

Q & A

September 2015 MIHP Coordinator Trainings

Discharge Summary

1. Maternal DS asks for duration of breastfeeding. This is inappropriate as she just had the baby.

Some MIHP agencies wait to discharge maternal beneficiaries until two months postpartum. We are working hard to collect information on breastfeeding among MIHP beneficiaries.

2. Drop down menu on Discharge Summary on 2 prepopulated boxes: Male/Female and Yes/No (infant followed in MIHP).

Federal guidelines require that we offer the male/female option, although the *Maternal Discharge Summary* for this field defaults to female. If you need to change the gender of the mother or the infant is not followed in MIHP, you must use the drop-down menu.

3. Recently I haven't been able to close infants that have inactive Medicaid. Also Maternal Considerations will not close because for some reason, their Medicaid ID is not showing up on closure paperwork, but is on the original identifier. So I used written closure. Is that ok?

No, a paper *Discharge Summary* is not acceptable. *Discharge Summary* data must be entered into the MIHP database. If you are having issues with the *Discharge Summary* for a particular beneficiary, contact your consultant.

4. I think it would be a great idea to have a standard patient questionnaire or survey for patients who have completed the program; not discharged for non-communication reasons. More consistencies with procedure information. One way.

We think this is important too and are taking it under consideration.

Information Technology (IT)

1. Please add a MIHP provider to the workgroup of computer projects for MIHP to help prioritize needed projects. Thank you.

The MIHP IT team encourages provider feedback and carefully considers it as IT projects are prioritized.

2. When will progress notes and other forms be available as online forms? This has been a priority project for years and some of us are holding off on key decisions based on this time frame.
3. The MIHP electronic progress note was discussed at previous coordinators meeting and a projected date for release was given. Why was this postponed again and other things have taken priority? We need that promise kept!
4. Please, please finish putting all forms online!! We have waited long enough. This should become a top priority!

The electronic progress note and other electronic forms are still on the list of IT priorities, but we are unable to say when they will be available due to multiple competing priorities.

5. Our hospital requires us to use IE 10. They will not allow 8, 9, or 11 due to security issues.
6. If the computer version of d/c is correct, but the printed version does not match because we are forced to use IE9 due to county requirements, will this computer version as correct be acceptable?

The MIHP application is not compatible with the IE9 or IE10. To assure continuous quality improvement, we continue to assess opportunities to make enhancements.

7. If Medicaid number doesn't get entered at screener, could system do a reminder to agencies?

We will take this into consideration.

8. The screen list on the RI shows "complete" even if you forget to fill out the mood hx (under stress/depression section). The RI can even be completed without ever filling this section in.

We need more information about this. Please contact your consultant.

Staffing

1. Tell me a diploma in nursing with 35 years of experience – 20 years of doing this job is sufficient!

Staffing requirements are specified in Medicaid policy.

2. There is no need to give the resumes of MIHP staff for your audit. That appears offensive. We have to provide our scholastic degrees, why is that not enough?

Scholastic degrees are not required by the State, although many MIHP agencies choose to require them.

3. How do you verify a license?

Please see "Licensure and Verification" on page 4.7 of the *MIHP Operations Guide* (11.01.15).

4. Care coordinator should be able to do the *Risk Identifier* – even if he or she is not the RN or SW.

The care coordinator must be an RN or SW. If you mean that the MIHP program coordinator should be able to do the *Risk Identifier*, this is acceptable if he or she is an RN or SW who meets Medicaid policy staffing requirements and is also serving as a care coordinator.

5. Do both the social worker and nurse need to see every patient or just if needed?

In Cycle 6, it will be expected that the SW and RN will each see every beneficiary at least once. If both disciplines do not see the beneficiary at least once, the reason must be documented in the chart (e.g., beneficiary declined visit by the other discipline). The beneficiary's identified risks should determine which discipline or disciplines will conduct the other visits.

Risk Identifier and POC 2

1. On the IRI, why isn't transportation a domain available as a Maternal Consideration?

A POC 2 is not needed in order to provide transportation. You are only required to document why transportation assistance is needed.

