Maternity Support Services Infant Case Management Resource Guide

Updated December 2012

Health Care Authority

Table of Contents

Introduction

The Maternity Support Services/Infant Case Management Resource Guide is meant to serve as a support document to the Maternity Support Services (MSS)/ Infant Case Management (ICM), and Childbirth Education (CBE) Billing Instructions. It also provides general information about other related services and practical advice for working effectively with First Steps clients and community resources. The current billing instructions and numbered memoranda for MSS/ICM and CBE are the primary source documents for program requirements. The Maternity Support Services / Infant Case Management Resource Guide replaces the First Steps Manual and is available electronically at: http://hrsa.dshs.wa.gov/firststeps/index.htm

First Steps Overview

First Steps is the term used to describe the program created under the 1989 Maternity Care Access Act (RCW 74.09). This program includes:

Medical Services, including prenatal care, delivery, post pregnancy follow-up, and one year of family planning services post pregnancy for eligible women. Newborns receive one year of full medical care.

Enhanced Services, including:

- Maternity Support Services (MSS),
- Infant Case Management (ICM), and
- Childbirth Education (CBE)

Expedited (quicker access) alcohol and drug assessment and treatment services for eligible pregnant women and their infants. This is offered through the Omnibus Drug Act, which encompasses residential treatment, outpatient treatment and transitional housing (WAC 388-533-0701).

Ancillary services: including expedited eligibility determination, case finding, outreach, and transportation services.

History of First Steps

Late 1980s

During the late 1980s, women across Washington State faced increasing difficulty in accessing prenatal care. Increasing malpractice premiums and low Medicaid reimbursement resulted in a shortage of obstetrical providers. Maternity care providers were increasingly reluctant to provide care to the growing number of Medicaid clients.

1985–87

Private practitioners, representatives of state agencies, public officials, and the University of Washington faculty recognized this crisis in maternity care and formed the Access to Maternity Care Committee, sponsored by the Washington Chapter of the American College of Obstetricians and Gynecologists. This committee was instrumental in identifying major causes of the maternity care crisis and in shaping the First Steps legislation.

1989

In 1989, the Washington State Legislature passed the Maternity Care Access Act. The result of this legislation was to expand eligibility for Medicaid during pregnancy to 185% of the federal poverty level, authorize MSS and MCM (Maternity Case Management) services, increase physician reimbursement for medical care, and initiate a public outreach campaign through the Healthy Mothers Healthy Babies coalition, now known as Within Reach. The Maternity Care Access Act also enabled pregnant women to receive expedited substance abuse assessment and treatment. *[RCW 74.09.790]*

2003

In 2003, the First Steps MSS and ICM program underwent a major redesign to improve the service delivery module while containing costs.

2009

A 20% reduction to the MSS/ICM budget along with a legislative mandate to target service to women at increased risk of poor birth outcomes resulted in another redesign. A First Steps provider workgroup, including DOH, HCA and RDA met for approximately one year to develop a new screening tool. All Medicaid eligible women are screened and the level of service they receive is based on identification of specific risk factors known to be associated with poor birth outcomes. There are three levels of service for MSS and two levels for ICM.

Today

First Steps services continue to evolve as the result of limited resources and evidence based data. Prenatal care to low-income pregnant women and infants remains a priority. Some enhanced services including maternity support, infant case management, childbirth education, and expedited eligibility determinations and referral to DASA (Division of Alcohol and Substance Abuse) services remain available. The current model for MSS and ICM services is being examined to determine if there is a more cost effective strategy to serve pregnant Medicaid women and their infants, especially those with the prioritized risk factors. Women who receive First Steps services remain eligible for family planning only services from Medicaid through one-year post pregnancy.

Maternity Support Services (MSS) Overview

http://maa.dshs.wa.gov/download/publicationsfees.htm

Maternity Support Services are enhanced preventive health services designed to supplement medical visits and include screening, assessment, education, intervention, and brief counseling.

MSS Eligibility

An accelerated application process is available through a Community Service Office (CSO) or call center. To locate the closest CSO, please see: http://www.dshs.wa.gov/onlinecso/findservice.shtml. Medicaid eligibility must be determined prior to the end of the pregnancy.

Teens living with their family can be qualified on their own personal income. Women who receive their medical care through a managed care plan such as the Healthy Options program are also eligible. Full medical coverage is available for pregnant and post-pregnant women who are non-citizens. These clients are exempt from Healthy Options.

Infant Case Management (ICM) Overview

The Infant Case Management program serves high-risk infants and their parents. The purpose of ICM is to improve the welfare of infants by providing parents with information and assistance in order to access needed medical, social, educational, and other services.

ICM Eligibility

Eligibility for ICM may be determined anytime during the ICM eligibility period (which is from the end of the maternity cycle, through the month of the infant's first birthday). For complete ICM eligibility, see the MSS/ICM Billing Instructions at: http://hrsa.dshs.wa.gov/download/Billing_Instructions/MSS-ICM/MSS-ICM_BI.pdf

FIRST STEPS PROGRAM This program helps low-income pregnant women access the health and social services they may need. These services will help you be a healthy mother and have a healthy baby. You can apply for First Steps as soon as you know you're pregnant.				
First Steps Components	**Obstetric/Medical Care**	**Maternity Support Services (MSS)**	**Infant Case Management (ICM)**	**Childbirth Education Classes (CBE)**
Who receives it?	**Income eligible pregnant women and infants**	**Income eligible pregnant women**	**Infants at high risk who are Medicaid eligible and the parents need help**	**Income eligible pregnant women**
What do they receive?	**Full medical services, including prenatal care, delivery and postpartum follow-up, and one year of full medical care for newborn**	**Supportive health services including, screening, assessment, education, interventions, and case management services**	**Case management services**	**At least 8 hours of group childbirth education classes**
When is it provided?	**Pregnancy through two months post-pregnancy for the women, and for the infant through the first birthday**	**Pregnancy through two months post-pregnancy**	**Anytime from three to twelve months old**	**Anytime during the Pregnancy. Usually starts the 3rd trimester**
Who provides it?	**Any Health Care Authority provider approved to provide these medical services**	**A nurse, a dietitian, a counselor and a community health worker who works for a First Steps MSS/ICM agency approved by HCA**	**An ICM qualified provider who works for a First Steps MSS/ICM agency approved by HCA**	**Any qualified childbirth educator and/or organization approved by HCA**
Where is it provided?	**Offices, clinics, hospitals, homes or other sites**	**Offices, homes, and other places**	**Offices, homes, and other places**	**Offices, schools, hospitals and other places**
Additional Services	**Transportation to and from all medical appointments and interpreter services**	**Transportation to and from all MSS appointments and interpreter services**	**Transportation to and from all ICM appointments and interpreter services**	**Transportation to and from all CBE appointments and interpreter services**
****Expedited alcohol and drug and assessment and treatment services**** ****After two months post-pregnancy women will continue to receive Family Planning Only services for an additional 10 months**				
How does a person apply for First Steps	**On the web, go to parenthelp123.org or call the Family Health Hotline at 1-800-322-2588 or the DSHS Customer Service Center at 1-877-501-2233**			

MSS/ICM Provider Agency Requirements and Administration

Information on MSS/ICM provider requirements are in the Billing Instructions

Billing and Reimbursement

Information describing what is reimbursable under MSS/ICM is in the Maternity Support Services and Infant Case Management Services Medicaid Provider Guides (Billing Instructions) at:

http://hrsa.dshs.wa.gov/billing/maternity_support_services.html

First Steps Coordinator

If an agency chooses to identify a person as a First Steps Coordinator, the following list suggests qualifications and roles that person **may** fulfill:

