First Steps Nutrition Modules

Module 1 – The Role of the MSS RD in First Steps

Introduction

The First Steps program includes, Medical Care, Child Birth Education (CBE), Maternity Support Services (MSS) and Infant Case Management (ICM). The goal of First Steps is to give mothers and newborns the best possible start by providing them with information to improve birth outcomes, infant mortality and self-sufficiency.

The MSS and ICM portions of the First Steps program provides enhanced support services to Medicaid-eligible pregnant women throughout their eligibility cycle. For MSS this is from the time the mother is pregnant through two months post pregnancy, and for ICM this is from the end of MSS, through the month of the infant's first birthday. MSS services focus on improving birth outcomes and decreasing infant mortality (see Module 9 for a discussion of client-centered care).

View a flow sheet that depicts the services provided by the First Steps Program.

For more details about MSS/ICM services, refer to the ABC's of First Steps online training. This may be accessed by contacting the MSS/ICM Management Team via the First Steps mailbox firststepsmessages@doh.wa.gov

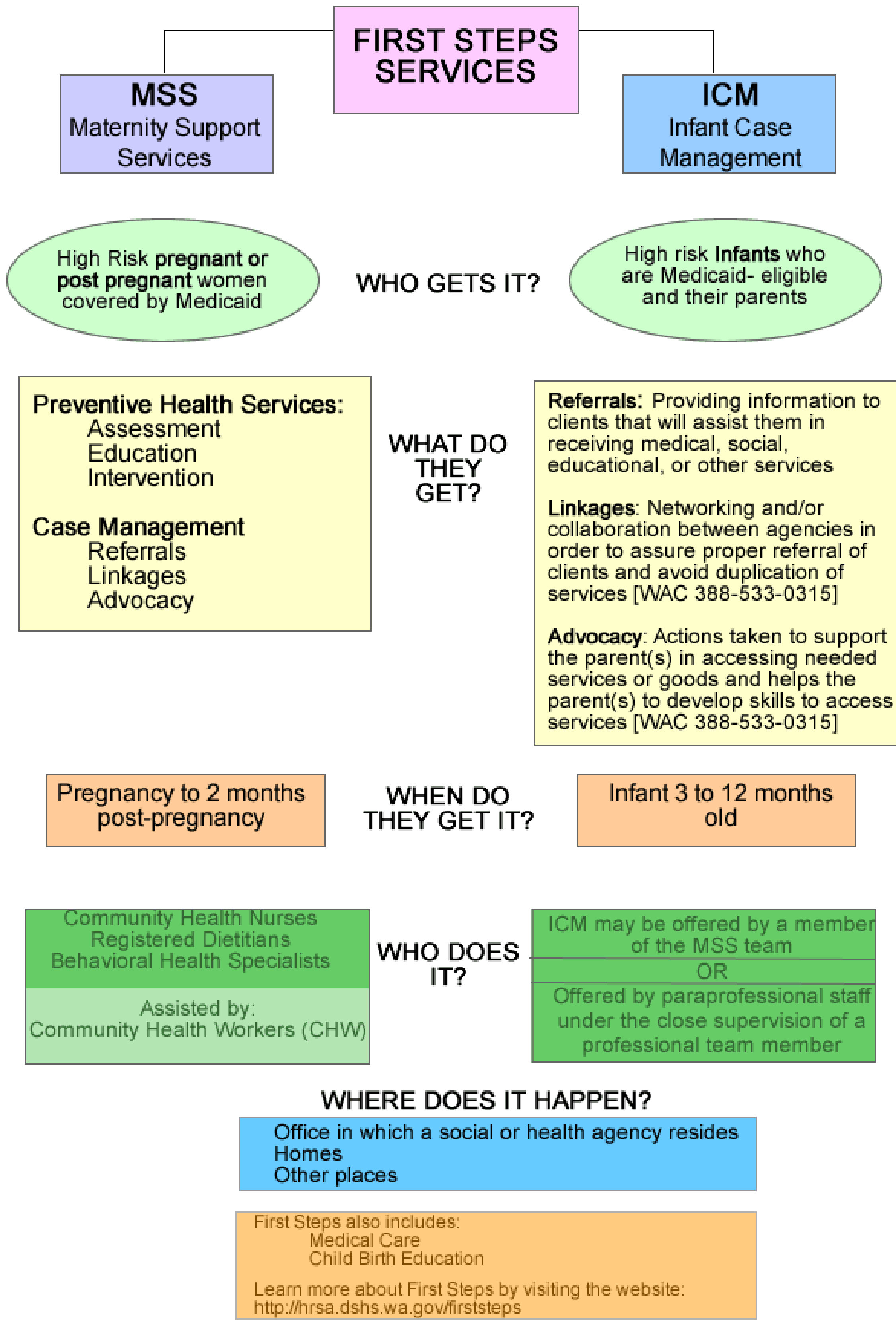
This module addresses the specific role of the dietitian on the MSS & ICM team. The dietitian is described in detail, along with a brief overview of the other MSS/ICM team member roles. Examples of interdisciplinary collaboration are provided, and the entire process is summarized through the use of a case example.

