file transfer process work with?

The file transfer process will work with any EHR platform where the local agency wants DCH to send their data back to them after they have sent it to DCH. The individual agency's IT staff will have to adjust their programming to accept data from DCH.

6. We heard that the Infant Screener and Maternal/Infant Discharge Summaries would be ready by July of this year for our use. This is excellent news! Please confirm that this is the target, and we will move forward in preparing our Insight program to accept the data transfer. We require that our client charts be all together in one location. We can gladly enter the data into your data base using the SSO as long as we have a way of getting this data back into our client chart electronically. On our end we will need to get prepared so that when you do launch the Risk Identifiers and DC Summaries we are ready to receive the data back to us.

This is correct. We will let you know when you can start using these new tools.

Developing the POC

1. POC 2 – where do you want additional risk identified by clinical judgment documented? We're not supposed to change results page.
2. POC 2 – if doing electronically, you cannot add anything other than date and check the boxes. In this case, where do we document clinical judgment? Prenatal/Infant Communication form? Comment box on screener? Sometimes a domain/risk may not be added till the 2nd discipline looks at it and that is after the risk screen is completed, so you can't use the comment section.
3. When an additional risk or something does not pull on RST – for example, I had a patient who was brutally raped (10 surgeries for repair, suffers PTSD) but RST did not pull abuse as a risk. How do we add that POC 2 since we aren't using a progress note at that time? Add it in RST comments?
4. How do we document increased risk level during the course of care?

We will add lines to each risk level in the first columns of the POC 2 where you will enter the date that the risk level changed or the date that a new domain was added. When adding a new domain to the POC 2, it must be documented on the POC 3.

5. So we can change risk if it goes up but not if it decreased?

*If the beneficiary meets the criteria for the risk level to go up **or** down, document this on the POC.*

6. If interventions are completed at the intake visit, is there a way to document those interventions to demonstrate fidelity?

Any interventions provided at the time of the Risk Identifier visit should be documented in the comment section of the Risk Identifier, because the POC has not been done.

7. If you add risks from Supplemental Questionnaire, do you have to document clinical judgment?

No. The boxes on the POC 2 come from the Supplemental Questionnaire.

8. Should POC 2s be pulled at the same date of POC 3 or pulled before for POC 3 (team meeting date)? We pull at enrollment to be ready for POC 3 team meeting by RN who does assessment.

POC 2 domains must be pulled before the required disciplines sign the POC 3.

9. What if a client has zero risks identified? Do we not see them?

Generally speaking, you would not visit a client who has zero risks identified. However, if the client states that she wants you to visit her anyway, you may do so. In this case, you must carefully document why she wants you to visit. As you discuss this with her, you may find that she actually does meet risk criteria in one or more POC 2 domains (e.g., social support, transportation, etc.) and then you would develop a POC 2. As the client begins to trust you, she may reveal other information indicating that she is at risk in additional domains. If you do not determine that she meets risk criteria in one or more POC 2 domains, you would be implementing the POC 1 and documenting your interventions on the Professional Visit Progress Note under "Other visit information."

10. If there is an update on a maternal consideration, should a form letter B be sent to the infant provider?

This is determined according to your individual agency's policy regarding communicating the mother's information to her infant's pediatrician/medical care provider.

11. Need to change interventions to match domains, especially with maternal considerations in infant chart. All considerations say "during pregnancy." Interventions for drugs and housing don't match.

Yes, we need to update interventions for Maternal Considerations.

12. Is there going to be a substance abuse care plan for infants- especially when using substance abuse care plan?

There are three POCs for substance-exposed infants: positive at birth, primary caregiver use, and environment. They are posted on the MIHP web site.