- Demonstrates skills and knowledge in the delivery of services to the maternal child health population
- Relevant experience working with low-income families and/or disparate populations
- Understands the HC Core Provider Agreement, WAC chapter 388-533, the MSS/ICM Billing Instructions and the First Steps Resource Guide in order to provide services that are in alignment with program requirements.
- Participates in meetings (including those convened using technology), trainings, and other interactions with state staff specific to the agency
- Establishes a mechanism to oversee the management and fiscal affairs of MSS and ICM services delivered, which may include the following:
    - Organize and direct the ongoing delivery of client services
    - Accurate documentation of personnel, client, and billing records
    - Participate with the state and other providers to implement quality improvement efforts
    - Assure accuracy of public information materials

- Participate in the recruitment and retention of qualified staff, the implementation of staff orientation and training plans and a method to regularly evaluate staff performance
- Assure that pertinent information (letters, memos and electronic communications) is disseminated to all agency staff providing, overseeing, or billing for MSS/ICM services
- Implement a quality improvement plan to include identification and correction of problems in service delivery system, evaluation of client satisfaction, evaluation of client outcomes, and methods for processing complaints
- Act as a liaison representing the provider to state agencies providing program management
- Inform the appropriate state contact of changes in agency contact person, agency name, mailing address, physical location, phone number, email address, service area or program capacity
- Participate in community collaboration regarding delivery of MSS/ICM services.

Staff Roster

The agency must update the staff roster listing all staff and subcontractors at least every twelve months. The roster must include the full name of staff members, credential /license number when applicable, descriptions of educational degree and years of experience in Maternal and Infant Health, as well as the number of hours each works in the First Steps program. Rosters must be kept for a minimum of 6 years and made available to the Department upon request.

First Steps Email Message Box and State Contacts

Providers will send all questions and other communication regarding Maternity Support Services, Infant Case Management, and Childbirth Education to firststeps@hca.wa.gov

Within Reach- Parent Help 123:

Providers and community members trying to locate a MSS/ICM provider in a given area of the state can log onto http://firststeps.parenthelp123.org/, maintained by WithinReach. In order to keep information about agencies up to date it is the responsibility of each First Steps provider to send updates directly to WithinReach at this email box help@parenthelp123.org

First Steps Childbirth Education providers can also be located by checking the First Steps Website at http://www.hca.wa.gov/medicaid/firststeps/pages/index.aspx, or visiting WithinReach Website at http://parenthelp123.orgpregnancy/childbirth-and-parent-support.

Websites

First Steps: Current information and critical program communications are posted on the First Steps Website. It is up to each provider to check the website on a regular basis to keep informed of the status of the program.
http://www.hca.wa.gov/medicaid/firststeps/pages/index.aspx:

This website contains billing instructions for Maternity Support Services and Infant Case Management. A user's agreement may come up when accessing the DSHS website. Click **Accept** and proceed.

It is important that providers visit this site on a regular basis to ensure the billing instructions being used are the most current.

http://www.hca.wa.gov/medicaid/billing/pages/maternity_support_services.aspx

Reimbursement Schedule: http://www.hca.wa.gov/medicaid/rbrvs/pages/index.aspx#M

MSS/ICM Screening Tools:

http://www.hca.wa.gov/medicaid/firststeps/pages/provider.aspx

The First Steps website contains the MSS/ICM Screening Tool on the Provider Page under "Forms". A user's agreement may come up when accessing the DSHS website. Click **Accept** and proceed.

The following forms can be accessed at this site:

MSS Prenatal Screening Tool

MSS Post Pregnancy Screening Tool

ICM Screening Tool

Service Delivery Model

Client Centered Services

Services in First Steps are client centered and focus on helping pregnant women understand their "risk factors: that could lead to poor birth outcomes. The First Steps provider is expected to use clinical judgment and expertise to develop interventions specific to the identified risk factors with the goal to improve pregnancy, birth and parenting outcomes. Client-centered means that the client comes first in the service delivery relationship.

A client-centered approach includes:

- Delivering services in an environment where a client can expect understanding, respect, fairness, accurate information, convenience, and results.
- Determining the pregnant woman understands positive pregnancy and parenting health care practices and the presence of specific risk factors targeted by the program through review of the screening guide or similar tool.
- Developing a plan for care, in collaboration with the pregnant woman and interdisciplinary team members, that prioritizes targeted risk factors to support positive birth outcomes.
- Providing interventions related to targeted risk factors to reduce the risk of adverse pregnancy and parenting outcomes as defined by the MSS/ICM program.
- Using communication skills such as Motivational Interviewing to:
    - Expand the client's understanding of her situation;
    - Support and guide the woman by exploring risks and how those risks may affect her or her infant;
    - Discuss what she is willing to do to reduce or eliminate the risks; and
    - Problem-solve collaboratively to reduce barriers or access services to help her achieve her goals.
- Referring and linking the woman to appropriate services when situations of immediate risk to the life of the woman, infant or family are disclosed and/or recognized, i.e. domestic violence, suicidal ideation with a plan, child abuse, or neglect.

Client Responsibilities

The client:

- Decides the client goals.
- Gains skills and knowledge needed to meet goals.
- Makes decisions about behavior change.

Staff Responsibilities

The First Steps provider:

- Alerts the client to potential benefits associated with healthy habits.
- Provides opportunities for the client to:
    - Work through their feelings about the topic;
    - Be encouraged and supported;

- Value the new habit;
- Acquire a sense that they can do it; and
- Learn and develop skills.

- Develops a Plan for Care incorporating client priorities while remaining within the focus of the MSS/ICM targeted risk factors.
- Explains the agency's services clearly and how the services might meet the client's needs. The provider needs to convey the value in the MSS/ICM service and be able to identify what can be offered to the client.
- Checks in with the client and/or provide the client with information on how to re-contact the provider if their situation changes on a regular basis to ensure needs are being met.
- Documents risk factors, interventions, and outcomes.

Tools for Client-Centered Services

These are some of the tools for client-centered services:

- Active Listening
- Understanding the Stages of Change
- Motivational Interviewing
- Providing services in an environment that is client centered
- Conducting a client satisfaction survey once the client is done receiving MSS/ICM services

When providers remain non-judgmental and open-minded, while listening and working to meet the client's needs, they will naturally keep a client engaged. As the client feels heard and their needs are addressed, trust will develop and the client will want to continue working with the provider. Additional information on Motivational Interviewing is found at: http://www.motivationalinterview.org

Teamwork and Teaming

Maternity Support Services reflects the interdisciplinary team concept of care. An interdisciplinary team is a group consisting of individuals from different professions and occupations that work closely together and communicate frequently (case conferencing) to optimize care for the pregnant woman and infant. Each team member contributes specialized knowledge, skills, experience to support, and augments the contributions of the other team

members. The MSS team consists of community health nurses, registered dietitians, and behavioral health specialists and in some cases community health workers. The team may also include health care providers and staff from other agencies who are also working with the client.

The team approach to care offers the services of specialists in a comprehensive and coordinated manner. The interdisciplinary team can achieve better outcomes than any individual member providing services alone. A successful team shares common treatment goals for the client and coordinates efforts through case conferencing to reduce duplication and maximize the time spent with the client.

