

Washington State First Steps News

A Newsletter for Maternity Support Services & Infant Case Management Providers

Issue 9

July 2007



Spreading Her Wings of Light on a New Program

Lenore Lawrence has been with Washington State Medicaid since January 1995. She came with extensive experience in economic services, including program support to pregnant women and family planning outreach, as well as child welfare agency experience. She was hired to implement an extensive communication strategy with First Steps Agencies and other stakeholders. She has gone on to fulfill many other responsibilities as well, all of which strengthen the First Steps Program: she has provided staffing and coordination for the First Steps Database workgroup; managed First Steps childcare; created linkages between the CSO's, First Steps agencies, and post-partum family planning; developed the provider quality policy; managed the First Steps website; and worked on the manual. In all activities, Lenore has demonstrated her commitment to the health and well-being of pregnant women and their infants. She has also become our historian, because she remembers so well the first days of First Steps. Now, Lenore is moving on to another program that needs her wisdom and care: administrative match in the schools. Those of us who work with the First Steps program will really miss her!

Lenore sends this message to her friends in the world of First Steps: *"Thank you for all the support and help you've given over the years. Your caring dedication and joy in serving our clients has always inspired me. May all your steps be blessed!"*

The Four W's of Billed Charges:

Submitted by Melissa Usitalo, CRA Office of Professional Rates Health and Recovery Services Administration

WHO:

First Steps providers are reminded to bill their *usual and customary* charges.

WHAT:

The *usual and customary* charge is the provider's charge for providing the same service to a non-Medicaid client. If only Medicaid clients are served, then the provider's charges should take into consideration the cost for providing the service.

The following are some general WAC references regarding usual and customary charges:

WAC 388-530-1050: "Usual and customary charge" means the fee that the provider typically charges the general public for the product or service."

WAC 388-550-1050: "Usual and customary charge" means the charge customarily made to the general public for a procedure or service, or the rate charged other contractors for the service if the general public is not served.

WHERE:

The Maternity Support Services and Infant Case Management Billing Instructions tell you to "bill HRSA your usual and customary fee."

WHY:

Billed charges should be the cost of providing a service and not the amount that HRSA has designated as a maximum reimbursement.

For more information or questions on usual and customary charges, contact the Medical Assistance Customer Service Center line 1-800-562-3022 or for a general resource use the Google search engine on the internet.



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What are Numbered Memoranda & Replacement Pages?

Submitted by Maureen Lally, First Steps Program Manager, DSHS



UPDATE

You may have already received a memo from Douglas Porter, Assistant Secretary of DSHS HRSA regarding a Numbered Memorandum #07-21. It supersedes Numbered Memorandum 6-49 distributed in June of 2006.

What are numbered memoranda how do they affect you? Numbered memoranda notify providers of policy, Provider requirements, billing, reimbursement changes, new fee schedules or other general reminders. When a numbered memorandum changes a billing instruction page (s), the new information is included in the billing instruction replacement pages attached to the Numbered Memorandum

In September, several policy updates and clarifications for the Maternity Support Services (MSS) and Infant Case Management (ICM) programs will become effective.

The policy updates and clarifications for MSS include:

- Update Place of Service (POS);
- Billing clarification if two or more MSS/ICM providers visit a client together;
- Student interns cannot bill for services
- [Refer to WAC 388-533-0325];
- Registered Dietitian (RD) certification
- [Refer to WAC 388-533-0325];
- Policy change in minimum number of units;
- Update coverage table; and
- New Community Health Worker procedure codes.

Policy updates and clarifications that affect both MSS and ICM include:

- Clarification on how to bill units per visit;
- Update Place of Service codes; and
- Documentation requirement for client visit start and end times.

Birth Certificate Data Are Getting Better

Submitted by Patricia Starzyk, Department of Health Center for Health Statistics

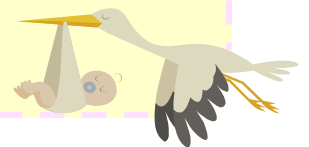
How do we know which women are not getting timely prenatal care? If we establish programs to improve access to care, how do we know whether or not they're working? Birth certificate data are essential for answering these questions. However, birth certificate data often have quality issues which reduce the certainty with which we can answer these questions.

