Right From the Start
Healthy Beginnings for You and Your Baby

Policy and Procedures Manual May 2024

Empowering Families for Healthy Beginnings

Mission Statement
Provide professional, individualized, and comprehensive care that empowers families to achieve the healthiest possible outcomes during pregnancy, postpartum, and infancy.

Vision Statement
Become a sustainable program that empowers participants to choose lifestyles resulting in healthy families.

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1.0 GENERAL ADMINISTRATION

1.1 INTRODUCTION

Ensuring access to health care for low-income women and children has been an ongoing concern for state and federal officials. The West Virginia Department of Human Services (DoHS), Bureau for Medical Services (Medicaid) and the West Virginia Department of Health (DH), Bureau for Public Health, Office of Maternal, Child and Family Health (OMCFH) have worked collaboratively to develop special initiatives that extend support services to women and infants at-risk of adverse health outcomes. This partnership has not only expanded the State's capacity to finance health care for women and children, but has also strengthened the delivery of care by establishing care protocols, recruiting medical providers and developing supportive services, such as case management and nutrition counseling, which contribute to improved client well-being.

Medicaid and OMCFH have worked collaboratively to develop a systematic approach to deal with the problems of access to prenatal care. The Right From the Start (RFTS) Program was implemented in response to the mandates of West Virginia State Code §9-5-12.

RFTS is a home visitation program, which provides comprehensive services for Medicaid and the West Virginia Children's Health Insurance Program (CHIP) maternal clients and infants, including care coordination and/or provision of enhanced prenatal care services. RFTS utilizes a standardized curriculum, *Partners for a Healthy Baby* (*PHB)*, to provide services to enrolled clients, based upon needs identified in the Initial Client Assessment and the Service Care Plan.

PHB is a research-based, practice-informed curriculum used in evidence-based programs that have achieved positive outcomes as documented in numerous studies. The curriculum was developed by a multi-disciplinary faculty team at Florida State University and targets topics such as improved prenatal health, positive parenting, enhanced child health and development, infant mental health, economic self-sufficiency, family stability, healthy lifestyles, and well-being.

All services are provided by professional staff that must be either a:

- Registered nurse licensed to practice by the West Virginia Board of Examiners for Registered Professional Nurses. Graduate nurses with temporary West Virginia licenses must pass the West Virginia State Board Examination to continue to provide RFTS services; or
- Social worker licensed to practice by the West Virginia Board of Social Work Examiners or social workers with temporary licensure status (certain criteria apply – visit www.wvsocialworkboard.org for details). A bachelor social worker (BSW) or master social worker (MSW) is preferred. In regions where licensed social worker (LSW) shortages exist and agencies have documented a hardship in recruitment of a BSW or MSW for Designated Care Coordinator (DCC) positions, the agency may submit documentation to the State RFTS Office for waiver considerations. All non-BSW/MSW applications and credentials are to be reviewed by the Regional Care Coordinator (RCC) and Director of the West Virginia Home Visitation Program (WVHVP) prior to approval as a DCC; this includes non-BSW/MSWs under temporary licensure.

RFTS is a comprehensive statewide initiative for government-sponsored maternal clients whose incomes are at or below 185% of the federal poverty level, and for Medicaid and CHIP-eligible infants up to the age of one year. A major component of the Program is to provide in-home care coordination services whereby registered nurses and licensed social workers visit eligible maternal clients in their homes throughout the pregnancy and first year of parenting, and eligible infants up to the age of one year. The purpose of the home visit is to assess educational, social, nutritional and medical needs, and to facilitate access to appropriate service providers.

Coordination components include a personalized in-home assessment to identify barriers to health care, an individually designed care plan to meet the client's needs, community referrals as necessary, follow-up, and monitoring. All Maternal Medicaid, CHIP, and RFTS Maternity Services cardholders are eligible for educational activities designed to improve their health (i.e., childbirth education, smoking cessation counseling, parenting, and nutrition).

Consistent with the provisions of West Virginia State Code §9-5-12, the West Virginia Medicaid (Title XIX) funds provide financing for most RFTS activities. OMCFH uses Federal Maternal and Child Health Block Grant (Title V) funds and State Appropriations to provide a limited health benefit package to maternal clients whose income makes them ineligible for Medicaid. Funds available to OMCFH are also used to defray portions of the administrative costs of RFTS.

Administration of RFTS is accomplished with OMCFH WVHVP staff and regional staff consisting of eight RCCs and many DCCs employed by various community, social, and health care agencies throughout the State.

RFTS providers follow Standards of Care established by the American College of Obstetricians and Gynecologists (ACOG) for enrolled clients. Program services focus on the mother's personal health, quality of care giving and life-course development. Providers are dedicated to the public health function of assisting with access to early and adequate prenatal health care.

ACOG provides updated *Practice Bulletins* regarding Standards of Care. *Practice Bulletins* provide obstetricians and gynecologists with current information on established techniques and clinical management guidelines. ACOG continuously surveys the field for advances to be incorporated in these series and monitors existing bulletins to ensure they are current. Individual bulletins are withdrawn from and added to the series on a continuing basis and reaffirmed periodically. For more information on ACOG and/or to view publications such as *Committee Opinions, Technology Assessments, Patient Safety Checklists* and *Practice Bulletins* visit the website at www.acog.org.

This manual contains policies and procedures of RFTS and serves as an operational reference for participating in the Program. It is expected that all providers will conform to the policies and procedures contained in this manual and all future revisions.

This manual is reflective of RFTS' dedication to improving the health and well-being of West Virginia's families. Staff must be familiar with the Program's policies and procedures in order to deliver quality care to participants.

Questions relative to RFTS, including operational policies and procedures, should be directed to:

West Virginia Department of Health
Bureau for Public Health
Office of Maternal, Child and Family Health
Right From The Start Program
350 Capitol Street, Room 427
Charleston, West Virginia 25301-3714
Phone: 1 (800) 642-8522 or (304) 558-5388
Email: dhomcfhrfts@wv.gov
www.wvdhhr.org/rfts

Questions regarding Medicaid and CHIP eligibility, provider enrollment, status of claims or other billing questions, call Gainwell Technologies at 1 (888) 483-0793 or (304) 348-3360.

2.0 ELIGIBILITY

RFTS serves Medicaid/CHIP/Maternity Services eligible maternal clients and Medicaid/CHIP eligible infants up to the age of one year. The category "women" includes adolescent females. A RFTS client is defined as an eligible woman/infant who receives care coordination and/or an eligible woman who receives enhanced services paid under RFTS billing codes.

2.1 ELIGIBILITY FOR WOMEN

A. Criteria For RFTS Services Eligibility

To be eligible for RFTS Care Coordination and/or Enhanced Prenatal Care Services throughout her pregnancy, the month she delivers, and through the last day of the 12th postpartum month:

- Be a West Virginia resident;
- Have either a valid Medicaid card, CHIP, or RFTS Maternity Services card; and
- Have had a Referral Form to RFTS completed.

Pregnant teens ages 19 and under are eligible for RFTS services regardless of family income, if uninsured, for maternity care. The pregnant teen must first make an application for Medicaid coverage at the local DoHS office and be denied coverage. The DoHS forwards the Medicaid denial information to OMCFH for eligibility coverage assessment for pregnancy service.

Maternal clients under the age of 18 can provide consent for RFTS services.

B. Program Access

A referral to RFTS may be made in one of the following procedures:

- West Virginia Prenatal Risk Screening Instrument (PRSI) completed by a medical provider;
- Completion and submission of a Referral Form to RFTS;
- Medical provider or other agency supplying a list to the RCC of newly diagnosed pregnant clients;
- Director of WVHVP forwarding referrals received by OMCFH to the appropriate RCC; and/or
- Direct contact by maternal client, family member, friend, etc. to OMCFH, RCC or DCC.

2.2 ELIGIBILITY FOR INFANTS

To be eligible to receive Care Coordination up to the age of one year, an infant must:
(For example, last day of their birth month)

- Be a West Virginia resident;
- Be up to the age of one year;
- Have a valid WV Medicaid card or CHIP; and
- Have had a Referral Form to RFTS completed.

Infants are not eligible for enhanced services.

Medicaid or CHIP-eligible infants may be referred to RFTS by a physician, nurse practitioner, nurse, social worker, other individual, or parent/guardian because of medical, social and/or environmental factors.

Examples:

- Parent exhibits a knowledge deficit in, or expresses a desire to improve parenting skills;
- Family has inadequate resources;
- Infant has low birth weight;
- Infant is technology dependent;
- Infant has had frequent hospitalizations;
- Infant is diagnosed as failure to thrive, etc.; and/or
- Family involved with Child Protective Services (CPS).

Infants identified by Project WATCH as high birth score Medicaid or CHIP-eligible are referred for RFTS services and must be given priority enrollment status. Client referral received from a Drug Free Moms and Babies site, substance use/behavioral health center, or drug court referrals must be given priority enrollment status.

2.3 RETROACTIVE MEDICAID ELIGIBILITY FOR NEWBORN CHILDREN UP TO THE AGE OF ONE YEAR

If an infant is born and is underinsured or uninsured, the infant's parent, legal guardian or caretaker must be referred to the local DoHS office to file a Medicaid application. The DCC will advise the mother to request retroactive coverage to the date of the infant's birth. The infant's Medicaid coverage may be **backdated** up to three months from the month of application or to the month of birth (whichever one is closest to the month of application) only if verification of information required deems the infant eligible for Medicaid coverage for the month for which coverage is needed. Otherwise, coverage begins the month in which eligibility is established.

A. Newborn Coverage: Medicaid

Clients presenting the WV Medicaid card are entitled to receive the full range of services covered under the Title XIX State Plan.

B. Newborn Of A Minor Mother

Newborns of Medicaid-eligible women (including minors) qualify for Medicaid until 12 months of age as long as the child resides continuously with the mother or foster care caregiver. The minor mother who is not Medicaid-eligible and whose income is 150% or below the federal poverty level (FPL), must apply for Medicaid coverage for the newborn as soon as possible after the delivery. If the mother's income is 150-300% of the FPL, the newborn may qualify for CHIP and must make the application before the end of the infant's birth month. If the mother would like to apply for CHIP coverage for the infant, they will need to call the DoHS, Customer Service Center at 1 (877) 716-1212. All claims related to the infant will be placed on hold by CHIP until a social security number has been reported to the DoHS Customer Service Center for the child being born. A minor parent can sign consent for services for her infant.

3.0 PROGRAM COMPONENTS AND CARE COORDINATION

The following are required components for all clients participating in RFTS.

3.1 INITIAL ASSESSMENT

In conjunction with the client or guardian of the infant, a comprehensive assessment of conditions/causes for risk and/or identify other factors that may adversely affect the client's outcome must be completed. Documentation must be completed using the Initial Client Assessment Form which must be signed and dated.