Common Characteristics of Effective Teams

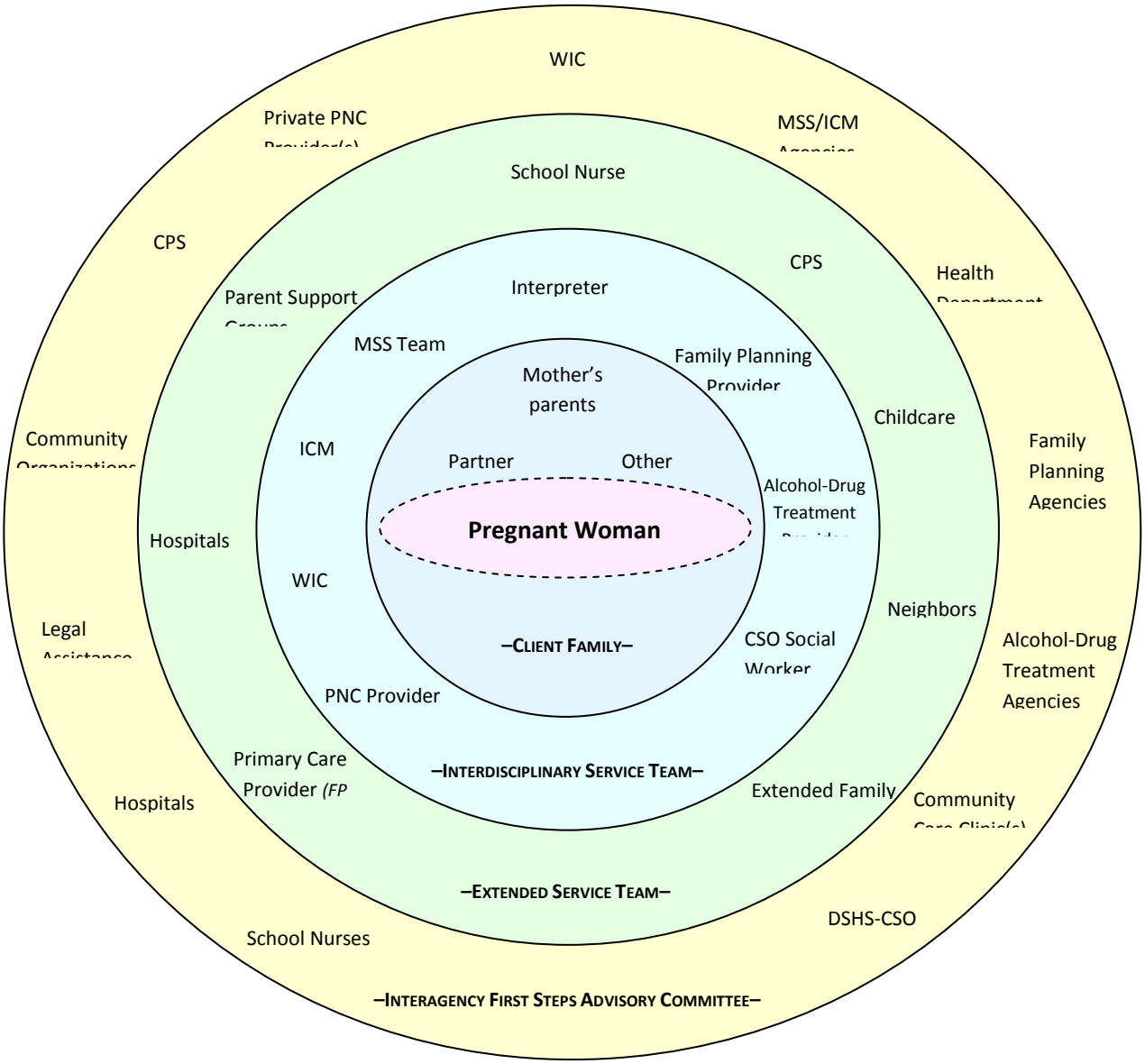
- The purpose, mission, or main objective is known and understood by all team members.
- Communication in the team is open, direct, and honest.
- Sufficient leadership is available in the team.
- There is regular review of how well the team is performing toward achieving its goal.
- There is an agreed organizational structure to the team.
- Adequate resources are available to permit the team to perform its function, including skills, tools, facilities, and budgets.
- Synergy exists, so the team performs in a way that is greater than the sum of its parts.

On-The-Job Actions of Successful Team Members

- Listen to understand
- Contribute ideas and solutions
- Recognize and respect differences in others
- Value ideas and contributions of all team members
- Participate fully and keep all commitments
- Be flexible and respect partnership created by team
- Have fun and care about team and outcomes

Interdisciplinary/Interagency Model of Care

This graphic illustrates the circle of service a First Steps client can participate in during the time MSS/ICM services are provided. Since linkage to systems is a critical part of the First Steps mission, the First Steps agency and its employees need to make contact and coordinate with other service providers involved in the client's life.



Legend

WIC	= Women, Infant and Children	CPS	= Child Protective Services
MSS	= Maternity Support Services	ICM	= Infant Case Management
PNC	= Prenatal Care	FP	= Family Planning
DSHS	= Department of Social and Health Services	CSO	= Community Services Office

Adapted from model by National Training Center for Drug Exposed & HIV Infected Children and their Families. Roxbury, MA

Age of Consent for Health Care

Health Care

A person over the age of 18 has the ability to make decisions in regard to his or her own body, "including but not limited to consent to surgical operations." *[RCW 26.28.015(5)]* Inferentially, a person under age 18 does not have the ability to consent to health care. This inference may also be deduced from *[RCW 11.88.010(1)(e)]*, which provides that for purposes of giving informed consent for health care pursuant to *[RCW 7.70.050]* and *[7.70.065]*, an incompetent person includes persons under the age of majority.

Disclaimer: Laws and rules can change and it is the responsibility of each provider to stay informed about what the most current ones require. The information above is not an interpretation of the law but an effort to summarize the content and provide a resource to agencies and individuals in need of this information.

However, persons under age 18 have the ability to consent to certain kinds of health care because of specific statutory provisions and, in the case of reproductive health care and emancipation, case law, such as:

Sexually-Transmitted Disease/HIV Testing

[RCW 70.24.110] allows minors 14 years of age and older to consent "to the furnishing of hospital, medical and surgical care related to the diagnosis or treatment" of a sexually-transmitted disease. If the minor alone consents to the procedure, then the parent or legal guardian is not responsible for payment. The minor's medical record cannot be released to the parent/guardian without the minor patient's authorization. *[RCW 70.24.105]*

Alcohol/Drug Abuse Treatment

Outpatient: Under *RCW 70.96A.095*, a minor 13 years of age and older may consent to outpatient treatment by a chemical dependency treatment program certified by the department. Parental authorization is required for any treatment of a minor under age 13. The consent of a minor is not required for evaluation if the parent brings the child to the provider. *[RCW 70.96A.250 (2)]*

Inpatient: Under *RCW 70.96A.235*, parental consent is required for inpatient chemical dependency treatment of a minor, unless the child meets the definition of a child in need of

services in *RCW 13.32A.030(4)(c)* as determined by the department. Parental consent is required for any treatment of a minor under age 13. The consent of a minor is not required for admission, evaluation, and treatment if the parent brings the minor in for inpatient treatment. *[RCW 70.96A.245(2)]*

Mental Health Treatment

Minors age 13 years of age and older may request and receive outpatient and inpatient mental health treatment under *[RCW 71.34.030]* and *[71.34.042]*, respectively, without parental consent. For inpatient treatment, admission shall require the professional person in charge of the facility concur in the need for inpatient treatment. Parental authorization is required for outpatient treatment of a minor under age 13. The consent of a minor is not required for admission, evaluation, and treatment if the parent brings the minor to the inpatient facility. *[RCW 71.34.052(2)]*

Interpreter Services: Legal Responsibility - Title VI of The Civil Rights Act Of 1964

Medical providers, as recipients of federal funds, are required to ensure equal access to medical care for their patients, as determined by the Office for Civil Rights. For more information, please refer to the website at http://www.usdoj.gov/crt/cor/

MSS Core Services

Screening/Assessment

1. The focus of the screening is to aid the professional team members in identifying targeted risk factors that may need further assessment and/or intervention, provide a minimum level of health messages to include the warning signs of pregnancy and determine the client's interests and priorities.
2. The process for completing/reviewing the screening tool, choosing which health messages and linkages to emphasize is a collaborative effort between the pregnant woman and one or more team members. This process is guided by the client needs and professional judgment.
3. Nonverbal communication, physical health signs as well as client verbal communication can assist in determining the client's ability to prioritize her needs.
4. At times, more in depth assessment is needed for an identified risk factor to determine severity and determine appropriate interventions. An example is more in depth assessment for depression.