Estimated time to complete this module: 30 minutes.

Learning objectives

Participants will be able to:

- Describe the role of the RD within MSS & ICM
- Briefly describe the roles of other MSS & ICM team members
- Describe the benefits of interdisciplinary collaboration
- Identify opportunities for interaction as part of an interdisciplinary team


FIRST STEPS SERVICES
MSS
Maternity Support Services
ICM
Infant Case Management
High Risk pregnant or post pregnant women covered by Medicaid
WHO GETS IT?
High risk Infants who are Medicaid- eligible and their parents
Preventive Health Services:
Assessment
Education
Intervention
Case Management
Referrals
Linkages
Advocacy
WHAT DO THEY GET?
Referrals: Providing information to clients that will assist them in receiving medical, social, educational, or other services
Linkages: Networking and/or collaboration between agencies in order to assure proper referral of clients and avoid duplication of services [WAC 388-533-0315]
Advocacy: Actions taken to support the parent(s) in accessing needed services or goods and helps the parent(s) to develop skills to access services [WAC 388-533-0315]
Pregnancy to 2 months post-pregnancy
WHEN DO THEY GET IT?
Infant 3 to 12 months old
Community Health Nurses
Registered Dietitians
Behavioral Health Specialists
Assisted by:
Community Health Workers (CHW)
WHO DOES IT?
ICM may be offered by a member of the MSS team
OR
Offered by paraprofessional staff under the close supervision of a professional team member
WHERE DOES IT HAPPEN?
Office in which a social or health agency resides
Homes
Other places
First Steps also includes:
Medical Care
Child Birth Education
Learn more about First Steps by visiting the website:
http://hrsa.dshs.wa.gov/firststeps

Outline

I. INTRODUCTION

II. THE RD'S ROLE

  a. Staff Qualifications

  b. Essential functions of the dietitian
    i. MSS Screening and Eligibility
    ii. Nutrition Assessment
    iii. Nutrition Interventions
    iv. Care Plan – Development, Documentation, and Evaluation
    v. Team Participation
    vi. System Development

  c. Skill Development
    i. General Knowledge and Skills:
    ii. Specific Knowledge and Skills for Nutrition Assessment and Education

  d. Best Practices

  e. Schedule of MSS Nutrition Visits

    i. Subsequent Nutrition Visits
    ii. Late Prenatal Visit
    iii. Initial Postpartum Visit
    iv. Subsequent Postpartum Visits

III. INTERDISCIPLINARY COLLABORATION

  a. The Interdisciplinary Team
  b. Case Conferencing
  c. Case Management

IV. THE MSS/ICM TEAM

  a. The Team Members

  MSS Services:
    i. Community Health Nurse
    ii. Behavioral Health Specialist
    iii. Registered Dietitian
    iv. Community Health Worker (an optional position)