Care Coordination for Procedural Implementation:

- Complete at the first visit for both infant and maternal clients.
- Identify needs and areas of risk.
- Use Initial Client Assessment to create the Service Care Plan.
- Complete accurately, thoroughly, and legibly with the client or guardian of infant.
- DCC must sign, date, and forward a copy to the RCC within seven calendar days.
- One assessment per client (per pregnancy); updates and changes may be made if needed. All changes must be initialed and dated by DCC and copied to RCC within seven calendar days.

3.2 SERVICE CARE PLAN

Based on areas identified in the Initial Assessment, this individualized plan is developed with the client or guardian of the infant. The Service Care Plan (SCP) designates the goals and objectives of the client. The client's individualized SCP guides the services that the client receives during RFTS participation. Care coordination can begin only after the SCP has been completed and signed by the client or guardian of the infant.

Care Coordination for Procedural Implementation:

- Complete at the first visit for both infant and maternal clients.
- Address needs identified on the Initial Client Assessment by client or guardian of infant, medical provider, or DCC.
- Goals and objectives for the individualized SCP must be developed in conjunction with the client or guardian of infant.
- Discuss with the client or guardian of infant how, when and where referral, coordination, and follow-up will occur.
- Ensure the SCP is signed and dated by the DCC and the client or guardian of infant. A copy of the SCP is to be given to the client or guardian of the infant on the date the Initial Client Assessment is completed. Copies are to be sent to the RCC and medical provider within five working days.
- Make referrals as specified in the client's SCP and provide appropriate follow-up.
- Act as advocate for resolution of problems that may arise in implementing the SCP.
- Client or guardian of infant contact must be completed at least three times monthly to ensure identified goals and objectives are met/pursued.
- Periodic review and revision of the SCP should be done to ensure appropriate quality, quantity, and effectiveness of services. Revisions to the SCP must be completed as indicated (significant junctures in client care/status).
- All revisions/changes made to the SCP must be signed and dated by the DCC and client on the revision line. The DCC must forward the revised SCP to the RCC and medical provider within seven calendar days.

3.3 RIGHTS AND RESPONSIBILITIES

To ensure an individual's rights are protected, the DCC will explain to the client or guardian of the infant their "Rights and Responsibilities" (R&R), confirm with verbal understanding, and obtain client signature for consent. Documentation must be completed using the R&R Form before care coordination can begin.

Care Coordination for Procedural Implementation:

- Complete at the first visit for both infant and maternal clients.
- Explain R&R to client or guardian of infant.
- Document verbal acknowledgement of understanding.
- Complete, sign, and date by the client or guardian of infant client and DCC at the first visit.
- Must be completed and signed prior to initiation of any services. Copy provided to the client.
- Forward copy to RCC and medical provider within seven calendar days.

3.4 RIGHT FROM THE START – SMOKING CESSATION PROJECT

The RFTS Smoking Cessation Project is designed to help maternal clients (prenatal and postpartum for up to one year) quit smoking; it is a component of a patient education program. All DCCs are required to take the RFTS Smoking Cessation Project training created by a Master Certified Tobacco Treatment Specialist with a National Certificate in Tobacco Treatment Practice (NCTTP). This course enables DCCs to have a better understanding of tobacco use/nicotine addiction, approved treatments, and Motivational Interviewing (MI). After taking this training, DCCs are better prepared to provide interventions using their knowledge of tobacco cessation and their skills to conduct MI in counseling. The DCCs are provided with the RFTS Smoking Cessation Project manual which describes the program and provides step-by-step guide to intervention and educational materials.

The DCCs are trained in the use of a device detecting the carbon monoxide (CO) level of clients, called the Smokerlyzer®, designed by Bedfont Scientific. The CO monitor is utilized to observe patients progress during their process of quitting smoking. It is a non-invasive method to collect two measures: 1) the number of parts of CO in one million parts of breath air (parts per million, PPM) and 2) the level of CO in the bloodstream which is the carboxyhemoglobin (COHb).

As an additional source, clients are referred to the West Virginia Quitline (1-800-QUIT-NOW) to be further assisted in overcoming nicotine addiction. With the consent of the client, DCCs complete the Quitline referral form and send it to the Quitline. The clients are then contacted by a trained Quitline professional and offered services such as counseling sessions over phone and may include Nicotine Replacement Therapy (NRT). Infant clients whose caregiver is not enrolled in RFTS are given information to the West Virginia Quitline.

Care Coordination for Procedural Implementation:

- An initial smoking assessment of smoking status and exposure to environmental tobacco smoke (ETS) must be completed at enrollment, during the initial visit with all prenatal/postpartum clients.
- Documentation must be completed using the RFTS Smoking Cessation Project Form.
- If smoker, provide clear message about risks of smoking to mother/baby; provide clear, strong, and personal advice to quit; and document education on the Tobacco Screening Form.
- Clients interested in smoking cessation or reduction are to be offered a RFTS Smoking

Cessation Project intervention following the 5 “A” protocol.

- Additional follow-up on tobacco usage will continue during every visit. DCCs will document the CO value of the client (when feasible) and the number of cigarettes currently smoked on the Client Tracking Sheet.
- Additional follow-up on tobacco usage will continue during every in-person visit. DCCs will document the CO value of the client and the number of cigarettes currently smoked on a Client Tracking Form.

3.5 EDINBURGH POSTPARTUM DEPRESSION SCREENING (EPDS)

The EPDS Scale is used to monitor clients for early warning signs of depression issues throughout the course of care coordination. The EPDS must be completed with all prenatal/postpartum clients to assess depression during the prenatal and postpartum periods. DCCs are required to make necessary referral when indicated by the client’s EPDS score. However, screening is not limited and may be administered at any time. DCCs will utilize the evidence-based Mothers & Babies curriculum to enhance maternal mental health discussion with clients. Note: The National Maternal Mental Health Hotline is 1-833-TLC-MAMA (1 (833) 852-6262).

Care Coordination for Procedural Implementation:

- The EPDS must be administered on prenatal and postpartum clients. The EPDS must be administered within the first 30 days after client enrollment and must be repeated every three months thereafter.
- Instructions for Users:
    1. The mother is asked to underline the response which comes closest to how she has been feeling in the previous seven days.
    2. All ten items must be completed.
    3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
    4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading and/or writing.
- Scoring: Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptoms. Items marked with an asterisk (*) are reverse scored (i.e. 3, 2, 1, 0). The total score is calculated by adding together the scores for each of the ten items.
- Interpretation:
    1. Women who score above the threshold of 12-13 are likely experiencing an episode of depression and must be referred to a physician or mental health care provider. If evidence of suicidal tendencies/hopelessness exists, establish a safety plan with client/family and arrange urgent (24-48 hrs.) or emergency evaluation at a Mental Health Center or Emergency Room based on the DCC assessment.
    2. A score of 9-11 might indicate depression therefore a referral should be made to the client’s medical provider. A careful assessment should be carried out to confirm the results of the screen and in certain cases it may be useful to repeat the EPDS after two weeks (earlier if indicated).
    3. A score of 0-8 may indicate minimal/mild depression. The client should be carefully assessed and the RFTS individualized SCP followed. If questions or concerns arise, the screen should be repeated.
    4. Submit copies to the RCC and medical provider within seven calendar days of completion.

NOTE: Users may reproduce the Scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies. [1]

3.6 RELATIONSHIP ASSESSMENT TOOL (RT) - DOMESTIC VIOLENCE SCREENING

RT is a domestic violence screening tool for intimate partner violence. It is designed to measure women's experiences in abusive relationships and assess the possibility of domestic violence or partner violence occurring in the home. Note: The National Domestic Violence Hotline is 1 (800) 799-7233.

Care Coordination for Procedural Implementation:

- The RT is to be completed for all prenatal clients, postpartum clients, as well as for all female caregivers of infant clients. For male caregivers, use the Violence Screening Tool for Domestic Violence & Intimate Partner Violence (HITS) (Hurt, Insult, Threaten & Scream) form.
- The RT is to be administered during the initial visit after client enrollment and be repeated every three months thereafter.
- If the DCC feels that it is not safe or suitable to administer the RT at a visit, the DCC can forgo administering the screening for that specific visit. However, in the case the RT screening is delayed for any reason, the DCC will attempt to complete the RT at the next visit.
- The RT must be administered regardless of relationship status. The intent is to discuss healthy and unhealthy relationships. The tool and discussion points could impact future relationships.
- When an RT screening is not completed for a visit, the DCC must complete proper documentation. The designated location for documentation can be found on the first page of the RT screening, at the beginning of the page. Note: Explanation for the delay of RT screening must also be documented in the Progress Note for that visit.
- RT screening can be administered at any time there is a concern domestic violence is occurring.
- A score of 20 points or higher on the RT is considered positive.
- If the client has a positive score of 20 points or higher, the DCC will then make the appropriate referral(s) to domestic violence professionals using the RFTS External Referral Form.
- A copy of the RT is to be submitted to the Regional Lead Agency (RLA) office within seven calendar days of completion.
- Provide "Healthy Moms, Happy Baby" Safety Domestic Violence Wallet cards to all clients.
- To reach the National Domestic Violence Hotline: 1 (800) 799-7233.

3.7 SUD (Substance Use Disorder) Screening

The SUD screening tool is adapted from the UNCOPE (Used, Neglected, Cut Down, Objected Preoccupied, Emotional Discomfort) screening tool. UNCOPE can be used to screen for drugs and alcohol. Comprised of six (6) questions, it provides a quick and simple way of identifying risk for abuse and dependence on alcohol and other drugs.

[1] Reprint with permission from: Cox, J. L., Holder, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry, 150, 782 - 786.

Care Coordination for Procedural Implementation:

- Initial screening of the SUD screening will be administered by the DCC within the first three visits of client enrollment, as well as every three months thereafter, for the duration of the client's enrollment.
- SUD screening is to be administered on all prenatal clients, as well as all primary caregiver/guardian of infant clients, during face-to-face contacts.
- Note: Completion of the form "SUD Screening" is not required if the maternal client or the primary caregiver/guardian of the infant is currently undergoing DoHS-approved Medication-Assisted Treatment (MAT). MAT treatment should be indicated using the checkbox on the form and documented in the Progress Note.
- If the SUD screening results in less than two "Yes" answers, the SUD screening process can be considered complete and documented as such.
- When the screening results in two or more "Yes" answers, an external referral to SUD counseling and treatment services is required with client consent.
- Submit copies of the completed screening to the RLA office within seven calendar days of completion, along with other documents for that visit.
- Note: Subsequent SUD screenings can also be completed with clients, on an as needed basis.

3.8 REFLECTIVE PRACTICE

Reflective practice supports professional and personal development of home visitors by attending to the emotional content of their work and how reactions to the content affect their work. Reflective Supervision encompasses the supervisor's ability to listen without providing solutions to problems, allowing the supervisor and staff member to mutually explore alternative solutions together. Reflective practice should occur on a monthly basis either through group or one-to-one sessions.

Care Coordination for Procedural Implementation:

- Based upon the discretion of the RLA and the DCC on frequency based upon DCC needs and caseload.
- Structure can be defined upon the discretion of the RCC based upon number of DCCs and emerging needs of DCCs related to caseloads.

