Chapter 10	Nursing Services

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Description of CIS Nursing Services	10A

CIS nurses assist eligible individuals to gain access to needed medical, social, educational and other community services. The nurse promotes safe, preventive health and prenatal care practices, and prepares moms and their partners for childbirth and becoming a parent. The nurse assists new moms by supporting their growth in understanding the complex social, emotional, physical and economic challenges and changes that occur during these role transitions. The nurse also continually assesses mom's educational and health needs in the context of her own learning needs, which build on existing knowledge, experiences, strengths and successes to help her find other supports and resources.

CIS nursing services are described as case management services under Title XIX of the Social Security Act. The Vermont state plan for Title XIX defines the target group; areas of the state in which services will be provided; definition of services; referral and related activities; monitoring and follow-up activities; qualifications of providers; freedom of choice; and access to services and payment.

I. Case management includes:

- *Comprehensive assessment and periodic reassessment* of individual needs in order to determine a complete assessment of the individual including:
  - taking a comprehensive client history; documenting areas of need; gathering information from other sources (family, medical providers, screenings and/or assessment results) and sharing results with the individual/family.
- Nursing services include:
  - History taking and screening - use of observation, conversation and valid and reliable tools to gather comprehensive information about

individual health and well-being in the context of the individual's family and community:

- Eliciting what the client's concerns and/or questions are.
- Gathering personal history and observations of the mom and infant/child symptoms, activities, experiences and support systems; e.g., thorough physical exam, vital signs (including blood pressure, pulse, respirations, weight, any complaints/pain, infections); history of medical tests and the results; general nutrition and daily food/beverage intake; information about breastfeeding - if applicable; medications; substance use, including tobacco; environmental or safety recommendations/concerns; access to medical care and health insurance; immunization status; previous health screenings and diagnosed conditions; social/emotional status; pregnancy and birth history - mom and infant; physical and developmental exam(s); relationship(s) with significant other(s), family and friends; level of community engagement; support networks; educational achievement and goals; knowledge about their own or child's health and well-being.
- Synthesis and summary of all the information gathered, which then informs the mutual planning and goal setting process with the individual/family.

II. *Developing a specific care plan* that:

a. is based on history, assessment information; specific actions , goals and outcomes that address identified needs related to medical, social, educational or other services;
b. ensures active participation of the client and others working with that individual to develop achievable goals;
c. identifies an action plan that addresses the priority needs of the eligible individual, using evidence-based practices/recommendations
d. Nursing services include:
    i. Development of an individual/family plan with the family; focus on family strengths; counseling and/or education activities; risk reduction (assisting with development of a safety plan or help to

stop using substances); links/referrals to other community services; and/or other case management activities.

II. *Referral and related activities that help an eligible individual obtain needed services* links individuals with:
    a. appropriate medical, social or educational providers, e.g., Reach Up, dentist, child care, or other program(s)/services that support individuals in meeting the goals identified in their plan
    b. Nursing services include:
        i. Broad knowledge of health and social resources in the community
        ii. Established relationships with other providers and knowledge of their programs so services are offered to families with up to date knowledge of their benefits; and vice versa
        iii. Identification of any gaps in services and work with community partners to find resources to meet this need as needed
        iv. Identify any barriers that families encounter to accessing services and work with community partners to find ways to reduce or eliminate them

II. *Monitoring and follow-up activities* that include:
    a. Activities and contacts necessary to ensure the plan is implemented and addresses the individual's needs;
    b. Assure that there is coordination and regular reviews with the family around goal attainment and non-duplication of effort if a CIS or other community provider is also working with the family;
    c. Reassess and revise the plan as needed or at least every 6 months
    d. Develop a transition plan when needs are met or the individual is no longer eligible for CIS nursing services
    e. Nursing services include:
        i. Substantive knowledge of the MCH population, including health promotion and prevention best practices and recommendations; knowledge and use of screening and assessment tools and case management skills; developing relationships and networking with a wide range of family and community providers

II. Goals and Objectives:
    a. Goals are to:
        i. Promote health and wellness for children and parents
        ii. Promote attachment between adult and child, peers, and between families and community

iii. Promote resiliency in both children and adults
iv. Develop competence, independence and self-sufficiency in parents to support active contribution to the welfare of their community
v. Prevent abuse and neglect of young children
vi. Decrease family violence and avoid interactions with the criminal justice system
vii. Assure an accessible network of community supports for families

b. *Objectives are to:*

i. Increase the proportion of women who receive early and adequate prenatal care.

1. Increase the proportion of women who receive prenatal care beginning in the first trimester to at least 90%

ii. Increase abstinence from alcohol and other substances among pregnant women to 94%.

iii. Increase smoking cessation during pregnancy to 30%.

iv. Increase the proportion of infants and children who have a specific source of ongoing health care to 96%.

v. Reduce the proportion of young children with dental caries experience in their primary teeth to 11%.

vi. Reduce the proportion of children who are regularly exposed to tobacco smoke at home to 10%.

vii. Increase the vaccination coverage levels for universally recommended vaccines among young children to 90%.

viii. Assure all infants have had appropriate health screenings, according to *AAP Bright Futures Guidelines* 3rd Edition, e.g., physical exam, nutrition, development, behavior, environmental safety, risk reduction, family adjustment, etc.

ix. Reduce the incidence of substantiated abuse/neglect to less than 5 per 1,000.