The Center for Health Statistics (CHS) tracks 17 birth certificate items (such as mother's race and pre-pregnancy weight) as indicators of data quality. We chose these items because maternal and child health programs use them extensively, but unfortunately they have data quality problems. Washington State has traditionally not met completeness goals established by the National Center for Health Statistics (NCHS) for the items.

Data for the first three quarters of 2006 show that for the first time, we have met the NCHS completeness goals for four items (mother's education, mother's race, day of last normal menses, and characteristics of labor and delivery). Even though we have not met goals for the other items, the data are moving in the right direction. Nearly all of the items showed substantial decreases in "percent unknown" for 2006.

One reason for the decrease is the new Birth Data Quality Query System (BDQQ) created by CHS. The BDQQ is an online system which hospitals use to see their data completeness for these 17 items. The new version also shows them how they compare to their peers (based on number of births) and to the national goal.

Even though unknowns are decreasing, we are still far from meeting the goals for the date of the first prenatal care visit and the day and year the last normal menses began. These items are the subject of a targeted intervention. CHS is collaborating with staff from Community and Family Health (CFH) and the Regional Perinatal Coordinators on a quality improvement project for these data. The four regional programs are working with their network of hospitals to problem-solve where needed, and ascertain best practices from those hospitals whose data are more complete. They will also work to create networks between the hospitals so that hospitals can benefit from each other's experience and ideas. Thus, we hope to see more quality improvements in the future.



Release of Confidential Information

Submitted by Becky Peters, Behavioral Health Specialist Consultant, DOH



All information collected in the charts of First Steps (FS) clients is considered protected health information (PHI). FS providers must follow state and federal privacy laws and rules regarding the confidentiality of clients' PHI. FS state staff cannot interpret these laws or give legal advice. A review of links within this article and follow up with your agency's privacy officer or legal council for specific questions is strongly encouraged. Some agencies have more stringent requirements than others.

The FS program requires all FS provider agencies use an agency-specific release of information form with every client in order to protect the client's PHI. The agency release of information form must comply with HIPAA and other relevant federal and state laws for medical records.

The HIPAA regulations can be found at 45 CFR Parts 160, 162 and 164. You can access the text of the law at this web site:

http://www.access.gpo.gov/nara/cfr/waisidx_02/45cfrv1_02.html.

HIPAA protects the confidentiality of health information held by health plans, health care clearinghouses and health care providers. HIPAA regulations establish standards for maintenance, use and disclosure of health information.

This includes:

- what must be done before a disclosure of confidential information can be made,
- the manner in which the information may be disclosed, and
- to whom it may be disclosed.

Except under certain specified conditions, HIPAA prohibits the use and disclosure of records or other patient related information, without proper consent.

State RCW 70.02 contains the general regulations for medical records and can be found at <http://apps.leg.wa.gov/RCW/default.aspx?cite=70.02>. It is recommended that providers read the entire RCW.

Two sections that apply to many of the questions asked by FS providers are RCW 70.02.030 and RCW 70.02.050. RCW 70.02.030 states that a disclosure authorization must be in writing, and must be dated and signed by the client. The release must:

- Describe the nature of the information to be disclosed,
- State to whom the information is being disclosed,
- Define who is making the disclosure,
- Include the name and birth date of the identified patient,
- Include patient or their representative's signature and date of signature; and
- Designate a specific date or event when the authorization will expire.

RCW 70.02.050 describes the few conditions under which health care information may be released without the patient's authorization to the extent a recipient needs to know the information.

Mental health, substance abuse treatment and HIV/AIDS status have more stringent rules that providers to release information. In addition to RCW 70.02.030, RCW 71.05.390 <http://apps.leg.wa.gov/RCW/default.aspx?cite=71.05.390> identifies specific disclosure for mental health information. It describes who can request information, under what circumstances and what information can be shared. A release of information request must be very specific about what information is being requested and why. HIV/AIDS status is not to be released except when specifically requested in the release of information request signed by the patient.

Drug and alcohol treatment and prevention are covered by two distinct federal laws that protect patient privacy. For over 30 years, the federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records and its implementing regulations, 42 CFR, Part 2 has protected information regarding patients of drug and alcohol treatment and prevention programs.

45 CFR, Parts 160 and 164, address many of the same issues as CFR 42, Part 2. These regulations establish standards for maintenance, use and disclosure of health information and what must be done before a disclosure can be made, the manner in which the information may be disclosed, and to whom it may be disclosed. A general medical release form or any consent form that does not contain the elements specified in CFR 42, Part 2, is not acceptable for disclosure of drug and alcohol information.

