CPSP

Comprehensive Perinatal Services Program

Provider Handbook

To improve the outcome of every pregnancy.

Comprehensive Perinatal Services Program

Provider Handbook

This publication is produced by the California Department of Public Health (CDPH) under contract with Maternal, Child and Adolescent Health (MCAH) Division.

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Inspiration for the completion of this project came from the knowledge that there exist countless health and human service providers, administrators, and dedicated clients who actively participate in CPSP on a daily basis and, in this way, contribute to the improvement of perinatal services and healthier birth outcomes.

Acknowledgments

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How to Use This Handbook

This Comprehensive Perinatal Services Program (CPSP) Provider Handbook was developed to provide you, a CPSP provider, with the information and tools you need to implement the program at your site.

Why You Need This Handbook

Find your local PSC by consulting the CPSP web site at http://www.cdph.ca.gov/programs/CPSP/Pages/PerinatalServicesCoordinators.aspx

This handbook guides you in the development and ongoing delivery of the CPSP services, defined in CCR, Title 22 and (W&I) Code found in the appendix of this manual.

Delivery of CPSP services is a team effort. Use this *Provider Handbook* and the *Steps to Take Manual* to orient staff members to the program and to involve them in developing your CPSP services delivery plan and protocols. The handbook includes the CPSP guidelines, an explanation of program requirements, and easy-to-use tools.

Use this handbook with the other supports available to implement CPSP in your office. The Perinatal Services Coordinator (PSC) in your local health department is available to answer questions and provide expertise. Training opportunities are available to assist staff members in successfully fulfilling their roles.

CPSP training opportunities are on page 6-15.

How The Handbook is Organized

Chapter Contents

Chapter 1 provides background information on the CPSP model and service components

Chapter 2 describes the service components of CPSP.

Chapter 3 tells how to implement CPSP at your site.

Chapter 4 gives specific information on Medi-Cal eligibility.

Chapter 5 discusses an overview of billing for services rendered and types of health care delivery systems deliverng CPSP services.

Chapter 6 lists the resources available to you to assist with implementing CPSP.

Chapter 7 is a Tool Kit with instructions for completing assessments and care plans, a sample care plan, instructions for developing protocols, a patient handout on applying for Medi-Cal, referral forms for the Women, Infants and Children (WIC) program, dental and abuse/injury referrals, and quality assurance (QA) tools.

Appendix

An Appendix at the back of the handbook contains information that underlies the implementation of California's CPSP, including Title 22 regulations, Welfare and Institutions Code, Medi-Cal Managed Care Policy Letters affecting CPSP service delivery, and Interconception Care Guidelines.

Margin Text

Throughout the handbook, comments in the left margin point to related information other sections of the handbook or to resources that provide more information on a subject.

Icons

Icons throughout the handbook provide a visual guide to specific topic areas, or alert you to related information in another section of the handbook.

An additional icon refers the reader to the *Steps to Take Comprehensive Perinatal Services Program Guidelines*. These guidelines provide the information CPSP approved staff members may use to effectively assess, provide interventions, and appropriately refer clients for support services. Steps to Take can be downloaded at no charge from the CPSP website at this link: http://www.cvent.com/events/cpsp-orientation-training/event-summary-11940c67e1ab4d8dac1fe0d5d3847bb3.aspx. Call the PSC in your local health department for additional assistance.

To help you easily find what you need in this handbook, the icons shown below are used.

CPSP SERVICE COMPONENTS

Obstetric

Health Education

Nutrition

Psychosocial

CPSP SERVICES

Client Orientation

Initial Assessments

Individualized Care Plan (ICP)

Interventions

Reassessments

Postpartum Assessment and Care Plan

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Steps to Take

Found elsewhere in this handbook

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There are approximately 1,750 enrolled CPSP providers, throughout California.

Program Background

The Comprehensive Perinatal Services Program (CPSP) was created in 1987 to reduce morbidity and mortality among low-income pregnant women and their infants in California after the Obstetric Access pilot project (OB Access Project) demonstrated the effectiveness of this model of care.

The goals of the OB Access Project were to improve access to care in underserved areas and to improve pregnancy outcomes through enhanced prenatal care. This project, conducted by the Department of Health Services, demonstrated that obstetric care supplemented by nutrition, health education, psychosocial services, and prenatal vitamins and minerals, could reduce the incidence of low birth weight in infants by more than one-third.

The OB Access Project

From July 1, 1979 to June 30, 1982, the OB Access project operated in 13 counties and registered 6,774 women. Of the 5,388 women who completed care and gave birth to live infants, 2,575 were Medi-Cal beneficiaries and 2,813 were Title V low-income mothers.

OB Access Project Findings

- Most (87.2 percent) registrants started prenatal care during the first or second trimester.
- Despite a variety of access barriers, most (84 percent) registrants completed care.
- Women who received a basic package of comprehensive perinatal services had a low birth weight rate of less than 3.1 percent compared to 7.7 percent in a matched group who received only traditional obstetric care.
- The cost of providing enhanced care was 5.0 percent higher than the average cost of care provided under the existing Medi-Cal program.
- For every dollar spent on the OB Access model of services, two to three dollars were saved compared to Medi-Cal obstetric services alone.

CPSP Program

See Appendix for Title 22 regulations and Medi-Cal Managed Care Policy letter No. 12-003.

Impressed by the results of the OB Access project, the California State Legislature enacted a law (AB 2821, Bates) in 1982 requiring all publicly subsidized prenatal care to include nutrition, health education, and psychosocial services in addition to obstetric care.

In 1984, legislation (AB 3021, Margolin) implemented a Medi-Cal reimbursement mechanism for these enhanced perinatal care services. In September 1987, CPSP began. Title 22 of the California Code of Regulations (CCR) describes the required services and defines regulations for CPSP. The new regulations enabled Medi-Cal approved health care providers to apply to become CPSP certified and receive Medi-Cal reimbursement for the enhanced CPSP services.

Although State-certified CPSP providers deliver CPSP services, local health jurisdictions (counties and selected cities) play a major role in administering CPSP. Local health jurisdictions employ PSCs and other staff to:

- Maintain a network of perinatal providers, including certified CPSP providers
- Offer assistance to providers in completing the CPSP provider application
- Conduct quality assurance (QA) activities with providers to assist with program implementation

PSCs may also develop models of service in their county, conduct outreach to inform eligible women about the program, and provide consultation and technical assistance to providers and Medi-Cal Managed Care (MCMC) plans. The Plans must inform members of childbearing age of the availability of comprehensive perinatal services and how to access such services as soon as pregnancy is determined. Plans are also required to implement a comprehensive risk assessment tool for all pregnant members that is comparable to the American College of Obstetricians and Gynecologists (ACOG) and the Comprehensive Perinatal Services Program (CPSP standards (California Code of Regulations, Title 22, Section 51348). Individualized care plans must be developed to include obstetrical, nutrition, psychosocial, and health education interventions when indicated by identified risk factors. While MCMC providers are

exempt from certification as CPSP providers, MCAH encourages them to attend or participate in the California Department of Public Health (CDPH), Maternal Child Adolescent Health's (MCAH) Provider Orientation training so that they understand the requirements of CPSP and its availability.

MCMC Plans are required by contract to execute a subcontract or Memorandum of Understanding (MOU) with local health departments in the area of Maternal and Child Health (MCH).

All MCMC Plans must ensure initiation of prenatal care as soon as possible and must not require prior authorization for basic prenatal care or preventive services.

Plans are required to cover and ensure the provision of all medically necessary services for pregnant women. Plans must ensure that the most current standards or guidelines of the ACOG are utilized as the minimum measure of quality for perinatal services.

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The CPSP Model of Care

CPSP is a Medi-Cal program that provides a comprehensive set of services for eligible low-income pregnant and postpartum women, from conception to 60 days postpartum. These services are delivered by certified fee-for-service (FFS) CPSP and Medi-Cal Managed Care (MCMC) providers. Pregnancy and birth outcomes improve when pregnant women receive nutrition, health education, and psychosocial services in addition to routine obstetric care.

Reimbursement for comprehensive services is discussed In Section 5 of this Handbook.

The CPSP client receives a client orientation, initial and ongoing assessments, care plan development, case coordination, appropriate nutrition, health education, and psychosocial interventions and referral services from a multidisciplinary team. The perinatal nutrition, health education, and psychosocial services are commonly referred to as "enhanced services" or "support services." CPSP providers receive reimbursement for the delivery of comprehensive perinatal services either directly from Medi-Cal for fee-for-service clients, or through contractual agreement with health plans for those women enrolled in Medi-Cal managed care. All CPSP services are delivered with the following underlying philosophy of care:

Steps to Take guidelines cover several basic nutrition, health education, and psychosocial perinatal issues that can be referenced or integrated in protocols for staff to follow.

- Health care services are client-centered; delivered in consultation with the client and based on her prioritized needs
- Services are individualized for the client
- Client strengths are assessed and incorporated into the care plan
- A multidisciplinary approach is used to address the client's full needs
- Services are culturally sensitive and respect the clients' values, beliefs, and traditions
- Clients' choices and rights are valued and respected
- Services delivered are based on protocols approved by nutrition, health education, and psychosocial consultants
- Linkages to some services in the community are required and others are encouraged to enhance the client's care
- Client participation in all medical services and procedures, including CPSP, is voluntary

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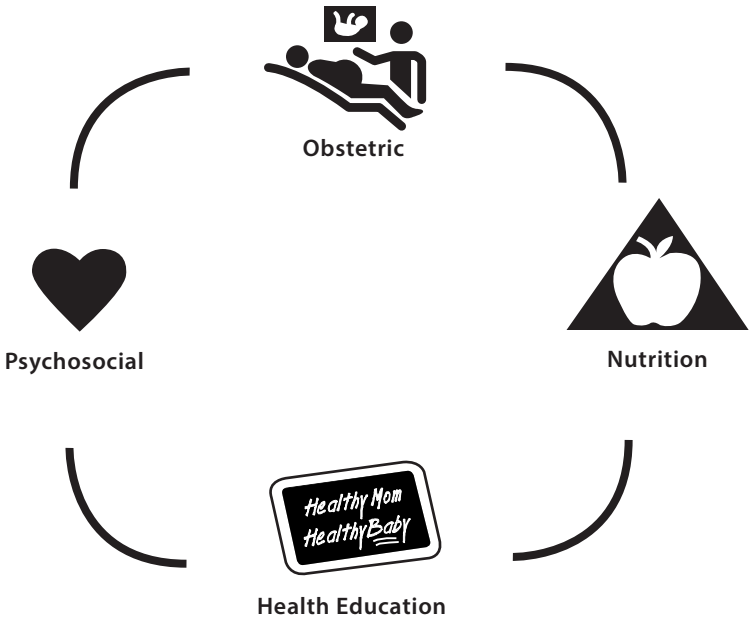
CPSP Components and Model of Care

CPSP provides an effective model for delivering a wide range of health-related services to pregnant and postpartum women. A CPSP provider working with a multidisciplinary team of health care practitioners delivers obstetric care services and nutrition, health education, and psychosocial services to address the client's full spectrum of needs.

The standards of care for the CPSP components are described following this page.



A multidisciplinary team is important for the success of CPSP. Refer to Chapter 3 for tips on staffing CPSP services.

Obstetric Standard of Care

A detailed description of obstetric clinical management is beyond the scope and purpose of this handbook. In conformance with CCR, Title 22, 51348.1, the Comprehensive Perinatal Standards of care shall be provided in conformance with the following:

- American College of Obstetricians and Gynecologists, "Guidelines for Perinatal Care" (current edition)
- Newborn Screening regulations as set forth in Title 17, California Administrative Code, Section 6500 et seq
- Hemolytic Disease of the Newborn Requirements as set forth in Title 17, California Administrative Code, Section 6510 et seq. NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 14134.5, Welfare and Institutions Code

The ideal program begins early in pregnancy, continues during pregnancy, and extends through the postpartum period. The earlier pregnancy is diagnosed and the woman seeks care, the sooner efforts can be undertaken to assess risk factors, establish an ongoing management plan, and, if necessary, alleviate problems or modify behavior.

Before receiving any assessment, medication, procedure, or treatment, the client should be informed of potential risks or hazards that may adversely affect her or her unborn infant during pregnancy, labor, birth, or postpartum, and the alternative therapies available to her. The client has a right to consent or refuse the administration of any assessment, medication, procedure, or treatment.

CPSP providers are expected to foster team building, and coordinate care among the various specialty and support services to deliver optimum, thorough perinatal care. It is recommended that providers encourage pregnant and postpartum women to include the support of family members in their plan of care.

Nutrition Standard of Care

Adequate nutrition is vital before, during, and after pregnancy to help ensure the optimal health of both the mother and the infant. Inadequate food access and intake, extremes in weight status, eating disorders, severely restricted diets, chronic medical conditions, and detrimental personal habits such as tobacco, alcohol and opioid use are just a few of the factors that impair a woman's nutritional status and impact her health and the health of her children. Ongoing nutrition services are a critical aspect of a woman's perinatal care. Including Registered Dietitians (RD)/ Registered Dietitian Nutritionists (RDNs) on the CPSP team is encouraged as these health care providers are specially qualified to provide nutrition services and education for clients and technical assistance to other CPSP team members.

CPSP nutrition assessment requirements are listed beginning on page 2-9.

Basic Nutrition Services

CPSP requires that basic nutrition services be integrated into the care of all expectant and new mothers. Basic nutrition services include nutrition initial assessment and follow-up reassessment for each trimester, education and intervention. Nutrition interventions are needed for problems detected in the assessment. The client actively participates in an individualized care plan addressing her nutritional needs and goals. Assessments, reassessments and interventions are carried out by designated and trained CPSP staff and should occur at the initial assessment, trimester reassessments, postpartum, and anytime as needed.

For a list of nutrition risk conditions, refer to page 2-25.

Integrated Breastfeeding Support, Supplies and Counseling

Education and support for breastfeeding is another aspect of basic nutrition care and is best provided by an individual with specialized breastfeeding training and experience. Consideration of the woman's cultural and traditional practices and beliefs is essential for the delivery of quality nutrition services.

Medical nutrition therapy is the use of specific nutrition services to treat an illness, injury, or condition.

The DHCS MMCD 98-10 policy addresses Medi-Cal Managed Care obligations to provide fully integrated breastfeeding support, supplies and counseling. Since 1998, California Medi-Cal policy requires health plans and contracted providers to:

1. Provide breastfeeding promotion, education and counseling services, integrated into perinatal, postpartum and pediatric services.

2. Provide medically necessary interventions, including access to DME.
3. Implement procedures to ensure that postpartum mothers receive necessary breastfeeding counseling and support after delivery.
4. Have appropriate procedures to refer to lactation professionals.
5. Refer to WIC
6. Offer health education (if contracted) in breastfeeding (detailed instructions in policy.)
7. Not market formula.
8. Provide lactation aids (DME.)
9. Cover enteral feeding (i.e. banked human milk, special formulas.)

Medical Nutrition Therapy

Women presenting with complex medical conditions may require more in-depth nutrition assessment, diet modification, frequent monitoring and revision of the nutrition care plan. Medical nutrition therapy, and other specialized forms of nutrition support for complex medical conditions should be provided by an RD with expertise in perinatal nutrition. All services provided must be referred by and coordinated with the medical provider responsible for the care of the woman.

Health Education Standard of Care

Pregnancy and expectant parenthood naturally create new learning needs for each woman, her partner, members of her family, and her support system. These needs may include accurate health and perinatal care facts, active learning for specific behavior change, and the practice and mastery of new skills or modification of current habits for optimal health.