5. Before completing, a screening on a client attempt to determine if one was already done. If so, DO NOT re-screen, request the screening from the other provider or if you are referring them on, send the screening to the new provider.

Basic Health Messages

Providers can discuss many issues with clients during the maternity cycle. Listed below are examples of basic health messages. Which ones are emphasized depends on the individual client's needs and level of service:

Maternity Cycle

- Importance of prenatal care and what to expect including information on HIV testing, Group B Strep, and TB screening
- Self care and coping, e.g. stress management
- Importance of support system
- Physical and psychological changes of pregnancy
- Nutrition, e.g. maternal nutrition, food insufficiency, and weight gain/loss
- Environmental dangers, e.g. hot tubs, lead poisoning, mercury, cat litter, gun safety, work hazards, seat belt use
- Physical activity in pregnancy
- Tobacco use and/or second hand smoke exposure
- Drug and/or alcohol use during pregnancy
- Oral health/prevention of dental disease
- Warning signs in pregnancy
- Breastfeeding
- Family Planning (Unintended Pregnancy Prevention)

Infant Related

- Baby Basics, e.g. sleep position (Back to Sleep), Shaken Baby Syndrome, Well-Child exams, immunizations, car seat safety, second hand smoke, care for minor illness, childcare choices
- Child Profile—health promotion materials the client should receive
- Bonding and attachment, e.g. eye contact, responsiveness, smiling and mirroring, normal child development

- Postpartum mood disorders, signs and symptoms and their impact on infant development
- Infant feedings

Advocacy, Linkage and Referral

The MSS period includes linkage, advocacy, and referral services in addition to education, brief counseling, and interventions. The goal of linkage during MSS/ICM is to address the client's current needs and develop a plan to improve the parents' self-sufficiency to access existing community resources. There is a sample

Minimum referrals and linkages include:

- WIC
- Prenatal Care
- Pediatric Care
- Family Planning
- Childbirth Education
- Family Health Hotline toll free phone number and baby book, operated by WithinReach (formally Healthy Mothers Healthy Babies)
- Local community resources specific to individual needs, e.g. D.V. hotline, educational resources, Crisis Clinic, mental health resources, car seats, food bank, CPR training resources, childcare, transportation, , disability services, and the tobacco quit line

Targeted Risk Factors

Many factors may affect birth outcomes. Maternity Support Services focuses on specific risk factors, as mandated by the Washington State Legislature. The presence of one or more of the targeted risk factors determine the level of service a client receives and form the foundation for the care plan and interventions provided. The Risk Matrix for MSS prenatal and post pregnancy are located on the First Steps Website under "Resources" at: http://www.hca.wa.gov/medicaid/firststeps/pages/provider.aspx

Use professional judgment to determine when to intervene and what interventions best match the client's needs and priorities.

Risk factors can be identified any time during the MSS period. Priorities of interventions for identified risk factors may change as the pregnancy progresses and a more trusting relationship is developed with the client.

Interventions, and care plan development are discussed with MSS team members during the case conferencing process, for clients with expanded or maximum levels of service. Client participation in prioritizing needs should be included and documented on care plan.

Health information regarding risks will be provided to the woman in a non-confrontational manner, to help her understand the immediacy of need to change behavior or seek services.

Interventions

Interventions are the actions taken by MSS or ICM staff to help reduce or eliminate the potential harm associated with the targeted risk factors. This can be accomplished by providing interventions focused on reducing contributory factors to the risk or helping the woman develop protective factors to deal with the risk. In MSS and ICM, the interventions must reflect the targeted risk factors identified on the Care Plan as the focus of care. Interventions include education, linkage, referral, advocacy and counseling. It is important to document what services are provided and how they relate to the targeted risk factors of this program.

MSS Case Conferencing

Case conferencing reduces the duplication of services and allows for a coordinated service delivery system that utilizes the allowable units in the most efficient and productive manner. Interdisciplinary case conferencing is expected during the maternity cycle for all expanded and maximum level clients. The frequency of interdisciplinary case conferencing for any MSS client is based on client need, client risk factors, and whether or not more than one agency is involved in the client's care. See MSS/ICM Medicaid Provider Guides.

The case conference may take place in a variety of ways: through regularly scheduled team conferences, informal face-to-face discussion among two or more team members, by phone, or by written communication. The case conference is documented in the primary client record specifying the date, who attended, and a brief discussion of issues. The plan for care is modified based on the case conference decisions and includes the issues, intended interventions, and outcomes.

Infant Case Management Core Services

Infant Case Management (ICM), a part of the First Steps program, serves Medicaid infants and their parents. Infant/parent(s) who meet certain risk criteria may receive services that focus on referrals, and linkage to community resources and client advocacy. The purpose of ICM is to improve the welfare of infants by providing parents with information and assistance in order to access to needed medical, social, educational, and other services.

Core Functions of the Infant Case Manager

The core functions of the Infant Case Manager are to provide or assist in providing:

Screening

- An initial in-person screening for identification of medical, educational, social, and/or other services that may negatively impact the welfare of the infant. The screening process also assists the case manager to determine how much assistance the parents(s) need in order to access those services. The Infant Case Management Screening Tool is used for this purpose and may be found on the Provider Page of the First Steps Website under "Forms" at: http://www.hca.wa.gov/medicaid/firststeps/pages/provider.aspx

Care Planning

- Building on the information collected through the screening process, this activity ensures client participation to develop goals and identify a course of action to respond to the identified needs.

ICM Actions

- Advocacy: actions taken to support the parent(s) in accessing needed services or goods and helping the parent to develop skills to access services.
- Linkages: Networking/collaboration between agencies in order to assure proper referral of clients and avoid duplication of services.
- Referral: Providing information to the client that will assist them in receiving medical, social, educational, or other services.
- Monitoring/Follow Up
- Activities and contacts necessary to ensure the care plan is effectively implemented, adequately addressing the needs of the Medicaid eligible individuals.

ICM Actions and Plan for Care

There are three major actions noted on the plan for care: referrals, linkages, and advocacy. Actions suitable for ICM interventions include:

- Reinforcing the importance of self-care and coping, social support systems.
- Brief education regarding environmental dangers such as tobacco use or secondhand smoke.
- Reinforcing "baby basics" and infant health messages such as:
- Oral health
- Bonding and attachment with infant

- Normal infant development
- Breastfeeding
- Immunizations
- SIDS/Safe Sleeping
- Shaken baby syndrome
- Car seat safety
- Care for minor illnesses
- Child care choices

Infant Case Management Case Conference Requirement

There is no overall requirement for Infant Case Management clients to have interdisciplinary case conferences. Infant case management is not an interdisciplinary model of service. The Infant Case Manager is a generalist, who advocates, links and refers an infant and family to appropriate community health and social services.