3.9 MOTHERS & BABIES CURRICULUM

Mothers & Babies is an interactive program with lessons and activities proven to promote healthy mood, bonding with one's baby, and strategies for coping with stress. The Mothers & Babies Program can be delivered to pregnant women and new parents individually in one-on-one visits or in a group setting. Each session incorporates aspects of psychoeducation to foster observation of one's mood and identification of the things that affect one's mood, as well as promotion of healthy bonding and developmentally appropriate mother-infant interactions. Mothers & Babies can be delivered by individuals with background/training in mental health (e.g., clinical social worker, psychologist) or individuals without specialized mental health training (e.g., home visitors). For these women experiencing more significant depression, Mothers & Babies may be the support needed to guide women to accessing additional mental health services.

Care Coordination for Procedural Implementation:

- Upon completion of the required Mothers & Babies curriculum training, DCCs should offer Mothers & Babies to women that screen positive for mild depression as a referral source. In addition, for women who screen higher, Mothers & Babies can be used until other mental health services are provided.

- Individual settings can be up to twelve 15–20-minute sessions. Sessions can be delivered with varying frequency, in person or over the phone, and individual sessions are brief enough to be able to incorporate within the context of other types of visits (e.g. home visits, WIC, prenatal visits, etc.)

3.10 AGES AND STAGES DEVELOPMENTAL SCREENING TOOL (ASQ-3)

The ASQ-3 screening system is a questionnaire designed to be completed by parents or other primary caregivers at any point for a child between one and sixty-six months of age. The ASQ-3 is to be completed on all infant clients. These questionnaires can accurately identify infants or young children who may need further assessment to determine whether they are eligible for early intervention or early childhood special education services.

Care Coordination for Procedural Implementation:

- Complete for all infants at 2, 9 and 12 months of age.
- The primary caregiver is to complete the questionnaires.
- If the score is below the referral cutoff, a referral to Birth To Three (BTT) must be made.
- The most recent age-appropriate screen score is to be used on the Infant Outcome Measures form at case closure.
- When an infant leaves RFTS, a referral must be made to Help Me Grow (HMG) or an appropriate home visitation program to ensure a continuum of service for the child through the age of five if family wishes continued services.
- Submit copies to the RLA for future steps.
- RLA submits the ASQ-3, along with a form letter from the RCC to the medical provider.
- Note: Completion of the ASQ-3 is not required if an infant client is enrolled with BTT. Documentation of the BTT enrollment should be included in the Progress Note.

3.11 AGES AND STAGES SOCIAL-EMOTIONAL SCREENING TOOL (ASQ-SE2)

The ASQ-SE2 screening system is a questionnaire designed to be completed by parents or other primary caregivers for children ranging in age from two to 72 months of age. The ASQ-SE2 was developed to complement the ASQ-3 by providing information specifically addressing the social and emotional behavior of children.

Care Coordination for Procedural Implementation:

- Complete for all infants at 2 and 6 months of age.
- The primary caregiver is to complete the questionnaire.
- If the score is above the referral cutoff, a referral needs to be made for diagnostic social-emotional or mental health assessment.
- Submit copies to the RLA with future steps.
- RLA submits the ASQ-SE2, along with a form letter from the RCC to the medical provider.

3.12 CLIENT TRACKING SHEET

The Client Tracking Form is used to document client services and DCC billing codes for every visit or contact, minus contacts via text. This includes preparation time, travel time, and distance for each visit. Other facets of RFTS services such as Safe Sleep, Period of Purple Crying, breastfeeding, and smoking information for the visit are also recorded on this form. The tracking sheet is for billing purposes and not to be confused with the Progress Note.

Coordination for Procedural Implementation:

- Complete at every contact for both infant and maternal clients, starting with the Initial Client Assessment (i.e., home visits, telephone calls, client advocacy, face-to-face contacts, etc.).
- Individual DCC Agency tracking logs cannot be used for RFTS Program documentation. Documentation is to be completed on the Progress Note.
- Must be completed accurately, thoroughly, and legibly. DCCs must respond to all applicable questions on the Tracking Sheet appropriately. To ensure accurate data collection, the RLA will return any Client Tracking Sheet that has incomplete applicable fields back to the DCC for correction. Any returned forms must be resubmitted within seven calendar days from the date they were returned.

Complete Safe Sleep, Period of Purple Crying, breastfeeding, and smoking questions.

- Submit appropriate copies to:
    - RCC: Must accompany Initial Client Assessment, Progress Note, SCP, R&R, and Smoking Cessation Form within seven calendar days of signature.
    - DCC Billing Department: Within seven calendar days of service date.
- Must include maternal client or guardian of infant client signature on all visits. Verbal consent can be used in non-face-to-face visits.
- Any and all interactions with clients through texting cannot be considered a contact for the purposes of billing and completing a Client Tracking Sheet. The Tracking Sheet must not be used to document such contacts. Note: Texting with clients can lead to potential privacy violations and is not a recommended practice by the RFTS State Office.

NOTE: DCC Agency Signature Logs cannot be used to document the client signature. The RFTS Program will only accept client signatures on the Client Tracking Sheet.

3.13 PROGRESS NOTES

The Progress Notes of events, with regards to RFTS services that are provided to the client, are maintained by DCCs. Progress Notes, communicate information, facts and assessments, as well as a repository for critical thinking regarding RFTS case coordination for individual clients. A Progress Note must be submitted for both infant and maternal clients, for every contact (i.e., home visits, phone calls, client advocacy, etc.).

Care Coordination for Procedural Implementation:

- Initial Progress Notes must include the date and time the referral was received by the DCC, as well as documentation regarding the DCC's contact.
- All Progress Notes must describe all events for that contact accurately.
- Progress Notes must be complete, legible, and concise.
- All Progress Notes must include the time (in and out) and date of the contact.
- All Progress Notes must include DCC signature at the conclusion of each note.
- Progress Notes must be completed and submitted with each billable Client Tracking Sheet.

3.14 EXTERNAL REFERRAL FORM

The External Referral Form is used to track all outgoing referrals made by the DCC for individual clients. The form tracks when the referral was made, what agency was referred to, and any known outcome(s). The External Referral Form can also be used to refer individuals who are not eligible for RFTS services to other home visitation programs or community agencies that may meet client needs.

Care Coordination for Procedural Implementation:

- All referrals are to be documented on the External Referral Form and must be completed for all outgoing referrals made for maternal and infant clients.
- A new External Referral Form is to be initiated with every visit or contact where each new referral is made.
- All applicable columns on the External Referral Form are to be completed.
- The External Referral Form will be considered complete only at the next subsequent home visit or contact, or within 30 days of the date of the initial referral(s), and when referral follow-up has been completed.
- The DCC will utilize the correct Follow-Up outcome to complete the follow-up column of the form.
- The External Referral Form can also be used to refer individuals who are not eligible for RFTS services to other home visitation programs or community agencies that can meet their needs.
- Submit a copy to the RLA office within seven calender days of completion of follow-up.
- The original form is to be kept in the client's chart.

3.15 NUMBER OF CLIENT CONTACTS

All RFTS clients are designated as intensive, requiring, at a minimum, two face-to-face visits, in-person or virtually, and one phone call for both maternal and infant clients per month. The primary focus of the RFTS Program continues to be home visitation therefore client contact should primarily be conducted through in-home visits**.** If a home visit is unable to be completed, the DCC must clearly document the rationale in the client chart.

Care Coordination for Procedural Implementation:

- All RFTS clients are designated as intensive, requiring monthly contacts for both maternal and infant clients.
- Client contact should primarily be conducted through either virtual or in-person home visits**.**
- If a home visit is unable to be completed, the DCC must clearly document the rationale in the client chart.
- Maternal clients must receive a minimum of:
    - A face-to-face contact for Initial Assessment and SCP development.
    - Each month, at a minimum, two face-to-face contacts, in-person or virtually, at the client's home or at other agreed upon location, and a phone call. Visits are based on a calendar month.
    - If enrolled while pregnant, face-to-face contact within two weeks after hospital discharge following delivery.
- Infants will receive a minimum of:
    - A face-to-face contact for Initial Assessment and Service Care Plan development.
    - Each month, at a minimum, two face-to-face contacts, in-person or virtually, at the client's home or at other agreed upon location, and a phone call. Visits are based on a calendar month.
    - A face-to-face contact within 30 days prior to infant's first birthday (can be counted as case closure).
    - Both the maternal client and infant client can be provided services on the same day. Separate Client Tracking Sheet must be completed. Start and end time must be documented for both visits. Billing is permitted for both visits.

TABLE 1 - CLIENT CONTACT SUMMARY

1.	Initial Assessment and Service Care Plan	In home, other agreed upon location, or virtually.
2.	Contacts monthly through delivery of infant	In home, other agreed upon location, or virtually.
3.	Post Hospital Discharge within two weeks	In home, other agreed upon location, or virtually.
4.	Maternal Case Closure contact within last two weeks of eligibility	In home, other agreed upon location, or virtually.
5.	Infant Case Closure contact within 30 days prior to first birthday	In home, other agreed upon location, or virtually.

3.16 PHYSICIAN'S LETTERS

The physician's letter is to be completed and forwarded to the medical provider. It serves to notify the provider of RFTS eligibility and enrollment.

Care Coordination for Procedural Implementation:

- Must be completed for both infant and maternal clients.
- Submit to medical provider within five working days with SCP and R&R.

4.0 REFERRAL PROCESS

4.1 WEST VIRGINIA PRENATAL RISK SCREENING INSTRUMENT (PRSI)

Uniform Maternal Screening Act – W. Va. Code §16-4E-1, et seq., effective January 1, 2011, states all health care providers offering maternity services shall be required to utilize the uniform maternal risk screening tool (which is the PRSI) in their examinations of any pregnant woman. Additionally, they shall notify the woman of any high-risk condition which they identify along with any necessary referral and report the results to the Bureau for Public Health, OMCFH in the manner provided in the legislative rule. The PRSI is completed through an online web-based system or faxed to OMCFH at (304) 957-0176.

When a PRSI is received by OMCFH and the pregnant woman is eligible for RFTS, the referral is submitted to the RFTS RLA. The RLA staff will then attempt to contact the potential client to establish whether or not the client would like to enroll in RFTS. If the client states that she would like to receive RFTS services, the referral is assigned to an agency or DCC. The DCC must make contact with the pregnant woman within seven calendar days from receipt of the referral to schedule a home visit for enrollment into RFTS.

If the RLA office is unable to establish contact, the referral will be closed.

4.2 RFTS REFERRAL FORM

Maternal or infant clients may be referred to RFTS using the RFTS Referral Form.

The RFTS Referral Form may be completed by anyone who desires to make a referral to RFTS including medical providers, DCCs, Women, Infants and Children (WIC) program staff, DoHS staff, community individuals, etc.

If the client states she would like to receive RFTS services, the referral is assigned to an agency or DCC.

Upon seven calendar days of receipt of the RFTS Referral Form by the RCC, the case will be assigned to the appropriate DCC.