Pregnancy and a new infant challenge a woman's lifestyle, her current health behavior patterns, and possibly her personal resources. CPSP provides an opportunity for women to obtain health education services from her CPSP provider that address her unique health education needs and to participate in routine perinatal health education services such as childbirth preparation, breastfeeding, and infant care classes.

Orientation is explained in further detail on pages 2-5 and 2-6.

Basic Health Education Services

Health education begins with orientation that sets the tone for informed client participation by informing the woman and her support person(s) about CPSP, routine services, the provider setting, and much more. Because a fundamental principle of the CPSP program is respect for the client's dignity and rights, orientation may occur during the entire perinatal period to reinforce information given initially and to help the woman understand new procedures, tests, or services, so that her consent and participation is truly informed.

CPSP health education assessment requirements are listed beginning on page 2-11.

The process continues with the initial assessment, which identifies the woman's current health practices, strengths, and health education needs.

The client-centered educational process continues with her active participation in creating an Individualized Care Plan that includes health education objectives that specify the health education services and interventions she will receive to meet her needs.

During each subsequent trimester and postpartum, reassessments assist staff and client to:

- Evaluate the effectiveness of teaching
- Evaluate the progress towards achieving health education objectives

- Adjust the care plan as necessary
- Evaluate patient satisfaction with services

CPSP providers who offer classes onsite, or by an agreement offsite, need protocols that include sign-up and referral procedures, maintenance and record-keeping of class outlines and the list of instructors identified on their application or the application change form.

Health education interventions include individual instruction, small group, and class sessions provided throughout the prenatal period and to the end of the postpartum period.

Using the information gained during the assessment process regarding how the woman prefers to learn, the provider can create planned sequential health and perinatal education to meet the woman's specific needs and interests. While written materials can be useful additions to reinforce verbal instruction, by themselves they are not considered a complete health education program. Likewise, while video programs can present information in a concise and interesting format, videos must be shown in the presence of a CPSP staff member who can introduce important themes, gauge client response, and be available to answer questions and review important points.

CPSP staff can competently provide appropriate health education when these resources are in place:

- Supervision from or access to a professionally prepared health education consultant
- Ongoing training in health education
- Linguistically and culturally appropriate teaching tools, curricula, and guidelines

Risk conditions that should be referred to a health education professional or other specialized referral are listed on page 2-29.

Health education protocols should include detailed curricula on such topics as prenatal care, self-care, the progress of pregnancy, fetal development, labor and delivery, postpartum care, safety topics, infant care, and common conditions in pregnancy.

Specialized Health Education Services

The master's level health education professional who is required to approve health education protocols can provide supervision, consultation, and staff training. This professional can also provide direct services to women with health education risk conditions and complex learning needs requiring a more in-depth assessment or other specialized services.

Psychosocial Standard of Care

The CPSP program provides psychosocial assessment, individual care plan development, and interventions for all clients. The goal is to help the client understand and deal effectively with the biological, emotional, and social stresses of pregnancy, thereby increasing her ability to improve the health outcomes for herself and her baby. CPSP psychosocial care assists the woman with crisis intervention, community resources, transportation needs, or any psychosocial problem affecting her care.

CPSP psychosocial assessment requirements are listed on page 2-15.

Assess the woman's strengths and needs in the context of her environment. Treat the woman with respect. Acknowledge her strengths and accept and respect cultural diversity. Base all assessments, individualized care plan development, and interventions on the belief that the client is the person most concerned with her care.

Basic Psychosocial Services

The initial psychosocial assessment is the beginning step in determining what impact social, emotional, and economic issues and needs may have on a woman during her pregnancy. Assessments are carried out by designated and trained CPSP staff and should occur at the initial assessment, trimester reassessments, and again in the postpartum period. The importance of providing quality psychosocial services to women cannot be overemphasized. Many of the problems being presented can be ameliorated by brief social work interventions.

Psychosocial risk conditions that should be referred to a discipline-specific professional are listed on page 2-30.

Psychosocial interventions are needed for problems discovered in the assessment. These interventions are directed toward assisting the client to understand and effectively manage the biological, emotional, and social stresses of a pregnancy.

Specialized Psychosocial Services

Including a master's-prepared social work professional (MSW) or other master's-prepared psychosocial professional on the CPSP team is encouraged as these health care practitioners are specially qualified to provide a full range of psychosocial services and support for clients and other CPSP team members. The services of an MSW or Marriage, and Family Therapist (MFT) (previously known as Marriage, Family and Child Counselor, or MFCC) are recommended for women with complex psychosocial problems needing a more in-depth assessment and other specialized services.

The CPSP Services

What Are the CPSP Services?

"Comprehensive perinatal services" means obstetric, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery. NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 1434.5, Welfare and Institutions Code.

Obstetric Services

All routine obstetric services are provided by a qualified practitioner who is on the CPSP provider's staff or through contract with another qualified practitioner. These services include prenatal care, antepartum, intrapartum (delivery) care, and postpartum care.

Enhanced Services

A CPSP provider offers client orientation and nutrition, health education, and psychosocial assessments, individualized care plans, interventions, coordination of care, and referrals. Services can be provided by qualified practitioners on the CPSP provider's staff, or through contract with other qualified practitioners.

Vitamin/Mineral Supplement

A 300-day supply of vitamin/mineral supplements may be dispensed to the client or prescribed as medically necessary.

Required Referrals

The Comprehensive Perinatal Provider shall refer patients, as appropriate, to services not specifically made part of comprehensive perinatal services, as defined in Title 22 CCR Section 51179. These services shall include, but are not limited to the following:

- Women, Infants and Children's (WIC) Supplemental Nutrition Program
- Genetic screening

- Dental care
- Family planning
- Child Health and Disability Prevention Program (CHDP)

Who Can Be a CPSP Provider?

ACPSP provider must be enrolled as an active Medi-Cal provider in good standing with an approved National Provider Identifier (NPI) number with Medi-Cal, and be in one of the categories listed below:

- Physician in general practice, family practice, obstetrics/ gynecology, or pediatrics
- Group medical practice, if at least one member is one of the physician types identified above
- Preferred Provider Organization (PPO)
- Clinic (hospital, community, or county)
- Certified Nurse Midwife (CNM)

Who Can Be a CPSP Practitioner?

A CPSP provider may employ or contract with any of the practitioners listed below who may give comprehensive perinatal services appropriate to their credentials and skill level.

CPSP practitioners are the members of the health team who are approved to provide the comprehensive services.

- Physicians (general practice, family practice, obstetrician/ gynecologist, pediatrician)
- Certified Nurse Midwives
- Nurse Practitioners
- Physician Assistants
- Licensed Midwives
- Registered Nurses
- Licensed Vocational Nurses
- Social Workers
- Psychologists

- Marriage and Family Therapists (MFT)
- Registered Dietitians/ Registered Dietitian Nutritionists (RD/RDN)
- Health Educators
- Certified Childbirth Educators (Lamaze, Bradley, ICEA)
- Comprehensive Perinatal Health Workers (CPHW)

Refer to Title 22 Section 51179.7 for education, licensure/ certification, and experience requirements.

All CPSP services, including those provided by a CPHW, must be provided by or under the personal supervision of a physician. In accordance with CCR Title 22, 51179.5, personal supervision means evaluation, in accordance with protocols, of services provided by others through direct communication, either in person or through electronic means. For more information on protocols, see the "Implementing and Maintaining CPSP" section of this Handbook.

Title 22 regulations are located in the Appendix.

02 Delivering CPSP Services to Clients

The scope of services CPSP clients receive is based on the recognition that providing comprehensive obstetric, nutrition, psychosocial, and health education services during the course of perinatal care contributes significantly to improving perinatal outcomes.

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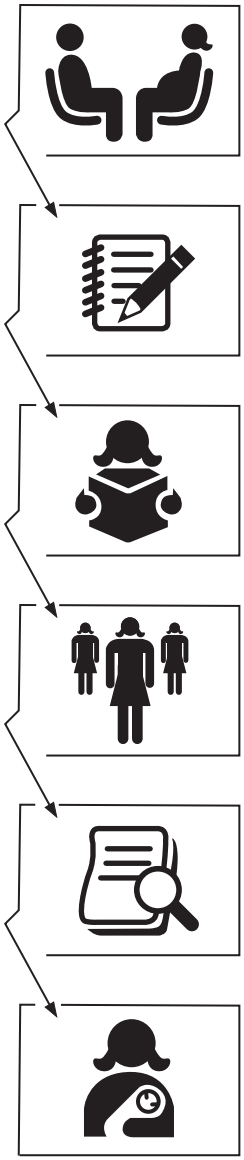
CPSP Scope of Services



Client Orientation

Orient the client to comprehensive perinatal care at entry of care and throughout the pregnancy as needed.

Initial Assessments

Complete assessments in the four components— obstetric, nutrition, health education, and psychosocial—using approved assessment forms.

Individualized Care Plan (ICP)

Complete the ICP with the client following the initial assessments. Prioritize problems and actions planned to resolve them.

Interventions

Provide services, classes, counseling, referrals, and instructions as appropriate to the needs and risks identified on the ICP.

Reassessments

Reassess in each trimester to identify changes or new developments since the previous assessment and to provide continued support for the client's strengths. Revise and update the ICP as needed.

Postpartum Assessment and Care Plan

Assess the mother and infant postpartum and update the ICP. Provide appropriate interventions for the client and her baby.

Guidelines for providing these Title 22 services to CPSP clients are in this chapter.

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Client Orientation

WHY

Keeping the client informed about her pregnancy care and available CPSP services is necessary to best match services to the needs of the client and her family.

WHAT

Orientation is an opportune time to inform the client of her rights as well as her responsibilities. CPSP providers provide an initial orientation and continue to orient the client to needed services, procedures, and treatments throughout her pregnancy.

HOW

The client orientation includes but is not limited to the following:

- Where to obtain services (hospital, office, clinic, etc.)
- Where, when, and how comprehensive services are provided, including initial assessments, reassessments, interventions, and referrals
- What to expect at prenatal and postpartum visits
- Information about routine tests and procedures
- Clinic hours (scheduling missed appointments, etc.)
- Identifying danger signs and symptoms and what to do in case of an emergency
- An opportunity to ask questions and express concerns the client may have about her prenatal care, services, or any of the information provided

Provide orientation at other times during perinatal care as needed to address:

- Informed consent and orientation to procedures, such as prenatal screening, genetic testing and other procedures or issues that arise over the course of the client's pregnancy
- Referrals to other services outside the scope of the CPSP Program such as WIC, Cal Fresh, dental care, genetic screening, and pediatric and well-child care services
- Hospital pre-admission procedures and other routine hospital practices

Steps to Take "First Steps" contains detailed information about client orientation, including a list of patient rights.

- Availability of tours or other hospital orientation services (If the hospital does not provide a maternity floor tour, a full orientation to the hospital should be provided by the CPSP staff.)
- Postpartum orientation to services and referrals; for example, referral for rubella immunization for the mother and postpartum orientation to breastfeeding support groups and lactation services

Initial Assessments

WHY

During the initial assessments, the CPSP practitioner gathers baseline data and asks questions designed to identify issues affecting the client's health and the pregnancy outcome, her readiness to take action, and resources needed to address the issues. The practitioner and the client use the initial assessment to develop an individualized care plan (ICP) identifying interventions to meet the client's unique needs.

WHAT

The initial obstetric, nutrition, health education, and psychosocial assessments are the first steps taken to determine a client's individual strengths, risks, and needs in relation to her health and well-being during pregnancy. Ideally, all four assessments are completed within four weeks of entering care.

HOW

Each initial assessment is completed by a qualified CPSP practitioner in a face-to-face interview with the client. To facilitate the process:

- Use a state approved assessment form that includes all items required by Title 22 and State MCAH
- Conduct the interview in a space that assures confidentiality
- Explain the purpose of the assessment and how it will benefit the client and the care she receives
- Make sure the assessment is offered in a culturally and linguistically appropriate manner
- Review the client's medical history or consult with the provider, if available, prior to the interview to be aware of medical risks
- Ask questions in a nonjudgmental, conversational, open-ended manner
- Probe beyond superficial or conflicting responses
- Inform the client that she has the right and responsibility to ask questions throughout the interview and the right not to answer any questions she finds uncomfortable
- Respond to any problems the client raises by asking her if she wants help, stating clearly the help that can be provided, and reviewing appropriate community resources

Providers are required to use a CPSP assessment form integrating the assessment requirements from CCR, Title 22, 51348. for each CPSP component. The PSC can provide sample forms that contain all required elements.

Be sure to check with your PSC if you want to use an assessment form other than an already approved sample assessment form.

- Summarize the issues that will be the basis for developing the Individualized Care Plan (ICP)
- Complete documentation needed for WIC program eligibility

Assessing Risk Conditions

Risk conditions are listed on pages 2-25 through 2-31.

Certain complex conditions identified by the initial assessment and reassessment should be referred to a Registered Dietitian (RD)/ Registered Dietitian Nutritionist (RDN), or a master's-prepared social worker or health educator for effective assessment, intervention, and referral as needed.

Complex conditions that warrant referral to discipline-specific professionals are listed following the description of nutrition, health education, and psychosocial interventions in this chapter.

In summary, CPSP practitioners can use the initial assessment to develop a tailored ICP that includes medical, nutrition, health education, and psychosocial components and identifies risks as well as strengths. This ICP also includes specific interventions to assist the client in enhancing her health and the health of her baby.

The following provider toolkits assist providers address identified maternal risk factors to prevent or minimize maternal or infant morbidity and mortality.

A. Hemorrhage toolkit: https://www.cmqcc.org/ob_

B. Hemorrhage: <39 weeks toolkit: https://www.cmqcc.org/_

C. 39_week_toolkit
Pre-eclampsia toolkit: https://www.cmqcc.org/preeclampsia_toolkit

Obstetric Initial Assessment Requirements

The initial obstetric assessment must include a comprehensive history and physical examination done by the OB provider, who is also responsible for reviewing the support services assessments and participating in case coordination. The history and physical exam must be consistent with the most recent American College of Obstetricians and Gynecologists (ACOG) Guidelines for Perinatal Care.

Nutrition Initial Assessment Requirements

The purpose of the nutritional assessment is to encourage sound nutrition practices and to identify women at risk for a poor pregnancy course and outcome who can benefit from nutritional intervention. The four required components involved in the nutrition initial assessment are described below.

Anthropometric

Weight gain in pregnancy is one of the key determinants of a healthy birth outcome. Pre-pregnancy weight status, weight history, and prenatal weight gain and rate of gain are important factors influencing birth outcome, infant birth weight, and the mother's nutritional status. Inappropriate weight gain can signify other health risk behaviors and practices.

Biochemical

Laboratory tests may indicate existing nutritional inadequacies or abnormalities associated with poor birth outcomes and risks for the mother. Assessing laboratory findings is essential for planning and executing appropriate nutrition interventions.

Clinical

Previous and current medical and obstetric conditions such as diabetes, hypertension, hyperemesis gravidarum, etc., affect a woman's nutritional state. These conditions may reduce the woman's ability to meet the nutritional demands of her pregnancy. Some chronic and current medical conditions may require medical nutrition therapy as part of their management. Such conditions are most appropriately referred to an RD/RDN.

Nutrition and drug interactions may impair a woman's nutritional status. Appropriate assessment and intervention is needed.

Dietary

An inadequate intake of essential nutrients can affect the course and outcome of pregnancy. Excessive intake of fats and sugars can displace nutrients and further impair nutritional status and promote obesity. Adequate shelter, access to food, cooking facilities, skills, and resources are needed for optimal nutritional intake.