2. The Family Planning Care Plan gets pulled in the Risk Identifier on maternal clients, even if it is a planned pregnancy. Is this because of the question: Were you using birth control at the time of getting pregnant? Once this risk is pulled, is it always a risk (even at discharge)? Can this be changed? Is this an exception?

Possible revision is being considered.

3. The Risk Identifier asks about smokeless tobacco. Does this include e-cigarettes? Some clients are answering this question as if it is referring to e-cigs. Will e-cigs be included in the RI in the future? Should we be pulling the Care Plans for this now?

E-cigarettes are considered to be a tobacco product because they contain many of the same ingredients that are found in cigarettes. You may pull the *Smoking/Second-hand Exposure POC 2* when a beneficiary is using e-cigarettes, but you are not required to do so. The FDA has not approved e-cigarettes as a device for quitting tobacco; more research is needed. There may be training resources in your community. A brochure titled *The Truth About Vaping, E-Cigs and Hookah Pens* may be purchased from Journeyworks Health Promotion and Health Education Publishing, PO Box 8466, Santa Cruz, CA 95061. www.journeyworks.com

4. Under Breastfeeding on the RI. After clients report never breastfeeding before, there is no option for marking an unsuccessful experience. What should be done with attempts to initiate?

Any attempt to initiate breastfeeding counts as breastfeeding on the *Risk Identifier*.

ASQ

1. If the ASQ: SE is done at 3, 4, 5 months and I did not do another ASQ: SE until 12 months. I still did it in correct age range for the tool. Shouldn't that be ok?

Please see the *MIHP Operations Guide (11-01-15)*, pages 8.44 – 8.45, for the ASQ: SE-2 MIHP screening intervals. These screening intervals will be required in Cycle 6. However, we encourage you to start using them now.

2. Can we pull the POC 2 and notify MD when ASQ-3 gray area is in same area, not two different areas?

You should pull the POC 2 in this situation. You may pull the POC 2 whenever you have a concern about an infant's development. Err on the side of caution. If you add a domain to the POC 2, follow the regular procedure to notify the medical care provider of this significant change.

3. Guidance manual, pg 8.48 (top paragraph) *After 2 months old. Pg. 8.49 at bottom – 2 successive ASQ-3 (close to cutoff).

Please see the Developmental Screening section of the *MIHP Operations Guide (11-01-15)*, beginning on page 8.42 for updated information.

Substance Use Disorders

Responses to the following six questions were provided by Sara Sircely, Northern Michigan Regional Entity. Sara presented at the Traverse City MIHP coordinator meeting.

1. Can you explain the risk of the infant going through withdrawal from Methadone/Suboxone and experiencing those same symptoms?

Let me start by noting that infants exposed to opioids while in utero will experience symptoms of Neonatal Abstinence Syndrome (NAS) shortly after birth. This will usually require that the infant stay in the NICU and receive medications to control their withdrawal symptoms. Hospitals are developing protocols for managing NAS and becoming more aware of the importance of encouraging the bond between mother and infant during that time. Thankfully, there are no long term repercussions from NAS and the infant has an excellent chance in life if the mother's recovery and needs can be supported and sustained. That said, Methadone is an opiate. However it is dose controlled and much safer than street drugs as it is medically monitored and the individual receives counseling services as well. Because methadone is an opiate it is possible that the baby will experience NAS. However many of the other issues that come with untreated substance use (smoking, poor nutrition, etc.) are not issue when taking methadone as medication assisted treatment. With Suboxone, it is a partial agonist which is effective with managing withdrawal symptoms and keeping a woman from going through withdrawal (the purpose of using Methadone and Suboxone). From subjective information from NICU Doctors it's been reported babies whose mothers are on Suboxone tend to stay in the NICU for shorter amounts of time.

Babies who are going through withdrawal are medically managed in the NICU. I've heard that many NICUs are now using Methadone to treat NAS but each center would have their specific protocols to follow. Symptoms of NAS include excessive crying, fever, irritability, seizures, slow weight gain, tremors, diarrhea, vomiting, and possibly death.