In specific cases, however, the need may arise to have an intra-agency case conference or an interagency case conference. There are times when infant case managers bring specific cases to their supervisor(s) for additional input or advice. In some instances, the supervisor may suggest the infant case manager discuss the case with the Maternity Support Services or First Steps team as an intra-agency case conference. Since the infant case manager's duties include advocacy and linkage, there may be other occasions where the infant case manager initiates a meeting or telephone conference call with other agency service providers to ensure care continuity for a specific infant and family.

Ancillary Services

Childbirth Education (CBE) Classes

Childbirth education classes are an ancillary service offered to all Medicaid eligible women.

The purpose of childbirth education is to help prepare the client and her support person(s) to:

- Understand the physiological, emotional, and psychological changes the client is experiencing.
- Develop self-advocacy skills.
- Understand what to anticipate prior to, during, and after labor and delivery.
- Understand and plan for the changes that occur post-pregnancy.
- Increase positive relationships with local community resources.
- Understand positive and basic parenting skills.

Instructions are delivered in a group setting and must be completed over several sessions.

A CBE client does not need to be enrolled in MSS/ICM in order to qualify for CBE covered services.

CBE Providers

All agencies and/or individuals that choose to offer CBE in a group setting need to apply to Medicaid for an appropriate provider number. Reimbursement is limited to one series per client, per pregnancy. Details for billing Childbirth Education classes is found in the *Childbirth Education Billing Instructions* at:
http://fortress.wa.gov/dshs/maa/download/BillingInstructions/

Any childbirth education provided by an approved MSS/ICM provider during a one-to-one home or office visit is to be billed as part of MSS services (within the maximum allowable units based on client need).

Childbirth Education Provider's Application

[WAC 388-539-0390(3)]

All agencies and/or individuals that choose to offer CBE in a group setting must apply for a separate CBE provider number and meet the provider requirements listed in WAC.

HCA considers services provided and billed by staff not qualified to provide those services as erroneous billings and will recoup any resulting overpayment during an audit.

Required Topics Covered in Childbirth Education Classes

Pregnancy Topics

- Prenatal Care
- Appropriate pregnancy exercises and their benefits
- Coping with common discomforts of pregnancy
- Danger signs in pregnancy and what to do
- Environmental hazards (including but not limited to alcohol use; tobacco use, secondhand smoke exposure, mercury, toxoplasmosis, listeriosis)
- Nutritional needs of mother and fetus
- Physical and Emotional changes during pregnancy
- Sexuality during pregnancy, (including safe sex education)
- Preparing to breastfeed
- Planning for a future pregnancy

Labor and Birth Topics

- Informed consent and decision making
- The value and role of labor support persons (Doula, partner, friend, relative)
- Signs and symptoms of true vs. false labor

- Warning signs and what to do
- Coping skills for each stage and phase of labor
- Pain management techniques and options
- Minimizing and/or working with labor complications
- Medical procedures and interventions
- Analgesia and anesthesia options
- Types of deliveries (benefits and drawbacks of each)
- Unexpected outcomes and what to do
- Hospital routines, including a tour of a hospital/birthing center

Newborn Topics

- Newborn procedures standard in Washington State (APGAR test, metabolic screening, newborn eye prophylaxis, Vitamin K injection)
- Practices to discuss ahead of time with health care provider: such as cutting the cord, circumcision, bonding with baby immediately after birth, breastfeeding/lactation consultation
- Safe sleeping position (on the back), car seat safety, well-child care

Family Adjustment Topics

- Physical and emotional changes
- Sexuality after pregnancy (including safe sex education)
- Protection from secondhand smoke exposure
- Signs of postpartum blues vs. postpartum depression vs. postpartum psychosis
- Potential stresses within family and how to access local supportive resources
- Breastfeeding (nutritional needs of mother, lactation consultation resources)

Recommended Topics Covered in Childbirth Education Classes

Each CBE should be prepared to address the following topics in class, as time allows, either verbally or with handouts, and should know of local resources where clients can get for more information.

- Breastfeeding/bottle

- Shaken baby syndrome
- Importance of well-child care, immunizations, etc.
- Normal newborn appearance, reflexes, characteristics, abilities, and needs
- Infant temperaments, quieting, sleep states, physical appearance, abilities, reflexes, normal stages of development
- When to call the health care provider
- Parenting classes in the community

Whenever possible, classes should be taught in the language of the participant. The client's culture, ethnicity, religion, and values should always be incorporated into the curriculum. All educational materials should be made available to all participants and chosen based upon reading level, cultural appropriateness, and accuracy. A variety of materials, including videos, charts, and teaching aids may be used.

Transportation

HCA pays transportation services to get clients to and from needed non-emergency health care visits. These medical visits must be for services covered by the Medicaid program. Details about transportation services can be found at the following website:

http://www.hca.wa.gov/medicaid/transportation/pages/index.aspx

Other Resources

Managed Care

Healthy Options is the HCA Medicaid managed care program for low-income people in the state of Washington. A website with more information is located at:

http://www.hca.wa.gov/medicaid/healthyoptions/Pages/index.aspx

Women who are required to enroll in a Healthy Options plan should choose a pediatric provider for her infant that participates in the same plan.

Kid's Health

Information regarding Medicaid coverage for low-income children in Washington State is located at: http://www.hca.wa.gov/applehealth/Pages/default.aspx

Stepping Up Website

Health promotion and prevention strategies for pregnancy, parenting, and infancy were created by the University of Washington, School of Nursing, as a resource for the First Steps Program. Stepping Up is managed by the Washington State Department of Social and Health Services, Health Care Authority and the Department of Health, Maternal Child Health and is located at: http://steppingup.washington.edu

Related State Programs

The First Steps client can receive services from a wide variety of agencies that are directly and indirectly linked to the First Steps Program. Since linkage to systems is a critical part of the First Steps mission, the agency and its employees need to make contact with these other service providers.

It can be challenging to keep linked with the service providers in the community. Good collaborative relationships are dependent upon the following criteria:

- Consistent staffing levels.
- Trust that is built over time.
- Regular positive interactions and exchanges.
- Tangible benefits for the First Steps client.

Chemical Dependency/Substance Abuse Services for Pregnant Women

Chemical dependency/abuse by pregnant women can result in poor pregnancy outcomes in a variety of ways. When an MSS team member identifies women with possible chemical dependency/abuse issues, referral needs to be made to the appropriate DASA program. There are a number of treatment options for pregnant women and new mothers.

Pregnant Women Chemical Dependency/Abuse Resource Guide

The Pregnant Women Chemical Dependency/Abuse Resource Guide is produced and revised by DASA and can be found at:
http://www.dshs.wa.gov/pdf/dbhr/PPW%20Resource%20Guide%20Jul%202011.pdf

It provides information about available services, contact information, and additional resources. Services include assessment, childcare, hospital-based detoxification, stabilization, treatment, and safe housing. Some residential services can accommodate children.

Women, Infant and Children's Supplemental Nutrition Program (WIC)

Women, Infant and Children's supplemental nutrition program is a preventive health program designed to positively influence lifetime nutrition and health behaviors through supplemental nutrition packages and nutrition education. WIC serves pregnant, breastfeeding, and postpartum women, and children up to age five, who:

- Live in Washington State
- Meet Income Guidelines and
- Have nutrition or medical risks verified by a health professional

  http://www.doh.wa.gov/cfh/WIC/

Mandatory Reporting Laws

Mandated Reporting Laws [RCW26.44]

All MSS/ICM provider agencies sign an application and agreement form and a core provider agreement with Health Care Authority. These agreements require that all agencies must follow Washington State laws. This includes the state requirements for reporting child abuse and neglect to local authorities.