See **Steps to Take** for instructions on assessing food intake and weight status, and for information on many common nutritional concerns.

Nutrition Assessment Skills

All CPSP practitioners performing the nutrition assessment are required to be able to:

- Accurately measure height and weight
- Select appropriate weight gain grid by correct classification of pre-pregnant weight status
- Accurately plot weight on weight gain grid at each prenatal visit
- Monitor and interpret weight changes during pregnancy and postpartum
- Provide basic assessment of dietary practices, i.e., accurately complete the nutrition assessment questionnaire plus a Perinatal Food Group Recall (PFGR), 24-Hr Dietary Recall, or other approved diet recall form.
- Review information from the client's medical record and consult with the provider to be aware of nutrition problems before, during, and after pregnancy
- Identify appropriate interventions, resources, and referrals for problems or potential problems based on the nutrition assessment
- Respect and have knowledge of cultural, traditional, or religious practices that influence nutrition intake practices
- Obtain a history of the woman's breastfeeding attitudes, knowledge, experience, support, and educational needs

Nutrition risk conditions are listed on pages 2-25 through 2-28.

Assessing Risk Conditions

Certain conditions identified by the initial assessment require nutritional expertise for effective assessment, intervention, and referral. High-risk medical/nutrition problems are most appropriately referred to the RD/RDN. These nutrition conditions are listed following the description of CPSP interventions in this chapter.

Health Education Initial Assessment Requirements

The purpose of the health education assessment is to identify a client's learning needs as they relate to her pregnancy. The components required in the health education initial assessment are described below.

Current Health Practices

Assessment of current health practices provides the opportunity to identify and reinforce those practices or behaviors the woman has that promote health or reduce health risks. Risk behaviors can be determined by an examination of key health practices, and serve to identify barriers or challenges and areas of need for intervention and/or referral.

Prior Experience with and Knowledge of Pregnancy, Prenatal Care, Delivery, Postpartum Self-Care, and Infant Care and Safety

Effective health education builds on prior experience and current knowledge. Learning and skill development needs vary for each client based on prior prenatal, postpartum,and infant care and safety experience.

Knowing the client's prior experience and existing knowledge helps the CPSP staff identify where specific education is needed, determine more effective and meaningful educational interventions, and identify ways to enhance the client's motivation to participate in the education plan.

Prior Experience with Health Care Delivery Systems

Positive or negative experiences with and perceptions of the health system affect a client's willingness to participate in prenatal care. Examining previous use of health care services identifies the woman's needs, strengths, and confidence navigating the health system. It also uncovers barriers she may be experiencing accessing health care services. This information helps the CPSP provider or practitioner to determine where appropriate instruction and/or referral to services may be needed.

Client's Expressed Learning Needs

Health education should address the woman's interests and self-determined learning needs. Including these needs in the ICP will increase the client's motivation to both participate in educational activities and make behavior changes.

Formal Education and Reading Level

Health education should be communicated using concepts and terminology familiar and appropriate for the client. Determining these factors assists in selecting useful and relevant education methods and tools in delivering CPSP services. Health literature and instructions should be available to match the individual's literacy level.

Reading ability affects understanding of medical instructions, referrals, directions, and medication/prescription labels. Hazards due to misunderstanding written information can be avoided if the provider is aware that a client has low literacy or does not fully understand. The provider can assist her in understanding and provide her access to CPSP practitioners trained in concepts and techniques to work effectively with clients who have low literacy skills.

Languages Spoken and Written

Whenever possible, services and information should be provided in a language familiar to the client. Frequently, recently immigrated, non-English speaking women are not literate in their native language. The provider and CPSP practitioners need to know if available written information is adequate to meet her needs or if she needs additional support understanding medical instructions, a referral, prescriptions, or CPSP services.

Learning Methods Most Effective for Client

To be effective, health education must actively involve the client and provide a variety of learning methods and options to allow her to master new skills or change behavior. Having the client identify the methods she knows or feels will help her learn lets her influence the CPSP learning experiences and increases the likelihood she will be satisfied with services and adopt new health practices.

Disabilities That May Affect Learning

The CPSP provider and health educator can better anticipate and understand the client's response to medical instructions and health education if they are aware of disabilities or impairments that create barriers to learning.

Determining disabilities that may impact learning helps to create a realistic health education plan and identifies methods or facilities which may assist a learning-disabled client meet her health education needs. All reasonable accommodations and/or referrals should be made to make participation possible for interested clients with learning disabilities.

Client and Family/Support Person(s) Motivation to Participate in Education Plan

Determining the client's motivation to learn about pregnancy, birth, newborn care, parenting, or to adopt healthy practices assists in identifying her strengths and needs toward the development of a practical education plan.

People in the woman's life who are affected by her pregnancy or health problems or who have influence should be actively involved. Health education should include those who can encourage and support clients in following recommended health practices. The woman's partner, a family member, or other significant support person may play a helpful role in encouraging and supporting a woman in her learning and/or making health behavior changes.

Religious and Cultural Factors

When recommending health education for a client, consider the religious and cultural context of the recommended plans or changes. An analysis of the cultural factors influencing the client's perinatal care helps to identify positive patterns and practices which contribute to the health and well-being of a pregnant/postpartum woman and the baby, as well as practices that are potentially harmful or conflict with her ability to follow medical advice or care.

Respect for those customs that are strongly valued and important to the client and her family is essential to the partnership between the client and the provider.

Mobility/Residency

The provider and CPSP staff need to be aware of how the woman's mobility or residency may affect continuity of care and her ability to follow the advised prenatal care routine or participate in CPSP services. Assessment of factors affecting mobility and residency may reveal risks which can be alleviated by appropriate modes of communication (ie. texting, e-mail, skype), support information, or referrals. Transiency may make it difficult to contact a woman with test results, appointment changes, or other information she needs.

Education Needs Related to Diagnostic Impressions, Problems, Needs, and Risk Factors

The health education assessment process includes bringing together data from a multidisciplinary perspective to identify all problems and health education needs and priorities. Medical, nutritional, and psychosocial dimensions of the client's needs or problems must be considered in setting applicable priorities and realistic health education goals.

Health education risk conditions are listed on page 2-29.

Assessing Risk Conditions

Certain risk conditions identified by the initial assessment require health education expertise for effective assessment, intervention, or a specialized program referral as needed.

Psychosocial Initial Assessment Requirements

The purpose of the psychosocial assessment is to identify the client's social, emotional, relational and environmental issues that can affect her pregnancy. The components required in the psychosocial initial assessment are described below.

Current Status Including Social Support System

A social support assessment provides a basis for understanding the client's potential for psychosocial adjustment throughout the pregnancy. Social supports are mediators of stress and pregnancy risks. Optimally, a stronger support system provides a better buffer from crisis and stress and enhances the client's ability to cope. It may also help increase the woman's self-esteem.

Personal Adjustment to Pregnancy

How a woman views her pregnancy, whether she has some ambivalence or she has certain fears or concerns, is a very important factor in her approach to pregnancy care. To help her make informed decisions, it is important to gain an understanding of the client's adjustment to this pregnancy.

History of Previous Pregnancies

The prior experience a client has had with a particular pregnancy and its context affects how she and/or her family will cope with the present pregnancy. A history of loss may affect how she views the pregnancy (loss due to abortion, miscarriage, adoption, foster care, or death of a child). Understanding how the client views past pregnancies can help the provider understand how she views the current pregnancy.

Client's Goals for Herself in the Pregnancy

Many women will never have thought in terms of goals for themselves. Having goals implies that she has some control over what happens to her. When the woman is responsible for selecting changes and identifying goals, her compliance will increase. Defining goals allows the woman to maintain self-respect and dignity, thereby helping her to become responsible for her own care.

General Emotional Status and History

By understanding the client's current emotional status and her past history, you can help her improve her ability to manage her pregnancy. This assessment can help to screen and identify a client who may not cope well with the demands of daily living, or has underlying conditions that may be exacerbated by pregnancy such as depression, chronic anxiety, etc.

Wanted or Unwanted Pregnancy

When the pregnancy is unexpected, unplanned, or unwanted the client is at risk for marital stress, poor adjustment, medical complications, and poor self-reported general health.

Acceptance of the Pregnancy

Mixed feelings are normal during pregnancy. A woman may be either happy or unhappy about a pregnancy. A good psychosocial assessment will enable you to assist the client in finding a level of adaptation that is comfortable for her.

Alcohol, Tobacco, and Other Drug (ATOD) Use

Any use of substances poses a risk to the developing fetus, with risk increasing with the amount of use. Harmful substances include alcohol, tobacco, and prescribed and non-prescribed drugs. A pregnant woman using substances is likely to present with a unique constellation of symptoms and factors. Although any substance use during pregnancy may be dangerous, it is important to identify whether a client is experiencing problems related to substance abuse and, if so, whether she has progressed to the stage of addiction. By understanding the full spectrum of problems, you can more easily identify the interventions that may be needed.

Women who use ATOD are more likely to be truthful about their use in settings they perceive as nonthreatening. Throughout the assessment and intervention process, coordination, collaboration, and communication among all responsible individuals and organizations is vital.

Pregnancy may create a unique "window of opportunity" to help a woman limit or stop her substance use. Her desire to protect her baby and the increased level of health care received may impact her behavior.

Housing/Household

The safety and stability of the client's home, household members and neighborhood are important factors that influence your client's ability to successfully manage her pregnancy.

Education

Knowing the client's current education level and any goals she may have will assist you in identifying the best educational approach for her.

Employment

Understanding the client's employment situation will assist you in helping her make plans for her self-care on the job during her pregnancy and postpartum. Identify resources and help the client access needed referrals to promote economic sufficiency and stability.

Psychosocial risk conditions are listed on pages 2-30 and 2-31.

Financial and Material Resources

Food, shelter, and clothing are primary needs. Determine whether the client has access to the basic resources she needs to focus on her pregnancy-related health care needs. Be sure to know the local resources where you can refer your client for food, clothing and shelter needs.

Assessing Risk Conditions

Certain risk conditions identified by the initial assessment require psychosocial expertise for effective assessment, intervention, and referral as needed. Be sure to utilize your psychosocial consultant when the level of need indicates.

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Individualized Care Plan

WHY

The Individualized Care Plan or ICP is an effective tool for coordinating a client's perinatal care. It maximizes the coordination of care and documentation of services provided by all CPSP practitioners: obstetrics, nutrition, health education, and psychosocial.

A sample ICP form and instructions for completing it are located in the Tool Kit beginning on page 7-13.

The ICP provides the following benefits:

- It identifies and documents the client's strengths and a prioritized list of risk conditions/problems, sets goals for interventions, and identifies appropriate referrals
- It is an effective tool for coordinating client care
- It can be used by the provider and county and state officials as a quality assurance tool to assess the effectiveness, accessibility, and feasibility of the delivery of CPSP services

WHAT

A client's ICP is developed based on her unique risk conditions, problems, and strengths identified during the CPSP initial assessments and re-assessments. It is a summary of the perinatal services planned for the client during her pregnancy and during the postpartum period and covers the four CPSP components: obstetrics, nutrition, health education, and psychosocial. The client's ICP is a part of her medical record.

The ICP should build on the client's strengths, not simply identify her deficits. Acknowledging past and current strengths empowers a client to make positive changes during the current pregnancy and in the future.

Based on CCR Title 22, Section 51179.8, the "ICP" means a document developed by a comprehensive perinatal practitioner(s) in consultation with the patient. The plan consists of four components; obstetrical, nutritional, health education, and psychosocial. Each component includes identification of the following:

- Risk conditions
- Prioritization of needs

- Proposed interventions including methods, time frames, and outcome objectives
- Proposed referrals
- Staff persons' respective responsibilities based on the results of assessments

HOW

The ICP can be developed using one form or format that combines the four CPSP components or an ICP can be developed for each component. The ICP can be a separate form, incorporated within the assessment form, or in another standardized location in the medical record.

- The Perinatal Services Coordinator (PSC) can provide sample ICP formats that meet state requirements.
- The ICP is developed by one or more practitioners in consultation with the client and based on the risk conditions and problems identified in the initial assessments. The issues included on an ICP are prioritized to those that are important to the client and those that can feasibly be addressed.
  - Items for which the staff is responsible even though they may be obstetric, such as evaluation for an incompetent cervix, should be included on the ICP.
  - Medically related issues for all women are not required to be included on the ICP. These items may be incorporated into a patient care flow sheet; providers can then initial items as they are resolved.
- While all the risk conditions and problems identified in the initial assessments need to be addressed, not all need to be included on the ICP.
  - Some issues can be addressed with immediate intervention and documented on the initial assessment form or in progress notes. Immediate interventions might include referring for emergency food services, discussing gun safety in the home, and prescribing over-the-counter medications. Reassessment of these issues is necessary.
  - The client may not be interested in addressing some of the identified risk conditions and problems at the present time.

For example, she may be involved in a domestic violence situation but choose not to take any immediate action. In this type of situation, a note identifying the risk and stating that the client refused services should be made on the initial assessment, in the progress notes, or on the ICP.

- Interventions must be identified for the risk conditions and problems included on the ICP. These interventions may include teaching, counseling, providing referrals, problem solving, or any other action the client or staff takes to resolve a risk or problem.
  - All proposed interventions should take the client's cultural background and linguistic needs into consideration.
  - Whenever appropriate, people who provide the client's social support, such as her partner or family, should be involved in the interventions.
  - The ICP should clearly identify who is responsible for carrying out a proposed intervention and the proposed timelines. The results of each intervention (or referral) should be documented in the ICP.
- The final outcome for each planned intervention should be documented on the ICP form by any staff person designated by the provider. However, interim activities carried out to achieve ICP goals may be documented in progress notes or in the medical record. Provider protocols will define how personal supervision by a physician occurs in their practice, how the practice documents this in the patient records, who is designated to document and/or sign the ICP under the personal supervision of a physician, according to Title 22, Section 51179.5.

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Interventions

WHY

Women generally have a heightened interest in and need for health information during pregnancy and are more likely to make health behavior changes. Appropriate and individualized interventions increase the possibility of a successful pregnancy course and birth outcome and overall improved health for the woman and her family.

WHAT

Appropriate obstetric, nutrition, health education, and psychosocial interventions during pregnancy enable a woman to increase control over and improve her health and the health of her baby.

Interventions provided to a client should be based on approved CPSP protocols.

Each CPSP provider is responsible for providing appropriate individual or group interventions for problems, risk areas, and educational needs and interests identified during the initial assessment. These interventions are identified on the client's ICP. Frequent and continuous assessment may reveal new areas where intervention is appropriate. All interventions should be described by protocols approved by the provider and the required CPSP discipline-specific specialists. **Steps to Take** is a useful resource for planning appropriate interventions for common issues.

HOW

- Develop and follow protocols that describe appropriate interventions and personnel required.
- Plan interventions for the course of the client's pregnancy during the development of the ICP. Involve the client and ensure that the interventions reflect her interest and ability. Also consider resources available to her within the health setting and the community.
- Provide immediate interventions when the situation requires it. Provide interventions continuously throughout the woman's pregnancy and postpartum period.
  - CPHWs and other staff should have access to discipline specialists to ensure appropriate interventions for complex or high-risk conditions.
  - Vary the types of interventions to increase active learning. Interventions may be provided through classes, activities, demonstrations, small groups, games, etc.
  - Provide appropriate community referrals as needed.

Steps to Take guidelines provide useful information on how to provide intervention for many common issues.

Risk conditions that should be referred to discipline-specific professionals are listed on the following pages.

Steps to Take provides recommended referral criteria for particular nutrition, health education, and psychosocial interventions.