Visits Before POC 3 is Signed

1. Can RN do visit if RN has signed POC 3 but SW has not yet?
2. Op Guide says both RN and SW must sign POC before any visits are made. At the regional mtgs, we said a visit could be made by the discipline that did the RI before the other discipline sees the POC. Is this in emergency situations only? Would the provider have to pay back Medicaid for doing a home visit before the POC3 is signed by both RN and SW, unless it's an emergency? (Deb)
3. Concern: Scenario: woman has intake by RN (Risk Identifier) in clinic. She is depressed or homeless or substance abusing. RN feels MSW should see client ASAP (same day). MSW has good idea what POC 2 will look like for those domains and can follow appropriate interventions (her clinical judgment on mod or high). But you are saying we shouldn't do a professional visit before Risk Identifier is processed, POC 2 created by results page. I suggest this is a liability! MSW should be able to do a visit same day (if RN did intake and client has need) or RN should be able to do a visit (if MSW does intake and client has RN need). This is the advantage of MIHP in a clinic setting. For those in need, the sooner the better.

The Medicaid Provider Manual states that "The Risk Identifier and POC must be completed before professional visits are initiated." If there's a need for an emergency visit on the day of the Risk Identifier visit, this is permissible, as long the emergency situation is documented in the record. 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.

Documenting Date Outcome Achieved on POC 2

1. MSU presentation states that they looked for expected outcomes checked, dated and initialed when completed. On electronic forms you cannot add initials. This has never been required before.
2. When we finish POC 2 at discharge, do we put down date of achievement and initial by staff or just the date of achievement?
3. Are initials required on POC 2 when dating outcomes? We have never used initials, only dates which correlate to the progress note of that date. However, MSU reported (on pg. 10 of their outline, 1st box) that "expected outcomes checked, dated, and initialed when completed."

You are not required to initial Date Outcome Achieved in the POC 2.

4. POC 2 requirement that all outcomes are completed: Every outcome is not appropriate for every client.

Every outcome is not appropriate for every client. We will be reviewing the POC 2 for possible changes and clarifications.

5. POC 2: Related to Fidelity Assessment. When should the expected outcome be checked? The instructions for POC 2, now state, to check expected outcome when the intervention outcome is achieved. Should this be changed to assist with program evaluation by MSU?

You check and date the outcome the first time you achieve it.

Interventions

1. Are Ix delivered by appropriate staff? I thought we were supposed to be cross-trained and able to deliver interventions across disciplines, especially since Ix are delineated in the care plans!

Cross-training is allowed within your scope of practice. For more info on scope of practice, go to:

Nurse [LARA - Nursing - State of Michigan](#)
Social Worker [LARA - Social Worker - State of Michigan](#)
Dietitian [Michigan Legislature - Section 333.18351](#)

2. Scope of practice: if you must address family planning at every visit and you are saying that it's not in the RD's scope of practice, what do you document?

MIHP program interventions are primarily delivered by RNs and SWs. When a client has nutritional needs, the RD becomes an important part of the team. A physician order is required before RD services can be provided. Non-nutrition interventions should be delivered by the RN and SW. Please see "Discussing Family Planning" on the MIHP web site for family planning topics that can be addressed by all MIHP professional staff.

3. When a discipline provides an intervention "outside the scope of practice," where should this be documented?

You should not perform services outside of your scope of practice.

4. At baby open if mom has not been on program, is she to get the maternal education packet also?

The maternal and infant educational packets have been combined into one packet. All beneficiaries should receive the packet at the time of MIHP enrollment. The only exception to this is if the beneficiary prefers to sign up for text4baby, instead of taking the packet.

5. Written materials POC 2 provided to address depression are inadequate.

We think that the HRSA booklet referenced in the interventions is very well done and is applicable for our MIHP care coordination model. (*Depression During and After Pregnancy: A Resource for Women, Their Families & Friends.* [Perinatal Depression Booklet](#))

Professional Visit Progress Note

1. We need a lot more room to chart blended visits!!

We will make more space for you.

2. Must all progress notes on a client have documentation each visit why all domains were not addressed? For example, if a client has 6 different POC2s but only wants to discuss one concern each time, do we document this every time on every note?

3. Client has 6 domains in POC2. I address 2 of the issues on progress note. Are you saying that on progress note I have to say why the other 4 domains weren't addressed at that visit? Didn't think I had to do that. Not doing it.

No, you don't have to document the rationale every time, but you must make multiple attempts to address all high-risk domains and document that you have done so.

4. Comment re: women who do not want to address any care plan needs – need to review that they signed consent to participate and the education is part of the program.