The specifics of the mandatory reporting laws may be found at http://www1.dshs.wa.gov/ca/safety/abuseReport.asp?2. A short video is also available for viewing that specifically covers "Mandated Reporters."

Refer to http://www1.dshs.wa.gov/ca/general/index.asp to find the local office.

For CPS Publications, please see:
http://www1.dshs.wa.gov/ca/pubs/pubcats.asp?cat=Child_Abuse_and_Neglect

Guidelines for Assuring Staff and Subcontractors are informed of the Mandated Reporting Requirements

Each provider agency is responsible for assuring staff and subcontractors are informed of the responsibilities of mandated reports.

The following strategies are suggested to assist individual professionals and agency coordinators follow the law:

- In-service training.
- Supervisory follow-up on at-risk or potential at-risk cases.
- Development of strong relationships with local Child Protective Services office staff.

Agencies can implement these strategies in the following ways:

In-Service Training

- Schedule training for all staff two times per year as part of the in-service schedule. Invite local CPS trainers to staff meetings to review the mandated reporting laws, CPS policies, and updates on new information.
- Assist staff in how to report abuse and neglect by using role play, modeling from senior workers, and supervisory support.
- Develop intra-agency methods for supporting staff with reporting.

Supervisory Follow-Up

- Track and discuss the rate of referral in the agency with staff during supervisory conferences.
- Provide a forum in staff meetings for staff to discuss issues and concerns regarding mandated reporting.

Development of Strong Relationships with CPS

- Set up a method of consultation with CPS that allows staff to discuss a possible referral.
- Set up a procedure for referral with CPS that allows for more client-sensitive referral processes and leads to better collaboration.
- Ask for support from CPS supervisors when problems occur rather than avoiding the agency and staff. Try to work out issues in an open forum.


CPS has Policies and Standards that it must adhere to when receiving referrals. CPS makes the final decision about each case based on a number of factors including risk to children and parent protective factors.

Developmental Disabilities Services

Occasionally, MSS/ICM team members will encounter a pregnant woman who has a developmental disability or a family may have a child who is eligible for services through this program. It is important as a First Steps provider to know local resources, referral processes, and eligibility criteria. It is just as important for staff in Developmental Disabilities to be aware of the services First Steps offers so that every woman and her family have the most support possible.

DDD

The Division of Developmental Disabilities (DDD) is part of the Department of Social and Health Services. DDD assists individuals and their families to obtain services and support based on individual preferences, capabilities and needs that promote everyday activities, routines and relationships common to most citizens. DDD uses state and federal funds to provide or purchase services and support for eligible persons and their families.

For more information, see: http://www1.dshs.wa.gov/ddd/services.shtml

Family Health Hotline

If a woman has a question or a concern about her baby's development, call the Family Health Hotline operated by WithinReach (formally Healthy Mothers, Healthy Babies) at 800-322-2588 for the name of the lead Family Resources Coordinator in their county.

Infant Toddler Early Intervention Program

Additional information is available at the Washington State Infant Toddler Early Intervention Program website: http://del/wa/gov/development/esit/Default.aspx

Mental Health Services

The Washington State Mental Health system has a limited set of crisis services for the general state population and more extensive services for people on Medicaid that are managed locally by Regional Support Networks (RSNs). This section will assist in finding connections to this system that may be helpful.

Mental Health Services Provided to the General Population

Crisis and Commitment Services: Regional Support Networks are required to purchase or provide 24 hour a day crisis response services for those in a mental health crisis. Every county has a toll free crisis line. Contact information for the crisis lines is found in the emergency section at the front of most phone books and on the Mental Health Division website: http://www.dshs.wa.gov/dbhr/mhinformation.shtml

Mental Health Services for People Receiving Medicaid Benefits (Enrollees)

Community Mental Health Agencies have contracts with Regional Support Networks to provide services to those who are covered by Medicaid. All Medicaid enrollees are entitled to:

1. An intake evaluation to determine medical necessity.
2. Crisis and stabilization services.
3. Inpatient mental health treatment if determined to be medically necessary.

If medical necessity is met at the time of the intake evaluation, then community support services may be provided. These services include but are not limited to:

- Brief therapy.
- Individual services such as case management.
- Medication management.
- Group therapy.

Family Planning Services

Family planning and other primary health care service is the key to improving the health status of women. Most women of childbearing age receive primary care at the place where they get annual reproductive health checkups and birth control. Preventive services such as pap smears, breast exams, and follow-up of other medical conditions are provided. Women may choose private providers, managed care plans, community health clinics, Planned Parenthood or other family planning agencies.

It is important to ensure that women have a source of ongoing women's health care, they have an easy transition into this care, and they have adequate access to a variety of birth control options. This type of care is an investment in subsequent birth outcomes, which are improved if the interval is at least 24 months between births.

Guidelines for Enhancing the First Steps Family Planning Continuum of Care

1. Have local family planning health educators provide counseling/education at MSS/ICM agencies, and/or teach that topic within the childbirth education class (potential partners include local family planning agency or other provider).
2. Provide cross-training sessions between local family planning providers and MSS/ICM agencies (possible contacts are local family planning agency or other providers).
3. Ensure family planning agency and primary care representation on local First Steps Community Advisory Committees.
4. Set up a meeting of Maternity unit staff, family planning and First Steps agency staff to discuss the feasibility of providing a supply of foam, condoms, and emergency contraception with family planning information and referral sources to clients before they leave the hospital or at a near term MSS visit. These kits could be colorful and attractive. Go to area community groups with ideas and ask for funding. Potential partners in creating the kits are pharmaceutical representatives, TAKE CHARGE Providers and local family planning agencies.
5. Negotiate user-friendly transition procedures if the agency provides the prenatal medical care but not the ongoing women's health care. Examples include:

- Copy post partum physical exam and agency's physical exam form: keep a copy for the agency's own records while forwarding the original to the provider;
- Provide an early post partum visit and refer client to the follow up agency for the traditional post partum exam; or
- Negotiate use of family planning staff in the agency to provide the post partum exam and orient the client to other facility for subsequent care.

6. Promote knowledge of emergency contraceptive pills (ECP). Learn more about ECP from the local family planning agency. Find out which providers in the area provide ECP. Provide clients with contacts and information. Keep this information updated and visible.

To find out more about family planning services visit the following website: http://www.hca.wa.gov/medicaid/familyplan/pages/index.aspx

Across All Disciplines

General topics that apply to all members of the MSS/ICM team, including ethics and professionalism, conflicts of interest, cultural competency, personal safety, and home visiting and clinic safety are discussed in this section.

Ethics and Professionalism

Ethics are the rules or standards governing the conduct of a person or the members of a specific profession and serve to guide individuals in their daily lives. Ethics are based on principles of correct conduct formed by a combination of influences including culture and personal beliefs, attitudes, desires and laws. Ethics at a minimum include guidance designed to avoid harm to others, respect the rights of others, be honest in word and action, and obey the laws.