Risk Conditions and Complex Interventions

Appropriate nutrition, health education, and psychosocial interventions begin with a comprehensive initial assessment to identify strengths and risk conditions. These strengths and risk conditions are then re-evaluated at periodic reassessments. As areas of need are identified, the CPSP provider must discern each condition's degree of severity and identify the level of expertise needed to assist the client most appropriately.

As a condition's complexity increases, so does the level of expertise required to provide the client with the appropriate assessment, counseling and education, and other specialized interventions.

CPSP providers are required to have protocols in place describing intervention and referral procedures.

Nutrition Risk Conditions

The conditions listed below may impact the health and nutritional status of a client and her baby. Some conditions require less complex interventions and limited nutrition education. Others are more complicated and require the involvement of skilled nutrition professionals who are able to manage and instruct clients about complicated dietary modifications or provide other specialized support.

This list identifies nutrition needs or risks that may be found in perinatal care, but is not exhaustive. The nutrition consultant may recommend other risk conditions needing specialized assessment or intervention.

Well-trained CPSP practitioners can successfully intervene on less severe conditions using the guidelines from **Steps to Take**. The clinical skills of a trained RD/RDN working in consultation with the client's medical provider are required for conditions that involve medical nutrition therapy and/or for conditions that have not improved with basic nutrition intervention.

See **Steps to Take** for specific weight criteria.

Anthropometric

Obese:	Prepregnancy BMI ≥30
Overweight:	Prepregnancy BMI 25.0-29.9
Underweight:	Prepregnancy BMI <18.5
1st Trimester:	Weight loss
2nd or 3rd Trimester:	Excessive or inadequate weight gain outside of IOM recommendation of weight gain during pregnancy.
Total recommended weight gain for pregnancy:	Underweight 28-40 lb Normal weight 25-35 lb Overweight 15-25 lb Obese 11-20 lb

Biochemical

Anemia:	Hemoglobin (Hgb) 1st & 3rd trimester <11dL Hemoglobin 2nd trimester < 10.5dL Hematocrit (Hct) 1st & 3rd trimester <33 vol% Hematocrit (Hct) 2nd trimester <32 vol%
Mean Corpuscular Volume: (MCV)	(first trimester) <85 cu mi or >97.3 μ^3 (second trimester) <85.8 or >97.8 μ^3 (third trimester) <82.4 or >100.4 μ^3
Glucose Intolerance:	results of 75 gram, 2-HR Oral Glucose Tolerance Test Diagnostic blood glucose values: Fasting: ≥ 92 mg/dL One hour: ≥ 180 mg/dL Two hour: ≥ 153 mg/dL One abnormal value is diagnostic of GDM.

Steps to Take provides recommended referral criteria for particular nutrition interventions.

Clinical (Physical/Medical/Obstetrical)

Previous obstetric history/complications:

- Gestational diabetes
- Preeclampsia (pregnancy induced hypertension)
- Low birth weight infant (<5.5 lbs)
- Small-for-gestational-age (SGA) infant
- High birth weight infant (>9 lbs)
- Congenital anomaly

Current medical/obstetric complications:

- HIV/AIDS
- Anesthesia/surgery/recent trauma
- Cancer
- Cardiopulmonary disease:
  - Functional heart disease
  - Organic disease (tuberculosis)
  - Asthma requiring treatment
- Developmental disability
- Diabetes Mellitus including type 1, type 2, and gestational diabetes
- Gastrointestinal disease
- Hemorrhage (antepartum)
- High blood pressure (hypertension)
- Hyperemesis Gravidarum (severe nausea and vomiting unresponsive to routine management causing dehydration, metabolic disturbance and weight loss)
- Infection, severe
- Intrauterine Growth Restriction (poor fetal growth)
- Liver disease (chronic)
- Multiple pregnancy
- Neurological disease/epilepsy
- Physical signs of malnutrition
- Preeclampsia (pregnancy-induced hypertension)
- Sickle Cell Anemia
- Thyroid disease
- Use of prescription drugs known to affect client's nutritional status

Adolescence:	15 years or less at time of conception Less than 3 years since onset of menses
High parity:	5 or more previous deliveries at greater than 20 weeks gestation
Short interpregnancy interval:	18 months or less between delivery (or termination of pregnancy) and conception
Breastfeeding:	Breastfeeding while pregnant Breast/nipple anomalies Medical diagnosis complicating breastfeeding, such as diabetes, PCOS, C-section, preterm delivery, breast surgeries, and stunted breast development (Tanner 4).
Substance Abuse/ Alcohol:	Any alcohol during pregnancy or prepregnancy daily intake of more than 2 mixed drinks, 2 12-oz cans/bottles of beer, or 2 6-oz glasses of wine, or seven drinks/week. Binge drinking: 3 or more alcoholic drinks on one occasion
Tobacco:	Any tobacco during pregnancy, or more than 10 cigarettes/day before pregnancy
Street recreational drugs:	Use of narcotics, opioids, cocaine, hallucinogens (LSD, etc.), marijuana, amphetamines, and/or other street drugs
Over-the-counter (OTC) medications and herbal remedies:	Chronic use of laxatives, antacids or other OTC drugs known to affect nutritional status; use of herbal remedies known or suspected to cause toxic side effects
Vitamin/mineral supplements:	Excessive use of nutrient supplements

Dietary Reference Intake (DRI) Tolerable Upper Intake Level (above poses risk of adverse health effects):	Vitamin A 3,000 (µg/day) or 10,000 IU Vitamin D 100 (µg/day) Vitamin C 2,000 (mg/day) Vitamin B-6 100 (mg/day) Iodine 1.1 (mg/day)
Pica:	Eating of nonfood substances (starch, clay, ice, coffee grounds, dirt, etc.)

Psychosocial problems:

- Severe emotional distress or anxiety affecting appetite or eating
- Eating disorders (current or history of anorexia nervosa, bulimia, compulsive eating)
- Developmental delays
- Homelessness/no cooking facilities

Dietary

- Diet inadequate in two or more food groups with no improvement on second visit
- Within the past 12 months either worried whether their food would run out before they had money to buy more or the food they bought didn't last and they didn't have money to get more.
- Special or therapeutic diet (current)
- Other unusual or restrictive dietary practices that CPSP provider is unfamiliar with (i.e., vegan food habits)

Additional conditions for referral to a nutritionist:

- Any nutritional problem with which staff does not feel comfortable in counseling

Health Education Risk Conditions

The risk conditions listed below may impact the health of the client and her baby. Some conditions require less complex interventions while others are more complicated and may require a referral to a master's-prepared health educator for effective assessment, intervention, or referral to other appropriately trained practitioners or programs.

This list identifies health education needs or risks that may be found in perinatal care, but is not exhaustive. The health education consultant may recommend other risk conditions needing specialized assessment or interventions.

- Problems cooperating with the prenatal health care regimen or other medical treatments, or prior history of persistent problems using health care services
- Low literacy/inability to read; poor comprehension
- Human Immunodeficiency Virus (HIV) risk behaviors or exposure
- Tobacco use; inability to quit
- Drug/alcohol/cannabis use; inability to quit
- Possible lead exposure
- Pregnant teen
- Cultural considerations
- Poor participation or other learning barriers such as low motivation or excessive shyness, and disabilities or impairments that affect learning
- Health care maintenance issues such as:
  - Vision problems/lack of optometric care
  - No dental care during 6 months or longer
  - Lacks provider for previous child(ren)
  - Lacks general health care provider for self
  - Lacks child safety seat and/or has poor auto safety habits
  - No rubella immunity
  - Little knowledge of, or previous problems with, family planning methods
- Poor parenting history or insecure with parenting and/or infant care
- Wants to breastfeed but has a history of problems with previous breastfeeding experience; is undecided about breastfeeding
- Obstetric issues such as:
  - History of preterm labor or current preterm labor risk
  - History of surgical delivery or current risk for cesarean; plans Vaginal Birth After Cesarean (VBAC)
- Existing chronic or acute medical conditions(s) such as Sexually Transmitted Infections (STIs), urinary track infections (UTIs), hypertension, diabetes, lupus

Steps to Take provides recommended referral criteria for particular health education interventions.

This list identifies psychosocial needs or risks that may be found in perinatal care, but is not exhaustive. The psychosocial consultant may recommend other risk conditions needing specialized assessment or interventions.

Steps to Take provides recommended referral criteria for particular psychosocial interventions.

Psychosocial Risk Conditions

The risk conditions listed below may impact the health of the client and her baby. Some conditions require less complex interventions while others are more complicated and may require a referral to a psychosocial professional for assessment and development of a care plan as appropriate.

Pregnancy-Related Issues

- Teenage pregnancy
- Unwanted pregnancy
- History of abortion or miscarriage
- Fear of labor that cannot be resolved through client education
- Illness associated with the pregnancy
- HIV infection
- History of infant death
- Poor timing of pregnancy
- A child in the home younger than 12 months
- Prenatal diagnosis indicating genetic abnormality

Relationship Issues

- Living in a battered woman's shelter/homeless
- Living in foster care
- Current family violence, physical or sexual abuse, reproductive coercion or birth control sabotage
- Inadequate support system
- Single parent
- Isolation
- Limited emotional support
- Current involvement in more than one sexual relationship
- Stressful relationship with partner or father of the baby

- Relationship problems with other family members
- History of sexual abuse or molestation

Economic Issues

- Financial problems (difficulty coping with them)
- No job/income
- Limited financial support or resources

Mental Health Issues

- Current or history of psychiatric problems, including depression, anxiety or postpartum mood disorder
- Current or history of psychiatric hospitalization
- Bizarre thinking, suicidal thoughts, threats of violence against self or others
- Unrealistic thoughts about the future

Other

- Children removed from the home
- Substance use
- Uncertain immigration status
- Unsafe environment
- Physically disabled
- Less than high school education
- Poor housing situation
- Psychotropic medications and breastfeeding

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Reassessments

WHY

Reassessments are a time to identify other risks and check the client's progress on those issues the woman wants to change. It is also a time to see if new issues have arisen for the client and her family, as well as an opportunity to get feedback about her perceptions of the care she has received.

WHAT

CPSP requires that support service reassessments be offered once each trimester and postpartum. However, the magnitude of a woman's problems and the interventions planned may require more frequent follow-up. Obstetric visits are on a standardized schedule in accordance with ACOG guidelines.

HOW

- Use a form that includes all required elements.
- Review the client's chart to see what has happened with the various practitioners during the previous trimester or since her last visit.
- Explain the purpose of the reassessment.
- Summarize the needs identified on the ICP, asking the client whether she has made any of the desired behavior changes. Offer encouragement and reinforcement if she has been successful. Find more intermediate steps or identify referral sources if the client has found the change to be difficult.
- Review the outcome of any referrals made during previous visits.
- Review the list of topics on the initial assessment with the client to identify any topics about which she would like more information.
- Ask the client to assess her care in the CPSP program. Ask about her doctor/midwife visits and visits with other CPSP practitioners.
- Summarize the changes, if any, on the ICP. Assess her willingness to carry through on those changes.
- Evaluate barriers that may have impacted the client's ability to follow through with planned interventions. Discuss problems and identify other strategies with her, if necessary.

- Evaluate the effectiveness of the interventions and services that have been provided. Determine if the information, counseling, education, classes, or other interventions have assisted or improved the client's behavior in adopting healthy practices, adjusting to the pregnancy, and dealing with problems identified on the ICP.
- Indicate changes made on the ICP at least each trimester in terms of outcome statements. The update should include:
  - Topics reviewed
  - New referrals
  - Classes that the client is urged to attend
  - Special needs of the client
- Any new goals that a client wants to address
- Complete documentation for continued WIC participation.

Obstetric Reassessment

Routine obstetric visits are on a standardized schedule in accordance with ACOG guidelines. High-risk clients should be referred to a perinatologist or other medical specialist, as needed.

Follow the most current *ACOG Guidelines for Perinatal Care*

Refer to the **Steps to Take** handbook for nutrition and breastfeeding referral criteria and intervention guidelines.

Nutrition Reassessment

Each trimester, reassess the following nutrition components:

Anthropometric

- Review the weight gain grid that Includes weights taken at each OB visit.
- Make appropriate weight gain recommendations for the second and third trimester.
- Use the weight gain grid to educate the woman about her weight gain progress.

Biochemical

- Review current lab results; notify clinician or make referrals as needed.
- Review status of previously abnormal laboratory results, and provide intervention as needed.
- Between 24 and 28 weeks, screen for glucose intolerance.
- If there are abnormal lab values, discuss with the CPSP team and provide direction to any unlicensed personnel regarding appropriate interventions

Clinical

- Review medical record and support service assessments for clinical information that may put the client at nutritional risk (i.e., nausea and vomiting, constipation, lack of resources, etc.,) and make appropriate interventions.
- Review blood pressure.
- If there are clinical findings that impact CPSP services, discuss with the CPSP team and provide direction to unlicensed CPSP staff regarding appropriate interventions.

Dietary

- Review the ICP to assess progress in meeting previously agreed upon dietary goals.

- Complete the nutrition reassessment questionnaire, plus a Perinatal Food Group Recall (PFGR), 24-Hr Dietary Recall, or other approved diet recall form. Analyze the food intake using My Plate for Moms and record an agreed upon food intake goal in the woman's care plan.
- Inquire about prenatal vitamin intake.
- Assess caffeine, tobacco, alcohol, marijuana, and other substance use.

Breastfeeding

- Assess the woman's attitude, experience, beliefs and interest in breastfeeding.
- Review medical record for any physical challenges to breastfeeding such as implants, inverted nipples, etc.
- Promote breastfeeding by providing needed information and education.

Health Education Reassessment

The health education reassessment should include, but not be limited to, the following components:

If the woman enters care during the second or third trimester, expand the initial assessment to incorporate appropriate trimester reassessment items.

2nd Trimester

- Relevant items from initial assessment
- Changes in knowledge, attitudes, beliefs and interest around breastfeeding
- Readiness for labor/birth, class enrollment completed, labor support person changes or is newly identified
- If undecided, feeding method decision making, breastfeeding class enrollment status
- If undecided, contraception planned/decision making method choices
- Changes/resolution of discomforts experienced in 1st trimester, additional discomforts common to 2nd trimester
- Newly identified conditions which can be alleviated by patient education
- Progress with behavior changes initiated in 1st trimester, smoking cessation, drug/alcohol use relapses
- Warning signs and symptoms, emergency procedures
- Satisfaction with services

3rd Trimester

- Relevant items from initial assessment and 2nd trimester lists above
- Changes in knowledge, attitudes, beliefs and interest around breastfeeding
- Progress of labor/birth preparation, breastfeeding decision/ readiness, infant care instruction or classes
- Readiness for newborn, sleep safety, injury prevention; availability of safety seat, knowledge of safety seat use; minimizing environmental hazards
- Hospital registration, admission and orientation tour
- Newly identified conditions that require patient education

- Signs of labor, warning signs of emergency, and emergency procedures
- Readiness and preparation for self-care in the postpartum period
- Importance of postpartum care and scheduling the postpartum visits prior to delivery
- Information about family planning, birth control, birth spacing
- Newborn care: expectations and risks, when to recognize complications and when to use emergency care
- Changes/resolution of discomforts experienced in 1st/2nd trimesters, additional discomforts common to 3rd trimester

Psychosocial Reassessment

The psychosocial reassessment should include, but not be limited to, the following components:

2nd and 3rd Trimester

- Any changes in the information gathered in the previous assessment(s)
- Current signs and symptoms of psychiatric problems, depression, anxiety or other mental health disorders
- Any ongoing personal or family challenges
- Need for emotional support
- Substance use such as alcohol, tobacco, marijuana or other substances
- Client and family readiness for delivery, including physical, social and emotional concerns
- Safety plan if history of family violence
- Financial concerns or needs after baby is born
- Status of problems identified on the ICP
- Identification of new problems or risk factors
- Evaluation of effectiveness of services provided to the client
- Updates to the ICP based on the reassessment

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Postpartum Assessment and Care Plan

One of the benefits of CPSP is that the provider has the opportunity to provide excellent, comprehensive postpartum care that will benefit the mother and infant and impact them throughout the life course. The postpartum period is an excellent time to assess for various issues that may arise, including but not limited to difficulties breastfeeding, postpartum depression and mood disorders, issues with mother/infant bonding or care, and early education on birth control management, optimal birth space planning and making arrangements for management of ongoing chronic conditions. It is essential to provide interconception care and counseling at the postpartum visit, because this is the only visit many women receive before they conceive again.