You need to determine the woman's willingness to participate.

5. If a POC2 has been "completed," does it need to be documented and addressed each visit?

No.

6. How do we address family planning each time if mom has tubal? Just note it on form?

There's an NA box after "family planning discussed this visit" on the Progress Note. Check this box if the mom has had a tubal.

Drug-Exposed Infants

1. Drug-exposed infant – how do you use the multi-care plan, all may fit of the (3) care plans?

If all three care plans are applicable, you would use all three of them.

2. Baby opened – has had 18 visits – drug-exposed, needs transportation. Mom is pregnant. Can we open mom and keep baby open for transportation only?

There are multiple options in this situation. Please call your consultant to discuss them.

3. Is alleged drug use by significant other as reported by friends or family sufficient to implement safety/risk drug use?

Yes, if reported/rumored info is sufficient to raise RN/SW concerns, it is sufficient to implement the Substance-Exposed Infant - Environment interventions.

ASQ Screening and Referral

1. Do we have to have copies of ASQ and ASQ: SE if Early On is in? Do we do them too?

No, but be sure to document that the infant is in Early On.

2. ASQ is done by another tribal entity on the reservation. Do we need a copy of the score sheet and documentation of referral to Early On in MIHP file, or can we secure it for the reviewer? Certification Tool says it has to be in the file.

You don't need to keep a copy in the MIHP record, but the MIHP record must document where the ASQ and Early On referral information is filed. MIHP staff must know how to access it, as needed.

3. How many ASQ-SE are required in chart? One every age or just one per chart?

No, you do not administer the ASQ: SE at every questionnaire age interval. The number of times that the ASQ: SE is administered depends on a variety of factors, such as the infant's age at MIHP enrollment, previous screening results, etc. Please refer to the detailed instructions in the MIHP Operations Guide.

4. If a parent declines Early On referral, is there a particular way that should be documented?

At a minimum, you may simply state that "The parent declined to accept an Early On referral."

Discharge Summary

1. What should date of discharge be? The date of last visit? The first of the next month after last visit? The date that Discharge Summary is completed? The date that the dr. letter is sent?

The discharge date should be within 30 days of your determination that services have ended, eligibility has ended, or the family has been lost to follow-up.

2. MSU Fidelity Assessment – Discharge Summary. Was Discharge Summary sent to the medical provider within the appropriate time frame? Do we have a time frame for Discharge Summary?

The date that the Discharge Summary is sent to the medical provider should coincide with the discharge date.

3. There is zero DC domain for family planning or social support. Need to be added.

Both domains are included in the Maternal Summary. Family Support is included in the Infant Summary. Family Planning is included in the Infant Summary of Maternal Considerations.

4. With blended visits we have two assessments, so do we have two discharges?

Yes.

Woman Seen by Two Providers

1. Please clarify what paperwork needs to be completed when only one visit is made and then you find out another MIHP has client and will continue to see her?

This question is not clear to us.

2. What do we do if a woman comes in for a screen but we find out she has already been screened somewhere else for the current pregnancy? On previous occasions, we've proceeded with a

professional visit, assessing immediate needs, signing consents and a request to transfer. Then, following the visit, we request the file from the other MIHP.

What you are doing is correct.

Transfers

1. If it is a transfer case, and pt has emergency needs (e.g. homeless), do we wait until the other agency sends over the risk score, or can we go ahead and visit?

You can go ahead and visit to assist with the emergency and then get the transfer info before the next visit.

2. If a person transfers from another agency (was screened elsewhere), can we do a billable visit before we get the transfer info from that agency?

Yes, you can do a billable visit, as long as you assess the client's immediate needs. You could assess her needs by interviewing her or administering the Risk Identifier, knowing you would not be paid for it. You must get the transfer info ASAP.

3. For a transfer case, sometimes the agency said they never did open that pt. Can you check please?

You need to go into SSO and see if they have seen the client. If the agency says they haven't seen the client, then that agency needs to delete it. If they are unable to do so, they need to call their consultant.

Checklists

1. Could you include in Maternal Checklist a spot for packet given and text4baby?

We will add a space to the POC1 to document whether the client chose the packet, text4baby, or both. We can also add this to the Checklist.