Suggestions or recommendations for release of information

1. An original release of information request should be signed by the patient for each entity from whom you are requesting or sending information.
2. The form must specify if the release is requesting information be sent to you or if the client is requesting information be sent by you to the other provider. Another possibility is the client is consenting for you and the other provider to exchange information back and forth.
3. Be as specific as possible about the information being requested and its purpose. Clearly identify the patient and their date of birth.
4. Ensure you have the patient or the patient's representative's signature and the date the document is signed on each request form.
5. Include in the request all necessary identifying information about you, your agency including address and contact information.

Clearly identify when the consent to release or exchange information expires. Specify a date or event, and ask only for the essential information needed for treatment planning or follow-up services.



Ways We as Individuals Can Work Toward Eliminating Racism

*Written by Vazaskia Caldwell, Director
Community Education & Public Policy, YWCA, Pierce County*

10 simple ways to eliminate racism

- Think before you speak. Words can hurt, whether you mean them to or not. When describing a person, think if mentioning their race is important to the story. Do you refer to everyone from South or Central America as Mexican? If you don't know someone's country of origin, don't assume. Some people prefer Black, while others like African American. Some prefer Latino/a, others like Hispanic. If you're unsure which to use, ask. It's important to use the correct language.
- Don't make assumptions. Do you assume that African Americans like rap music or that Asians are good at math? Stereotypes hurt everyone.
- Examine what your prejudices are and make adjustments to look at everyone as an individual.
- Don't laugh at racist, sexist, ageist, homophobic, and other stereotypical jokes or assumptions. By laughing, you're acknowledging the joke is appropriate and encouraging more inappropriate comments. You can interrupt without being rude. Don't let your silence speak for you. Simply say, "I don't find that funny," or "I don't appreciate jokes like that."
- Make an effort to get to know people different than you. Look for things in common with other people and celebrate the differences. We can learn from and appreciate something about everyone. Learn about other people and their culture. By learning about other people, your life will be greatly enriched and your appreciation for your own culture will deepen.
- Be a role model. Be vocal in opposing discriminatory views and practices, especially with friends and family who respect your opinion. Don't criticize, but help educate others about issues and about your own experiences.
- Explore the unfamiliar. Attend an organization meeting, religious service or travel to a new region where you are in the minority. For example, if you are Christian, attend a Jewish service at a synagogue. If you attend an all-white suburban school, visit an inner-city multi-cultural school. This first-hand experience can be enlightening and give you perspective.
- Work on projects with members of groups different from your own. Working as an equal alongside others from different groups on a common project is one of the best ways to undo prejudice and increase familiarity with others.
- Be a proactive parent. Expose your children to diversity at a young age. Read stories that explain the point of view of other groups. Discuss TV shows, movies or books that present stereotypes. Children can benefit from knowing other children from different groups at very early ages, before prejudices and biases are formed.
- Support anti-prejudice and anti-racist organizations. Whether your efforts are in volunteering, financial donation or being an advocate, working with other groups toward the same goal can be beneficial to you and the community. You'll meet great people and find real support for your efforts. By getting involved, your voice can make a big difference at the local level.

*Note from Dr Nancy Anderson:
Recent literature has highlighted the contributing role of racism in health disparities. Racism in the health care system has affected the quality of care that people of color receive, as well as their health outcomes. As caring professionals, we can make a difference if we take stock of our own values and behaviors. This article provides some ideas for self reflection and individual action.*

Piloting a Registered Dietitian (RD) Electronic Mailing List

Submitted by Cynthia Huskey, Nutrition Consultant, DOH

In an effort to improve communication we will be piloting an electronic mailing list for RD's. The purpose of the electronic mailing list is to:

- ✓ Improve communication between the FS program and MSS RD's.
- ✓ Provide RD's with nutrition research focused at maternal and infant health.
- ✓ Provide information on nutrition training and Continuing Education Units (CEU) opportunities.

If the electronic mailing list is received positively by First Steps providers the state team will develop electronic mailing lists for other First Steps disciplines (RN, BHS, CHW). If you have any questions regarding this list please contact Cynthia Huskey at Cynthia.huskey@doh.wa.gov or (360)236-3599

*Nurses are
in the CSO
at least
30hrs each
week*



Did you know...?