The DCC must initiate contact with the pregnant woman within seven working days from receipt of the referral to schedule a home visit for enrollment into RFTS. If a situation occurs where RFTS does not have capacity at the time of family requesting services, a referral to another home visitation program or HMG within OMCFH must occur.

4.3 HIGH BIRTH SCORE REFERRAL

The Project WATCH office will send referrals to RFTS electronically for all infants identified as having a high birth score and being Medicaid eligible. High birth score referrals are a priority for RFTS.

NOTE: A minimum of three attempts (telephone and/or letter) must be made for client enrollment and all attempts must be documented in the Progress Notes.

5.0 ENHANCED SERVICES

5.1 ENHANCED MATERNAL CARE SERVICES

RFTS offers Enhanced Maternal Care Services which must be rendered in accordance with established Program criteria. Client encounters for Enhanced Maternal Care Services are called sessions. Each category of Enhanced Maternal Care Services has a limited number of sessions for which reimbursement will be made. All Enhanced Maternal Care Services are to be provided to the client using the educational components in the *PHB* curriculum. Enhanced Maternal Care Services may be provided to clients who are participating in full case management during face-to-face encounters.

Providers who choose not to provide case management services may provide Enhanced Prenatal Care Services as face-to-face sessions such as childbirth education, parenting classes, etc. to women who are pregnant or fall within the one-year postpartum period. The education provided by Enhanced Services Only providers should follow the *PHB* curriculum.

A. Referral Criteria

1. Referral for RFTS Enhanced Prenatal Care Services is based on:
    - Referral of Medicaid or CHIP client from RCC;
    - Physician's treatment plan established for the client; or
    - Client's request (self-referral).

2. Referral from RFTS Enhanced Prenatal Care Services must come from the RCC through the RLA. A DCC cannot begin enhanced services until services are approved by the RCC.

3. DCCs will offer RFTS care coordination to all Enhanced Maternal Care Services clients.

B. Eligibility Criteria

A maternal client is eligible for Enhanced Prenatal Care Services if she:

- Has a valid WV Medicaid card or RFTS Maternity Services card for a current pregnancy; and
- All RFTS clients are eligible for Enhanced Maternal Care Services, even if they choose not to participate in care coordination.

5.2 ENHANCED MATERNAL CARE SERVICES COMPONENTS

A. Parenting Education

One session per day with service limit of 32 sessions during the prenatal period and up to the last day of the 12th postpartum month. Topics covered in Parenting Education should include, but not be limited to, topics such as:

- Feeding, bathing, dressing of infant
- Recognition of preventive health needs
- Recognition of acute care needs
- Newborn/child development
- Child safety
- Sibling issues
- Smoke free environment

Instruction must be rendered by approved DCCs for enhanced services who have appropriate education, license or certification.

B. Childbirth Education

Instruction must be rendered by a Medicaid certified provider who is a certified childbirth educator or a registered nurse. A DCC can provide one session per day with a service limit of seven sessions within nine months (total of 14 hours) during the prenatal period. Sessions should include, but not be limited to, topics such as:

- Maternal and fetal development
- Nutrition, fitness, and drugs
- Physiology of labor and delivery
- Relaxation and breathing techniques for labor
- Postpartum care and family planning
- Newborn care and feeding

C. Preventive Self-Care

Instruction during the prenatal period and through last day of 12th postpartum month - one session per day with a service limit of 32 sessions. Topics should include, but not be limited to:

- Physical and emotional changes during pregnancy and postpartum
- Warning signs of pregnancy complications
- Healthful behaviors

Instruction must be rendered by Medicaid-certified providers who have appropriate education, license, or certification.

The *PHB* curriculum must be used to base and guide Preventive Self-Care sessions for women enrolled in care coordination.

D. Nutrition Education

Certain medically related dietary concerns will require specialized nutrition services that are extensive, that is, highly complicated and/or intensive. These cases will be referred to a registered dietitian for comprehensive nutrition evaluation, care plan, and counseling.

The following non-comprehensive list identifies medical conditions requiring specialized nutrition services by a registered dietitian:

Pregnant Women:

• Pregnancy-induced hypertension/pre-eclampsia
• Multiple gestation
• Metabolic condition, chronic disease or disability which complicates present pregnancy, impairs dietary intake, or requires a special diet such as: Chronic pulmonary disease; Chronic hypertensive disease; Gestational diabetes; Diabetes mellitus; Renal disease; Hypolipoproteinemia; Chronic cardiac disease; Cystic fibrosis; Phenylketonuria**;** Other inborn errors of metabolism*****; Anorexia nervosa/bulimia; Maternal gastrointestinal diseases; malabsorption syndromes; Conditions requiring an elemental diet, enteral (specialized formula feeding by mouth or feeding tube), or total parenteral nutrition
• Adolescent pregnancy (i.e., ≤ 15 years of age or ≤ 2 years since onset of menses)
• Intrauterine growth retardation
• Anemia of pregnancy (i.e., iron and/or Focalin - Hgb ≤ 10 g, Hct ≤ 30%, Focalin < 3 mg/ml)

• Hyperemesis gravidarum
• Maternal protein deficiency: Severe hypoalbuminemia < 2 g/dl; Persistent ketosis; Hypercholesterolemia; Negative nitrogen balance; Lymphocytopenia
• Low pre-pregnancy weight (i.e., < 85% standard weight for height)
• Inadequate weight gain (i.e., < 2 pounds per month during last 2 trimesters of pregnancy or unsatisfactory pattern of weight gain per weight gain grids)
• Significant weight loss in the first trimester due to nausea/vomiting (i.e., ≥ 5% of body weight [120 lb. woman would lose 6 lbs.])

**Referral should be made, if not done previously, to: West Virginia University – Department of Pediatrics, Robert C. Byrd Health Sciences Center, Genetic/Metabolism Section, Post Office Box 9214, Morgantown, West Virginia 26506 - Telephone: (304) 293-7331.*

Postpartum Women (through end of 12th postpartum month) whose infants have the following conditions:

• Low birth weight < 2273 grams or 5 lbs.
• Congenital anomaly affecting ability to feed or requiring special feeding techniques such as: Cleft lip/palate; Cerebral palsy; Esophageal strictures
• Chronic diseases and/or conditions requiring a therapeutic formula (i.e., renal, hepatic or cardiac disease, bronchopulmonary dysplasia)
• Cystic fibrosis
• Metabolic disorders such as:***** Diabetes mellitus; Phenylketonuria (PKU); Other inborn errors of metabolism
• Medical diagnosis of failure to thrive
• Developmental delay with associated feeding problems (i.e., ineffective sucking, frequent regurgitation, persistent vomiting, etc.)
• Infant gastrointestinal diseases, malabsorption syndromes, such as necrotizing Enterocolitis, short gut, etc.
• Conditions requiring an elemental diet, enteral (specialized formula feeding by mouth or feeding tube) or total parenteral nutrition
• Weight for length ≤ 5th percentile (based on National Center for Health Statistics [NCHS] growth chart)
• Weight for length ≥ 95th percentile (based on National Center for Health Statistics [NCHS] growth chart)
• Gastroenteritis and/or chronic diarrhea
• Failure to gain weight

**Referral should be made, if not done previously, to: West Virginia University – Department of Pediatrics, Robert C. Byrd Health Sciences Center, Genetic/Metabolism Section, Post Office Box 9214, Morgantown, West Virginia 26506 - Telephone: (304) 293-7331.*

To provide specialized nutrition education and counseling for highly complicated medically related conditions, one session of evaluation and counseling services can be provided. This must be during the prenatal period and through one-year postpartum with one session per day, up to 32 sessions total.

Qualified provider of these specialized nutrition services must be a registered dietitian in accordance with the Commission on Dietetic Registration.

Responsibility of Nutrition Education Enhanced services provider:

- Receive a copy of the physician's order before providing the services.
- Complete a nutritional assessment/develop nutritional plan.
- Provide counseling and discharge when appropriate.
- Send required copies of the physician's order and tracking information to the RCC for RFTS clients (Enhanced Services Education Report – R060) within five working days of completion.
- Referral to Children with Special Health Care Needs (CSHCN) Program.

5.3 ENHANCED SERVICES ONLY (MATERNAL CLIENTS WHO REFUSE CARE COORDINATION)

For those Enhanced Services clients who do not choose to participate in care coordination services, the Enhanced Services Education Report should be completed for the maternal client's entry into RFTS Enhanced Services Only.

If, upon initial contact for Enhanced Services Only, the client chooses to enter into RFTS care coordination services, the Enhanced Services Only provider should forward a copy of the Enhanced Services Education Report to the RCC within five working days to advise the RCC of the client's Program participation. The Enhanced Services provider should check the "YES" box at the bottom of the Enhanced Service Education Report to notify the RCC that the client desires entry into RFTS care coordination services. The RCC will then complete a Referral Form for the client and refer the case to a DCC for entry into RFTS care coordination services. Copies of all subsequent Client Tracking Sheets will be sent to the RCC by the Enhanced Services Only DCC within five working days.

Upon receipt of the Enhanced Services Only client referral from the RCC, the DCC will contact the client to offer full RFTS care coordination services and schedule a home visit within five working days. At the home visit, the DCC will complete the Initial Client Assessment and Service Care Plan. The DCC will then proceed with full care coordination services and all associated RFTS components according to protocol.

Closure of Enhanced Services Only:

This category is for clients who choose to participate in Enhanced Services Only.

1. All records must be closed in accordance with specified time frames and reasons for closure.
2. All closures will be accurately recorded in the Enhanced Services Education Report.
3. Closure of a record by a DCC will include:
    - A copy of the Enhanced Services Education Report forwarded to the RCC within five working days of the closure.
    - The original maintained at the DCC agency.

5.4 ENHANCED SERVICES EDUCATION REPORT

Complete on maternal clients who choose not to participate in care coordination. Send a copy to the RCC within five working days of initial contact.

Within seven calendar days of termination of services, send copy of the Enhanced Services Education Report to the RCC and medical provider:

6.0 CASE CLOSURE

6.1 TRACKING FORM

At case closure, the appropriate case closure reason is marked on the Tracking Form:

- Refused Further Services – Client indicates to DCC that she does not want to continue receiving services for herself/infant.
- Lost to Follow-up – Contact has been made with client, but then DCC is unable to make contact again.
- Induced Abortion – Client chooses to have an abortion.
- Spontaneous Abortion – Client has a spontaneous abortion or miscarriage (grief support is applicable with permission from RLA).
- Moved Out-of-State – Client moves out of state.
- Death – Prenatal client or infant of mother dies (grief support is applicable with permission from RLA).
- Transferred (with date) – Client moves into another region and the case must be transferred in order to continue services.
- Closed by RCC – Case closed at RCC's discretion.

A copy of the SCP must be submitted with the closure date written in the appropriate box. If client is closed prior to the end of eligibility, the reason for closure (from list on Tracking Form) must also be written in the appropriate box on the form.