2. Please explain weaning from Methadone as an option.

Weaning from methadone is a very slow process once an effective dosage has been established. This is due to the risk factors involved. Going from a level that is comfortable and staving off withdrawal to a lower level would increase discomfort not only for mom but for baby as well. This is why weaning is done slowly and with a lot of coordination between medical staff, counseling staff and client. Weaning also increases the risk of relapse as the individual is slowly going through withdrawal. Albeit at slow and incremental steps but it is withdrawal. The whole reason methadone is the standard for treating pregnant women with an opiate use disorder is that it staves off the withdrawal due to the high risk of fetus death when withdrawal occurs.

3. What education is provided regarding their ability to breastfeed while on Methadone/Suboxone?

The education provided about the ability to breastfeed would depend on a woman's doctors. And, the education appears to be quite varied. All the articles I have seen say that the

benefits of breastfeeding far outweigh the risks. In addition, the fact that the small amount of methadone or buprenorphine (Suboxone) found in breastmilk help with the withdrawal symptoms and as baby begins naturally weaning so does the dose.

4. Could you share the literature on breastfeeding when taking suboxone?

A lot of literature can be found on the internet but SAMSHA publishes *Treatment Improvement Protocols (TIPS)*. TIP 40, Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, goes over breastfeeding while taking buprenorphine on Page 70.

5. Is it true that only 1% of drug abusers quit for good?

That number seems extremely low. Substance use statistics in general are very difficult to obtain due to stigma and what substances are being reviewed (all substances including coffee, nicotine, etc. or just illicit substances). I've heard around 30% on average.

6. This may be a question for Sara Sircely but... On the substance abuse presentation it is mentioned under biological and psychological characteristics: "Medical/Disorders & Gynecological Needs." What is meant by this?

This was focusing on the fact that moderate to heavy substance use increases specific health risks and physical disorders among women. Alcohol use significantly increases risk for breast and other cancers, osteoporosis in premenopausal women, peripheral neuropathy, and cognitive impairments. In addition, women develop cirrhosis, and heart and nerve damage with fewer years of heavy drinking and illicit drug use is associated with greater risk for liver and kidney diseases, bacterial infections, and opportunistic diseases. Substances have quite a negative effect on the reproductive processes- such as the role of heavy alcohol consumption on infertility and drug use on menstrual cycles. Many young and low income women have never even had a gynecological exam.

Medicaid

1. Pending lactation consultant policy – two visits. Who can we contact to encourage getting this approved? Thanks you!

The policy has already passed the public comment period.

2. Will MIHP providers have a signed agreement with each of the 7 MI Health Link (Medicare and Medicaid dual eligibles) Integrated Care Organizations (ICOs) or only if we have an ICO beneficiary?

MIHP providers may choose to have a signed agreement/contract with an ICO in order to service beneficiaries of that particular ICO.

3. We need to be able to communicate with the state DHS. They have nothing to do with us as to returning calls to help to set up clients. We have clients that have a hard time getting enrolled, therefore can't be an MIHP client with us.

We appreciate the feedback, however at this time, no system changes are anticipated.

Medicaid Reimbursement

1. ASQ takes longer than 30 minutes. Any chance for separate billing/payment above MIHP visit billed?

Not at this time.

2. Have you considered allowing us to bill for an hour for a proper time for an ASQ or ASQ: SE? Thirty minutes is not enough time.

Not at this time.

3. Reimbursement for discharges so there is more incentive to complete them in a timely manner.

Not at this time.

4. Increase pay or downgrade the certification degree for social workers and nurses. We have a high turnover because of the workload.

Not at this time.

5. Increasing reimbursement would improve MIHP.

Thank you for your feedback.

6. Will MIHP ever see an increase in pay rate for MIHP visits?

Rates for MIHP services are reviewed on an annual basis to confirm that they are in alignment with other Medicaid reimbursable services. In is not anticipated that there will be an increase in the rates for MIHP services in the near future.

7. If you are a LBSW but don't have a social work degree but a Masters in Counseling and licensed which is eligible to bill through Medicaid, can they be considered?

Refer to Section 1.2 Staff Credentials, MIHP Chapter, *Medicaid Provider Manual*.