During the postpartum period, in addition to the OB visit, CPSP reimburses:

- 1 hour (4 units) nutrition assessment and intervention,
- 1.5 hours (6 units) psychosocial assessment and intervention, and
- 1 hour (4 units) health education assessment and intervention.

In addition, the provider may bill for individual or group perinatal education units that were not used in the prenatal period (Z6410 - maximum 16 units, 4 hours; Z6412 - 16 units per day, 18 hours total), as well as any orientation units that were not billed.

CPSP postpartum services can be provided any time after discharge from the hospital. For example, the provider or practitioner can deliver postpartum nutrition, psychosocial and health education care at one, two, and three-four weeks postpartum, and provide the OB visit at 4-6 weeks postpartum. It is essential that the provider see the woman early and often in the postpartum period (being careful not to exceed the allowable number of units) to assess and address the patient's needs, such as early breastfeeding challenges and postpartum depression.

As with the initial assessments and reassessments, the postpartum assessment addresses all four components in the CPSP model of care, and must be delivered individually, face to face with the client, not in a group setting. Interventions may occur individually or in a group setting.

- Use an assessment form that includes all required elements. The Perinatal Services Coordinator (PSC) can provide sample forms.
- Review the medical chart to see what happened during the labor, delivery, and postpartum period. Make sure you have systems in place to obtain the delivery record so that it is available for review.
- Explain the benefits of the postpartum assessment.
- Discuss any significant events, such as extremely long or difficult labor, a surgical delivery, or initial problems with the newborn.
- Review the needs identified in the Individualized Care Plan and identify the ones that are relevant.
- Complete nutrition, health education, and psychosocial postpartum assessments with the new mother.
- Collaborate with the client to develop realistic interventions based on her needs, strengths, and resources.
- Update the care plan as needed.
- Make appropriate referrals based on the client's needs.
- Complete any documentation required for continued WIC participation for mother and infant. The postpartum form is available at this Web site: http://www.cdph.ca.gov/programs/wicworks/Documents/WIC-Forms-CDPH-PM247-PostpartumBF.pdf
- Schedule subsequent postpartum services (e.g., family planning, lactation consultant, well-baby care, parenting education), as needed.
- Assure linkage to important referrals, as indicated: WIC, Cal Fresh, family planning, dental, genetic counseling, CHDP.
- Postpartum clinical management algorithms and companion education materials (Interconception Care Project) are available to assist providers to deliver interconception care to women who have had adverse outcomes (infant death, low birth weight, preterm birth) or have a chronic health problem that may affect the woman's health and future pregnancy outcomes, such as obesity, hypertension or diabetes.
- When the birth outcome indicates a need for it, genetic counseling is covered when provided within the postpartum period (through the end of the month in which the 60th postpartum day occurs).

Obtain the Interconception Care Project Clinical Algorithms and patient Handouts at http://www.everywomancalifornia.org/

Increasing Utilization of Postpartum Care

Often, women don't return for postpartum care. Reasons for not returning for postpartum care may include:

- Lack of knowledge of the benefits of postpartum care
- Lack of child care for other children
- Overwhelming responsibilities or stress with the new baby
- Postpartum depression or mood disorder
- Fear of receiving a diabetes diagnosis, if the client had gestational diabetes
- Physical discomfort
- Fragmentation of care between the CPSP provider and the delivery provider
- Barriers such as transportation or financial issues

In order to encourage utilization of postpartum care, the provider should discuss the importance of postpartum care during the prenatal period, elicit agreement from the patient to return, schedule the postpartum visits prior to delivery, and develop a tracking system to follow up with clients, and ensure that she keeps her appointments. Examples of effective client tracking mechanisms include: automated text reminders, appointment post card reminder mailings, e-mails, voicemails, etc.

OB Visit

- Conduct a postpartum exam consistent with the most current ACOG guidelines
- Arrange follow up with primary care provider and/or other appropriate specialist for chronic health conditions and/or other health conditions identified during pregnancy
- If there is a genetic birth defect, refer to genetic counseling.

The following information describes the additional services required by CPSP that the provider or practitioner should deliver to the client.

Nutrition

Assess the following nutrition components:

Anthropometric

- Weigh the woman (and measure teens) to assess her weight status
- Calculate the BMI and identify with the client a healthy weight range
- Discuss desired weight goal and appropriate weight loss (or gain) patterns for all women
- Assess infant weight gain (if the provider is responsible for the care of the infant)

Biochemical

Assess and document:

- Hemoglobin, hematocrit to screen for nutritional anemia
- Blood glucose if indicated
- Other laboratory indicators as appropriate and/or available, such as albumin, Mean Corpuscular Volume (MCV), serum ferritin, etc.

Clinical

- Review the medical record for birth outcome and postpartum complications that may put the woman or infant at nutritional risk
- Review the mother's blood pressure history

Dietary

- Complete the nutrition questionnaire, plus a 24-hour Perinatal Dietary Recall, Perinatal Food Group Recall or other approved dietary recall form.
- Assess for appropriate dietary intake for breastfeeding or non-breastfeeding women. For breastfeeding, use the *California My Plate for Moms*. https://www.cdph.ca.gov/Programs/CFH/DMCAH/NUPA/Pages/MyPlate.aspx
- Assess the adequacy of the infant's dietary intake and appropriateness of feeding methods.

See **Steps to Take** breastfeeding guidelines.

- Assess food security and assure referral to WIC and Calfresh for mother and infant.

Breastfeeding

Breastfeeding is highly protective for mother and baby. Determine the progress of breastfeeding and intervene or refer as needed for breastfeeding assistance.

- Provide integrated client-specific information and medical care to sustain breastfeeding.
- Refer to in-network breastfeeding support.
- Refer to WIC for ongoing breastfeeding support and WIC Baby Behavior classes that help new moms understand infant cues. Note: Women enrolled in WIC who are exclusively breastfeeding receive the most food.
- Discuss plans for returning to work or school and provide support regarding required employer accommodations.

Post-pregnancy Weight Loss

A postpartum exercise regimen coupled with appropriate caloric intake is important to the future weight and health of every new mom. Breastfeeding may help new moms lose weight faster, because nursing burns extra calories.

- If the client wants to lose weight, develop an appropriate weight loss plan for the client's individual needs.
- Following health provider clearance, walking for low-impact exercise can begin after one or two weeks, and more vigorous exercise programs can begin by six weeks.
- Realistic weight loss is one to two pounds per week.
- Use MyPlate's Super Tracker to identify postpartum caloric need. https://www.supertracker.usda.gov/
- The client should consume between 1,800 to 2,000 calories per day, and a nursing mom should add 500 calories

Nutritional Care Plan

The ICP must be updated and revised as appropriate following the postpartum nutrition assessment.

Postpartum Health Education Assessment and Intervention

CPSP postpartum health education helps the client understand how to make decisions to prevent and resolve health problems for herself and her infant, including how to access needed services. Review previous assessments and care plans to identify issues related to formal education, reading level, language, disabilities, learning methods for client, religious and cultural factors, mobility, residency, any past experience with postpartum self-care and follow up as needed.

Assess the following health education components:

Family Planning

Discuss the client's plans for future children. Inform the client of the importance of waiting at least 18 months before conceiving again. Assess the client's plans for effective contraception. Ask the client whether the previous pregnancy was unplanned. If the client indicates this, ask why and be sensitive to possible intimate partner violence, including reproductive coercion or birth control sabotage. If indicated, inform her of family planning methods that the partner does not need to know about and refer to a mental health specialist or domestic violence resources.

- Encourage the client to use some form of birth control before she resumes having sexual intercourse, regardless of whether she has menstruated or is breastfeeding.
- Help the client identify a contraception method that will best suit her individual postpartum needs.

Mother and Family Health and Safety

- Postpartum symptoms and signs that emergency care is needed, and how to access emergency care
- Postpartum self-care, including exercise and perineal care
- Postpartum physical discomforts, including rest and sleep.
- Education and referral for rubella immunization for non-immune women.
- Refer to provider for ongoing care of medical and dental needs.
- Follow up on environmental exposure to toxins and educate the client to avoid exposure before conceiving again.

Baby's Health and Safety:

Make sure the mother is well-versed in basic baby care, including:

- Normal stages of infant development
- Symptoms and signs that emergency care is needed, and how to access emergency care
- Ongoing medical care and immunizations. Refer to CHDP.
- Home safety-proofing, and child safety knowledge, practices and preparedness
- Use of the infant safety seat, and auto restraint devices.
- Infant should see a dentist at first year or first tooth.
- Sudden Infant Death Syndrome (SIDS) risk reduction (Safe to Sleep)
  - No blankets, crib bumpers, pillows or toys in crib (nothing but the baby)
  - No tobacco smoke around infant
  - Protective factor of breastfeeding
  - Baby sleeping on back

For more information and downloadable materials, please refer to the CDPH, MCAH website on the SIDS program: https://www.cdph.ca.gov/Programs/CFH/DMCAH/SIDS/Pages/Default.aspx.
The ICP must be updated and revised as appropriate following the postpartum health education assessment.

The ICP must be updated and revised as appropriate following the postpartum health education assessment.

Postpartum Psychosocial Assessment and Intervention

The postpartum psychosocial assessment determines whether the mother and baby have bonded effectively, and ensures the client has adequate physical, social and psychological resources in place to meet the needs of herself and her child(ren). Any inadequacies should be addressed with immediate interventions, education or referrals.

Postpartum is a period of high risk of relapse for women with a history of tobacco, alcohol or other substance use. Assess for history of and current smoking, drug, or alcohol use. Engage the client on the purpose of healthy lifestyle and impact on maternal and infant's health. Advise about the negative impact of substance use to the client's and baby's health... If there is a drug or alcohol problem, you may address it using the available postpartum psychosocial units. If the client wishes to quit smoking, refer to (1-800-NO-BUTTS) or other community-based resources.

- Encourage not to allow smoking around the baby.
- If the client uses alcohol and is breastfeeding, wait at least three hours after a drink before breastfeeding or pumping milk for the baby's consumption.

The ICP must be updated and revised as appropriate following the postpartum psychosocial assessment.

In addition, treatment and intervention should be directed towards helping the client understand and deal effectively with the biological, emotional, and social stresses of pregnancy and postpartum, with referrals, as appropriate.

Mother/Baby Bonding:

Identify and address manifestations of ineffective bonding, such as:

- Infant excessive irritability
- Inability to be comforted
- Absent signaling behavior and ineffective sucking
- Inability of infant to engage with the mother
- Feeding problems not related to a medical condition

Perinatal Mood and Anxiety Disorders and Other Mental Illness:

Screen, refer and link to services as needed for perinatal mood and anxiety disorders and other mental health issues. Suggested protocols are described below:

- Perinatal depression: Ask: Over the past 2 weeks, have you felt down, depressed or hopeless? Over the past 2 weeks, have you felt little interest or pleasure in doing things? If yes, use validated screening tool such as Edinburgh Postpartum Depression scale or PHQ-9. If needed, refer to Postpartum Support International (1-800-844-4PPD), postpartum.net, and/or a mental health professional.
- Anxiety disorders: Ask: Over the past two weeks, have you felt nervous, anxious or on edge? Over the past two weeks, have you been unable to stop or control your worrying? If yes, use a validated screening tool such as the Generalized Anxiety Disorder 7-item (GAD-7). If needed, refer to a mental health professional.
- Refer for follow up of ongoing psychiatric diagnoses (e.g., schizophrenia, bipolar disorder)

Drugs, Alcohol and Tobacco

- If the client has expressed any tobacco, drug or alcohol use, use psychosocial units to address the issue.

Support system

Assess the effectiveness of the client's support systems, including family and friends, which could affect the mother's ability to care for the baby, identify indications of a weak or ineffective support system, and address any needs. For example:

- Spousal/partner relationship difficulties
- Employment
- Child care
- Adequacy of financial and material resources

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03 Implementing and Maintaining CPSP

CPSP providers and practitioners are encouraged to foster team building among the various specialty and support services in order to deliver optimum and thorough perinatal care.

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Staffing for CPSP Services

Delivering comprehensive client-centered perinatal services mandated by CPSP regulations involves teamwork among a group of health care professionals and paraprofessionals.

The local PSC can assist in identifying a staffing model that best suits a specific practice.

There are many different configurations for staffing the CPSP team. A provider may employ or contract with any of the practitioners listed below who may give comprehensive perinatal services appropriate to their skill level. Qualifications of CPSP practitioners are defined in the Appendix in CCR, Title 22 CPSP regulations, Section 51179.7.

- Physician (general practice, family practice, OB/GYN, pediatrician)
- Certified Nurse Midwife
- Nurse Practitioner
- Physician Assistant
- Licensed Midwife
- Registered Nurse
- Licensed Vocational Nurse
- Social Worker
- Psychologist
- Marriage and Family Therapist
- Health Educator
- Certified Childbirth Educator (Lamaze, Bradley, ICEA)
- Registered Dietitian
- Comprehensive Perinatal Health Worker who :
  - Is at least 18 years of age, is a high school graduate or equivalent, and has at least one year of full-time paid practical experience in providing perinatal care

The minimum qualifications and typical duties for discipline-specific professionals are listed beginning on page 3-4.

In addition to being able to be practitioners, the following staff may be consultants in their area of expertise and may advise on and approve protocols, defined in CCR, Title 22, Section 51179.9:

- Physician (general practice, family practice, OB/GYN, pediatrician)
- Social Worker

- Psychologist or Marriage and Family Therapist
- Health Educator
- Registered Dietitian (RD)/Registered Dietitian Nutritionist (RDN)

While a CPSP provider may employ or develop professional relationships with other practitioners for delivery of services, ultimately the CPSP provider is responsible for the client's care.

Discipline-Specific Professionals

A provider is required to develop and implement protocols approved by discipline-specific professionals within six months of becoming CPSP certified (See the section on Developing Site-Specific CPSP Protocols for more information). The discipline specific staff are the preferred professionals to provide consultation and/or direct services when a CPSP client presents with complicated conditions. Additionally, these professionals can enhance the delivery of CPSP services in the following ways:

- Group education for staff and/or clients
- In-service training and development for CPSP staff
- Quality improvement of discipline-related services
- Selection or development of appropriate client education materials
- Participation in care, case coordination, follow-up of care through appropriate referrals for complex medical cases
- Program management and support staff supervision

These consultants should be available for consultation with the CPSP staff who may be providing obstetric, nutrition, health education, and psychosocial services. Consultants should also provide detailed intervention protocols for staff to follow and ongoing staff training.