6.2 OUTCOME MEASURES FORM

Complete both maternal and infant clients who have had an Initial Client Assessment and SCP completed upon closure of the case. If prenatal client closes after delivery, but before the end of eligibility, complete as much of the Outcomes Measures Form as possible. For the infant, complete as much of the Outcome Measures Form as possible upon closure. Submit to the RLA with all other closing documentation.

When an infant leaves RFTS, a referral must be made to HMG or an appropriate home visitation program to ensure a continuum of service for the child through the age of five if family wishes continued services.

NOTE: If a client transfers within the same region or to a different region, do not complete the Outcome Measures Form and do not close the case. Client Tracking Sheet should be coded as transferred and submitted to the RCC immediately. A copy of the client's entire record must be forwarded to the RCC for reassignment. RFTS Epidemiologist should be notified about the client transfer so appropriate changes can be made in the data system.

Date, reason for closure, and DCC's signature will be recorded on the SCP, Client Tracking Sheet as well as Progress Notes.

Submit Outcome Measures Form to RCC within seven calendar days of case closure.

6.3 PHYSICIAN – CASE CLOSURE LETTER

The Physician – Case Closure Letter is used to notify the medical provider of case closure specifying reason for closure. It must be completed for both maternal and infant clients. Submit to RCC and medical provider within seven calendar days of case closure.

7.0 CLIENT RECORD MAINTENANCE

7.1 RECORD MANAGEMENT

Upon receiving a client referral, the RCC will assign the referral to a DCC agency/DCC and send a copy of the approved referral to the DCC agency/DCC with all pertinent information about the client.

Upon completion of client opening:

- The RCC will send a copy of the Referral Form and/or any other pertinent information about the client to the DCC.
- The original documents used in the client assessment and development of the SCP and all other documents used in the revision of care coordination services will remain in the agency of the DCC. A copy of the Initial Client Assessment, SCP, Client Tracking Sheets, and any other document required for the provision of services will be forwarded to the RCC.
- Original case records will be maintained through timely and accurate scheduling and documentation (must use policies and procedures, forms, and record formats approved by RFTS).

7.2 RECORD STORAGE

All record keeping and storage of records must assure client confidentiality as indicated below:

- Original client records will be maintained in a locked storage cabinet or drawer nightly and during weekends. Original records are not to be kept in staff vehicles or residences but are to be kept at the agency of employment.
- Only duly authorized Program personnel are permitted access to case records.
- All RFTS providers must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (The Individually Identifiable Health Information [Privacy Rule] effective on April 14, 2003.).
- For those providers who work from their homes instead of out of their agency of employment, original client records must be maintained at the employing agency. Sections of client records containing information needed for DCC use in service provision may be copied. Original client records, as well as copied records, must be maintained in accordance with HIPAA guidelines to protect the privacy of individually identifiable health information. (Examples: client files must not be accessible for viewing by unauthorized individuals, computers must be secure, telephone discussions with or about clients must not be overheard, etc.) All original client records must be kept current at the employing agency.

7.3 CONFIDENTIALITY OF RECORDS

Care should be exercised to ensure client privacy at all times to include:

- Recording in the client's file;
- Telephoning the client;
- Seeking information about the client;
- Providing consultation;
- Referring the client; and/or
- Correspondence by email, social media or text.

All RFTS staff (RCCs, DCCs, support staff) must have completed a confidentiality/ethics/HIPAA training and sign a confidentiality document to be maintained on file at the appropriate RCC or DCC agency. An example of the DH policy is found in Exhibit E and can be used as a reference

if an agency does not have one in place.

7.4 CLIENT REVIEW OF RECORD

The maternal client or the guardian of an infant may review their record at a reasonable, scheduled appointment date and time. The following procedure must be adhered to:

- Client must sign and date a Client Request for Record Release Form before the record is reviewed; and
- A private area must be made available for record review.

7.5 CLIENT REQUEST FOR COPY OF RECORD

The maternal client or guardian of an infant must sign and date the Client Request for Record Release Form before the record is copied.

- Upon request, the record may be mailed to the place of residence by registered mail with return receipt requested; or
- The record may be obtained from the RLA or the DCC's office.

7.6 CLIENT RECORD RELEASE

During the Initial Assessment, the client or guardian of infant should sign and date the R&R Form, which includes the Client Release/Exchange of Information to/from medical providers and agencies participating in care. Copies should be forwarded to the RCC.

7.7 ROUTINE RECORD COPYING

Copying of a case record will be for the following purposes:

- Referrals for care coordination and other needed services as appropriate
- Client moves out of region
- Client moves within region but not in working area of DCC
- Case closure by DCC
- Case closure by RCC
- Request by RLA or State Office for utilization of review and monitoring
- Submission of tracking sheets to RCC
- Sections of client charts containing information needed for DCC to make a home visit

7.8 RECORD IDENTIFICATION

Infants or non-citizens who do not have a Social Security Number (e.g., NICU infants that are low-birth weight, preterm, and who are automatically eligible for SSI) will be assigned a computer-generated Social Security Number. Refer family of infant to the local Social Security Office to obtain a social security number. When the infant's Social Security Number has been obtained, records must be changed to use the infant's true Social Security Number.

All clients are assigned a computer-generated ID number when entered into the RFTS Data System. The Medicaid/RFTS Maternity Services eligibility number will be included in the record.

7.9 RECORD RETENTION

All active and closed records must be kept for seven years after case closure, or three years after the completion of the Federal audit, after which time the record may be destroyed.

7.10 CLIENT REFERRALS MADE BY DCCs FOR OTHER SERVICES

All external referrals made by DCCs shall comply with standards for protection of client confidentiality and be documented on the RFTS External Referral Form.

8.0 COLLABORATION WITH CHILD PROTECTIVE SERVICES (CPS)

As registered nurses and licensed social workers under West Virginia Law (W. Va. Code 49-6A-2), it is the responsibility of the RFTS DCC to report suspected or apparent child abuse and/or neglect to Child Protective Services (CPS). Detailed reporting information is available on the Bureau for Social Services website at https://dhhr.wv.gov/bss. After the information is reported by the DCC, it is the responsibility of CPS staff to determine what further action will be taken. Observation to determine further action is not within the role of the DCC but is the responsibility of CPS staff.

- DoHS must notify any person mandated to report suspected child abuse and neglect according to West Virginia Law (W. Va. Code 49-6A-2a), as to whether an investigation has been initiated and when the investigation is complete.
- Any contact/collaboration between the RFTS DCC and CPS staff must be documented in detail in the client's file.
- Client information may not be released to CPS staff without written permission from the client or guardian of infant.
- In the event CPS opens services, the role of the RFTS workforce does not change. RFTS workforce does not replace the CPS workers' visitation and direct observation of the child at risk.

9.0 RESPONSIBILITY TO THE CLIENT'S MEDICAL PROVIDER

The DCC will provide an update of client status to the client's medical provider as changes occur.

The update may contain:

- Notification of case closure, reason for closure and/or referral to another agency for additional services using the Physician Case Closure Letter.
- A copy of any changes in the SCP or any other significant change in the client's status (i.e. loss of housing, family dysfunction including abuse or neglect).

10.0 REFERRAL TO THE WV BIRTH TO THREE PROGRAM

The West Virginia Birth To Three Program (BTT) assist children from birth to 36 months of age who have a diagnosis of hearing loss, a developmental delay(s), or a condition known to lead to developmental delay(s). Referrals are made during the RFTS Initial Assessment or at any time deemed necessary during enrollment in RFTS.

The DCC will:

- Explain BTT to the parent/guardian and ask if a referral is desired.
- Submit the referral, if indicated, to BTT serving the county of client's residence and notify the primary medical provider that the referral has been made. Document all referral information on the External Referral Form and in the Progress Notes.
- Inform the primary medical provider if the parent/guardian refuses the referral.

NOTE: BTT referrals can be made by calling the West Virginia Statewide Toll-Free referral line at 1-866-321-4728. Information and electronic referral forms are available on the BTT website at www.wvdhhr.org/birth23/.

11.0 REFERRAL TO THE HELP ME GROW PROGRAM

Help Me Grow (HMG) is a FREE referral service that connects families with critical developmental resources for their children birth through five years of age. The goal of HMG is to successfully identify children at-risk and link them to the help they need.

HMG offers parents and medical providers:

- Referral line. Get expert advice and a referral to community resources to help support early childhood development.
- Ages and Stages Screening Questionnaire-3 (ASQ-3)™. A developmental screening tool endorsed by the West Virginia Chapter of the American Academy of Pediatrics and available upon request.

HMG is part of a national program that connects families to resources in West Virginia. The program is funded by the WVHVP.

The DCC will:

- Explain HMG to every parent/guardian and ask if a referral is desired.
- If desired by parent/guardian, submit the HMG referral at case closure. Document all referral information on the External Referral Form and in the Progress Notes.
- Include the completed HMG Referral Form and External Referral Form in the closure paperwork and submit them to the RLA within seven calendar days after case closure.

12.0 ADOPTION POLICY

12.1 POLICY ON CONFLICT OF INTEREST FOR DESIGNATED CARE COORDINATION AGENCIES

OMCFH requires agencies providing RFTS and adoptive counseling services to provide separate staff for the performance of the two services.

The RFTS DCC agency goal is to provide quality services to high-risk pregnant women, infants, and their families through care coordination services and accessing needed medical, health, educational, psychosocial, and nutritional services. These services are intended to preserve families and give those families the best possible foundation for successful parenting. The agency expects staff to be assertive in ensuring that clients' needs are met, they are protected from harm, and their legal rights are not violated.

To avoid actual or perceived conflict of interest, any RFTS provider (RCC, DCC, clerical staff or other RFTS staff) will under no circumstances recommend or advocate for adoption or fostering an infant born to a RFTS maternal client.

Note the following role clarifications:

ROLE OF DCC	ROLE OF ADOPTIVE AGENCY
• Provide client with names of licensed adoption agencies. • Emphasize client's right to choose adoption agency. • Clarify DCC's role as defined in RFTS Manual and explain adoption planning is not included or discussed. • Outline client's options such as foster care placement, adoption, or pregnancy termination. • Provide referral information if requested by client. • Adhere to rules of confidentiality and provide no written or verbal information to adoption staff without the written consent of the client. • When working with adoption agencies whose program staff wish to provide total birth parent counseling services, contact the RCC to determine if the RFTS client's care coordination services will be closed and transferred to the adoption agency staff. • When working with adoption agencies whose program staff does not wish to provide total care coordination, DCC will continue RFTS care coordination services.	• Inform client of legal rights, responsibilities, and obligations. • Provide adoption planning.

13.0 HOME VISITATION PROGRAMS STATE OFFICE

13.1 RESPONSIBILITIES OF THE STATE HOME VISITATION PROGRAMS OFFICE REGARDING RFTS

A signed grant agreement between OMCFH and DoHS/Bureau for Medical Services designates the WVHVP to administer and be responsible for the operation of RFTS. WVHVP subcontracts with other health care agencies and service providers to operate RFTS.