Training and TA

Requests for PPT Slides

1. Please send Top 10 Not Met Indicators slide in coordinator email. It's not legible on the handout. Thx!

This slide has been updated and will be presented at the February 18 MIHP webcast.

2. Follow-along guides with snapshots of slides are mostly unreadable due to size. Please consider eliminating the # of lines for notes and enlarging text and/or making snapshots larger. I would like to be able to review, share or copy charts and show other staff later, but cannot slides are illegible. Thank you.

We are working on this in order to approve future presentations.

3. Please send slide re: reactivation and deletions.

This has been addressed.

Face-to-Face Coordinator Meetings

1. Please consider doing MIHP updates earlier in the day so you don't have to rush through the material.

We are taking this into consideration.

2. May I suggest that no announcements about policy or program updates be made until policy or updates are finalized.

Your suggestion has been taken under advisement. Medicaid policy must be distributed for public comment before it can be finalized. Also, we often ask for provider input before decisions are made.

3. Please consider coordinator's training date NOT in the summer.
4. Please have face-to-face meetings in Sept or at least NOT in the summer.

When scheduling the June 2016 coordinator's training, we did consider school vacations, travel issues, and other considerations.

5. Please put education training online so each program can view with staff. Keep coordinator meetings for program specific items changes, updates, and questions. Also, if trainings provide info for all counties represented.

We plan to offer educational sessions for all staff as part of the MIHP live webcasts scheduled for February 18, 2016 (9:00 am to 12:00 pm), and September 2016.

6. Loved the 2nd half of the coordinator training. (All the stuff after lunch.) Thank you! Also want to thank the consultants for all of their professional, timely assistance with the "cries for help" we constantly throw at you all! Smiley face. Thanks!

You are very welcome.

Two Webcasts in Lieu of One Face-to-Face Coordinator Meeting

1. Don't have webcast during lunch, please, so that we don't have to provide lunch.
2. Consider less than full-day webcast – it's hard enough to stay engaged live. Also, I'll miss the opportunity to network.

The live webcasts will run from 9:00 am to 12:00 noon.

Forms

1. New forms and revised forms should be introduced at the Coordinator Training before implementation. This will allow staff time to address questions/input timely.

We were able to do this in some years, but the timing, in the context of competing priorities, does not allow us to do it every year.

2. New forms should only be issued and Personnel Rosters due once a year. Too much frequent change all the time. Very hard on staff.

We'll revise the form to make it easier to use, but we need it quarterly for SSO and monitoring purposes. If there are no changes in a quarter, all you have to do is change the date and re-submit it.

3. Could ROI and consent to participate be all in one form?

MDHHS Office of Legal Affairs has indicated that these forms need to be separate.

4. Also consider revising the consent forms. They are confusing and not user-friendly in the field.

They were revised and posted November, 2015.

5. Could we have new forms instructions in writing?

Yes, they are now posted on the web site.

6. Please fix the drug exposed infant visit note; the signature of the visitor and date on the bottom of the page.

When typing text in this document, the text moves down the page. After typing in each section, make sure to delete the extra spaces after what you've written, which will move the text back up the page.

Requests for Documents on Web Site

1. Could we get an easy to find MIHP directory by county on the web site?

We will add a separate link titled *MIHP Coordinator Directory*. Once you are in the directory, click at the top of the column heading to sort by county or by any other field.

2. Can we get an easy to find EPDS on the web site that is printable in English, Spanish and Arabic?

We will move the *EPDS (English version)* up to a higher position on the *Program Documents and Guidance* list on the *Policy and Operations* web site page. Also, we are in the process of obtaining the *EPDS* in other languages and will post these versions as soon as possible.

Requests to Improve MIHP Processes

1. MIHP Personnel Roster – when sending a revised document for MIHP coordinators to use, please name it the same as the previous version with the revision date at the end. This way we can easily save it to our computers and it will show up next to the previous version. It would really help keep us organized.

We continue to work on consistency as we revise and re-date MIHP documents. When we revise the MIHP forms annually in the fall, we almost always keep the same form name, but use the new date of revision (which is the same on all forms – even if they were no changes to a particular form). If we must revise a single form before the next annual release, we use the same document name and date, but add the revision number and date.