2. No area on checklist to put date of signatures for update. Also, place for update sent to dr. I've been putting date under POC 3 date.

There is a Prenatal Communication/Notification of Change in Risk Factors checkbox and a space for the date on the Maternal Checklist (right beneath the Progress Note section). We don't require signatures on the Checklist.

3. Does Medicaid policy require that we maintain the Infant Forms Check List and the Maternal Forms Check List? Since we are progressing toward paperless, 100% of our Professional Visit Progress Notes are now electronic using Insight. We are able to run a report for each client which gives us the dates of the encounters. Is this report, stapled to the back of your Check List form, sufficient?

The answer to both questions is yes.

4. Once we get every form including the Risk Assessment and Discharge Summary into an electronic format, we could have the entire checklists completed electronically using a report from Insight. Is that acceptable with MDCH and Medicaid? It is very time consuming to complete these Check Lists by hand, and they really don't provide much benefit to us.

If it contains all of the data elements and the reviewer can follow it, it's fine.

5. If the Infant Forms Check List and the Maternal Forms Check List are truly only intended to facilitate the audit process when the site visitors come to our HD, can we prepare these check lists only for the 18 charts that are being audited rather than the many hundreds that are never seen by the State auditors?

The Check Lists are not only for MDCH certification review purposes; they are also intended to assist you with internal monitoring. The Check Lists are the only place to document some items, such as communications with medical providers, and they provide the recommended flow format for charts.

Quarterly Reports

1. Who is getting quarterly reports? Our organization is not.
2. Quarterly Reports: We are not getting these reports quarterly.

If you are not getting quarterly reports, contact your consultant.

MIHP Evaluation

1. When will we see our agency's results from the completed MSU study?

We are currently working on this.

2. Are we penalized for an increased number of opens that do not have visits? Suzette said all women should be screened but may not want services. It is a lot of work to do an open if client doesn't want to follow through with visits.

You are not penalized, as long as the client's consent form documents that she did not wish to participate in MIHP.

3. How does increased risk during course of care impact evaluation?

The new (electronic) Discharge Summary will capture the highest level of interim risk (the highest level of risk documented during the period that the client was in MIHP).

4. How will you know that what we are reporting for outcome on Maternal Discharge form is accurate and consistent in measuring across MIHP programs?

We need to know if you are referring to summary risks or progress during interventions.

5. Comment: if MSU wants to collect data about women who refuse MIHP services, could there be a question/statement on the Maternal Risk Identifier that states why services or screen were refused!?

We are currently working on a process to gather this data.

6. When I do a screening and the client declines further visits, I document that info in the narrative on the last sheet. Does anyone look at that?

Reviewers look at it. Be sure that you get the woman's signed consent to administer the Risk Identifier, even if she declines to enroll in MIHP.

7. Record review finding related to documentation is a direct result of the idea that check box minimal charting is recommended for 30-minute visit. We only get paid for 30-minute visit but increased documenting/charting is required. No way to provide adequate care in 30-35 minutes.

Thank you for your comment. A visit must be at least 30 minutes in duration to be billable per Medicaid policy.

8. Suzette: Re: smoking cessation and alcohol use. If a woman quits alcohol when she finds out she is pregnant, she scores out as mod, even though she is no longer using. If a woman quits smoking when she finds out she is pregnant, she does not have a risk. But really, the woman is at moderate risk for relapse. Can this be changed so alcohol and tobacco are the same?

The alcohol use tool is the T-ACE. We don't have a valid and reliable tool to predict smoking relapse.

Medicaid

1. Doing online Medicaid application - sometimes a patient will not qualify online, but will qualify with "long form" or the paper form. Is there a difference between the two?

If the online application is denied but you believe the woman may be eligible for Medicaid, discuss it with the local DHS office.

