



Certification Specifications

**Maternal Infant Health Program
Division of Maternal and Infant Health
Bureau of Health and Wellness
Public Health Administration
Michigan Department of Health and Human Services**

Certification Tool: Cycle 9

Effective Date: June 1, 2022

Measurement Implementation Date: June 1, 2023

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References

Medicaid Provider Manual: Maternal Infant Health Program Chapter
Maternal Infant Health Program Operations Guide (Corresponding Section Numbers)

Scoring Information

- Each indicator has an identified weight in the right-most column, ranging from 1 to 5.
- Each indicator weight will be multiplied based on the following:
 - Met: x2
 - Partially Met: x1
 - Not Met: x0
- EXAMPLE:
 - For an indicator with a weight of 4, a provider who meets all of the requirements will earn 8 points ($4 \times 2 = 8$).
 - For an indicator with a weight of 4, a provider who meets some of the requirements will earn 4 points ($4 \times 1 = 4$).
 - For an indicator with a weight of 4, a provider who does not meet any of the requirements will earn 0 points ($4 \times 0 = 0$).
- The entire Certification Tool is worth 254 points. Certification status thresholds are as follows:
 - Full Certification: 85%
 - Conditional Certification: 70%
- NOTE: Some indicators may not be relevant to all providers. Additionally, not all indicators may be seen during a chart review. In those instances, the provider will receive an NA for that indicator and the total number of points possible will be reconfigured. The percent necessary to pass will remain.

The highlighted areas are new or revised indicators.

For information regarding specific requirements, please see the corresponding section in the Operations Guide.

Rev. 5.5.23 to reflect telehealth policies effective 5.12.23.

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Section 0 – General Certification Requirements			
0.1	Protocol and Document Submission	Protocols and Pre-review Documents (including beneficiary charts records) are submitted as required. NOTE REGARDING CLOSED CHARTS: only documents submitted as requested will be reviewed.	2
0.2	Corrective Action Plan (CAP) (Submission)	The following is accurate, when applicable: <ul style="list-style-type: none"> • Corrective Action Plan from previous review was submitted within the required timeframe • Corrective Action Plan was approved within three submissions 	3
Section 1 – Personnel & Training			
1.1^	Personnel Rosters	Personnel rosters are submitted as required.	2
1.2^	Licensure and Experience	Staff files indicate all Home Visitors conducting visits meet licensing and experience or waiver requirements.	4
1.3^	Staff Training	Review of staff files indicates all training and additional waiver staff requirements are met.	4
1.4	Ongoing Trainings	MDHHS attendance certificates indicate coordinator or designee attended all required trainings since the previous review.	3
Section 2 – Facility, Technology & PHI			
2.1	ID Badges	Staff ID badges meet requirements.	1
2.2	Provider Communication	The following is accurate: <ul style="list-style-type: none"> • The provider’s business phone is up-to-date and the message includes after-hours emergency information, including directions to call 9-1-1 or go to the nearest emergency room. • The provider communicates service delivery changes to MDHHS. • The provider is responsive to MDHHS inquiries and emails within the required timeframe. 	2
2.3	Facility	Facility meets requirements.	3

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2.4	PHI	All PHI is stored using a triple-locking system, unless actively in use.	3
Section 3 – Quality Assurance			
3.1**	Quality Assurance	Chart and billing audits at least quarterly and documented in accordance with provider protocol.	3
3.2	CAP (Improvement)	<p>Critical indicators (those weighted 3, 4, or 5) have demonstrated improvement since previous review based on percentage documented on data sheet of certification tool.</p> <ul style="list-style-type: none"> • 6 or more indicators – 4 or more • 4 – 5 indicators – 3 or more • 1 – 3 indicators – 1 or more 	2
Section 4 – Contracts & Community Engagement			
4.1	Contracts	Contracts for billable MIHP services are current.	1
4.2	Backup Staffing	Provider has written verification that backup staffing provider or individual identified in protocol has agreed to the backup staffing plan.	1
4.3	Resources	<p>Provider:</p> <ul style="list-style-type: none"> • Is actively linked to the Great Start Collaborative in each of the counties in their service area • Demonstrates knowledge of community resources in each of the counties in their service area 	2
Section 5 – Outreach & Enrollment			
5.1	Outreach	<ul style="list-style-type: none"> • Outreach is conducted and documented in accordance with provider protocol and illustrates outreach is conducted in each county served by the provider. • Documentation must be maintained in one location. 	2
5.2**	Referrals to MIHP	Referred beneficiary was contacted within the required timeframe.	3