2. We need a better process for record deletion and activation. Some requests go unanswered. A quick follow-up email or call would be appreciated to confirm receipt or if something was wrong with the request.

We are working to improve our response time. If you don't receive an email response to your request within 72 hours, contact your consultant.

Home Visiting Conference

1. Can home visiting conference be closer? (submitted by person from the north)

The contract with the Detroit Marriott at the Renaissance Center is a two-year contract, so the conference will be held there again in 2016. Other venues will be asked to bid for the 2017 conference, however the number of facilities in Michigan that can handle such a large group is limited.

2. Could the home visiting conference be held in a different week in August? Maybe alternate as that week we have the fair to which my kids take animals. Maybe hold next conference the 2nd week in August and the following year the first week? Would have loved to go this year. (submitted by person from Northern Michigan)

The 2016 conference dates have already been determined.

Other

1. Can the coordinator emails be posted on the MIHP web site or why aren't the coordinator emails posted on the web site?

Coordinator emails are sent directly to MIHP coordinators. We looked into the possibility of posting the coordinator emails on the web site and found it was not administratively efficient. FY 13-14 Coordinator emails may be accessed through the MDHHS-File Transfer areas of the Single Sign-On (SSO) system. FY 14-15 and FY 15-16 coordinator emails may be accessed through CHAMPS.

2. Is it possible to have written times for web casts when different portions are discussed (i.e., if we just want to review discharge portion or if we just want to update on progress note so we can go directly to that section)?

The Forms webcast is obsolete and is no longer available. Now forms instructions are available in writing at the MIHP web site.

3. Can the state present on the MIHP program to DHS? DHS doesn't seem to utilize the program for prevention.

We have done an MIHP presentation for local DHHS directors in Wayne County. We are considering the possibility of taping and posting an MIHP video for local office MDHHS staff who work directly with MIHP beneficiaries and their supervisors.

4. We need resources for Wayne County.

Please talk with your consultant about the specific type of resources needed.

MIHP Transition into Medicaid Health Plans

All questions related to the Medicaid Health Plan RFP will be answered when the contract process is complete. We appreciate the feedback and comments and will bring those to the table when the discussion process, specific to MIHP services, begins.

1. How and why did MIHP get carved out?
2. Who is the advocate for MIHP related to MIHP policy and contract changes? Please provide contact information.
3. Who is directly involved in influencing changes to MIHP? Which people, agencies or associations help to drive changes to positively impact the MIHP program in terms of certification, billing, allowable reimbursements, reimbursement amount, and changes to POC 2?
4. Please explain “carve out” as it relates to MIHP. How is this different from what exists currently?
5. Who’s responsibility was it to advocate for MIHP so that we did not get “carved out” (i.e., screwed)?
6. Will health plans be able to ration MIHP care?
7. Will we have to learn multiple billing systems for each plan?
8. Will different health plans pay different amounts?
9. Medicaid MIHP carve out concerns:
 - a. Lapse of service waiting for authorizations.
 - b. Increased need for more staff to request and track authorizations.
 - c. Decreased knowledge re: all different billing practices associated with each MIHP.
 - d. Past experiences – decreased number of MIHP visits performed; increased hoops to jump through; disjointed services.
 - e. Clients switch health plans frequently.
 - f. Still have an issue with transportation. MHPs are not transporting to WIC.
 - g. **WHY** are they doing this?!
10. We are an MIHP agency that “lived” through the health plans managing the payment process. The delays and problems encountered were the very reasons the payment process was changed to the State making payments. Here are the main concerns:
 - a. Provider contract with each HMO.

b. Provider approval process.

c. Each of these steps caused a significant delay in the start of care and subsequent visits.

I know from personal experience that 95% of current MIHP providers do not have a contract with the HMOs. What happens then?