ICM Services
- i. Infant Case Manager

b. Basic Health Messages
- i. Maternity Cycle
- ii. Infant-related

c. MSS Targeted Risk Factors and Interventions

V. CASE EXAMPLE

VI. REFERENCES AND RESOURCES

VII. QUIZ

The MSS Registered Dietitian's (RD's) Role

A brief overview of the dietitian's role is to:

- Provide nutrition assessments focused on the maternity cycle and MSS targeted risk factors.
- Develop nutrition care plans and provide nutrition counseling focused on improving birth outcomes and decreasing infant mortality.
- Consult with the MSS team regarding the nutritional needs of the client
- Be involved in system development

Staff Qualifications

Required:

- Registered with the Commission on Dietetic Registration of the American Dietetic Association. (This is the accrediting body for dietitians, and protects the term "Registered Dietitian – RD.") and
- Certified by Washington State (Certified Dietitian)

Recommended:

- 1-2 years of experience in public health and/or maternal and child health

Essential Functions of the Dietitian

1. Screening
2. Nutrition Assessment
3. Nutrition Intervention
4. Care Plan Development/Documentation
5. Team Participation
6. System Development

1. MSS Screening

Depending on the agency setup, some RD's routinely screen MSS clients for eligibility. Other agencies may designate a specific professional member of the MSS team to provide this screening. Regardless of the agency setup, all RD's need to be aware of the MSS/ICM screening and eligibility process.

It is important to note that if an RD is the only MSS provider involved with a client they are required to follow and complete all required screening eligibility determination. Please see documentation requirements for more detail on required forms and documentation requirements http://hrsa.dshs.wa.gov/firststeps/

2. Nutrition Assessment

The RD assures that a thorough nutrition assessment is completed. This assessment must be culturally sensitive and includes, but is not limited to the evaluation of the following: (this is covered in detail in Module 3, Assessment)

- *Dietary Intake* – nutrient intake compared to recommended intake for pregnancy, lactation, postpartum, and/or infancy period; issues that impact intake
- *Anthropometrics* – obtain current weight and height, pre-pregnancy BMI and determination if weight gain is within Institute of Medicines guidelines
- *Biochemical/Clinical* – health history and status, review lab values (e.g., hematocrit/hemoglobin, blood glucose), drug-nutrient interactions and physical activity level
- *Psychosocial/Environmental* – adequacy of food, household resources and food management skills; client's intentions regarding method of infant feeding; plans for contraception after current pregnancy; goals for work, education, and parenting that might affect infant feeding; influence of family beliefs on eating, nutrition, and parenting

3. Nutrition Interventions (education, counseling, and case management)

The development of nutrition interventions is based on the MSS targeted risk factors and needs of the client. Suggestions for specific risk factors are included throughout this curriculum. In general, nutrition interventions include incorporation of the following:

- Face-to-face individual visits
- Consideration of the client's individual needs and goals
- Providing nutrition messages based on best practice and state/federal guidelines.
- Use of handouts, as needed
- Providing referrals, linkages and advocacy to community resources (case management)
- Providing referral(s) to nutrition specialist, or another specialized care provider, for identified issues such as treatment for eating disorders, intensive diabetes management, and/or substance abuse.

4. Care Plan – Development, Documentation, and Evaluation

- Develop a nutrition plan of care based on the client's identified MSS targeted risk factor being sure to include client and MSS team input
- Incorporate the nutrition care plan into the MSS interdisciplinary care plan
- Maintain clinical records in one primary MSS chart that document comprehensive nutrition assessments, clear and concise care plans; nutritional counseling/follow-up care and progress toward outcomes.

5. Team Participation

- Participate in MSS case conferencing
- Provide nutrition consultation
- Assist with problem solving and interdisciplinary decision making
- Coordinate nutrition services among community resources and with the MSS team
- Collaborate with infant case manager (ICM), as needed
- Provide supervision, guidance, and support to Community Health Worker(s) as determined by the First Steps coordinator.

Please Note: CHW's should be supervised by one of the members on the MSS team and some RD's may provide this supervision. Please speak with the MSS/ICM coordinator regarding this supervision and see more information on the First Steps website.

