# Title V Maternal Health

## Enabling & Direct Care Services Orientation

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# Objectives & Prework

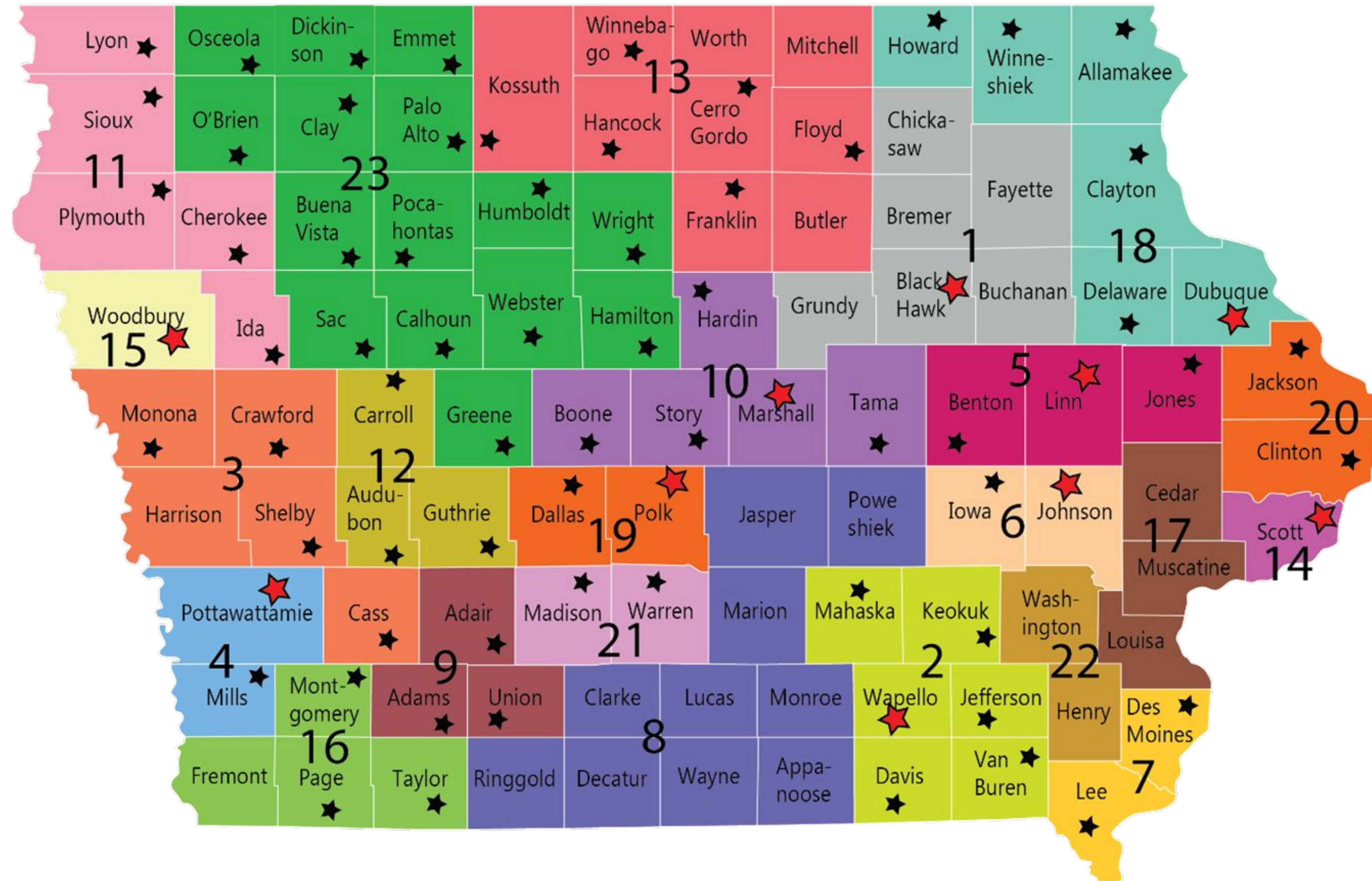
Pre-work

1. Review your agency’s policy manual for your program
2. Review list of provided resources, and visit any websites that are new to you