11. The MIHP agencies that were around during the time when the health plans were making payments should be asked to participate in this process. Crystal Home Health Care is one. Speaking on this issue could be equivalent to testifying. We should also be allowed to participate in the policy and procedures.
12. I have concerns the MHPs are/will take away what the program is established to do. We still have a "sour" taste about MHPs taking transportation away from LHDs. This will not get better, only worse, if MHPs take the program over. Public health and what we stand for should not be conducted by people that have no knowledge or background on what we do and why we do it.
13. I have many concerns about the MHP rebid. This could be a positive move but based on history, this change could place many barriers to providing cost effective, quality, and experienced MIHP services to those we serve in our MIHP. Why would the MHP want to pay for our services when they already have their own staff and employees? What will this do to the fidelity of MIHP, the evidence-based approach? The expertise? Will the MHP have control of how MIHP is administered? I will be emailing questions and concerns to Medicaid.
14. Grave concern for MIHP to go back to MHPs as it increases admin responsibilities to call for PA for visits. PA process for MIHP would be inappropriate as MIHP is a MA benefit for all pregnant women and newborn infants.

Improve Certification Process

The Cycle 6 certification process is currently under development. All of the comments below are being taken into consideration and some will be incorporated, as appropriate.

Extend Time between Reviews

1. If you pass certification with a good review, extend the time before you have to re-certify. Expend more effort and energy on agencies that are struggling.
2. Push cycle out to 2 years instead of 18 months.
3. For programs that are not new, change recertification to a longer cycle – every 2 years.
4. I suggest changing how often the reviews are completed from 18 months to 36 months.
5. Return to every 3 year certification, not 18 months.
6. Certification should be every 3 years, same as accreditation. Every 18 months is very labor intensive.
7. More time between surveys – Joint Commission is every 3 years! Maybe have agencies that are just starting do the 18 months, then after you reach 5-year or 10-year mark, every 3 years.
8. For agencies with consecutive good reviews to increase the certification period to 3 yrs.

Certification Process Training for Coordinators

1. Train coordinators the same way the reviewers are trained.
2. Train the coordinators properly. They should have the same training as the reviewers.
3. Surveyors covered by state to pre-survey agencies. Allowance for auditors 2 to 4 times a year for MIHP agency prior to audit. Since you love us and don't want us to fail, help prepare MIHP agency. Adopt policy: NO AGENCY LEFT BEHIND!
4. Assist in additional education from State when Not Mets have occurred. In the past, we have had several cycles when r/t POC 2's and discharges that shows our staff needed extra help in these areas.
5. We recently had a new MIHP coordinator start in our program and she claims to have been told we cannot check "neither" in the text4baby, Maternal/Infant education packet - we have to check text4baby or education packet. We were told in the MIHP training on the web site that we could if they were not addressed. I think coordinators need personal training and tested. Not just allowed to view online.

Opportunity to Evaluate MIHP State Team

1. Include an opportunity to evaluate the state's performance of coordinating, supporting and meeting the needs of the various programs.

2. All surveyors are not on the same page.
3. Surveyors need a survey themselves!

Requiring 40 Charts to Conduct Certification Review

1. Clearly define 40 cases requirement, i.e., “since last audit.”
2. Eliminate requirement for 40 open and closed charts.

Reviewers are Helpful

1. Like the reviewers – all knowledgeable and willing to explain issues/problems. The process is fine and helpful.
2. I was impressed with how much time they allowed for questions and explanations.

Review Should Focus More on Program Quality, Not Just on Documentation

1. More programmatic evaluation of services. Too much emphasis on check boxes and details. Give credit for program quality other than documentation only. Look at substance and story of notes, rather than just how to check boxes.
2. Staff feel like they are not given enough recognition or credit for services provided. They feel like too much of the review is documentation indicators – which is important for an evidence-based program but too much is based on a check box – not on the quality of services.
3. I would want it to be more educational than punitive. You should not face being shut down because you forget to check boxes or because you forgot to put your credentials.

Tell Us Which Charts had Errors

1. Post review, the reviewer should show coordinators specific examples of findings. Ex: Show them specifically what they did incorrectly – assessment, ASQ, Progress Note, POC, etc.
2. It would be nice to know which charts have errors so that we can assist staff in correcting errors.