Registered Dietitian (RD)/ Registered Dietitian Nutritionist (RDN) Consultant

Minimum Qualifications

Credential

- Registered by the Commission on Dietetic Registration, the credentialing agency of the Academy of Nutrition and Dietetics

Experience

- One year of experience in the field of perinatal nutrition

Expertise

- Has an understanding of the overall delivery of perinatal services with an in-depth knowledge of the nutrition component of comprehensive perinatal care
- The RD is the practitioner legally qualified to deliver medical nutrition therapy

Typical Duties

- Develop, approve, and annually update written protocols for the delivery of nutrition support services.
- Provide staff development and training initially and periodically, covering nutrition assessment, reassessments, care plan development, interventions, prioritizing nutritional needs of clients; case conferencing; and follow-up.
- Provide necessary medical nutrition therapy for high-risk obstetric clients.
- Select and/or produce culturally sensitive nutrition education materials suitable for the client served.
- Train staff to provide individual and group education for clients.
- Review regularly with CPSP staff: diet recall methods, accurate plotting of weight on grid, perinatal nutrition education and appropriate interventions.
- Provide consultation, technical assistance and/or delivery of direct client nutrition services.

- Establish and update annually local community resources and nutrition referral network for perinatal services, such as WIC, emergency food referrals, lactation support, etc.
- Develop and implement a quality assurance and evaluation plan for the nutrition component of CPSP services.

Health Educator Consultant

Minimum Qualifications

Credential

- Master's degree or higher in community or public health education from a program accredited by the Council on Education for Public Health

Experience

- One year of experience in the field of Maternal and Child Health

Expertise

- Has an understanding of the overall delivery of perinatal services with an in-depth knowledge of the health education component of comprehensive perinatal care
- The master's-prepared Health Educator (HE) is the practitioner qualified to deliver specialized health education services

Typical Duties

- Advise on and approve written protocols for the delivery of health education support services including client orientation and client education.
- Provide initial staff development and training and periodically cover care plan development, prioritizing educational needs of clients; case conferencing; and follow-up.
- Orient new staff to program.
- Select and/or produce culturally sensitive health education materials, including audiovisual aids, suitable for the client group and maintain an annotated list of these materials for the staff to use in selecting materials for individual clients based on each client's education care plan.
- Train staff for group and individual education of clients.
- Assist in defining the educational roles of all staff and the competencies required.
- Provide consultation and technical assistance to the provider and staff about prioritizing individual clients' educational needs, principles of adult learning, educational methodologies and materials, and educational barriers.

A health educator with a bachelor's degree with a major in community or public health education along with one year of experience in maternal and child health, may be a CPSP practitioner, but does not meet the qualifications to approve protocols. (reference: CCR Title 22, Section 51179.9).

- Establish and annually update local resources and referral network for perinatal services that are not available from the provider (i.e., prenatal and postpartum self-care strategies, childbirth education classes, hospital tours, parenting support groups, adolescent pregnancy services, dental, and infant care, etc.).
- Develop and implement a quality assurance and evaluation plan for the effectiveness of the health education component of CPSP services.
- Provide direct client education services as needed and supervision of and/or consultation to staff performing health education to high-risk clients.
- Develop and teach use and delivery of client education materials to the staff.
- Develop and evaluate a variety of learning modules to adapt to the learning needs of clients.

An individual with a bachelor's degree in social work or social welfare from a college or university with a social work degree program accredited by the Council on Social Work Education along with one year experience in maternal and child health may be a CPSP practitioner, but may not be a consultant or advise on or approve protocols (reference: CCR Title 22, Section 51179.9).

Psychosocial Consultant

Minimum Qualifications

Credential

- Master's degree or higher in social work or social welfare from a college or university with a social work degree program accredited by the Council on Social Work Education, or
- Master's degree in psychology or marriage and family therapy (formerly marriage, family, and child counseling)

Experience

- One year of experience in the field of Maternal and Child Health.

Expertise

- Has an understanding of the overall delivery of perinatal services with an in-depth knowledge of the psychosocial component of comprehensive perinatal care
- The master's-prepared Social Worker, Psychologist, or MFT is the practitioner qualified to deliver specialized psychosocial services

Typical Duties

- Advise and approve written protocols for the delivery of psychosocial support services.
- Provide ongoing staff development and training on assessment, reassessments, care plan development, interventions, prioritization of needs, case conferencing, and follow-up.
- Provide orientation training for all new staff to the program.
- Provide consultation, technical assistance and/or delivery of direct client psychosocial support services as needed.
- Select and/or produce culturally sensitive psychosocial educational materials suitable for the client group. Honor diversity including attitudes, practices, and/or policies that hold cultural differences and diversity in the highest esteem.
- Train staff to be sensitive to the relationship between personal and environmental issues.
- Educate team members regarding the client's attitudes, behaviors, and coping styles which may affect their approach to care.

- Establish and update annually a psychosocial resource and referral procedure for local community agencies.
- Develop and implement a quality assurance and evaluation plan for the psychosocial component of CPSP services.
- Provide consultation and technical assistance to the provider and staff about individual clients' psychosocial needs.
- Act as the client's advocate in procuring local, state, and federal benefits and services which she is entitled to receive. Take responsibility for being knowledgeable about and aligned in a working relationship with auxiliary service providers.

Developing Site-Specific CPSP Protocols

WHY

A CPSP provider must develop written protocols for each enhanced service—nutrition, health education, and psychosocial— within six months of the effective date of approval as a CPSP provider (reference: CCR Title 22, Section 51179.9)

WHAT

A protocol establishes a system for delivering services within a provider's specific setting. The protocol establishes criteria and standards by which the quality of care can be evaluated and maintained by the supervising physician.

CPSP staff should follow their site-specific protocols when delivering CPSP services.

California Code of Regulations, Title 22, Section 51179.5, defines personal supervision as "evaluation, in accordance with protocols, by a licensed physician, of services performed by others through direct communication, either in person or through electronic means." Each provider's protocols must define how personal supervision by a physician occurs. The occurrence of personal supervision by a physician, as defined in the provider's protocol, must be verified in the patient charts in case of Medi-Cal audit.

Use the Guidelines for Developing CPSP Enhanced Services Protocols in the Tool Kit to ensure that all necessary protocols are developed. Guidelines begin on page 7-5.

HOW

A Comprehensive Perinatal Health Worker must work under the direct supervision of a physician as defined in CCR Title 22, Section 51179.7. The definition of how physician direct supervision is conducted must be described in the CPSP Protocol. The direct supervision protocol definition must be tailored to the needs of staff and client population characteristics, complexity and risks.

- Involve multidisciplinary consultants and CPSP staff to develop CPSP protocols to create a practical program tailored to the provider's site.
- Write CPSP protocols with the detail necessary to meet staff needs. A guideline to follow is that protocols with less detail require a more advanced staff skill level.
- Have the CPSP enhanced services protocols approved by a qualified staff defined in CCR, Title 22, Section 51179.7.

See the CPSP Protocol Worksheet and Checklist located in the Tool Kit beginning on page 7-7.

- Local PSCs can assist providers in locating qualified nutrition, health education, or psychosocial consultants, and provide sample protocols.
- Introduce the protocols to the staff and provide education as needed to ensure that the protocols are understood and properly followed. Orient all new staff to the protocols.
- Attend to quality improvement by reviewing protocols for appropriate interventions and updating them as needed or indicated by staff changes or changes in the standards of care.
- CPSP **Steps to Take Guidelines** is a good reference for developing protocols. If your protocols direct you to follow **Steps to Take Guidelines**, be sure these are appropriate for your site.

Case Coordination

WHY

CPSP case coordination benefits everyone.

- The client receives integrated care that addresses her total needs and promotes her involvement.
- Health care team members have access to up-to-date client information that helps them to provide higher quality care.

WHAT

Case coordination helps to ensure that services delivered to clients are appropriate for their needs and are delivered in an efficient manner. It involves organizing the provision of comprehensive perinatal services and includes, but is not limited to, supervision of all aspects of client care including antepartum, intrapartum, and postpartum (reference: CCR, Title 22, Section 51179.6).

HOW

Case coordination is the provider's responsibility and may be delegated to appropriate staff. Written procedures for case coordination when providing psychosocial, nutrition, and health education services must be defined in the provider's protocol (reference: CCR, title 22, Section 51179.9)

The responsibilities included in the Case Coordinator's role are identified below.

Individualized Care Plan

The CPSP Case Coordinator works closely with members of the health care team and the client to develop and implement the ICP.

- Coordinate development of a complete ICP.
- Assess the effectiveness of interventions; and modify the care plan as necessary and as the client's condition changes.
- Assist the client with practical arrangements and access to information on resources and services such as: transportation, translation needs and tests, referrals, and special appointments.
- Oversee the completion of all care plan recommendations.

The CPSP fee-for-service provider receives a case coordination reimbursement from Medi-Cal if the assessments for the enhanced services are completed within four weeks of entry into care.

Communication with the Client

The Case Coordinator acts as an advocate for the client.

- Act as a liaison between the client and the health care team to promote effective communication.
- Maintain close contact with the client to ensure needs are addressed throughout pregnancy and the postpartum period.
- Track client's attendance at appointments, identify the barriers for missed appointments, and assist the client with making a new appointment.
- Assist the client in the access and utilization of available services. In addition, the case coordinator acts as a contact for problems and questions.

Communication with the Health Care Team

The Case Coordinator ensures that the client receives optimal perinatal care by promoting ongoing communication among health care team members.

- Ensure communication between team members and encourage case conferences to evaluate the client's progress and the quality of care given.
- Ensure that test results and referrals are given to appropriate team members, follow-up activities are conducted and are recorded in the client's chart.

Record Keeping

The Case Coordinator ensures that all client documentation is complete, up-to-date, and available to all team members.

- Oversee the client's chart for complete documentation of care.
- Ensure that appropriate copies of the prenatal record are at the hospital during the intrapartum period.
- Ensure that intrapartum records are at the outpatient site for postpartum visits.

Case Conferencing

WHY

The case conference creates a synergy among providers and practitioners that supports the client in making changes in her life and reaching her goals.

WHAT

The purpose of case conferencing is for CPSP providers and practitioners to work together as a multidisciplinary team to develop or adjust a client's ICP throughout her pregnancy.

As the pregnancy progresses, the client's strengths, weaknesses, and priorities need to be reconsidered in order to provide her with opportunities for successfully following her care plan.

HOW

- Organize
  - Set a fixed time and date for the case conference.
  - Have the client's chart available at the case conference.
- Collaborate
  - Facilitate cooperation by involving all team members.
  - Ask each team member to be ready to discuss 2-3 clients with complex conditions.
- Be creative
  - Look for new approaches to solving problems.
- Communicate
  - Share perspectives and expertise in addressing a problem.
  - Document the plan of action agreed upon by the team in each client's chart.
- Follow through
  - Assign responsibility for follow-up to ensure accountability.
- Encourage and praise
  - Celebrate all accomplishments.

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Monitoring Quality of Care

WHY

A CPSP provider might want to develop a quality monitoring program in order to:

- Improve client outcomes: healthy mothers delivering healthy, normal weight babies is the CPSP goal
- Provide culturally sensitive services: translation of materials, interpretive services, training, and protocols that reflect cultural diversity of clients
- Ensure services provided are services claimed: provider is at risk of Medi-Cal fraud if there is lack of documentation of services claimed
- Provide appropriate and cost- effective services: billing should be based on services provided to meet the needs of the clients, based on appropriate assessments and corresponding interventions
- Meet regulatory requirements: the provider may be associated with an organization, such as a hospital or managed care plan, that requires a formal quality assessment program

The CPSP provider who takes the time to formally organize a quality monitoring and improvement program and builds incrementally will most likely have a successful program that will ultimately improve clients' health and well-being.

WHAT

"Quality assurance" or "quality improvement" are processes a CPSP provider can use to ensure delivery of quality perinatal services that meet CPSP program requirements.

Guidelines for establishing a program to monitor the quality of CPSP services delivery are provided on the following page.

Quality Assurance (QA)

Refers to a process of setting standards of performance, then measuring performance against the standard. It focuses on individual performance and is a retrospective approach.

Quality Improvement (QI)

Refers to a process of setting standards of performance, then developing a plan to attain and exceed those standards. It focuses on the process of care rather than individual performance and is a prospective approach.

HOW

The success of any quality monitoring program is dependent on the support of all staff, from the medical provider to the Comprehensive Perinatal Health Worker (CPHW) to the front office person. The provider, especially, must be willing to support any proposed changes identified as a result of this process.

Guidelines for Establishing a Quality Assurance Plan

To establish a quality monitoring program, take these steps.

1. Identify a QA/QI lead staff person.

   This person is responsible for developing and implementing the program. A wide variety of individuals may be appropriate for this task. Generally, someone who is at the practice site a majority of the time, and who is willing and able to take on this commitment is the best choice. Time outside of other duties will be required.

2. Establish a QA/QI committee.

   The first task of the QA/QI lead is to establish a committee to assist in developing and implementing the program. In a small, solo-provider practice this may include everyone on staff. In larger practices, representation of the various staff employed (i.e., an RN, CPHW, front office staff, etc.,) should be included.

A sample format for developing a quality assurance plan is provided in the Tool Kit beginning on page 7-27.

3. Develop a quality assurance plan.

   The first task of the QA/QI committee is to develop a quality monitoring plan which outlines the specifics of the program. Monitoring can be approached in two ways:

   - Focusing on CPSP compliance
     Use a review form to review charts and note whether or not a client has received a service.

   - Evaluating the quality of care
     Select an aspect of care, such as prenatal care, nutrition, health education, or psychosocial, and monitor whether services are delivered in accordance with CPSP standards.

   It is usually beneficial to have an ongoing, structured quality assurance and improvement program evaluating CPSP compliance and quality of care with findings that can be tracked and improved over time.

4. Use findings to improve service.

   Whichever monitoring approach is chosen, use the findings to focus on problems within the system, rather than on whether or not individuals are doing their jobs.

The PSC can help create and implement a quality monitoring program.

For example, it is easy to find fault with the performance of a CPHW who records a client's weight on the prenatal record, but does not plot it on the weight gain grid. However, systems causes should be considered. Perhaps as a part of her orientation this responsibility was not made clear to her; or she knew the weights were supposed to be on the grid but thought it was the nurse practitioner's responsibility; or she was told it was her responsibility but she has never charted on a grid before and was too embarrassed to ask how it was done. Using a systems approach, the provider would review job orientation procedures to ensure new employees receive the training necessary to perform their jobs.

The PSC can help the quality monitoring team develop a program. The PSC can assist in implementation of the program by performing any of the following activities: completing full or partial chart reviews, administrative review through systems observation or staff interview, observation of any staff-conducted CPSP activity such as group health education session, client orientation, case coordination. The purpose of such reviews is to assist the provider in implementing a quality CPSP program. The reviews allow the PSC to identify areas where the provider may benefit from technical assistance. When the same issues are present for a number of providers, it may suggest a topic for a CPSP round table training sponsored by the PSC in your county.

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Maintaining Your CPSP Practice

Making Changes to the CPSP Provider Application

A change in ownership or National Provider Identification requires completion of a new CPSP application form.

A provider is certified to deliver CPSP services based on the review and approval of information contained in the CPSP application. Any proposed changes to the information provided in the application must be submitted for approval to the PSC who will evaluate them for compliance with CPSP regulations. This includes changes in the following areas:

- Staff name(s)
- Provider Address
- Provider ownership
- Primary contact person
- Forms used, including assessments and the ICP
- Delivery hospital
- Care delivery arrangements

Forms may be downloaded from the CPSP website: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx or obtained from your local PSC.

If possible, submit the proposed changes to your PSC 30 days before the requested effective date of the change.

If the proposed changes comply with regulations, PSC will issue written approval of the changes. If they do not comply, the PSC will provide assistance in bringing them into compliance.