Objectives

1. Verbalize understanding of enabling services
2. Verbalize understanding of core direct services
3. Verbalize understanding of where to find guidance after this session is over

# Maternal Health Centers



# Healthy Families Line

Healthy Families Line: 1-800-369-2229

The Healthy Families Line is a toll-free number that provides resource information on maternal, child and family planning services. The line is answered 24 hours a day, seven days a week.

Also where you call to get new resources for health education

https://idph.iowa.gov/Bureau-of-Family-Health/MCH-Portal/Maternal-Health

# Resources to Guide Practice

1. Your agency's policy manual
2. MHC Services Summary
3. MHC Provider Manual (Iowa Medicaid Enterprise Document)
4. DHS Documentation rules
5. Clinical Guidance:
    1. AWHONN Educational Materials
    2. Bright Futures
    3. ACOG
    4. Iowa Board of Nursing Laws and Administrative Rules

# Helpful Trainings

Motivational Interviewing

SBIRT – Drug and Alcohol use screening tools and brief intervention

Health Equity Resources - MHLIC

Ask, Advise Refer – tobacco use cessation training

5210 – Healthy Choices Count

Maternal Mortality in Iowa – Fall 2020 presentation

# Enabling Services- Care Coordination

- Additional Care Coordination Orientation must be completed – IDPH EPSDT Training
- Care coordination is linking a client to the health care system (medical, dental, mental health or other Medicaid programs or services).
- Activities involve collecting information on the health needs of the client and assisting families to connect to services based on those needs.
- Services must include linking the family to a Medicaid eligible service and may include linking the family to other non-Medicaid services as well. Care coordination includes assisting clients in gaining access to services and follow-up monitoring to assure that needed services are received and arranging support services such as medical transportation or interpreter services.
- Care Coordination and PE can be completed on the same day. Once a client is assigned to an MCO, a MHC can no longer charge for medical care coordination.
- Each maternal health program client should receive dental care coordination; including asking about dental home, making referrals to a dentist when appropriate and follow up monitoring to assure needed services are received. Dental Care Coordination remains the responsibility of the MHCs even after the client's assignment to their dental plan.
- See Services Summary for further details

# Enabling Services- Presumptive Eligibility

- To provide PE services, staff must be certified as Qualified Entities (QE) under the supervision and authority of a Presumptive Provider Organization (agency). To become a QE, staff must complete web-based training provided by DHS to do PE for Pregnant Women. The training is not that same as the child health training.
- The process of presumptive eligibility determination for pregnant women by a qualified provider.
- The agency must have a memorandum of understanding (MOU) with DHS prior to providing this service and then maintain a qualified provider status with DHS.
- Eligible clients must be pregnant and have an Iowa address. Eligibility is based only on a woman's statements regarding her family income; a qualified provider can "presume" that the pregnant woman will be eligible for Medicaid.
- For pregnant women, US citizenship verification is not required as part of the presumptive eligibility determination for pregnant women.

# Consents and Release of Information

1. This program is voluntary
2. Templates are available from IDPH for agency use
3. This is individualized for each agency, your director is your best resource for this element.
4. You must have consent for HIV, Mental Health, and  Substance abuse information prior to releasing this information specifically
5. Here is the link to the MCAH portal and consent templates:
    1. https://idph.iowa.gov/Bureau-of-Family-Health/MCH-Portal/General-Title-V-tools

# Prenatal Risk Assessment

1. Who can do the Prenatal Risk Assessment?
    1. RN or SW (only if there is adequate clinical support readily available)
2. Needs to be filled out at first visit
3. This will need to be submitted with prior authorization request as enhanced services are being requested.
4. Rescreen around 28 weeks if score is less than 10
5. In order to provide enhanced health services (including psychosocial visits), a client must score 10 or higher
6. You may bill for this the same day as Health Education and Psychosocial, use xu modifier