Other

1. Keep the same reviewer at the agency each year. This allows them to see/realized changes made.
2. Stop redundant requests for information that does not change from review to review, i.e., 1) managed care agreements, and 2) employees that have been retained from review to review.
3. The communication level and understanding of the day-to-day functioning of the program.
4. Do not try to deem for the second problem twice.

Improve *Certification Tool* Indicators

The *Cycle 6 Certification Tool* is currently under development. All of the comments below are being taken into consideration and some will be incorporated, as appropriate.

Indicators in General

1. So many indicators.
2. There are so many indicators, that I can't think of one at this time. It would be a good idea to ask these questions before we come so we could be better prepared.
3. Consider increasing the allowable Not Met indicators to 8 – 10 due to the large # of indicators.
4. Eliminate critical indicators. When (1) error is noted, it is a Not Met regardless of how many correct charts. This is demeaning.
5. Eliminate all 100% expectations on indicators. There are too many fields that have to be perfect – no room for human error.
6. On indicators that state "80% of documents must meet 100% accuracy," could this be changed to something like "100% of documents need to be 90% complete and correct?" This would ensure documents are more accurate and when only 4 charts are reviewed, one mistake can give you a Not Met on the indicator.
7. One improvement in the review process is to consider not making all the indicators 100% in order to meet standard.
8. When you meet an indicator's requirement, example: MPR states 80% of charts contain whatever they are looking for – it should NOT be considered a Met with Conditions. It is Met.
9. No one is ever perfect; the critical indicators should not be a Not Met if there is only one chart that had one thing or less than 100%.
10. Please consider not requiring agencies to mail staff training info, license, policies, if they have been reviewed in the past and there have been no changes.

POC 2

1. POC 2 – change criteria so that all POC 2 interventions can be used regardless of level of risk.
2. Allow for different levels of intervention based on the needs of client. Not all "higher" interventions belong solely to high risk. To put those in "other visit info" seems distracting and disjointed.
3. Can we have a list of interventions for each risk that are available to use for every risk level? Some clients score out at a low or moderate risk level, but the interventions that are most appropriate are considered high risk interventions.
4. POC 2 – do not focus so much on the dates on the POCs as long as the POC 3s are 10 days apart.

5. POC 2 – don't focus on the little things that don't affect quality of care (i.e., dates for POC 1, 2, 3 on checklist page.)
6. What difference does it make what date an intervention is taught the first time and all the documentation on the POC 2? The fact is it was taught and probably over and over again.

ASQ

1. There is too much in the ASQ indicator. It needs to be broken down. With so many sub points, it's difficult to pass every one.
2. ASQs should be reviewed on a percentage of ASQs reviewed, not the number of charts reviewed.
3. Consider changing #26 to % of ASQs somehow so that 1 or 2 erroneous ASQs don't make such a large impact.
4. ASQ timing of when to administer is still so confusing. One auditor said yes and another said no to the timing of ASQ administered in a similar situation. Need more or definite timing guidelines.
5. ASQ should be less strict. It's hard to locate client. They are in crisis at appointments.

Blended Visits

1. Blended visits need help with understanding. Too complicated. I see doing the second infant screener but put it in first infant chart and just document 2nd on PVPN and discharging one client.
2. Blended visit: Op Guide states "When two or more family members have had a RI completed, professional visits (after the RI visit) must be blended." Here is how I have interpreted this: When screening a baby at a maternal postpartum visit, I understood that, because at that visit, I would be billing two separate Medicaid IDs. I did NOT check blended visit that day (on mom's progress note). PLEASE CLARIFY.
3. Blended visits.

Other

1. #56. So hard to pass! Can it be weighted?
2. For MIHP roster, only have us send it in once a year or if there is a change in staffing.
3. Forms or POCs because they are not on computer. The process is not designed to be half on computer and half on hard copy. It's not fair when the process is not in place.
4. Stop sweating the small stuff!
5. Mandatory assistance with keeping and scheduling postpartum visit 21-56 days after delivery.
6. Mandatory assistance with scheduling and keeping first 2 sets of shots for newborns at 2 months and 4 months.