6. System Development

- Provide administrators and team members with information regarding nutrition needs of the MSS/ICM client population
- Develop positive relationships with other providers or organizations (e.g., WIC, Headstart, food banks) serving the public
- Provide leadership in connecting with other nutrition providers in addressing the nutrition needs of the MSS/ICM client population
- Be involved in internal quality control checks to ensure good client care. This includes self or peer evaluation of education and charting skills
- Promote nutrition services within the team
- Understand legal mandate for reporting abuse and/or neglect and documenting actions taken

Skill Development

The dietitian within MSS will have the skills described below, related to the maternity cycle. The topics covered by this curriculum are marked with an asterisk (*). Resources for additional training and continuing education are included at the end of this module.

General Knowledge and Skills

- Knowledge of pregnancy/post pregnancy issues (including breastfeeding), infant care and parental adjustments *
- Respect and appreciation for diversity (culturally-relevant and non-bias) *
- Effective oral and written communication skills
- Ability to perform services in a clinic, office, and/or home setting
- Ability to form and sustain effective relationships with clients, team members, and community health and social service providers
- Understanding of public health nutrition, community-based health systems, and the community's socio-economic system
- Ability to manage time, resources, and client caseload
- Ability to work independently

Specific Knowledge and Skills for Nutrition Assessment and Education

- Ability to provide nutrition consultation to MSS/ICM team members *
- Knowledge of human growth and development, throughout the lifespan, which can be applied to nutrition assessment and interventions and promoting healthy behaviors of the woman and her family *
- Understanding of Federal, State, and local regulations as they pertain to nutrition services *
- Knowledge in working with diverse populations *
- Ability to assess nutrition status and provide individualized nutrition education and care plans *
- Understanding of motivational interviewing and stages of change
- Knowledge of potential resources for referrals

Best Practices

Best practices for First Steps dietitians are outlined below and were developed from the American Dietetics Association's (ADA) best practice guide. In addition, the American Dietetic Association has developed a framework for the Nutrition Care Process, including a Standards of Professional Practice; specific information for pediatric nutritionists is also available. (ADA, 2006; Charney et al, 2009)

Read more about best practices related to the MSS dietitian:

The MSS Dietitian:

- *Collaborates with clients to assess needs, background, and resources available to establish mutual goals*
- *Collaborates with other professionals*
- *Implements quality practice by following policies, procedures, legislation, licensure, practice guidelines, and the standards of professional practice*
- *Continuously evaluates processes and outcomes*
- *Advocates for the provision of food and nutrition services*
- *Bases practice on sound scientific principles, research, and theory*
- *Communicates sound scientific principles, research, and theory*
- *Integrates knowledge of food and human nutrition with knowledge of social sciences and motivational interviewing*
- *Seeks out information to provide effective services*
- *Educates and helps clients and others to identify and secure appropriate resources*
- *Documents outcome of services provided*
- *Engages in lifelong self-development to improve knowledge and enhance professional competence*
- *Conducts self-assessment at regular intervals to identify professional strengths and weaknesses*
- *Adheres to the Code of Ethics for the profession of dietetics and is accountable and responsible for actions and behavior*

Example Schedule of MSS Nutrition Visits

All visits are based on MSS targeted risk factors and client needs
Initial Prenatal Visit (as early as possible in pregnancy)

- Complete nutrition risk assessment
- Develop nutrition care plan and incorporate it into the MSS interdisciplinary care plan
- Provide nutrition counseling & education that support the clients risk factors, food preferences, resources and needs
- Case management- Refer, link and advocate helping clients connect to community service.
- Ensure all documentation is in the MSS chart.
- Consult with MSS team members and other health care providers as needed.

Subsequent Nutrition Visits (follow-up as needed with risk identification.)