Professional Ethics

Professional ethics are agreed upon standards of behavior shared by a group of individuals having the same or similar professions. Individuals need to be familiar with the code of ethics for their profession. Some resources are listed at the end of this section. Professional boundaries come from ethics and help reduce potential for conflicts of interest. Boundaries make the relationship safe for the client and set the parameters for the services provided. In many cases boundaries are not always clear cut matters of right and wrong and require discussion with the appropriate person within the provider agency. Professional boundaries

are especially difficult in smaller communities where providers may also encounter their clients in numerous social settings.

Professional code of ethics for Dietitians
www.eatright.org

Professional code of ethics for Nurses
http://www.icn.ch/about-icn/code-of-ethics-for-nurses/

Professional code of ethics and practice standards for Behavioral Health Specialists

American Counseling Association
www.counseling.org

American Mental Health Counseling Associations
www.amhca.org

National Association of Social Workers
www.naswdc.org

NASW Code of Ethics

www.socialworkers.org/pubs/code/

Washington Counseling Association

www.wacounseling.org

Washington Association of Mental Health Counselors

www.wmhca.org

National Association of Perinatal Social Workers

www.napsw.org

American Association for Marriage and Family Therapy

www.aamft.org

Conflict of Interest

A conflict of interest occurs when there is a divergence between an employee's private interests and their obligations to their employer and clients such that an independent observer might reasonably question whether the employee's professional actions or decisions are determined by considerations of personal gain, financial or otherwise.

The possibilities for conflict of interest are almost limitless and cannot all be covered in this manual. All MSS/ICM agencies shall have a method to educate staff and review potential conflicts of interest for the agency and employees or contractors. Employees and contractors

are expected to conduct themselves at all times with the highest ethical standards in a manner which will bear the closest scrutiny, and are responsible for seeking guidance before embarking on activities which might be questionable.

Cultural Competency

MSS/ICM services are to be delivered in a culturally competent manner. The provider agency and staff are expected to demonstrate the knowledge and skills necessary to serve clients of diverse ethnic, cultural, religious and racial backgrounds.

> "To be culturally competent doesn't mean you are an authority in the values and beliefs of every culture. What it means is that you hold a deep respect for cultural differences and are eager to learn, and willing to accept, that there are many ways of viewing the world[1]."
>
> Cultural Competency Webpage
> http://cecp.air.org/cultural/
>
> National Center for Cultural Competency
>
> http://nccc.georgetown.edu/
>
> Cross Cultural Health Care Program
> http://www.xculture.org

Personal Safety

Safety is always a concern, whether you are visiting a family's home, going to work, or running errands. Here are some general suggestions for safety:

- Carefully map a route to your destination and make sure someone else knows your destination route and anticipated arrival/return time.
- Always use your seatbelt while traveling.
- Make sure your vehicle is in good working order and that you have adequate gasoline.
- Know how to change a flat tire. Be sure you have air in your spare tire and that all pieces of your jack are present.
- Lock and secure your vehicle at all times.
- Carry a fully-charged cellular phone along with the family's phone number and emergency phone numbers.

[1] Okokon O. Udo PhD, Integrative Health and Wellness, Northwestern Health Sciences University


In remote locations, cell phones are unlikely to function and you may need to carry a two-way radio device.

- When you arrive at your destination, lock items of value out of sight, such as in the trunk of the vehicle. Purses, backpacks, or other unnecessary items should not be taken into the home. These bags often contain items, which may be hazardous in small hands, for example, medications, cosmetics, batteries from calculators, coins, and personal defense items such as pepper-based sprays, or knives.
- When walking on a street or sidewalk, stand tall, do not make prolonged eye contact, look over passerby heads, do not smile at strangers, and walk purposefully, even if lost.

Home Visiting and Clinic Safety

Safety issues are not a concern with the majority of clients and should not interfere with a successful home or community MSS/ICM visit. Usually, common sense is the overriding principle of self-protection and behavior. Constant awareness of your surroundings and access to emergency contact numbers will assist you in avoiding unsafe and potentially unsafe conditions and circumstances.

The purpose of the following guidelines is to direct you toward safe behaviors and activities to be conducted before and during a home/community visit.

Safety precautions before a home visit:

Safety training

Personal safety should be taken seriously. Training should include information on agency safety policies and procedures, personal awareness, risk assessment, relevant interview techniques**.** Ask your local law enforcement authorities about speakers or available literature to help learn more about staying safe while conducting home visits in unfamiliar neighborhoods or high-crime areas.

Violence Risk Assessment

Regularly review the risk for violence in your area. It has been shown that the best predictors of violence in those with mental disorder *are the same* as those for the rest of the population: they include previous violence, poor parenting, and criminality within the family. Before agreeing to see any client with a history of active acute mental illness, it is important to assess the risk of that patient being violent and ensure that the home visitor is not exposing themselves to danger.

The risk factors for short-term prediction of violence are outlined below:

Risk factors for short-term prediction of violence

Demographic and personal history

Youth, male

A history of violence

Recent threats of violence

Belonging to a subculture where violence is prevalent

Clinical variables

Alcohol or other substance misuse

Symptoms of schizophrenia or mania, especially if there are:

- Delusions or hallucinations focused on an individual
- Specific preoccupation with violence
- Delusions of control with a violent theme
- Signs of agitation, excitement, overt hostility or suspiciousness
- Issues of poor compliance with treatment
- Antisocial, explosive or impulsive personality traits

Situational factors

Lack of social support

Immediate availability of a weapon

Personal information

Take precautions to prevent personal information from becoming available to clients. Information such as home address, telephone number, marital status and names of family members may be misused and facilitate harassment or stalking. Avoid calling clients from homes or cell phone unless personal numbers are blocked to reduce the chances of clients or family members acquiring staff personal telephone numbers.

Transportation

Staff should avoid transporting clients in any vehicle (this may also be agency policy). Always use reliable transportation that is well-fueled. In addition, staff members should have on file at the agency the make, model, and license plate number of the vehicle they are using.

Professional Attire

Professional attire represents who you are and the services you are delivering. Dress in a manner that is professional as well as suitable for the home visiting situation with a nametag as required for the agency.

Schedules

Before leaving for the workday, staff should provide the coordinator or administrative staff with a daily schedule of client visits, to include names and addresses and an estimated time of return to the agency. Also, be sure that someone in your agency knows how to contact you. Routine attempts at home or clinic visits should be set up for daylight hours of a normal service delivery workweek. When appointments are outside regular work hours, someone within the agency needs to be made aware of staff's destination and how to contact them.

Safety precautions during a home or clinic visit:

- When possible, travel with a partner.
- When possible, alert the destination client or agency that you are coming and have them watch for you.
- Have accurate directions to the street, building, or apartment. If the area is unfamiliar to you, print a map of your route and destination.
- Drive with the windows closed and all car doors locked. Keep your purse or wallet in the trunk.
- As you approach your destination, carefully observe your surroundings. Note the location and activity of people; types and locations of cars; and conditions of buildings (abandoned or heavily congested buildings).
- Before getting out of the car, once again thoroughly check the surroundings. If you feel uneasy, do not get out of the car. Observe the neighborhood and environment, including people who may be loitering nearby and if conditions appear unusual or unsafe, reschedule the visit.