# Care Plan

- Needed for all clients who have a Prenatal Risk Assessment score of 10 or more
- Can take many forms, this is up to the agency
- May use goals form in signifycommunity or needs and referral section
  - If your care plan is in signifycommunity, this must be referenced in the client's chart, and printed for any chart audit

# Intake Survey

- Included in the first Health Education, Psychosocial or Home Visit
- Opportunity to collect the demographic information, health history and pregnancy information
  - Important to be culturally sensitive and ask what Race and Ethnicity they consider themselves to be.
  - Options in Signify are on the IDPH provided forms.
- Will include all of your initial screenings such as: Edinburgh Postnatal Depression Screening (EPDS), Interpersonal Violence (IPV), drug and alcohol misuse screenings.

# Health Education (clinic setting) -H1003

- Must be provided by an RN
- New items will be added with new needs assessments
- Education should be individualized to the client
  - It's important to document your client's response to the education in a way that is individualized to them.
- Should flow through each trimester of pregnancy and postpartum
- Schedule is individualized to your agency
- Medicaid Maternal Health Center Manual can provide more in depth guidance
- EPDS and Intake assessment screenings

## 1st Trimester

- Self care & comfort measures
- Seat belt safety
- Physical activity and nutrition (5210)
- Medications and teratogen avoidance
- Danger signs:
  - How and when to call OB provider
  - Physical and mental health symptoms (see services summary list)
- Plans for childbirth education classes
- Infection prevention
  - Appropriate vaccinations
  - Good handwashing
  - Avoiding cat litter boxes
- Fetal Growth and Development

## 2nd Trimester

- Breastfeeding introduction
- Preparing for baby
  - Crib
  - Safe Sleep introduction
  - Supply needs- diapers, clothes, car seat
  - Parenting classes/education
- Birthing class plans; or
  - Introduce labor and delivery education
- Danger signs & when to call OB provider education or education reinforcement
- Any items needing reinforcement from 1st trimester
- Gestational Diabetes as needed

## 3rd Trimester

- Feeding plans and breastfeeding education
- Safe sleep
- Shaken baby
- Preparation for baby
  - Crib, car seat, diapers and other supplies
- Danger signs
  - When to call physician
  - When to go to ER or Hospital
- Labor and Delivery Preparation
  - Plan for transport to hospital
  - Signs of Labor
  - Coping strategies
  - Birth plan
  - Pain management
  - Emotional support
- Support for postpartum
  - Emotional support
  - Health support (plans for transport for postpartum care needs)
  - POST BIRTH warning signs introduction
- Family Planning

## Post Partum

- Feeding plans
  - Breastfeeding
  - Bottle Feeding
- POSTBIRTH warning signs
- Postpartum appointment
  - Family Planning options
- Pediatrician Appointment
- Parenting education
- Emotional changes
- Support systems
- Referrals as needed

## Required for all clients determined to be high risk by Prenatal Risk Assessment score greater or equal to 10:

- High risk medical condition
- Smoking cessation
- Alcohol and drug avoidance
- Environmental and occupational hazards
- High risk sexual behavior avoidance

*these are minimum requirements, please individualized education as needed for each client. Some items may be interchangeable within the trimesters based on client's educational needs and priorities.