- Review client health record for client concerns or new issues, current lab values, interdisciplinary team actions, weight gain pattern, developing problems, and other relevant assessment data
- Obtain dietary assessment as needed
- Evaluate adherence with care plan
- Identify client's concerns/needs
- Address any barriers to interventions
- Update/revise nutrition care plan and provide nutrition education/counseling
- Discuss infant feeding choices
- Refer to appropriate community services
- Document MSS nutrition issues and interventions and update the interdisciplinary care plan
- Consult with MSS team members and other health providers as needed

Post Pregnancy Visit

- Screen for MSS post pregnancy risk factors/eligibility
- Follow up on any MSS risk factors
- Provide brief guidance on infant feeding: positioning for feeding/burping, infant hunger and satiety cues, signs and symptoms of intolerance of feedings, appropriate use of water or other non-formula fluids for infants, well water testing for nitrate/coliform bacteria; use of bottled water.
    - If client is breastfeeding: screen the client around breastfeeding needs, provide anticipatory guidance on breastfeeding, choosing effective contraception method(s) while breastfeeding and local resources,
    - If client is formula feeding: review types of formula, formula preparation/storage, keep discussion about breastfeeding open
- Introduce post partum self-care issues: adequate rest, food, liquid; expected weight loss; normal feelings; family planning decision making; folic acid/multivitamin

- Revisit client's long-term goals, self-sufficiency/education/employment
- Assess progress on care plan, revise as needed
- Document nutrition issues and intervention and update the Interdisciplinary Plan for Care
- Consult with MSS team members and/or other health care providers

Interdisciplinary Collaboration

The MSS Interdisciplinary Team

MSS is based on the interdisciplinary team model of care. A team is a group of individuals with different skills working together collaboratively to achieve a common goal. Collaboratively means people cooperating, helping each other, and sharing responsibilities. The MSS team consists of community health nurse, registered dietitian, behavioral health specialist, and in some agencies a community health worker.

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

Together, the MSS team provides services, which include:

- Delivering services in an environment where a client can expect respect, understanding, fairness, accurate information, convenience, and results
- Determining the client's understanding of positive pregnancy and parenting health care practices
- Providing health education
- Developing an interdisciplinary care plan in collaboration with the client
- Addressing factors that could negatively affect the health of the woman and her infant
- Using communication skills, such as motivational interviewing, to:
    - gain the client's understanding of her situation
    - support and guide the woman through exploring behaviors and how those behaviors may affect her or her infant
    - discuss her readiness to reduce or eliminate risky behaviors
    - help her reduce barriers or gain access to services to help her achieve her goals
- Referring to and linking the woman with appropriate services when situations of immediate risk to the life of the woman, infant, or family are disclosed and/or recognized (e.g., domestic violence, suicidal ideation with a plan, child abuse or neglect)

Case Management

The goal of case management during MSS is to address the client's current needs and develop a plan to improve the parents' self-sufficiency to access existing community resources. MSS providers can help by offering to assist with referrals, linkages, and providing advocacy when needed.

Advocacy	acting on the client's behalf in order to ensure the client receives needed services *for example: If a client has tried to obtain her medical coupon with no results, the RD can call the local CSO to sort out why there is a delay and how to get it resolved.*
Linkage	networking and/or collaboration between different agencies or across programs in order to connect clients to services and avoid duplication *for example, communicating with the dietitian at the specialty care clinic about the care of a woman with type 1 diabetes*
Referral	providing information to the client that will assist her in obtaining medical, social, educational, or other services *for example, providing a referral to the Basic Food program*

Minimum referrals and linkages include the following: (your agency will have a list of resources specific to your community)

- WIC
- Medical care
- WithinReach
- Local community resources specific to individual needs, e.g., domestic violence hotline, childcare, transportation, interpreter services, disability services, tobacco quit line

The MSS/ICM Team

Roles of the individual team members are briefly described below. Complete job descriptions can be found on the First Steps website: https://fortress.wa.gov/dshs/maa/firststeps/.

As you read through each of the team members' roles, think about how your roles complement each other:

- Is there information that one of you collects that would be helpful to the other?
- How else could you collaborate – about a specific client? About a policy in your agency?
- Talk to the other team members – what ideas for collaboration do they have?