Once the PSC approves the changes, he or she will forward the changes that require State approval to the California Department of Public Health for final approval.

Notify your PSC immediately of changes in ownership, NPI, or location because these may impact your ability to bill Medi-Cal for CPSP services.

If a provider voluntarily decides to terminate provision of CPSP services for any reason, notification should be given to the PSC. The PSC will notify the California Department of Public Health to "end-date" the application.

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04 Medi-Cal Eligibility

You can help your low-income, pregnant clients achieve the comprehensive perinatal care critical to having a healthy baby by facilitating the Medi-Cal application process.

Medi-Cal Programs for Pregnant Women and Infants.....3

Medi-Cal Application Process.....5

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Medi-Cal Programs for Pregnant Women and Infants

Financial assistance for low-income pregnant women is available through California's Medi-Cal program. To participate in CPSP, a pregnant woman must be eligible for Medi-Cal.

Presumptive Eligibility Program

The Presumptive Eligibility (PE) for Pregnant Women Program was created to allow Medi-Cal Providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs related to pregnancy to low-income patients, pending their Medi-Cal eligibility determination. PE is designed for low-income California residents who believe they are pregnant and who do not currently have health insurance or Medi-Cal coverage for prenatal care (even if they have already applied for Medi-Cal but have not received a final determination). PE allows the provider to bill and receive payment for the initial prenatal care services, including pregnancy test, initial prenatal exam, CPSP assessments and interventions, lab work, immunizations, and many other services, without waiting for formal Medi-Cal approval. Even if the client fails to apply for Medi-Cal, or is deemed ineligible, the services provided during the PE period are reimbursable.

The PE provider determines if a client is eligible for the program by having her sign a declaration of California residency and comparing her monthly income to a poverty level screening chart. If the client is eligible, the PE provider:

- issues the client a PE card
- refers her to the county welfare department to formally apply for Medi-Cal
- Reports her eligibility to the Department of Health Care Services to establish an eligibility record

The woman may then use the PE to obtain ambulatory prenatal care services from any Medi-Cal provider.

For additional information on provider or client enrollment, or use of enrollment forms, refer to the Presumptive Eligibility websites:

http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Presumptive_Eligibility/CrrntqlfdprvdrsforPE.pdf or http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE.aspx.

Minor Consent Services

A person who is a "child" for Medi-Cal purposes (under 21 years of age with certain exceptions) may apply for Medi-Cal services without county welfare staff contacting the parents for their consent or for consideration of the parents' property and income. California Code of Regulations, Title 22, Section 51473.2, states that providers may render services to minors without parental consent only if the services are related to sexual assault, pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse treatment and counseling, and outpatient mental health treatment and counseling.

A woman who has a share of cost for pregnancy services, or who is low-income but not eligible for Medi-Cal, may be eligible for the Medi-Cal Access Program (formerly AIM). This is a low cost health insurance program for pregnant women and their infants. Call 1-800-433-2611 for more information.

Continued Eligibility

Pregnant women, and infants born to Medi-Cal eligible pregnant women, are entitled to Continued Eligibility until the end of the postpartum period and the infant's first year of life as long as other criteria are met. Increases in income are disregarded for these individuals.

Also, infants born to Medi-Cal eligible women are deemed eligible for one year as long as they continue to live with the mother. No application or Social Security number is needed until the infant's first birthday.

Medi-Cal Application Process

Eligibility for Medi-Cal is based on household size and income. After a woman applies for Medi-Cal, the county will review the application and if the application is approved, the client will receive a Benefit Identification Card (BIC) in the mail. Women with Medi-Cal need to update their eligibility annually.

The following information is from the DHCS Web site at:

http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-Cal%20Eligibility%20Division.aspx

http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-Cal%20Eligibility%20Division.aspx

Women may apply for Medi-Cal in the following ways:

Apply Online

Covered California
https://www.coveredca.com/

CoveredCA.com is a joint partnership between Covered California™ and the California Department of Health Care Services (DHCS). The Department of Health Care Services (DHCS) has partnered with Covered California to create an online "one-stop shop" for health coverage. For those who are currently covered by Medi-Cal or who are part of the newly eligible group for Medi-Cal services, the application process can be completed through Covered California. This will streamline the process to apply for Medi-Cal or purchase other health coverage. Phone representatives who speak languages other than English are available in Covered California that can assist clients navigate through the different insurance products based on the clients' income.

Apply In Person

County Social Services Office
http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx

Find the nearest office location to obtain your application and apply for Medi-Cal in person.

Apply By Mail

Medi-Cal Single Streamlined Application
http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SingleStreamApps.aspx

A client may apply for Medi-Cal with a Single Streamlined Application, provided in English and other languages. Clients may either apply online through Covered California, or may print out an application and mail it in. This Web site allows a client to print out an application in her language and mail it to the address for Covered California stated on the application. A client will get her results sooner if she applies online at CoveredCA.com.

Information a Client needs to apply for Medi-Cal:

A client will need the following information to apply for Medi-Cal:

- Social Security Number
- Employer and income information for everyone in the family
- Federal tax information
- Information about health insurance that the applicant or family member gets through a job.
- Proof of citizenship

Citizenship and Immigration Information:

- An undocumented person must meet the same eligibility requirements as any other beneficiary such as income limits and California residency.
- Applicants may qualify for health insurance even if they are not U.S. Citizens or U.S. Nationals.
- An immigrant who meets all eligibility requirements, but is not in a satisfactory immigration status for full scope Medi-Cal is entitled to emergency and pregnancy-related services and, when needed, state-funded long-term care.
- Federal policy states that information obtained for the determination of eligibility for health coverage, for individuals or their family members, will not be used to verify immigration status.
- A person on an H1 visa is a temporary worker or trainee. As long as they are living and working in California and provide evidence of that, they meet residency. If they meet all other

eligibility requirements, they will be eligible for restricted scope Medi-Cal limited to emergency and pregnancy related services. It does not matter how long they have lived in the United States. If they meet all eligibility requirements they will be eligible for restricted scope Medi-Cal.

- For updates regarding Medi-Cal enrollment of newly qualified immigrants who are 21 years of age or older under Affordable Care Act, referenced in W&I Code, Section 14005.6, please refer to http://www.dhcs.ca.gov/services/medi-cal/Pages/Affordability-and-Benefit-Program.aspx

How to Verify Recipient Eligibility:

Verify eligibility for Medi-Cal recipients monthly. Use the client's Social Security Number in the Eligibility Verification System, or if the client does not have a Benefits Identification Card (BIC), you can call the Medi-Cal County Contact for Providers https://files.medi-cal.ca.gov/pubsdoco/county_contacts.pdf

The link to the Eligibility Verification system is: https://www.medi-cal.ca.gov/Eligibility/Login.asp

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05 Billing and Reimbursement

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Fee-for-Service Reimbursement

CPSP providers are able to receive reimbursement for the cost of delivering CPSP. In order to bill Medi-Cal for CPSP services, you must apply to be a CPSP provider and your application must be approved by the Maternal and Child Health Division of the California Department of Public Health. Claims for CPSP services are submitted to Medi-Cal's fiscal intermediary; both paper and electronic methods for billing are used.

To receive these reimbursements, the enhanced services provided must be accurately documented in the client's record following CPSP and Medi-Cal guidelines. Accurate documentation helps ensure that services provided are billed and reimbursed and reduces the risk of Medi-Cal audit exception.

Services Reimbursed in CPSP

Obstetric Services

Reimbursement for obstetric services is the same for all Medi-Cal providers. Obstetric services can be billed globally (at one time for antepartum care, delivery, and postpartum care), or on a per visit billing basis. However, to bill globally, a provider must render total obstetric care. Providers may not bill a global fee if the beneficiary transfers care during pregnancy.

Bonuses

In addition to standard obstetric reimbursement, CPSP offers the following bonus:

- Early Entry Into Care – $56.63 may be reimbursed when a client's first obstetric visit occurs within 16 weeks from the last menstrual period (LMP).

If the client declines support services, the provider may still bill for the early entry into care bonus, but only if clear documentation exists in the client's medical record that indicates the CPSP support services were offered and refused.

Client Orientation

Client Orientation must be provided in a face-to-face individual encounter and may include initial orientation as well as ongoing orientation to tests, procedures, referrals, etc. An initial orientation may occur prior to the client's initial comprehensive obstetric exam. Services are reimbursed at a rate of $33.64 per hour.

Reimbursement for case coordination is included in billing code Z6500 Initial Combined Assessment and Case Coordination (includes nutrition, health education, and psychosocial assessments and development of care plan). Case coordination cannot be billed separately.

Nutrition, Health Education, and Psychosocial Support Services

Support services include: face-to-face individual nutrition, health education, and psychosocial assessments, antepartum and postpartum reassessments, and individual or group interventions. These services are billed in 15-minute increments, with the exception of initial assessments. Individual services are reimbursed at a rate of $33.64 per hour and group services are reimbursed at $11.24 per hour, per patient.

Case Coordination

A one-time case coordination fee of $85.34 is available when initial assessments and care plans in nutrition, health education, and psychosocial are completed within four weeks of the comprehensive obstetric visit. The initial comprehensive obstetric exam must be provided prior to billing code Z6500, which includes the case coordination fee.

Prenatal Vitamin and Mineral Supplements

A 300-day supply of vitamins and minerals may be dispensed as medically necessary. CPSP providers are reimbursed one unit (30-day supply) per visit up to 10 units (300-day supply maximum).

See **Steps to Take** for more information on documenting CPSP services.

Guidelines for Documenting CPSP Services

All CPSP services must be documented in the client's medical record and should include the following:

- A brief description of the service(s) provided
- Client refusal of any assessment, intervention, treatment, or referral offered
- A signature of the person providing the service, including their CPSP title (i.e., CPHW)

- The date the service was provided
- The length of time (in minutes) service was provided face-to-face with the client

Documenting CPSP Support Services

Orientation

Document all orientation topics covered in the progress note or on a client orientation checklist, or reference a standardized orientation protocol. This should include documentation that the client received and understands her rights and responsibilities.

Individual Nutrition, Health Education, and Psychosocial Services

Individual services are billable only if completed face-to-face with the client. Individual services reimbursed include initial assessment, care plan development, antepartum and postpartum reassessments, and interventions. Document the following in the client's record:

- Include the date, time in minutes in each notation of services provided, and the signature and CPSP title of the practitioner.
- Record initial assessments and reassessments on the approved forms. Initial assessments must be at least 30 minutes for each support service discipline, including development of the individualized care plan with the client. If initial assessments are billed using code Z6500, documentation must show that all three assessments (health education, nutrition, and psychosocial) were completed within 4 weeks of the initial comprehensive obstetric examination.
- Complete and update the care plan on the approved form.
- Document all interventions on the client record.
- Ensure that all completed and dated forms are in the client record.
- Fill in the blanks of all forms with the appropriate response (i.e., N/A, client refused, etc.).

Group Nutrition, Health Education, and Psychosocial Services

Two or more CPSP clients comprise a group. Reimbursement is available for face-to-face encounters only. For instance, a provider may receive reimbursement for a group class that includes a video only if a CPSP practitioner is present with the clients for the entire time. The following documentation is needed for group CPSP services:

- Maintain outlines identifying the class content (these should be part of the protocols).
- Include the date, topic, and name of the instructor on client sign-in sheets.
- Record attendance at the session in each client's record including the elapsed time (in minutes) of actual time the client spent in the session.
- Retain the sign-in sheet and the class outline in a file separate from individual client records (to avoid a HIPAA violation). They must be available to auditors if requested.

Prenatal Vitamin and Mineral Supplements

Record the date that vitamins were dispensed and the amount of vitamins dispensed. The CPSP provider may bill for vitamin/mineral supplements one unit (30 day supply) per day up to the maximum of 10 units (300-day supply).

Guidelines for Treatment Authorization Request

Include a Treatment Authorization Request (TAR) with the billing for support services that exceed the limits identified in CPSP regulations. TARs requesting additional services must be completely filled out and include the following:

- Expected Date of Delivery (EDD)
- Clinical findings of the high-risk factors involved in the pregnancy
- Explanation of why the basic CPSP services will not be sufficient
- Description of the services being requested
- Length of visits and frequency with which the requested services will be provided
- Anticipated benefit or outcome of additional services

For a current list of service codes and reimbursement rates, refer to the Medi-Cal rates section under the Reference tab online at: www.Medi-Cal.ca.gov.

For billing questions, contact the Telephone Service Center at 1-800-541-5555.

CPSP Reimbursement Rates

Service Code	Descriptor	Rate
Z1032-ZL	*Bonus* Early entry (within 16 weeks LMP)	56.63
S0197	*Prenatal Vitamin/Mineral Supplements* Per unit, 30 day supply, up to 10 units(300 day supply maximum)	$3.00/unit, $30.00 maximum
Z6500	*Initial Combined Assessment and Case Coordination*	135.83
Z6200	*Nutrition–Individual* Initial nutrition assessment and development of care plan, first 30 minutes	16.83
Z6202	Initial nutrition assessment and development of care plan, each subsequent 15 minutes	8.41
Z6204	Follow–up antepartum reassessment/treatment/intervention, each 15 minutes	8.41
Z6208	Postpartum assessment/treatment/intervention and development of care plan	8.41
Z6206	*Nutrition–Group* Antepartum nutrition education/treatment/assessment/intervention	2.81
Z6300	*Psychosocial–Individual* Initial psychosocial assessment and development of care plan, first 30 minutes	16.83
Z6302	Initial psychosocial assessment and development of care plan, each subsequent 15 minutes	8.41
Z6304	Reassessment/treatment/intervention, each 15 minutes	8.41
Z6308	Postpartum assessment/treatment/intervention and development of care plan	8.41
Z6306	*Psychosocial–Group* Antepartum psychosocial treatment/assessment/intervention	2.81
Z6400	*Health Education–Individual* Client orientation, each 15 minutes	8.41
Z6402	Initial health education assessment and development of care plan, first 30 minutes	16.83
Z6404	Initial health education assessment and development of care plan, each subsequent 15 minutes	8.41
Z6406	Follow-up antepartum reassessment/treatment/intervention, each 15 minutes	8.41
Z6414	Postpartum assessment/treatment/intervention, care plan development each 15 minutes	8.41
Z6408	*Health Education–Group* Health education assessment/treatment/intervention each 15 minutes	2.81
Z6410	*Perinatal Education (Antepartum or Postpartum)* Perinatal education - Individual, each 15 minutes	8.41
Z6412	Perinatal education group each 15 minutes	2.81

All current rates are published online at www.Medi-Cal.ca.gov. Click on "Medi-Cal Rates" under the References tab. Both OB and CPSP codes are included in these rates.

Billing for CPSP Services

Avoid delays or problems in Medi-Cal reimbursement for CPSP services by following these billing procedures.

- Only a direct, face-to-face client contact constitutes a reimbursable service. A telephone contact is not a reimbursable service. Refer to your Medi-Cal provider manual for specific billing instructions and claim examples.
- Provide a service before billing for it.
- Submit billing for a CPSP service no later than six months subsequent to the month in which the service was provided to receive the maximum reimbursable allowable amount if all other criteria are met.
- Bill for CPSP support services (health education, nutrition, and psychosocial) on a per visit basis; they cannot be billed globally. Obstetric services, however, may be billed globally by the provider who provides total obstetrical care, including all antepartum visits and delivery.
- Use the correct service code. Refer to these sources for up-to-date service codes, rates of reimbursement, and specific criteria for billing.
  - *Medi-Cal Provider Billing Manual*
    For more information regarding specific Medi-Cal CPSP policy on billing specific services, CPSP claims and example of completing a claim form, please refer to the Medi-Cal Manual on this website:

    http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp?pg=&PgDwn=Yes&hURL=&qu=comprehensive+perinatal+services+program&Action=Go
  - *Medi-Cal Provider Billing Seminar and Syllabus for OB/CPSP*
    For information and training for Medi-Cal billing, including CPSP billing, please see the Medi-Cal Learning Portal at:
    https://learn.medi-cal.ca.gov/Home.aspx
    or call 1-800-541-5555.