13.2 DEVELOPMENT OF POLICIES AND PROCEDURES

WVHVP is responsible for the development, revision and implementation of the RFTS Policy and Procedures Manual.

13.3 TECHNICAL ASSISTANCE

Be available to RLAs and service providers by phone, email or on-site.

13.4 TRAINING

- Make available training necessary to meet standards and procedures set forth in RFTS Policy and Procedures Manual. (RLAs and provider agencies' staff are encouraged to participate in training opportunities).
- Review, select and provide RCC training on standardized, best practice home visitation curriculum and supporting resources.

13.5 PROGRAM MAINTENANCE

WVHVP is responsible for maintaining the following in order to assure client access to early and adequate prenatal and infant health care:

State Office:

- Provider list updates
- Data collection and tracking system
- West Virginia birthing facility list
- OMCFH provider number list
- Website updates

Regional Lead Agency:

- Yearly grant agreement
- Monthly/Quarterly reports
- Quarterly training minutes
- Monthly timesheets and invoices upon request
- Correspondence
- DCC Equipment Assignment list

Designated Care Coordinator:

- Initial Letter of Agreement
- Annual agreement renewal
- DCC addition/deletion – Part A

Medical Provider:

- Initial Letter of Agreement
- Annual agreement renewal
- Medical provider addition/deletion

13.6 COMMUNITY OUTREACH

RFTS staff will work cooperatively with RCCs and community resources to enhance RFTS objectives, such as strengthening linkages and collaboration.

13.7 CONFIDENTIALITY OF RECORDS

- In conjunction with RLAs and provider agencies, RFTS staff will adhere to those conditions outlined in their respective agreement and the RFTS Policy and Procedures Manual regarding the safekeeping of client information.
- RFTS staff maintains compliance with the Health Insurance Portability and Accountability Act (HIPAA) enacted in 1996.

13.8 QUALITY ASSURANCE

Quality Assurance review for RLAs and DCC provider agencies will be managed by the OMCFH Quality Assurance Monitoring Team per the guidelines outlined in the RFTS Policy and Procedures Manual. The WVHVP Director or RFTS Program Coordinator will review and respond to Program monitoring reviews.

Quality Assurance:

- DCCs will participate in RFTS Quality Assurance review and monitoring activities.
- The DCC will use the Quality Assurance Report for RFTS to audit both prenatal and infant charts. At least ten maternal and ten infant charts must be audited each quarter, documented, and retained by the DCC provider agency, and sent to the RCC. The DCC may select either open or closed charts for audit.

13.9 RFTS FORMS

RFTS staff develop, provide and approve Program forms and letters to be used by RLAs and DCC provider agencies for the provision of RFTS services. A list of current forms can be found in Appendix C.

13.10 WEB-BASED DATA COLLECTION SYSTEM

RFTS staff maintain and monitor a web-based data entry system for the Program.

13.11 OMCFH PROGRAM COLLABORATION

OMCFH programs and staff functions identified in the RFTS Policy and Procedures Manual are an integral part of the total system design. The WVHVP Director is to be contacted if problems occur related to RFTS collaboration with other OMCFH programs.

13.12 QUALITY ASSURANCE MONITORING TEAM (QAMT)

OMCFH QAMT performs quality assurance activities for OMCFH programs using a standardized process to review and document services rendered. Reviews are conducted with all RFTS providers.

Responsibilities:

- Contact RLA or service provider to schedule the monitoring according to protocol.
- Notify the RCCs of monitoring activity in their regions.
- Conduct an on-site monitoring to verify by observation and documentation provider compliance with RFTS policies and procedures; and to review the conditions surrounding services rendered.
- Conduct an on-site annual monitoring of RLA data entry using client files selected from the RFTS data system.
- Randomly select twenty charts representing the active and closed caseload of pregnant or postpartum women and infants of the entity or person being reviewed.

13.13 CORRECTIVE ACTION PLANS

Within two weeks upon receipt of a Monitoring Report, the WVHVP Director or RFTS Program Coordinator will review the report, make recommendations to improve compliance, identify needs for in-service programs, and send the recommendations to the RCC.

13.14 REGIONAL LEAD AGENCY (RLA) CORRECTIVE ACTION PLAN

- Within three weeks following receipt of the Monitoring Report, the RCC will submit a written correction plan to the RFTS Program Coordinator addressing each item of concern noted in the recommendations.
- Inform the WVHVP Director or the RFTS Program Coordinator of any progress or delays in implementing the plan.
- WVHVP Director or the RFTS Program Coordinator will make site visits to RLA or schedule a conference call to discuss report and corrective action plan.

13.15 DESIGNATED CARE COORDINATING CORRECTIVE ACTION PLAN

- RCC will send a copy of the recommendations from WVHVP Director or RFTS Program Coordinator to the service provider within one week of receipt.
- RCC will meet with the DCC to develop a corrective action plan and include timetables for compliance.
- RCC will review, approve and submit the written service providers corrective action plan to the WVHVP Director and RFTS Program Coordinator addressing each item of concern noted in the recommendations within four weeks following receipt of the Monitoring Report.
- RCC will inform the WVHVP Director and RFTS Program Coordinator of any progress or delays in implementing the plan.

13.16 DESIGNATED CARE COORDINATING AGENCY RESPONSIBILITIES

- Work with the RCC to develop a corrective action plan to be submitted to the WVHVP Director and RFTS Program Coordinator within four weeks following the RCC's receipt of the Monitoring Report and recommendations.
- Inform the RCC of any progress or delays in implementing the plan.
- Implement activities identified in the corrective action plan to obtain DCC agency compliance with RFTS protocol.

14.0 REGIONAL LEAD AGENCY (RLA)

14.1 DESCRIPTION/QUALIFICATION

An agency designated as an RLA, under a grant agreement with the Bureau for Public Health, OMCFH, must meet specific agency criteria to provide for the administration of RFTS at the community-level in accordance with RFTS policies and procedures. The RLA must:

- Demonstrate capacity to provide core administrative and managerial support of RFTS at the regional level.
- Demonstrate experience in coordination and linkage of available community agencies meeting RFTS service provider status.
- Demonstrate experience with the target population to be served under RFTS.
- Demonstrate administrative capacity to ensure quality services in accordance with RFTS policies and procedures and with State and Federal regulations.
- Provide one full-time Registered Nurse for the position of RCC and a sufficient number of clerical staff meeting RFTS administrative qualifications.
- Provide a capable financial management system that will provide documentation of Program administrative services and costs.
- Demonstrate capacity to document and maintain client records in accordance with RFTS policies and procedures and State and Federal regulations.

NOTE: In case the RLA is no longer the service provider, all original closed client files will be maintained by the former RLA. Copies of active client files will be forwarded to the new RLA or to the WVHVP/RFTS Administrative Office.

- Provide and document ongoing RFTS in-service training for provider staff (DCCs, clerks). Report in-services and documentation of staff meetings and/or training sessions to the WVHVP Director/RFTS Program Coordinator to include dates, speakers, topics and attendees.
- Provide RCC with a copy of the signed and dated RLA contract upon receipt from OMCFH.
- Meet performance measures and activities outlined in the annual subrecipient grant agreement Statement of Work.

14.2 REGIONAL CARE COORDINATOR JOB RESPONSIBILITIES

Qualifications:

- Registered Nurse, BSN, licensed in the State of West Virginia with at least three years of community nursing experience as a registered nurse.
- Previous supervision and administrative experience: basic computer/internet, and data entry skills; skills in monthly report preparation and recordkeeping.

NOTE: In regions where nursing shortages exist and agencies have documented that a BSN and/or three years of community health experience presents a hardship in recruitment for the RCC position, the agency may submit documentation of the nursing shortage and a description of unsuccessful recruitment efforts for approval to the WVHVP Director/RFTS Program Coordinator. In these circumstances in place of community health experience a registered nurse with an associate in nursing with community health background and/or a DCC with one-year experience can be substituted with approval from the WVHVP Director.

- Qualifications must be submitted and approved by the WVHVP Director/RFTS Program Coordinator before assuming RCC position.

Job Objectives:

- Comply with RFTS guidelines to administer a regional system for eligible maternal clients and infants.
- Provide training and technical support to medical providers and other professionals to facilitate delivery of timely services to eligible clients.
- Maintain information systems for risk assessment and client tracking.
- Provide technical assistance and support for individuals or agencies that provide direct RFTS services.
- Network and foster collaborative relationships with community agencies/programs.

Authority Lines:

- Responsible to: RLA and OMCFH WVHVP Director/RFTS Program Coordinator.
- Responsible for: RFTS RLA Clerks; and DCC and other service providers in provision of care coordination and enhanced services in compliance with RFTS policy and procedures.

Chief Responsibilities Include:

- Participate in required RFTS curriculum training.
- Technical assistance to new DCC agencies for Medicaid/Managed Care Organizations (MCO)/CHIP enrollment process.
- Referral to other home visitation agencies or HMG if ineligible for RFTS.
- Maintenance of standardized RFTS display.
- Recruitment of providers (DCC and OB).
- Provider training.
- Client tracking.
- Community outreach.
- Attendance at required meetings, including in-person monthly RCC meetings.
- Communication with DCCs and DCC agencies within region.
- Oversight of RFTS data system at the regional level.
- Accurate documentation and timely reporting procedures.
- RLA staff time spent in the provision of RFTS administrative services will be documented on OMCFH time sheets by approved service codes. Time sheets are to be given to the RCC to be submitted (a copy should be kept at the RLA for auditing purposes). RCCs are expected to spend 100% of their time for the provision of RFTS RLA functions.

14.3 REGIONAL CARE COORDINATOR CODES AND ACTIVITIES

ACTIVITY
PROGRAM ELIGIBILITY Activities performed for potentially eligible maternal clients and infants to help obtain Medicaid or medical appointments: • Identifying potential Medicaid, CHIP, and/or RFTS Maternity Services eligibility for pregnant women and infants • Processing referrals • Notifying non-Program eligible clients of ineligibility and making referral to appropriate resource(s) • Referring of Program-eligible clients for SCP development and care coordination

ACTIVITY
OVERSIGHT OF DCC SERVICES Oversight of DCC services to ensure: • SCP met the needs identified in the assessment • SCP documented in chart • Referrals are completed • Medical provider notified of clients participation in Program • Use of CO monitor for all smokers and former smokers • Completion of the required screenings per Program protocol • Technical Assistance: DCC/RFTS service provider on-site and/or telephone assistance
PROGRAM DEVELOPMENT Time spent working with State Program staff in formal work committees to assess and plan or project activities that meet Program goals and objectives: • Training: Instruction on Program policies and procedures to prepare RCCs to train providers; professional training of DCC/medical personnel to enhance or up-date professional skills; and attendance at monthly state RCC meetings or other required training • Meeting with agency administrators, retreats, etc.
RLA OVERSIGHT • Supervising computer input of Client Tracking and/or written recording of client information for Program effectiveness and evaluation of client outcome • Working with State Office for technical assistance with RFTS Electronic Data System • Work with DCCs, clerical support, and State Office on electronic tracking of assessments, screenings, closures and other required RFTS activities
COMMUNITY ACTIVITIES • Preparing for community outreach activities such as participation on locally based committees, public speaking engagements, or baby showers that promote Program goals and objectives • Travelling to events and activities
REPORTS/SURVEYS/BUDGET PREPARATION/BILLING Time spent preparing required Program specific reports and conducting surveys to include but not limited to: • Projecting/reporting monthly caseload of service providers • Projecting yearly RLA budgets • Preparing monthly invoices • Reporting change in service provider agency or RLA agency staffing • Completing monthly RCC activity reports • Preparing of new agency agreements and/or Parts A • Completing reports

ACTIVITY
OUTREACH/CERTIFICATION OF SERVICE PROVIDERS/PROVIDER RECRUITMENT Includes time spent with the service provider in readjusting caseload assignments during a given period and time expended in processing service provider agreements to the RFTS State Office. • Agency qualifications • Agency staff qualifications • Assistance with projecting service provider caseload • Execution of service provider agreements • DCC and OB provider recruitment • DCC case reassignment

14.4 REGIONAL SECRETARY/CLERK JOB DESCRIPTION

Definition:
Direct office support to RCC; typing and general office duties, including computer data entry, minor administrative tasks, and office functions, limited participation in organization and Program matters based on policies and procedures.