MSS Services:

All MSS team members can offer general MSS screening/eligibility, education on basic health messages and risk factors within the program, but each team member also provides an area of expertise within the team.

Community Health Nurse (CHN)
The MSS community health nurse (CHN) has expertise in the medical needs of the mother and infant and works to provide preventive health education including self care during pregnancy and the postpartum period (e.g., recognition of warning signs of complications or early labor, care of acute or chronic illness, family planning decision making). The nurse also provides education and support to the mother and family regarding newborn care.

Behavioral Health Specialist (BHS)
The role of the Behavioral Health Specialist (BHS) is vital in assisting clients to gain self-sufficiency and control over their lives and the raising of their children. The Behavioral Health Specialist provides expertise on psych/social issues, mental health, how to facilitate change, and improving self-care techniques to improve emotional well being.

Registered Dietitian (RD)

Community Health Worker (CHW)
The Community Health Worker's (CHW's) role is to engage and assist clients by providing culturally-appropriate health messages and case management. CHWs are required to demonstrate competencies to their designated supervisor before meeting alone with clients.

ICM Services:

Infant Case Manager (ICM)

An Infant Case Manager (ICM) can be one of the MSS team members (CHN, BHS, RD, or CHW) or a completely separate position on the MSS/ICM team. Please note that if the infant case manager is also an MSS CHW the staff qualifications are different in ICM (see ICM staff qualifications on website). Infant case managers provide case management services to high risk infant's ages 3 through 12 months old.

The Infant Case Manager's role includes the following duties:

- Identify client needs
- Refer client/family to community resources based upon needs
- Link the client with other service delivery systems in the community
- Develop an on-going plan for care with the client's input
- Advocate for the client in accessing needed resources or services

Basic Health Messages

These basic health messages are to be covered by all members of the MSS/ICM team and are related to the Maternity Cycle.

Maternity Cycle

- Importance of prenatal care and what to expect
- Self-care and coping, e.g. stress management
- Importance of support system
- Physical and psychological changes of pregnancy
- Proper nutrition: maternal nutrition and weight
- Environmental dangers, e.g., hot tubs, lead poisoning, mercury, cat litter.
- Physical activity in pregnancy
- Tobacco use and/or secondhand smoke exposure
- Drug and/or alcohol use during pregnancy
- Oral health/prevention of dental disease
- Warning signs in pregnancy
- Breastfeeding
- Family planning (unintended pregnancy prevention)

Infant

Baby Basics: sleep position (back to sleep), shaken baby syndrome, well-child exams, car seat safety, secondhand smoke, care for minor illness, childcare choices.
Bonding and attachment- eye contact, responsiveness, smiling and mirroring, normal child development.
Infant feeding and growth

MSS Targeted Risk Factors and Interventions

Due to the 2009 budget cuts First Steps is not able to provide full Maternity Support Services to all Medicaid women and was directed by the legislature to focus the majority of services on clients at the highest risk for poor birth outcomes (i.e. LBW and preterm birth). In addition, minimal interventions have been developed to ensure that "basics services " are covered during the maternity cycle. This information is covered on the First Steps website and some are covered throughout this curriculum.

The following are a list of the MSS targeted risk factors:

- Race- African American or black and American Indian, Alaskan Native or non-Spanish speaking indigenous women from the Americas
- Food insecurity
- Pre-pregnancy BMI <18.5 or ≥ 30
- Medical – Diabetes, Hx gestational diabetes, hypertension, currently pregnant with multiples, Hx LBW or preterm birth, current preterm labor
- Maternal Age- <16 or >35 years
- Prenatal care- started after 24 weeks gestation or not initiated by 24 weeks.
- Mental health
- Severe developmental disabilities
- History of or current CPS involvement
- Intimate partner violence (IPV)
- Current tobacco use
- Alcohol abuse and substance use prior to and during pregnancy
- Delivered LBW infant this pregnancy (less than 5lb 8 oz)
- Delivered Preterm infant this pregnancy (born less than 37 weeks gestation)
- Infant with slow weight gain i.e. loss of more than 10% of body weight since birth, has not gained back to birth weight by two weeks of age Delivered Preterm infant (born less than 37 weeks gestation)
- Breastfeeding complications- inadequate milk transfer/ineffective suck, inadequate stools
- Infant with birth defect and/or health problems
- Drug/alcohol exposed newborn per program definition