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5.3 [^]	Consent to Participate	<ul style="list-style-type: none"> • Appropriate consent is dated on or before the Risk Identifier date and there are no alterations to the document. • Consent is signed by beneficiary/caregiver. 	3
5.4 [^]	Consent to Release PHI	<ul style="list-style-type: none"> • There is no evidence that the provider has violated the beneficiary's consent and there are no alterations to the document. • Consent is signed by beneficiary/caregiver. 	4
5.5 [^]	Risk Identifier	<p>Risk Identifier:</p> <ul style="list-style-type: none"> • Is conducted by a licensed social worker or registered nurse • Is completed prior to additional MIHP services, unless an emergency is documented • Approval of exception is included for Risk Identifiers that scored with no risk 	4
5.6 [^]	Welcome Packet	Welcome Packet includes all required documents.	2
5.7 ^{**}	Plan of Care, Part 2	<p>The following is accurate:</p> <ul style="list-style-type: none"> • All POC2 domains identified on the Risk Identifier scoresheet or by professional judgement must be added to the beneficiary's chart • Any intervention level change is documented appropriately • Additional domains added based on professional judgement are documented appropriately 	3
5.8 ^{**}	Plan of Care, Part 3	<p>The following is accurate:</p> <ul style="list-style-type: none"> • Both disciplines sign the form within 10 days of each other • Form is dated prior to any visits, unless an emergency is documented • Updated signatures are obtained within 10 days of each other when any additional POC 2 are added 	3
5.9	Beneficiary Transfers	Receiving provider does not serve the beneficiary prior to receiving documents from the sending provider, unless an emergency is documented.	2

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5.10**	Forms / Documents	<p>The following is accurate:</p> <ul style="list-style-type: none"> • Provider uses current versions of the required standardized forms, <i>or</i> • Physical or electronic records include the required data elements in the same order as current versions of the required standardized forms • Altered chart entries follow the required guidelines. • All required forms and documents are present, when applicable, and complete with respect to the required data elements indicated on the instructions. 	2
5.11**	Immunizations and Michigan Care Improvement Registry (MCIR)	<p>Michigan Care Improvement Registry (MCIR) immunization assessment, discussion and documentation required:</p> <ul style="list-style-type: none"> • At the first visit for all maternal beneficiaries. • At least twice during the infant’s care as follows: <ul style="list-style-type: none"> ○ As soon as possible following enrollment but no later than the third professional visit. ○ At first professional visit after 5 months of age for infants (or if enrolled after five months, a second time prior to discharge) ○ If infant remains enrolled beyond 16 months of age, an additional/third MCIR pulled prior to discharge • MCIR documentation must be located in the MIHP beneficiary charts (or a screen shot of attempts). A MCIR pulled at or after discharge does not meet the MCIR documentation requirement. • If immunization status is not discussed at a given visit or the MCIR is not reviewed at the appropriate timeframe, PVPN or Contact Log must illustrate the reason why. 	4
Section 6 – Communication & Professional Visits			
6.1*/**	Communication with Medical Care Provider	Medical care provider was sent the required documentation in the required timeframes.	3