Qualifications:
A Regional Secretary/Clerk must possess a high school diploma or GED, basic computer/data entry skills, and organizational skills.

Authority Lines:
Regional Secretary/Clerks are responsible to RLA under direct supervision of the RCC and OMCFH.

Chief Responsibilities:

- Support to RCC in daily administration of RLA.
- Routine office functions and coordination of Program activities that include assisting clients and/or service providers with routine inquiries.
- Preparation of routine correspondence/form letters for RCC signature.
- Timely data entry of client and Program information.
- Daily maintenance of regional office files and records.
- Schedule meetings and set up RCC appointments.
- Regional RFTS staff (RCC and clerical staff) will maintain an individual time sheet for the administration of RFTS activities.
- Any clerical support staff time spent in activities other than RFTS administration must be documented on the time sheet and deducted from the total amount of hours the RLA will be invoicing.

14.5 REGIONAL SECRETARY/CLERK CODES AND ACTIVITIES

ACTIVITY
COMPUTER INPUT • Entering Program data into RFTS data system as forms are received, completing data transfer, or retrieving data for RCC. Data Entry staff should follow the directions from the *West Virginia Data System Training Guide* provided by the RFTS Epidemiologist.

ACTIVITY
TECHNICAL ASSISTANCE • Assisting RCC, relaying information to the RCC • Scheduling RCC appointments • Assisting with RFTS DCC training
CLERICAL SUPPORT • Preparing letters/memos, routine correspondence, and form letters for Program • Preparing information to forward to DCC for case assignments and trainings • Maintaining files and records • Filing • Assessing Client Tracking Sheets, SCPs, and other RFTS forms for completion
OUTREACH WORKER • Contacting local provider offices, including medical, social service, and others to promote RFTS services and referrals. This may include telephone contact to inquire about new referrals, mailing brochures, or other requested information and providing information about related events, services, etc. • Placing brochures and other relevant information (such as posters, event flyers, etc.) on traditional and non-traditional sites. • Contacting referrals to the Program that have not yet engaged in services/agreed to enrollment, coordinated with the RFTS DCCs. This may include additional telephone contact, encouraging medical provider to participate in referral/enrollment process, establishing contact with referral through other agencies such as WIC, DoHS, Early Head Start, etc. • Making 1st attempt on referrals received within five business days. • Making at least three attempts within 15 business days and close ineligible or refused referrals.
REPORTS • Compiling information and preparation of reports
BILLING • Compiling information on invoicing for lead agency and completion of monthly invoices • Purchasing
TRAINING • Receiving training on Program policies and procedures, use of computer systems

15.0 DESIGNATED CARE COORDINATOR (DCC) PROVIDER AGENCY

15.1 PROVIDER ELIGIBILITY CRITERIA

All RFTS provider agencies must meet the following criteria.

Provider must be:

- A local health department as created in West Virginia Public Health Law, Chapter 16-2-1, 16-2-3, and 16-2A of the West Virginia Code;
- A health center as defined by U.S. Public Health Service Act 330; or
- Other federally qualifying health or community services facility as defined by 42 U.S.C. § 1396a (1) (2) (B).

Provider must:

- Demonstrate capacity to provide core elements of defined services as grouped below:

I. Prenatal Clients	II. Infant Clients	III. Enhanced Only Prenatal Clients
• Assessment • Service Plan Development • Care Coordination and Referral • Follow-up and Monitoring • Enhanced Services	• Assessment • Service Plan Development • Care Coordination and Referral • Follow-up and Monitoring	• Enhanced Services Education

- Commit to providing both in-home and virtual visits, based on clients' preference at the time of RLA outreach, except for virtual-only services in certain underserved areas where DCC coverage is lacking. DCC Agency's virtual-only services in these counties must be approved by the RCC in writing.
- Provide a sufficient number of qualified staff to meet core elements of the defined service(s) categories.
- Provide administrative capacity to ensure quality of services in accordance with state and federal requirements.
- Conduct quality assurance activities within each agency for the chart audit on ten prenatal cases and ten infant cases per quarter. (Quality Assurance Report).
- Provide financial management capacity and a system that documents services and costs.
- Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements (seven years or three years after a federal audit at which time the case records may be disposed/destroyed).

15.2 DCC PROVIDER AGENCY REQUIREMENTS

Service Provider Staff Licensure:
The licensure of the DCC must be validated by the RCC at the time of the Letter of Agreement (LOA) initiation, renewals, and prior to care coordination services being initiated. The RCC must maintain a list of license numbers and names of licensees on file at the RLA. Any new DCCs added by the provider agency must follow the same protocol. Since licenses expire at different times throughout the year, verification is required at the end of the fiscal year (June 30) or at the discretion of the RCC.

Agency DCC changes must be submitted by the RCC to the WVHVP Program Director/RFTS Program Coordinator on Part A of the LOA within seven calendar days of receipt.

DCC Agencies are financially responsible for all unreturned equipment that includes but is not limited to curriculum materials, CO monitors, and any other equipment which is provided by WVHVP.

Attendance at Meetings:
Requirements of DCC participation:

- All DCCs are required to attend all DCC Quarterly Meetings in their region. For any reason a DCC cannot attend a Quarterly Meeting, approval from the RCC is required at least seven calendar days in advance, except in emergency events, and a follow-up meeting must be scheduled between the RCC and the DCC to discuss the content of the meeting.
- All DCC provider staff must complete all RFTS Program training, in its entirety, prior to providing client services or receiving program educational equipment and materials. It is the discretion of the RCC as to whether the DCC is ready to receive referrals and provide services.
- If a DCC provides RFTS services in more than one region, the DCC must attend a quarterly training in at least one region. The DCC must make an effort to rotate quarterly meeting attendance to ensure every year they attend at least one from each region in which they provide services. The DCC must notify the RCC, in writing, of training attendance and obtain updates. It is also a must that the DCC communicate with each RCC for each region that they provide services on a regular basis and attend quarterly trainings in each region during different quarterly sessions.
- DCCs will attend on-site meetings, group technical assistance, or continued education training offered by the State Office or the RCC.

Research:
DCCs will participate in research and evaluation activities that address the RFTS target population. Activities will be designed by OMCFH/RFTS research personnel in conjunction with State and local RFTS personnel.

15.3 ENHANCED SERVICES ONLY PROVIDERS

Enhanced prenatal care services will be rendered by certified providers who have appropriate education, licensure, or certification such as, but not limited to:

- Registered Nurse
- Childbirth Educator
- Health Educator
- Social Worker
- Registered Dietician

NOTE: The license or certification will be validated by the same protocol used for the DCCs.

15.4 DCC PROVIDER AGENCY ENROLLMENT – LETTER OF AGREEMENT PROCEDURE

1. To be eligible for participation and reimbursement for services provided to Medicaid members, all providers shall:
    - Meet applicable licensing, accreditation, and certification requirements.
    - Have a valid signed provider enrollment application/agreement on file with the Bureau for Medical Services.
    - Meet and maintain all Bureau for Medical Services provider enrollment requirements.

2. The RCC will contact the State RFTS staff with the name and address of the interested agency.
3. The State RFTS Office sends LOA to the appropriate RCC who will forward it to the potential DCC agency for review and signatures.
4. Agency completes Part A, the Caseload Projections and signs Agreement (DCC licensing, titles and counties covered must be entered on Part A).

5. LOA is submitted to the appropriate RCC for certification of Part A. The RCC will submit the original certified LOA to the WVHVP Director/RFTS Program Coordinator for approval. After the LOA has been submitted to OMCFH, the RCC may start training the DCC(s). Training must be provided on the *PHB* curriculum and documented on the DCC Training Checklist.

6. Upon approval of the LOA, OMCFH will submit a copy of the LOA to Gainwell Technologies for the assignment of a Medicaid Provider number for billing purposes. OMCFH will retain the original LOA and will forward a signed copy to the RCC, DCC Agency Administrator and the DCC(s). DCC agencies will be provided guidance on the application process with the new DCC Agency.

NOTE: Providers may not participate in RFTS until certification is completed and a RFTS Medicaid billing number has been assigned. The RCC is not to make referrals or assign RFTS curriculum or equipment prior to receiving notification of the agency's Medicaid Provider number, effective date, and completion of DCC training.

The provider number assigned by Gainwell Technologies is to be used ONLY for the purpose of billing RFTS Care Coordination/Enhanced Services to Gainwell Technologies or the appropriate MCO. This number is not to be confused or exchanged with the ten-digit provider number assigned by OMCFH for the sole purpose of ordering materials (literature, forms, etc.) from OMCFH Materials Management.

7. In the event the provider wishes to modify the caseload volume or enhanced services offered during the contract year, the following process must be followed:
    - A revised Part A (Attachment I of LOA - Appendix E) must be submitted to the RCC with requests for modification of services.
        - ❖ The RCC will certify the provider has the personnel needed to modify the caseload/service volume; verify there is a demonstrated need for modification of services in the designated area; and send in revised Part A and Caseload Projection Worksheet to the WVHVP Director/RFTS Program Coordinator.

8. In the event of cancellation of a DCC LOA, OMCFH will notify Gainwell Technologies of the cancellation and the effective date. Agency must provide RCC and OMCFH with a letter of termination giving 30 days' notice according to the LOA. If any RFTS billing is submitted by this DCC agency with a service date after the end date of the LOA, the claim will be denied for payment by Gainwell Technologies/Health Maintenance Organization (HMO). The agency has 60 days following LOA cancellation to submit billing.