Case Example: Kayla

Kayla is a 20-year-old single woman, who came to her local WIC office seeking food assistance. She is living with a friend temporarily, but wants to find her own apartment. She works part time at a convenience store for minimum wage. Kayla is pregnant with her first baby and uncertain of her due date, but believes she is about four months pregnant. She has not received medical care for her pregnancy because she has no medical insurance. Kayla does not know how to apply for medical/financial assistance, but has serious financial difficulties including "running low on food."

Kayla says she experienced nausea and vomiting for about three months, and lost weight during that time. Her current weight is ten pounds more than her reported pre-pregnancy weight; her pre-pregnancy weight was appropriate for her height. Kayla says she smoked ½ pack of cigarettes per day, and is not concerned about the effects of smoking on the baby. Several of her friends smoked during their pregnancies and "their babies were fine."

What MSS targeted prenatal risk factors are present? Check all that apply:

- Race- African American or black and American Indian, Alaskan Native or non-Spanish speaking indigenous women from the Americas
- Food insecurity
- Pre-pregnancy BMI <18.5 or ≥ 30
- Medical – Diabetes, Hx gestational diabetes, hypertension, currently pregnant with multiples, Hx LBWor preterm birth, current preterm labor
- Maternal Age- <16 or >35 years
- Prenatal care- late entry or no prenatal care (started after 24 weeks gestation or not initiated by 24 weeks).
- Mental health
- Severe developmental disabilities
- History of or current CPS involvement
- Intimate partner violence (IPV)
- Current tobacco use
- Alcohol abuse and substance use prior to and during pregnancy
- Delivered **LBW infant this pregnancy** (less than 5lb 8 oz)
- Delivered **Preterm infant** this pregnancy (born less than 37 weeks gestation)
- **Infant with slow weight gain** i.e. loss of more than 10% of body weight since birth, has not gained back to birth weight by two weeks of age Delivered **Preterm infant** (born less than 37 weeks gestation)
- **Breastfeeding complications-** inadequate milk transfer/ineffective suck, inadequate stools
- Infant with **birth defect and/or health problems**
- **Drug/alcohol exposed** newborn per program definition

The MSS targeted risk factors include: Late entry prenatal care; Food insecurity and Tobacco use.

Which MSS/ICM team members might become involved? Check all that apply:

- Community Health Nurse
- Registered Dietitian
- Behavioral Health Specialist
- Community Health Worker (optional position)

All MSS team members (RD, CHN, BHS, CHW) might become involved, depending on Kayla's needs. ICM is for high risk infants so this team member would not provide services at this time.

References and Resources

References

American Dietetic Association. Nutrition Diagnosis: A Critical Step in the Nutrition Care Process. American Dietetic Association. 2006.

Charney P, Ogata B, Nevin-Folino N, Holt K, Brewer H, Sharrett MK, Carney LN. American Dietetic Association: Standards of Practice and Standards of Professional Performance (Generalist, Specialty, and Advanced) for Registered Dietitians in Pediatric Nutrition. *J Am Diet Assoc*. 2009; 109(8): 1468-78.

Trainings

WIC Nutritionist training for WIC/MSS staff
http://www.doh.wa.gov/cfh/WIC/clinic/training.htm

Regional WIC Breastfeeding Trainings
http://www.doh.wa.gov/cfh/WIC/clinic/training.htm#WIC_Breastfeeding_Trainings or
http://www.walwica.org/bfeeding/index.html

Breastfeeding trainings at Evergreen Hospital, Kirkland, WA

National Maternal Nutrition Intensive Course – University of Minnesota
http://www.epi.umn.edu/let/contedu/

First Steps Trainings
First Steps offers regular training about the following topics:

- Tobacco Cessation during Pregnancy Performance Measure (face-to-face training; watch for email announcements)
- Family Planning (Online training through the Smart Ph system https://fortress.wa.gov/doh/smartph, available Winter 2007)

Other trainings (e.g., cultural differences, ethics, and motivational interviewing) are suggested and often available through other resources. Watch for announcements from your agency.