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6.2*/^^	Visits from Required Disciplines	The beneficiary received at least one visit from both the nurse and the social worker during the course of service, or there is documentation on the Contact Log as to why not.	5
6.3*/^^	Maternal Home Visits	The required prenatal and postpartum home visits were conducted, unless documentation on the Contact Log shows the beneficiary declined. Based on the telehealth policy this indicator is a N/A.	NA
6.4**	Professional Visit Progress Note	<p>The following is accurate:</p> <ul style="list-style-type: none"> • At least one of the following is addressed at every visit: <ul style="list-style-type: none"> ○ Plan of Care risk domain interventions ○ Topics identified by the beneficiary ○ Topics identified through professional judgement of the Home Visitor • Beneficiary/caregiver's response to the visit intervention(s)/issues is documented from beneficiary perspective • Beneficiary/caregiver's feedback regarding the visit is documented • Documentation illustrates visits last a minimum of 30 minutes • Reason for community visit is documented, when applicable 	5
6.5*/^^	POC 2 Domains	All domains are addressed prior to discharge, or there is documentation on the Contact Log as to why not.	4
6.6**	High Risk Domains	High risk domains are addressed within the first three visits, or there is documentation on the PVPN or Contact Log as to why not.	5
6.7*/**	Safety Plan	Safety plan is discussed/developed with the beneficiary caregiver under the required circumstances, and the POC2 intervention number for that domain is documented, or there is documentation on the Contact Log as to why not.	4
6.8*/**	Action Plan	At least one Action Plan is developed during the course of care, the development or review of the Action Plan is documented on the PVPN checkbox, or there is documentation on the Contact Log as to why not.	4

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6.9**	Referrals	<ul style="list-style-type: none"> • Home Visitor makes referrals throughout the beneficiary’s course of care • Referrals documented on the PVPN • Home Visitor follows up on all referrals within three visits of the referral date • Documentation of follow up in the Outcome of Previous Referrals section, or there is documentation on the PVPN or Contact Log as to why not 	5
6.10^^	Telehealth and Home Visits	Provider follows telehealth protocol and requirements.	3
6.11*/**	Stress / Depression	<ul style="list-style-type: none"> • Home Visitor provides a referral for beneficiary whose POC 2 includes the Stress/Depression domain at moderate or high level • Intervention #11 or #12 documented in the domain section • When referral made, documentation present in the New Referral section of the PVPN • If not done, there is documentation on the Contact Log as to why not 	5
6.12*/**	Registered Dietician	<ul style="list-style-type: none"> • Home Visitor provides a referral or RD provides nutrition counseling for a beneficiary whose POC 2 includes high risk on Food/Nutrition domain • When referral provided, Intervention #13 is documented in the domain section and documentation present in the New Referral section of the PVPN • If not done, there is documentation on the Contact Log as to why not 	5
6.13**	Substance-Exposed Infant	<p>The following is accurate for beneficiary whose POC 2 includes Substance Exposed Infant:</p> <ul style="list-style-type: none"> • Substance Exposed Infant Plan of Care domain is added to the POC 2 when Substance Misuse scores on RI • Substance Exposed Infant interventions are initiated within the first three visits of addition to POC 2, regardless of risk level • Substance Exposed Infant interventions are implemented at every visit after the first 18 visits 	5
6.14**	Physician Orders	The following is accurate, when required:	3

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		<ul style="list-style-type: none"> Provider must add the date the order is implemented and the rationale for the order to the Forms Checklist. All necessary physician's orders are present and include all required elements. 	
6.15^^	Monthly Contact	All beneficiaries receive contact at least monthly.	4
6.16**	Bright Futures /ASQ-3	<ul style="list-style-type: none"> Screening repeated within two weeks utilizing the appropriate Bright Futures or ASQ-3 questionnaires if the Risk Identifier scores for Infant Development ASQ-3 screenings and follow up are conducted in accordance with the Operations Guide including: <ul style="list-style-type: none"> Home Visitor must complete the age-appropriate ASQ-3 questionnaire within the first three visits Home Visitor must complete ASQ-3 questionnaire with the caregiver every three to four months for infant whose score is in the white area Follow up occurs in accordance with the Operation Guide 	5
6.17**	ASQ: SE-2	<ul style="list-style-type: none"> Age appropriate ASQ:SE-2 screenings conducted at the times documented in the Operations Guide. Follow up occurs in accordance with the Operation Guide 	5
6.18*/**	Discharge Summary	Discharge summary is completed within the required timeframe.	3

* Denotes the indicator is for closed charts only.

** Denotes the indicator is scored based on the following: 80%-100%=Met; 70-79%=Partially Met; 0%-69%=Not Met

^ Denotes the indicator is scored based on the following: 100%=Met; 0%-99%=Not Met

^^ Denotes the indicator is scored based on the following: 90%-100%=Met; 0%-89%=Not Met

NOTE: Indicators without (**) (^) (^^) are scored based on the following: 100%=Met; 1%-99%=Partially Met; 0%=Not Met

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