The CSO Based Family Planning program has been in the CSO since 1994. Clients are provided family planning education, information and referral resources.

- Almost every Community Services Office (CSO) has a Family Planning Nurse.
- Nurses are in the CSO at least 30 hours each week.
- Medicaid Clients can use their medical ID cards to purchase over the counter birth control supplies such as condoms and foam.
- Emergency Contraception (EC) is now available over the counter and the medical ID card can be used to purchase this medication. Clients must be 18 years old or older to obtain EC with out a prescription.
- Medicaid clients can self refer to the Family Planning Nurse and don't need an appointment.
- The Nurse is a critical link with your First Steps client in the planning and spacing of future pregnancies. Contact June Hershey for the name and contact information for the nurses in your local area. June's email is HERSHJL@dshs.wa.gov.

For more information, visit the HRSA Family Planning website at:
<http://fortress.wa.gov/dshs/maa/familyplan/>

Stillbirth-Advocacy Role for First Steps Providers

Submitted by Diane Bailey, Community Health Nurse Consultant, DOH

First Steps providers can assist parents who experience a stillbirth and have unanswered questions with advocacy to obtain answers. The cause of almost one-half of the stillbirths in Central Washington during 2005 was not clear. The abstract below describes a project in the Central Washington Regional Perinatal Program at Yakima Valley Memorial Hospital. Dr. Rowles, Medical Director of Central Washington Regional Perinatal Program, is traveling to hospitals to share project findings and recommendations with perinatal healthcare providers in Central Washington. This educational project offers best practices about complete evaluation in determining stillbirth causes.

ABSTRACT—STILLBIRTHS IN CENTRAL WASHINGTON, 2005 Yakima Valley Memorial Hospital Central Washington Regional Perinatal Program

OBJECTIVE: 1) To determine if the increased number of stillbirths seen in Central Washington, compared to prior years, is greater than what would be expected based on national data. 2) Determine the etiology of the stillbirths. 3) Evaluate the extent of evaluation done to determine etiology of the stillbirths. 4) Make recommendation for evaluation of stillbirths in Central Washington, recognizing the geographic and economic limitations associated with this area.

STUDY DESIGN: A chart review was done of all stillbirths reported to the vital statistics department in the calendar year 2005, including all seven hospitals in the Central Washington

Regional Perinatal Program area. Data was abstracted looking specifically for possible causes of the stillbirths, including contributing factors. The charts were further reviewed to see if autopsy, placental examination, and chromosome tests were done. The extent of the laboratory evaluation was also assessed. The incidence of stillbirths, broken down into specific etiologies, was compared to recent national data.



RESULTS: The incidence of stillbirths in Central Washington for 2005 was 7 per 1,000, consistent with the rates in developed countries. However, there was a higher percent of stillbirths in which the etiology was undetermined compared to national statistics. The extent of the evaluation of the stillbirths was significantly less than what was recommended in recent publications, possibly accounting for the higher number of unknown causes. We speculate that the limited workup may be secondary to cultural and financial limitations, as well as lack of knowledge among providers.

PROPOSAL: We propose revision of our flow sheet for stillborn infants, with specific recommendations for evaluation of stillbirths and for overcoming some of the barriers. An outreach project to the seven hospitals in Central Washington will reach providers with education about best practices in determining etiology.

Depression Risk Higher in Girls with Low Birth Weight

The following article was reprinted with permission from Verbena Vine newsletter May/June 2007

Girls' risk for developing depression after puberty increased significantly if they had low birth weight, in a study funded in part by the National Institute of Mental Health. It also seemed to increase the risk effects of other adversities.

Among the 5.7 percent of girls in the study with low birth weight, more than 38 percent developed at least one episode of depression as teens, compared to only 8.4 percent with normal birth weight.

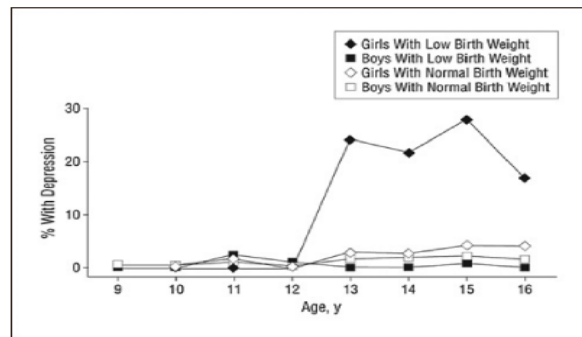
If a teenage girl with low birth weight had just one other risk factor for depression, her odds of developing depression increased to 19.6 percent versus 3.6 percent for normal birth weight girls. If she had two more risk factors, the risk rose to 68.5 percent vs. 19.7 percent for normal birth weight girls. It did not increase depression risk in teenage boys.