ABC of First Steps
An online orientation training located on the DOH Smart Ph learning management system (contact the First Steps Health Education consultant for information how to access this course)

Resource information

State Websites
First Steps: http://hrsa.dshs.wa.gov/firststeps/
Washington State Dietetics Association: www.nutritionwsda.org
Children with Special Health Care Needs: www.doh.wa.gov/cfh/mch/cshcnhome2.htm
WithinReach: http://www.parenthelp123.org/ and http://withinreachwa.org/
Washington State WIC Program: http://www.doh.wa.gov/cfh/WIC/default.htm
National Websites
WIC: www.walwica.org and www.nal.usda.gov/wicworks
American Dietetic Association: www.eatright.org
Bright Futures: www.brightfutures.org
Institute of Medicine: www.iom.edu
La Leche League: www.lalecheleague.org

Books

American Dietetic Association. Manual of Clinical Dietetics, 6e. American Dietetic Association, 2000. Available from ADA: http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/shop_1282_ENU_HTML.htm.

Institute of Medicine. Nutrition During Lactation. Washington DC: National Academy Press. 1991. Available for order from http://ask.hrsa.gov/detail.cfm?PubID=MCHD081, or online at http://www.iom.edu/CMS/3788/18255.aspx.

Institute of Medicine, Food and Nutrition Board. *Weight Gain During Pregnancy: Reexamining the Guidelines.*. Washington DC: National Academy Press. 2009. Online at http://www.iom.edu/en/Reports/2009/Weight-Gain-During-Pregnancy-Reexamining-the-Guidelines.aspx.

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Mohrbacher N, Stock J, LaLeche League International. The Breastfeeding Answer Book, third revised edition. 1997.

Nevin-Follino N, ed. Pediatric Manual of Clinical Dietetics, 2e. American Dietetic Association. 1998. Available from ADA: http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/shop_1278_ENU_HTML.htm.

Story M, Holt K, Sofka D, eds. 2002. Bright Futures in Practice: Nutrition, Second edition. Arlington, VA: National Center for Education in Maternal and Child Health. Available, with supporting resources, at www.brightfutures.org.

Quiz

1. True or false: Client services in MSS/ICM are client-centered and focus on improving pregnancy and parenting outcomes.

a. True
b. False

2. Which of the following is NOT an essential function of the MSS dietitian?

a. Screening
b. Medical Supervision
c. Nutrition Assessment
d. Nutrition Intervention

3. Which of the following is NOT an essential function of the MSS dietitian?

a. Team Participation
b. Case Conferencing
c. Database Management
d. System Development

4. True or false: Participation in the MSS/ICM team includes coordination of services among community resources and team providers.

a. true
b. false

5. The use of an interdisciplinary team is preferable because it:
a. duplicates services
b. is less expensive to implement than a non-team approach
c. is more enjoyable for the team members
d. is more effective than any individual member providing services alone

6. The goal of case management during MSS is to address the client's current needs and develop a plan to improve the parents' self-sufficiency to access existing community resources. This includes all of the activities listed below EXCEPT:
a. linkage
b. referral
c. activism
d. advocacy

7. The role of the community health nurse in the MSS program includes which of the following activities:

a. preventive health education
b. home health care
c. primary medical and obstetrical care
d. none of the above

8. The MSS Behavioral Health Specialist might provide expertise on the following issues, EXCEPT:

a. mental health
b. how to facilitate change
c. utilizing available resources
d. dispense psychotropic medications

9. With ICM services, the Infant Case Manager's role includes which of the following duties:

a. primary pediatric care
b. referral to community resources, based on needs
c. direct service, depending on professional expertise
d. provision of supplemental and basic health messages and safety education to clients