2. MCD no longer backdating automatically. Now, there is a box that requests for backdating. So, NOT backdating.

Concerns were raised in the March Coordinator meetings about the possibility that retroactive coverage for new pregnant Medicaid applicants is no longer available. The Bridges Administrative Manual (BAM) which DHS uses in processing applications states: "A client who is eligible for Healthy Kids (See BEM125, Healthy Kids for Pregnant Women, 129 and 131, Other Healthy Kids) for the application month is eligible for retro MA when all of the following conditions are met. This applies even if the retro MA question on the application is not answered or is answered no". The conditions listed after that statement is the conditions for general eligibility for Healthy Kids Medicaid. If your clients have problems with getting retroactive coverage, the DHS worker may be referred to page 10 of 29 in the BAM 115 section (Application Processing) of their procedure manual.

3. How can we service pregnant women on spend down (MIHP)? Not always qualifying for full Medicaid.

The spend-down requirement is considered to be met for pregnant women. The pregnancy must be reported to the DHS worker.

4. Spend down - we were told from MCD provider at state that we would take the loss if spend down was not met. They will not put them on Healthy Kids. They are re-applying and still spend down.
5. When mom has Medicaid with spend down, we get denials for MIHP bills for all care delivered prior to meeting the spend-down each month. Seems like she should get her prenatal care without being subject to the spend-down.

This is an eligibility issue, not a billing issue. Contact DHS to determine if an error has been made. If your local DHS continues to apply the spend-down requirement to pregnant women, contact your consultant.

6. Do most pregnant mothers continue on Medicaid for 60 days postpartum or until the end of the calendar month? I have two cases in Jackson where this did not happen. One case, the client is on spend down, and the other client has inactive coverage. Both women delivered in January. Have the rules about coverage changed?
7. We are finding mothers being dropped off Medicaid before 60 days PP or put on spend-down. Why is this happening?

A woman remains eligible for Medicaid for two full months after the birth month. For example, if she gives birth on any day in September, she remains eligible through November. If your local DHS office continues to terminate Medicaid coverage for pregnant women before two full months after the birth month, contact your consultant.

8. Payment correction for office visits: If local health departments are not affected because cost settled, doesn't that include FQHC?
9. Slide 7 - Payment Correction of MIHP Office Visits of the Medicaid PowerPoint presentation states that "local health departments likely not affected (cost settled)." FQHCs are also cost settled, so will this apply?

Medicaid decided to adjust all MIHP providers who were overpaid for office visits. Those MIHPs who are cost settled will have their previous settlements adjusted.

10. We were asked to develop a numeric filing system for billing. Prior to doing so we used the beneficiary's Medicaid ID number as the ACC#. Can we now up date by using the new filing #?

MIHP does not require a specific filing system for billing. You may use whatever system works for your agency.

Medicaid Health Plans

1. MHPs are still not transporting to WIC or parent education classes. How can we make sure they are utilizing the health plans for transportation if they don't take them to certain appointments?

MHPs do not transport to WIC or parent education classes – only to medical appointments. MIHP can transport to WIC and parent education classes.

2. Health plans “run around” – dictating times of appointments.
3. Clients are having difficulties with MHPs:
 - Don’t know what is available - fine print.
 - Call for rides and set it up and then transportation people call and cancel.
 - Time limits for time to be at hospital (moms going to NICU) – 9:30 to 10:30 only.
 - Emergency – can’t get transportation so calling 911.

The MHPs are responsible for providing transportation for their members for medical visits. MIHPs should develop a relationship with the MIHP liaison from each MHP in your service area. MIHPs may provide transportation to medical visits for FFS beneficiaries and for those beneficiaries who have just transitioned from FFS to a MHP and have a visit scheduled. There must be documented need for transportation assistance. Medicaid will provide clarification of MIHP transportation policy in the near future.

text4baby

1. Do we need to document if the client is using text4baby? If they aren’t using it, do we need to provide any additional information to the client?

You need to document that she signed up for text4baby, if that was her choice, on the POC 1. At subsequent visits, determine whether or not she is actually receiving text4baby messages and document this on the progress note. If not, give her the educational packet. Professional staff should always have an educational packet with them, to be used in this instance or to supplement the information that the client is receiving from text4baby.

2. Can you please post the text4baby script on the MIHP website for agencies to review?

No, we are not allowed to do this.

3. Text4baby documentation: It’s ok to document on any form in record that this was done at admission until this is added to progress note.