9. The potential DCC agency must also secure contracts with each West Virginia MCO.

15.5 DCC JOB RESPONSIBILITIES

Objectives:

- Coordinate the health, education and nutritional care for Medicaid-eligible or RFTS Maternity Services pregnant/postpartum women and infants with providers, professional specialists, and community resources.
- Improve the maternal client/infant's and the family's knowledge regarding the importance of quality health care.
- Use appropriate referral and follow-up procedures to access necessary resources for the primary needs of the family. This includes, but is not limited to food, shelter, safety, crisis intervention, mental health, transportation assistance, and child care.
- Empower the maternal client/family to have the knowledge and ability to access necessary resources following case closure.

Authority Lines:
The DCCs are responsible to:

- The RCC for care coordination/enhanced services activities and all RFTS training.
- The employing agency for human resource-related activities.
- Service providers for coordination, reporting, and communication related to services provided.

Chief Responsibilities:

A. Coordinates the health, education, and nutritional care for the RFTS-eligible pregnant/postpartum woman and infant.
    - Receives referrals from RCC.
    - Provides follow-up and coordination on referrals and offers RFTS care coordination to eligible infants.
    - Completes assessment and Referral Form, if necessary, to identify barriers to a healthy outcome.
    - Develops care plan with the client or guardian of the infant using RFTS SCP and does periodic evaluation for each objective included on the SCP.
    - Administer and complete all screenings as required by WVHVP including but not limited to the Relationship Assessment Tool, SBIRT, EPDS, Smoking Cessation, ASQ-3 and ASQ-SE2.
    - Arranges for interventions which meet identified needs.
    - Makes home visits and client contacts according to policy.
    - Follows a standardized recording system for documenting client care.
    - Reassess and revises SCP as needed.
    - Updates medical provider of client's progress/change in SCP as needed.
    - Sends required information to RCC.
    - Arranges for and/or participates in interdisciplinary and/or interagency problem/service care plan meetings for multi-problem clients to determine the appropriate agency to serve as primary case manager and to assign service care plan responsibilities.
    - Coordinates with other programs providing case management or home visiting services to infants such as the BTT and/or CSHCN.
    - Refers client or guardian of infant into appropriate case management system at time of closure or as risks are determined.
    - At or near case closure, completes Outcome Measures form and forwards copies to RCC.
    - Complete an External Referral Form for each referral made for clients.
    - Submit all paperwork to the RLA within seven calendar days from the date of services, and correct and resubmit all correction requests received from the RLA within seven calendar days.

B. Increases the pregnant or postpartum woman/infant's family's knowledge regarding the importance of quality health care.
    - Communicates with the client or guardian of infant and the family concerning the value of self-care.
    - Plans with the client or guardian of the infant for medical perinatal and/or pediatric care.
    - Plans with the client for participation in Women, Infants and Children (WIC) for nutritional needs, counseling, and food supplements.
    - Models and teaches problem-solving skills.
    - Plans with the client for receiving a postpartum exam and family planning services.
    - Plans with the client or guardian of infant for support systems.

- Plans with the client or guardian of infant for receiving well-child visits and immunization services.
- Informs the clients, caregiver of infant clients, family members the importance of safe sleep environments.
- Encourages and promotes routine oral health care.
- Uses guidelines and appropriate client handouts included in the *PHB* curriculum.

C. Advocates for the primary needs of the family, including, but not limited to, food, shelter, safety, crisis intervention, transportation assistance, and child care.

D. Uses appropriate referral and follow-up procedures to acquire necessary resources for the client or guardian of infant.
   - Establishes cooperative agreements and contacts for referral on the local level.
   - Coordinates services from all disciplines.
   - Communicates with medical care providers.
   - Refers parent or guardian of very low birth weight, preterm infants to Supplemental Security Income (SSI) (if not referred by hospital at birth). SSI approval provides Medicaid eligibility.
   - Monitors receipt of services.

E. Participates in all training provided by the RCC or OMCFH, including mandatory training on the *PHB* curriculum.

F. Safely maintain all State-supplied, assigned equipment, and return to RCC upon termination of agreement or DCC.

G. Wear State-supplied identification when providing all RFTS services.

15.6 DOCUMENTATION REQUIREMENTS FOR DCC

The DCC must:

- Maintain a separate individual case record for each RFTS referred client, including refusals.
- Open a new record for each client who has a subsequent pregnancy.
- Maintain a record for each client who receives Enhanced Services Only.
- Have all appropriate client information relative to the case and document immediately upon completion of a service unit. If unable to complete documentation immediately, documentation must be completed as soon as possible (no longer than five working days) following service delivery. Delay of documentation will be considered noncompliance and repeated offenses will risk termination of an agency's agreement to continue RFTS service provision. If a pattern of delayed submission of documents is determined, a quality assurance monitoring will be required by the RLA or OMCFH.
- With all RFTS forms, documentation must accurately reflect the services provided. This includes, but is not limited to:
  - ❖ Number of units provided for care coordination services on the Client Tracking Sheet.
  - ❖ DCC signature after each entry in Progress Notes.
  - ❖ Client or guardian of infant must sign Client Tracking Sheet for all face-to-face visits.
  - ❖ Documentation of the geographical location in which the service was rendered. The name of the town will be sufficient for a clinic site in a multi-clinic agency or provider's office. For services performed in the client's home, the address need not be repeated.

- ❖ Include reference to handouts provided to client from the *PHB* curriculum on the Client Tracking Sheet.
- Include copies of email correspondence in all RFTS records for those clients who are hearing impaired.
- Make appropriate corrections on original client record and return, along with copy of Corrections Request Form, to RCC within five working days after receipt. Maintain copy of in the client file.

15.7 DCC BILLING AND REIMBURSEMENT

Covered Services:
Covered services and procedure codes for targeted case management are outlined on Page 46.

Units of service for care coordination reimbursement represent the time spent in the actual service activity. A unit of service is defined as 15 minutes. Partial units are to be rounded up or down to the nearest whole unit. For example, if less than 7 minutes rounded down and 8 minutes or more rounded up. Chance meetings that result in conversation between RFTS DCCs and RFTS clients, in public locations cannot be considered a billable contact.

Enhanced Services are provided as sessions for prenatal clients only. These are limited to reimbursement for one session per code per day and must adhere to the specific service limits designated for each code according to Program guidelines. A session is not billed by a certain amount of minutes but is billed by the educational component. To ensure quality service to the client a session must not be less than 15 minutes.

All service providers will adhere to the allowable units/sessions of service established by the Program for reimbursable covered services. There is no provision for extension or approval of units of service beyond the approved number.

NOTE: Care coordination can be billed prior to completion of assessment and SCP contingent on RCC approval. Only in extreme or emergency cases can this be done (example: attempts to provide follow-up for infants with a high birth score).

Non-Covered Services through Medicaid:
- Services provided by non-Medicaid certified provider personnel, regardless of supervision. Persons rendering services must be approved during the provider agency certification process and must meet the qualification criteria for the categories of service they will be rendering.
- Telephone calls for Enhanced Services. Enhanced Services can only be provided with the prenatal/postpartum client.
- Any and all interactions with clients through texting as this can lead to potential privacy violations.
- Time spent seeking clarification on Program procedures/policies.
- Time used to train service providers or time used by service providers to acquire training.
- Time spent on the preparation of reports.
- Time spent preparing letters or literature to send to clients.
- Added time that it takes to get to or from a client.
- Added time for documentation after seeing, visiting, or talking with a client.
- Picking up supplies (diapers, food, etc.) and delivering to a client. A DCC can only charge for the actual time spent with the client.
- An infant client visit if the guardian of infant is not home (exception: caregiver permission form signed by parent/guardian).
- The initial contact (phone call, letter).

- Enhanced Services on an infant case.
- RFTS case management if coaching the prenatal client during labor.
- In cases where the client has refused RFTS services, DCCs cannot bill for a SCP and Initial Client Assessment if the client has not signed the SCP.
- Billing for Initial Client Assessment by a DCC/agency after the first one has already been billed.
- Calls made specifically to schedule (or verify) face-to-face visits.

16.0 GUIDELINES FOR CLAIMS

16.1 MEDICAID

RFTS claims processing for Medicaid clients will accommodate the national version of the Center for Medicare and Medicaid Services-1500 Health Insurance Claim Form. Federal regulations require the recipient to exhaust all benefits available to meet the costs of care prior to use of Medicaid benefits. Medicaid is the payer of last resort. For questions regarding billing issues, call Gainwell Technologies at 1-888-483-0793 or log on to https://dhhr.wv.gov/bms and choose the Gainwell Technologies link. For questions regarding a specific HMO, Gainwell Technologies will provide appropriate contact information.

16.2 RFTS PROCEDURE CODES - TARGETED CASE MANAGEMENT AND ENHANCED PRENATAL CARE SERVICES

PROCEDURE CODE	PROCEDURE DESCRIPTION	UNIT(S) SERVICE	SERVICE LIMIT
S5190HD $96.00	**Service Care Plan Assessment/Wellness Assessment (Prenatal Clients Only)** Based on medical Prenatal Risk Screening Instrument, assessment of the client's situation, identification of needed services, and development of an individualized SCP.	1 session	1 per case
T1016HD $12.78	**Care Coordination/Case Management** Based on the individualized SCP, care coordination, and referral for resources and services; follow-up and monitoring; SCP update.	15 minutes	None
T1016HDU1 $12.78	**Care Coordination/Case Management** Second place of service on same day	15 minutes	None
S9444HD $16.00	**Health Education – Parenting Classes; non physician provider** Client education for infant care; recognition of preventive and acute health care needs; child development and child safety. Should include but not be limited to topics such as: 1) Feeding, bathing, dressing of infant 2) Recognition of preventive health needs 3) Recognition of acute care needs 4) Newborn/child development 5) Child safety	1 session per day	32-15 minute sessions during the prenatal period and up to 1 year postpartum
S9445HD $12.00	**Health Education – Preventive Self-Care; not otherwise classified; non physician provider; individual** Intervention education for pregnant/postpartum women to include but not be limited to such topics as: 1) Physical/emotional changes during pregnancy and postpartum 2) Warning signs of pregnancy complications 3) Healthful behaviors	1 session per day	32-15 minute sessions during the prenatal period and up to 1 year postpartum
S9442HD $12.00	**Health Education – Childbirth Classes; non physician provider; group classes or individual sessions** Education during the prenatal period to include but not limited to topics such as: 1) Maternal and fetal development 2) Nutrition, fitness and drugs 3) Physiology of labor and delivery 4) Relaxation and breathing techniques for labor 5) Postpartum care and family planning 6) Newborn care and feeding	1 session per day	7/9 months (total 14 hours)

PROCEDURE CODE	PROCEDURE DESCRIPTION	UNIT(S) SERVICE	SERVICE LIMIT
S9452HD $18.00	**Nutritional Assessment/Counseling; non physician provider** To provide specialized nutrition education and counseling for highly complicated medically related conditions occurring during pregnancy, postpartum or to the infant. Qualified provider of these specialized nutrition services must be a registered dietician in accordance with the Commission on Dietetic Registration.	1 session per day	32-15 minute sessions during the prenatal period and 32-15 minute sessions up to 1 year postpartum

Note: See Appendix F for DoHS, Bureau for Medical Services, Targeted Case Management Policy.