- Park your car in a well lit, heavily traveled area of the street and lock your car. When parking at your destination, park with the car pointing toward the exit so if you need to leave in a hurry, you don't have to turn the car around.
- Do not enter the home if the situation seems questionable (e.g. drunk family members, family quarrel, combativeness, unleashed pets, etc). Have an alternative plan such as postponing visit or meeting client/agency in another designated place. If you need to leave the setting quickly, you may want to say, "I am leaving now, I must meet ____", or "I forgot I have an appointment. I have to go."
- Call 911 if in danger or a medical emergency presents itself. Never try to take care of this situation on your own.
- Remain cautious when approaching pets within the home/community setting. They may be territorial and protective of their owners. It may be necessary to ask a family member to confine them briefly while you are completing your assessment and/ or visit.
- Use common walkways in buildings and avoid isolated stairs.
- Always knock on a client's door before entering.
- If relatives or neighbors are or become a safety problem, do not make a visit alone.
- Schedule morning visits in neighborhoods of questionable safety or gang/drug related activity.
- Never go into or stay in a home if personal safety is a question. Always respect your "gut feelings."
- When leaving the client's residence, carry your car keys in your hand.

Communication Techniques

Communication is the key to escalating or deescalating a potential violent situation. The box below contains some techniques that promote positive interactions with all clients:

Safe interviewing techniques

Introduce yourself

Produce identification

Speak clearly without raising your voice

Use the patient's appropriate title and name

Allow plenty of personal space

Avoid prolonged eye contact, especially if the patient is experiencing a psychotic episode

Avoid turning your back on the patient

Persuade a standing patient to sit down

Do not sit down if the patient remains standing

Use an interpreter if appropriate

Avoid note-taking if the patient is suspicious

In the unfortunate circumstance of being unable to leave in a tense situation, for example if the door is locked, or your escape route is blocked, then using de-escalation techniques is the only option.

De-escalation techniques

Try to summon help on your mobile telephone

Maintain an adequate distance

Move towards the door and avoid corners

Explain your intentions to the patient and to any others present

Try to appear calm, self-controlled and coherent

Ensure that your non-verbal communications are non-threatening

Engage in conversation, acknowledge concerns and feelings

Ask for the facts about the problems and encourage reasoning

If a weapon is produced ask for it to be put down rather than handed over

Supervisor's role in promoting safety in the home or clinic setting:

- Review the files of assigned clients for indicators of potential violence.
- Include awareness of any known risks or signs of risk to safety in client referrals to staff.

- Make efforts to provide bridges for relationship building between staff and clients if possible, e.g. have staff members meet clients at the agency; have the staff member present when the client is in the agency for a health care appointment.
- Identify each staff member's training history and experience in violence prevention and identification of risk factors for danger to self and others. Provide safety training for new staff and annual updates for all.
- Review with staff how to conduct a safe home visit, e.g. purpose, structure, clarity of professional role, and care focus.
- Be aware of community areas of risk and times of risk and know where each home visit is taking place.
- Support staff by expressing interest in their responses and experiences and expressing concern for their safe methods of providing care.
- Encourage use of pagers, cellular telephones, and/or two-way radios if possible.

Additional Violence Protective Behaviors

Clinical staff should strive to use the following protective behaviors:

- Listen to your feelings
- Avoid having a negative or hostile attitude
- Avoid body language that conveys fear, negativity, or hostility
- Listen to others—be aware of body language as well as spoken language
- Do not continue treatment or an interview if it feels unsafe—leave
- Do not isolate yourself with a client
- Do not corner yourself without an exit
- Consider gender
- Do not be timid
- Be calm and slow
- Do not be controlling or judgmental
- Set boundaries and keep them
- Respect personal space: no touching, keep a physical distance
- Watch your own posture and body language

- Do not use first names until asked and never use terms of endearment such as “honey” or “sweetie”
- Use your first and last name
- Do not talk about yourself

Information taken from the following sites:

Personal Safety when Visiting Patients in the Community
http://apt.rcpsych.org/cgi/content/full/8/3/214

Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers
www.osha.gov

Preventing Workplace Violence, Seattle-King County Health Department—Field Safety Guide
www.NursingWorld.Org

Confidentiality

Protecting Confidentiality of Client’s Protected Health Information

All information collected in the charts of First Steps clients is considered protected health information (PHI).

First Steps providers must follow state and federal privacy laws and rules regarding the confidentiality of clients’ PHI. The First Steps state staff cannot interpret these laws or give legal advice. We can however, make recommendations and provide resource information regarding confidentiality laws.

Separate Charts for Mother and Infant

Although DSHS cannot regulate how client charts are organized, the First Steps state team highly recommends that separate charts are established for a mother and for her infant during Maternity Support Services and Infant Case Management. This practice is in keeping with the fact that the mother and baby are two distinct clients and it protects the agency, the practitioner, and the clients. For example, if there is sensitive information about a family member that affects the baby, it should be referenced only (e.g. “see mother’s chart note dated xx-xx-xx”) and not mentioned directly in the baby’s chart. The practice of separate charts for mother and infant also makes it easier for state staff to monitor what services are provided to each client during a site visit.

HIPAA Privacy

For more detailed information on HIPAA privacy:

- Contact your agency's Privacy Officer since all covered entities must have a Privacy Officer under the HIPAA privacy rules.
- Go to the federal Department of Health and Human Services (DHHS) website: http://www.hhs.gov/ocr/hipaa/
- Visit the Revised Code of Washington website: http://apps.leg.wa.gov/rcw/ and look at RCW 70.02, specifically RCW 70.02.050(1)(e) and .130
- Consult your agency's lawyers.

Quality Assurance

All approved Maternity Support Services (MSS) and Infant Case Management (ICM) providers will participate in on-going quality assurance activities, including:

Self Monitoring

Self-Monitoring done by the provider includes a method for reviewing client records for key items or issues. Possible issues include WIC (Women, Infants & Children's Supplemental Food Program) and childbirth education referrals, pediatric provider identification, presence or quality of current service care plan, case conferencing and client feedback or surveys. Self-monitoring assists the agency and staff in developing and improving quality services.

Chart Review

State staff to review certain topics or issues such as correct assignment of level of services, reviewing staff supervision or training plans, may use chart review. State staff will send a written request via email or letter requesting client records or other documents; the provider will copy and send these back to the requestor. After the review, the state staff may respond by email or letter regarding the results of the review.

Technical Assistance Visit

An agency or the state may request a technical assistance visit, allowing for feedback on a program before a formal review occurs. These visits usually consist of discussion with administrators and program staff and a brief chart review. A summary of the visit is emailed or mailed to the agency describing strengths and areas for improvement.

Monitoring

A monitoring visit is a formal visit. This is not a fiscal audit that is conducted by Medicaid audit staff and focuses more closely on the financial workings of the agency.

The monitoring visit consists of several steps, which may include a self review tool given to the agency prior to the site visit. The site visit starts with a brief discussion with the coordinator and other staff; includes a formal review of client charts, agency documents and policies; and ends with an opportunity for the agency and state staff to review the findings. A written monitoring

report including all required corrective action is e sent to the agency. The agency will respond with a plan for addressing the issues. There will be ongoing follow-up until all actions are satisfactorily completed.

Authority to Review Medical Records

Providers are required to make charts and records available to DSHS, its contractors, and the U.S. Department of Health and Human Services upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation *[WAC 388-502-0020 (1.c)]*.

Laws and Regulations Related to First Steps

CTRL + click *any of the links below for more information on laws and regulations related to First Steps.*

Code of Federal Regulations (CFR)

Revised Code of Washington (RCW)

RCW 74.09.760 - 900	Maternity Care Access Act of 1989

Washington State Plan under Title XIX of the Social Security Act

http://hrsa.dshs.wa.gov/medicaidsp/

Washington Administrative Code (WAC)

WAC 182-5300-0300 through 0345	Maternity Support Services
WAC 182-5300-0360 through 0386	Infant Case Management
WAC 182-5300-0390	Childbirth Education
WAC 182-5300-0701 through 0730	Chemically Using Pregnant Women (CUP)