You don’t need to document it until we add space on the POC 1 and the Progress Note, but you may document it now on any form in the record, if you wish.

MIHP and WIC

1. Does a health department need an MOU with WIC when the Director of Personal Community Health is also over WIC?

No.

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2. MIHP's role in breastfeeding: Is there a way to structure the breastfeeding interventions that will make it crystal clear to MIHP staff that: 1) a referral to WIC Breastfeeding Peer Counselors is expected; and 2) Peer Counselors will do the problem-solving and MIHP will play a support role?

Yes. This will be done as the interventions are developed.

Multiple Infants

1. Can two infants (not twins) be opened at the same time?

Yes. You can do Risk Identifiers on both, but the visits must be blended.

2. When we have twins on MIHP, are we supposed to put care plans in both charts? Say if LuAnn is in on the twins, do we need the nutrition care plan in the twin's chart that is not on ISS?

Beginning May 1, when you serve twins, you will do:

Two Infant Risk Identifiers

Two POCs

Two physician communications

Blended visits with documentation on both infants on the same Progress Note

Two Discharge Summaries

MIHP Training

1. Have you thought about giving training (webcast) about home visitor safety?

*We believe it's best if you contact your local, county, or State police to provide this training for you, as they can tailor it to your community. Another possibility is to invite police officers to provide a home visitor safety training at a regional MIHP provider group meeting. **It is your responsibility to ensure that all of your home visitors are properly trained on home visitor safety.** You may wish to review the home visitor safety resources that are posted on the MIHP web site that.*

2. Why don't we have substance abuse trainings regarding the actual abuse, for example, methadone training – what to look for during pregnancy, post pregnancy, and in infant. Medical MJ and what we need to chart. Technically, it's treatment, as is methadone/suboxone, so do we pull drug-exposed?

Substance abuse fact sheets from the September 2011 regional coordinator meetings have been posted on the MIHP web site.

Consents

1. Consent to Release Protected Health Info - do you need to add the OB doctor again under name of provider list?

No.

2. Regarding the other forms that we still have on paper which are HIPAA, Release of Information, and Consent for Services, all of which are signed by the client: Is it acceptable that we scan the forms into the individual EMR in Insight and then shred the original, or must we keep the original?

You can shred the original after scanning. We recommend that you have a back-up system in place for all of your electronic medical records.

3. Can a woman transfer from one MIHP to another without agreeing to release info?

No.

4. We have a 15-year-old client that just had her baby and has been removed from her mother's home by CPS. We are concerned with consent. Is the 15-year-old able to sign for herself and her baby or do we need the 15-year-old's guardian to sign as well? Is the 1-year-old considered the guardian of her baby? The 15-year-old is living with her cousin who according to CPS has temporary custody. We had the cousin sign all consents at the open as well as the client, however we were confused as to who the baby's guardian would be? The staff also wondered if the issues would be the same if the client was 16 instead of 15.

The 15-year-old is the baby's guardian. Also, over age 12, a minor can consent to MIHP services, since MIHP is considered to be a reproductive health services program.

Other

1. Blended services between maternal and infant – which paperwork required and how should documentation be done?

Documentation (Risk Identifier, POC, and Progress Notes) should be in the chart of the beneficiary whose Medicaid ID number is being used for billing purposes.

2. Need a policy if agency chooses not to send mom's info to pediatrician.

This decision is up to each individual MIHP agency.

3. Are MIHPs required to have staff conduct TB testing and have CPR training done because of the unique population of pregnant moms and infants we deal with?

No.

4. Everything sounds good - comments - but we have agencies that don't embrace each other.

Thank you for your comment.

5. Can we possibly have a list of MIHP providers by county also? It can be very hard to find a provider in larger areas when a client needs to be transferred.

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Go to the online "MIHP Coordinators and Transportation Directory" and enter the county you need in the "find" or "search" box. Keep hitting "next" until you've searched the entire directory and you will have identified all of the providers serving that county.

6. Are you going to make new forms for "referrals from doctors to MIHP" for moms and infants?

No.

7. Will NICU graduates (born out of state) be eligible for home visiting services through MIHP (they are Michigan residents)?

Yes.