The findings suggest that adaptations in the womb that optimize survival under adverse conditions that can lead to low birth weight may later impair girls' ability to cope with stress. Their lower thresholds for stress-triggered illness may remain latent until they "encounter adversities that strain their capacity," suggest Drs. Elizabeth Jane Costello, Adrian Angold, Duke University, and colleagues, in the March 2007 Archives of General Psychiatry.

The researchers drew on assessments of depression in 1,420 North Carolina boys and girls, ages 9-16, during the 1990s, relying on mothers' recollections of birth weights and other risk factors.

The researchers note that boys appear to be more prone to early developmental insults and have higher rates of early-onset disorders like ADHD and autism, while girls seem more prone to later-onset disorders like depression. Social phobia, post-traumatic stress disorder, and generalized anxiety disorders were three times higher in girls with low birth weight than in boys or girls with normal birth weight. However, evidence suggested that this was likely a reflection of the fact that these disorders co-occurred with depression.

"The findings suggest that pediatricians and parents of girls who were of low birth weight should pay close attention to their mental health as they enter puberty," suggest the researchers.



Girls with low birth weight showed much higher rates of depression after puberty than boys with low birth weight or girls with normal birth weight. Chart shows three-month prevalence of depression. Source: Duke University Medical School, Center for Developmental Epidemiology, Department of Psychiatry and Behavioral Sciences



Health Care Plans

Did you know Health Care Plans can provide high risk case management?

For this information and much more, please see the April 2007 First Steps Provider Advisory Group meeting minutes at <http://fortress.wa.gov/dshs/maa/firststeps/First%20Steps%20PAG.htm> Providers, it would also be beneficial to invite the Health Care Plans to your local area provider meetings to find out what the Health Care Plans have to offer and discuss how to better coordinate services with them.

Health Care Plan	Name	Phone Number	Email Address
Community Health Plan	Natalie Nelson	(206)613-8870	natalie.nelson@chpw.org
CUP Health	Keri Thompson	(360)449-8921	
Group Health Cooperative	Jeff Sakuma	(206)448-5823	sakuma.j@ghc.org
Kaiser Permanente	Kari Albrecht	(503)721-6435	Kari.M.Albrecht@kp.org
Molina	Glenice McKeon	(425)424-1176 or 1(800)869-7171 x141176	glenice.mckeon@molinahealthcare.com

Healthy Options Plans by County

This is a current list of active health plans in each Washington State county. You can also access this information by visiting the Healthy Options webpage: <http://fortress.wa.gov/dshs/maa/HealthyOptions/index.html>

County	Asuris NW Health	CUP	CHPW	Group Health	Kaiser	Molina	Regence Blue Shield
Adams			X			X	
Asotin (ffs)						B	
Benton			X			H	
Chelan			X			X	
Clallam (v)						X	H
Clark		X	X		B		
Columbia (V)						X	
Cowlitz			X		B	H	
Douglas			X			X	
Ferry			X			X	
Franklin			X			H	
Garfield (v)						X	
Grant			X			X	
Grays Harbor			B			X	H
Island			X				H
Jefferson (V)			X				
King			X	X (p)		X	
Kitsap			X	X		H	
Kittitas (v)						X	
Klickitat (V)			X				
Lewis			X			X	
Lincoln			X			X	
Mason			X			H	
Okanogan			X			X	
Pacific			X (H(p))			X	H
Pend Orielle			X			X	
Pierce			X	H (p)		X	H
San Juan			X			H	H
Skagit			X			H	H
Skamania (V)			X				
Snohomish			X	B		H	H(p)
Spokane	H		X	X		X	
Stevens			X			X	
Thurston			X	B		H	
Wahkiakum (V)			X				
Walla Walla			X			X	
Whatcom			X			X	
Whitman (V)						X	
Yakima			X			X	H
"B" = Basic Health Plus - represents where plan will be contracted for BHP+ only							
"H" = Healthy Options/SCHIP - represents where plan will be contracted for Healthy Options/SCHIP only.							
"X" = Healthy Options/SCHIP/BHP+ - represents where plan will be contracted for all three coverages.							
"(p)" = Partial County - represents where plan will serve only certain zip codes in a county.							
"V" = Voluntary County - represents county where enrollment in managed care is not mandatory.							
"(ffs)" = Fee For Service - represents Fee for Service coverage only - no plans available.							
Voluntary counties with Default Enrollment							
Voluntary county where there is not enough capacity to cover all eligibles							
Kaiser in Clark County to freeze enrollment after 1-1-07 until further notice							