# Psychosocial Visit (Clinic setting) -H0046

- Can be provided by: "registered nurse or a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies. "
- Need Prior authorization
- Medicaid Maternal Health Center Manual can provide more in depth guidance

Psychosocial assessment and counseling shall involve a psychosocial needs assessment of the mother outlining a profile that includes:

- Demographic factors
- Mental and physical health history and concerns
- Adjustment to pregnancy and future parenting
- Environmental needs
- A profile of the mother's family composition, patterns of functioning, and support systems
- An assessment-based plan of care
- Risk tracking
- Counseling and anticipatory guidance as appropriate
- Referral and follow-up services

# Nursing Assessment (clinic setting) -T1001

- This service must be completed in a “clinic” setting – not in a home setting.
- Must be completed by and RN
- This is situation where there is a nursing contact for a specific need related to a known known medical condition.
- Documentation needs to include:
  - A nursing assessment and physical assessment findings
  - Medical history and chief complaint (example: status postpartum)
  - Evaluation
  - Plan of care
- This is a comprehensive visit and the time spent should reflect the work completed

# Antepartum Nursing Home Visit-S9123

- Nursing assessment including physical status, mental and emotional status.
- Home environment in relation to safety and support services.
- Client’s knowledge of health behaviors to ensure healthy pregnancy outcome
  - Health education topics as needed by trimester (see Health Ed Slide)
- Psychosocial assessment as indicated and any follow up or referrals
- Community resource referrals

# Post Partum Nursing Home Visit -S9123

- The postpartum home visit is made within two weeks of the infant's discharge from the hospital. If you are unable to schedule in the first two weeks, it is best to complete no later than six weeks. If the client refuses a home visit, provide a postpartum clinic visit or phone care coordination.
- Nursing assessment to include mother's health status, discussion of physical and emotional changes postpartum, including relationships, sexual changes, additional stress, nutritional needs, physical activity, and grief support for unhealthy outcome.
- Family planning.
- A review of parenting skills including nurturing, meeting infant needs, bonding, and parenting of a sick or preterm infant (if applicable).
- An assessment of the infant's health including a review of infant care including feeding and nutritional needs, oral health, breast-feeding support, recognition of illness, accident prevention, immunizations, and well-child care.
- Identification and referral to community resources as needed.

# Social Work Home Visit -S9127

- Must be provided by a BSW or Licensed social worker
- Home visits made for the purpose of providing social work service include the following:
    - Social History
    - Psychosocial Assessment (see components of psychosocial visit)
    - Counseling Services and Plan of Care

# Screenings

Depression, Drug and alcohol, Interpersonal Violence

# Depression Screening - G0444

- Only use this if Health education, psychosocial, or home visit was not completed
- Must be provided by an RN or a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies.
- The Edinburgh Postnatal Depression Scale (EPDS) is the recommended tool for depression screening during pregnancy and for up to one year following the birth of the child.
- Narrative interpretation must be included even if the score is normal. Include any anticipatory guidance, e.g., instructions to contact the primary care provider if anything changes.

# Alcohol and/or Substance Abuse Screening with Brief Intervention -99408 or 99409

- Complete the SBIRT training prior to use
- Review services summary prior to billing as this can only be billed if a positive screen occurs and a brief intervention and referral occurs
- Utilize a 2 question SBIRT prescreen- then use the appropriate tool to complete the full screening as needed
- RN or BSW/Licensed Social Worker
- The tool must be retained in the client’s chart as well as a narrative of the brief intervention
- Motivational interviewing techniques should be utilized
- Referral should also be documented in the client chart

# Domestic Violence Screening 96160 or 96160-XU

- Must be provided by RN or a person with at least a bachelor’s degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies
- Training on intimate partner violence and the Abuse Assessment Screen
- Assure that referral resources are available

# Additional Services

Some agencies provide these services. Information on required elements are available in the services summaries and chart audit documents. You may not provide these services without prior approval from your supervisor and IDPH.

- Oral health services
- Administration of Medication; Oral, Intramuscular, or Subcutaneous
- Annual Alcohol Screening
- Counseling for Alcohol Misuse
- Counseling for Obesity
- Diabetes Management by a dietician
- Evaluation & Management
- Immunization Administration with Counseling
- Immunization
- Interpreter services
- Lactation classes
- Listening visits
- Nutrition services
- Preventive medicine counseling
- Transportation
- Urine pregnancy test

# Questions?