Pests Can Pester in Childcare Settings - USE IPM!

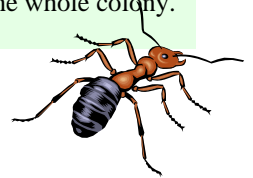
*Submitted by Cheryl J. Hanks, BSN, RN, Pesticide Programs
-Illness Monitoring and Prevention, DOH*

There are many reasons to control pests. Ants can spoil food, cockroaches shed a protein that may aggravate asthma, rodents can contaminate areas with their droppings and may carry disease, and wasps can be aggressive and sting children. Before reaching for the can of spray, consider that pesticides used around children may also cause health problems. So, how are pests most safely managed? When and how should pesticides be used?

Integrated Pest Management (IPM) has many advantages. IPM is a flexible approach that combines easy practices. These are physical, mechanical and biological. IPM often removes the need for pesticides and emphasizes cheaper prevention practices. This approach can be less harmful to children, staff, and the environment. IPM focuses on eliminating the cause of pests by minimizing access to food, water, and hiding places. IPM solutions often provide long-term control. See EXAMPLE below about ants.

AN EXAMPLE using IPM Strategy: Nuisance ants

1. **Inspect for ants.** Where do they come into the building? What are their food and water sources? Follow the ant trails to find their point of entry. Use a soapy sponge to remove live ants. Clean floors, countertops, and baseboards with vinegar water to remove the ant trails.
2. **Identify and learn about the ant.** Websites and resources will let you be sure that you have a nuisance ant and not a carpenter ant (which may do structural damage) or a thatch ant (which is mostly a beneficial outside ant). Different types of ants require different control methods.
3. **Keep them out:** Block their entry by use of caulk to seal cracks, weather strips to seal doors and windows, and door sweeps to minimize access.
4. **Prevent future problems:** Apply what you learned about ants. Don't welcome them! Minimize food supply. Clean up crumbs on floors and counters as soon as possible. Wipe up all food spills, especially sugary materials. Keep sugar and similar things in tightly covered containers. Limit eating and snacking to a few areas that are easy to clean. Fix leaks in plumbing that allow water to pool.
5. **If you still have an ant problem:** You may want help of a pesticide control company who uses IPM. Always start with the least hazardous product and protect children from any exposure. With nuisance ants, start with carefully placed pesticide baits in tamper resistant stations. Ants take the bait back to the nest where it kills the whole colony.



Finally, Be Careful with Pesticides:

1. Read and follow ALL label directions and precautions.
2. Do not apply pesticides when staff or children are present.
3. Store pesticides in a locked cupboard out of reach of children and not above food or beverages.
4. Choose products like gels and baits that can be applied to areas inaccessible to children. Avoid sprays that can move with the air and be inhaled.
5. If a pesticide spray is used indoors, be sure to thoroughly ventilate the area before allowing re-entry. If an odor is present after the recommended ventilation time, ventilate again before allowing children in.



RESOURCES:

What is IPM? <http://www.ecy.wa.gov/programs/swfa/upest/what.html>

IPM in Childcare Centers <http://spcpweb.org/childcare/>

For Staff <http://www.epa.gov/pesticides/ipm/brochure/>

For Kids- <http://www.epa.gov/pesticides/kids/index.htm>

The Safe Use of Pesticides Keeps Pests from Becoming a Problem in Schools

http://www.schoolpestfacts.com/ipm_white_ipm.htm

IPM for specific pests: <http://www.ecy.wa.gov/programs/swfa/upest/schoolIPM.html>

Health issues of pesticides in schools and daycares:

<http://www.doh.wa.gov/ehp/ts/Pest/pest-school.htm>

IPM Online <http://www.ipm.ucdavis.edu>