- Calculate billable time for CPSP support services at the rates identified below. A client must be seen for at least 8 minutes for a service to be billable.

Minutes	Units	
0 - 7	0	(not payable)
8 - 22	1	
23 - 37	2	
38 - 52	3	
[and so on]		

Service codes for Medi-Cal reimbursable services are listed on page 5-7.

Billing for Out-of-clinic Services

As of December 18, 1991, CPSP providers who are either hospital outpatient departments or clinics may receive reimbursement for OB and CPSP services rendered outside of the clinic location. These include medical visits provided in a physician's office or group health education provided in high school auditoriums and mobile vans operated by clinics. The service should be billed on the UB92 form with indication of a place of service (POS) 7.

Billable time for nutrition, health education, and psychosocial support services is calculated in 15-minute units.

Billing for Preventive In-home Services

CPSP services provided in a recipient's home may be reimbursed if the services are "preventive." HCFA regulation 42 CFR 440.130 (c) defines "preventive services" as "services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to (1) prevent disease, disability, and other health conditions or their progression, (2) prolong life, and (3) promote physical and mental health and efficiency.

Billing for Treatment Rooms

Treatment room charges are not reimbursable for CPSP services, however, they may be reimbursable for certain physician services. Specific billing instructions can be found in the Medi-Cal Provider Billing Manual.

Getting Help with Medi-Cal Billing

To make Medi-Cal billing easier, the Medi-Cal fiscal intermediary processes claims and offers these services to certified CPSP providers.

The Telephone Service Center (TSC)

1-800-541-5555

The TSC is the first line of communication between providers and the DHCS Fiscal Intermediary (Conduent).

TSC is staffed by knowledgeable telephone agents who can assist providers with:

- Medi-Cal billing policies and procedures
- Correct completion of claim forms, Claims Inquiry Forms (CIFs), Appeal forms, and Resubmission Turnaround Documents (RTDs)
- Claim denials
- Status of CIF, Appeal, and Over-One-Year claims

Small Provider Billing Unit

- To reach the Small Provider Billing Unit, dial the Telephone Service Center at 1-800-541-5555, or call (916) 636-1275.
- This is a free, full-service billing assistance program for providers with low claim volumes. However, providers must apply for permission to use this line. It is available to only a limited number of providers at any one time.

Correspondence Specialist Unit (CSU)

- The CSU specializes in various claim types and conducts in-depth research
- Providers may write directly to CSU (P.O. Box 13029, Sacramento, CA 95813) for clarification about recurring billing issues that have not been resolved through:
- Claims Inquiry Form (CIF)
- Appeal process that has resulted in claim denials

Outreach and Education (O&E)

The Provider Outreach and Education (O&E) Department consists of 21 Regional Representatives who live and work in cities throughout the State of California and perform the following tasks:

- Assist in resolving complex provider billing issues
- Research high-profile issues referred by DHCS
- Provide billing training to providers and their staff
- Conduct specialized billing workshops
- Conduct/attend Medi-Cal Provider Seminars
- Conduct Webinars
- Recorded WebEx Trainings
- eLearning Tutorials

Billing Seminars

There are seminars that cover Medi-Cal's obstetric and CPSP billing and reimbursement policies. Watch your monthly bulletins for date, time, and location of billing seminars.

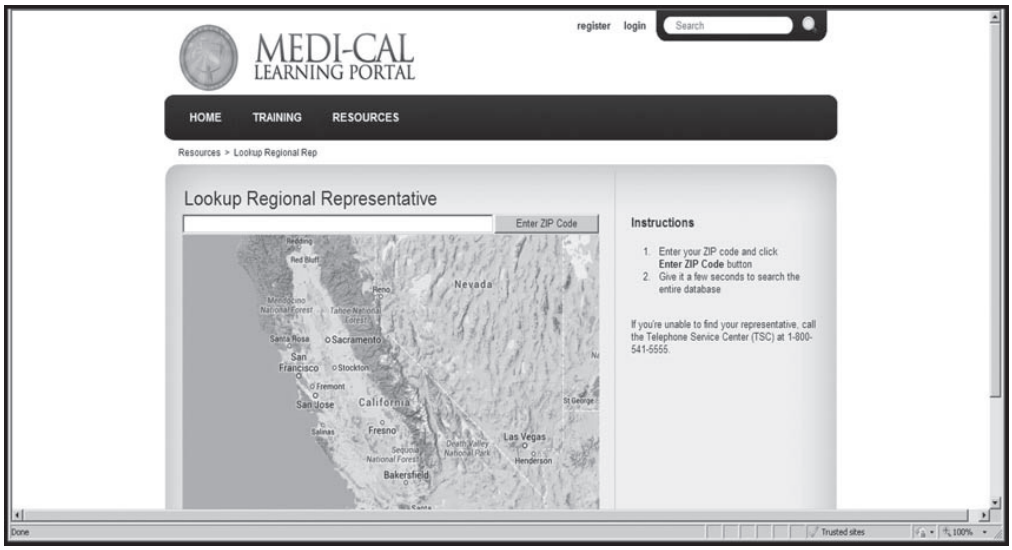
The Medi-Cal Learning Portal is an, easy-to-use, one-stop learning center for Medi-Cal billers and providers. First-time users must complete a one-time registration to have access to the MLP's easy-to-use resources, such as online tutorials, live and recorded webinars from the convenience of your own office and register for Provider Training Seminars.

Access the Medi-Cal Learning Portal at this website:
https://learn.medi-cal.ca.gov/

Medi-Cal Subscription Services (MCSS)

Providers can sign up to receive free e-mail alerts about Medi-Cal billing and policy changes and posting of monthly provider bulletins.

https://files.medi-cal.ca.gov/pubsdoco/mcss/mcss.asp



For more information visit : Medi-Cal Learning Portal (MLP)
www.medi-cal.ca.gov

Federally Qualified Health Centers, Indian Health Clinics,and Rural Health Clinics

Standard fee-for-service Medi-Cal service limits apply to services provided in the FQHC or RHC setting. The scope of coverage for Medi-Cal services is set by the Welfare and Institutions Code, Sections 14132, et seq. and Title 22 California Code of Regulations.

Federally Qualified Health Centers (FQHCs), Indian Health Clinics (IHC), and Rural Health Clinics (RHCs) are three types of Medi-Cal providers that establish their reimbursement for client services by filing annual cost reports. The Federal and State governments use these cost reports to calculate a prospective rate per visit. Services provided by FQHCs to Medi-Cal recipients are reimbursed at this prospective rate. FQHCs and RHCs may bill the State for the difference between what a Medi-Cal Managed Care plan pays and the prospective rate.

The RHC program was created by the enactment of the Rural Health Clinic Services Act of 1977. The passage of this act extended Medicaid coverage to many isolated rural communities throughout the country that had been unable to attract or retain physicians. Federal regulations implementing the program originated from a belief that traditionally low Medicare/Medicaid reimbursement created access-to-care barriers for eligible clients residing in rural, medically underserved areas. By allowing RHCs to be paid on the basis of reasonable costs through a flat fee per visit, as opposed to payment of a services fee for each service, it was believed that provider participation would be increased and low–income clients would have greater access to care.

FQHCs were added as a Medi-Cal provider type in response to the Federal Omnibus Budget Reconciliation Act of 1989. Federal law generally defines FQHC services the same as those offered by RHCs.

CPSP Providers

FQHCs and RHCs that are CPSP providers can include in their cost reports (and be reimbursed for) CPSP services provided to pregnant women. This includes all CPSP perinatal support services rendered directly by approved CPSP practitioners.

Treatment Authorization Request (TAR) Guidelines for FQHCs and RHCs

TARs are not used in FQHCs or RHCs. Claims for support services provided that exceed the basic allowances will not be denied

for the absence of a TAR. However, FQHCs and RHCs must meet the same documentation requirements that would otherwise be necessary to obtain a TAR. A TAR is not allowable for additional obstetrical (antepartum/postpartum) visits, which are only reimbursable within the regular Medi-Cal allowances. Required documentation includes:

- Expected date of delivery
- Clinical findings of the high-risk factors involved in the pregnancy
- Explanation of why the basic CPSP services will not be sufficient
- Description of the services being requested
- Length of visits and frequency with which the requested services are provided
- Anticipated benefit or result/outcome of additional services

For additional information, please refer to the Medi-Cal website: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/rural_o01o03.doc

The above information must be maintained in the client's medical record and be available for review by State staff.

Medi-Cal Managed Care Plans

The State of California provides Medi-Cal services via managed care in all California counties. There are six different models of managed care within California's Medi-Cal system.

In all six models, the managed care plan has entered into a contract with the State to provide full inpatient and outpatient services, including perinatal care, for a capitated rate. This rate is paid to the plan on a per-member-per-month basis.

In reference to the Department of Health Care Services Policy Letter 2012-003[1], all plans must ensure initiation of prenatal care as soon as possible and must not require prior authorization for basic obstetrical, nutrition, psychosocial, and health education services as described below. Plans must inform beneficiaries of childbearing age of the availability of comprehensive perinatal services and how to access such services as soon as pregnancy is determined.

- Plans are required to cover and ensure the provision of all medically necessary services for pregnant women. Plans must ensure that the most current guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.
- Plans are also required to implement a comprehensive risk assessment tool for all pregnant beneficiaries that is comparable to ACOG and the Comprehensive Perinatal Services Program (CPSP) standards (California Code of Regulations, Title 22, Section 51348). Individualized care plans must be developed to include obstetrical, nutrition, psychosocial, and health education interventions when indicated by identified risk factors.

Reimbursement for these services varies from plan to plan; some plans reimburse at a fee-for-service rate while others negotiate a capitated rate with the provider. It is important for providers to understand all service requirements and reimbursement provisions prior to signing any contract.

[1] Department of Health Care Services. Medi-Cal Managed Care Policy Letter 12-003 (Supersedes Policy Letter 12-001 and 96-01). June 26, 2012.

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Working with the Perinatal Services Coordinator

All counties have a PSC or an MCAH Director to support CPSP providers. Use this web link to find the PSC in your county: https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Contact-Us.aspx.

Providing clients with CPSP services involves a team effort and careful coordination. The PSC is an important resource you can call on to help make it happen. The PSC is a public health professional who can provide some or all of the following assistance:

Information and Education

- Provide information about CPSP requirements, the needs of the eligible population in your county, perinatal trends using local data, access to community perinatal resources and services, evidence-based practices, and national clinical standards.
- Give updates on topics related to perinatal health (i.e. maternal mental health, perinatal substance use and implications, chronic disease and implications to the perinatal period, intimate partner violence, oral health and other perinatal health-related services)
- Develop a comprehensive referral network with providers and community partners to ensure receipt of appropriate perinatal care and relevant services to at-risk women.

CPSP Provider Application

- Meet with prospective providers to discuss the purpose and philosophy of CPSP, regulations, models of implementation, and resources available to the provider.
- Provide information and technical assistance on completing the CPSP application.
- Review completed applications and make recommendations to the State CDPH for approval/denial.
- Review and make recommendations for application updates/changes and inform State officials of providers who intend to disenroll from CPSP.

Consultation and Technical Assistance

- Provide assistance to providers and managed care plans regarding CPSP implementation.

- Assist in identifying barriers and opportunities to improve access to early and comprehensive perinatal care.
- Conduct outreach and educational activities with local provider networks and/or health plans to improve perinatal access, service integration and coordination to meet the clients' complex needs.
- Assess adequacy of referral sources and assist providers to develop mechanisms to refer clients to appropriate programs and services.
- Identify qualified support service consultants who provide services for high risk clients and assist providers to incorporate specialized assessments/interventions such as smoking cessation, breastfeeding, and domestic violence.
- Assist providers with connecting with their local Medi-Cal representatives to resolve billing issues.
- Assist the provider in evaluating whether Electronic Medical Records meet CPSP documentation requirements. The documentation requirements for Electronic Medical Records system are the same as those for paper records.

Quality Assurance/Improvement

- Visit providers periodically to assess, maintain, or improve the quality of CPSP services.
- Assist providers in improving documentation by ensuring protocols are in place and implemented as intended.
- Assure appropriate care by identifying high-risk care resources and advocating for their appropriate use.
- Provide sample assessments, care plans, and protocols.
- Inform providers of up-to-date health education materials.
- Identify and inform providers about community referral resources.
- Assist providers in ensuring clinical and preventative services reflect evidence-based best practices or promising practices to improve early access to perinatal care.
- Develop shared policies or quality initiatives with the local health plans to ensure that pregnant and postpartum women receive adequate perinatal services (i.e. integration of maternal levels of care through ACOG standards).
- Participate and perform activities that promote and address a strong safety-net support for pregnant and postpartum women (e.g. food security, shelter, housing, school placement).

Referring Clients for CPSP Mandated Services

Ask your local PSC for assistance with referrals.

CPSP providers must refer clients, when appropriate, to services not specifically included in CPSP. These services must include, but are not limited to:

- Women, Infants, and Children Supplemental Nutrition Program (WIC)
- Genetic screening
- Dental care
- Family planning
- Well Child Care (Child Health and Disability Prevention Program-CHDP)

Women, Infants, and Children (WIC) Program

WIC serves women, infants, and children by providing nutrition education, breastfeeding support, partnerships to health care services, and nutritious foods to eligible families. WIC provides supplementary nutrition support services and referrals in every county in California through 84 local agencies. Services are available to eligible women, infants, and children up to five years old. For more information about WIC and local agencies, please see the website at: https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Program-Landing1.aspx or call 1-888-WIC-WORKS (1-888-942-9675)

Genetic Screening

California law requires that providers offer prenatal screening for pregnant women in order to identify women who are at increased risk for carrying a fetus with a specific birth defect. Providers must obtain a detailed family history of genetic disorders, mental retardation, and birth defects from all pregnant women. A family history form for obtaining this information is available from ACOG.

The **California Prenatal Screening Program (PNS)** is working to assure prenatal screening services and follow-up services where indicated are available to all pregnant women in California.

Prenatal Screening currently offers three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect.

For more information, see the California Prenatal Screening Program website at: https://www.cdph.ca.gov/Programs/CFH/DGDS/Pages/pns/default.aspx

The California Newborn Screening Program began in 1966 with the testing for phenylketonuria (PKU). In October 1980, the program was expanded to include galactosemia, primary congenital hypothyroidism, and a more comprehensive follow-up system. In 1990, screening for sickle cell disease was added to the State's existing program. This also allowed for the identification of some of the related non-sickling hemoglobin disorders, including beta thalassemia major, and HB E-Beta Thalassemia. In 1999, the program implemented screening for hemoglobin H and hemoglobin H-Constant Spring disease. In 2005, the program expanded to include congenital adrenal hyperplasia (CAH) and metabolic disorders detectable by Tandem Mass Spectrometry (MS/MS) screening. Cystic fibrosis and biotinidase deficiency were added in 2007.

Call 1-888-WIC-WORKS (1-888-942-9675) or use our online search feature at: http://www.apps.cdph.ca.gov/wic/resources/laSearch/search.asp to locate the WIC Program nearest the client's home.

State regulations (17 CCR 6500) require that prenatal care providers give pregnant women informational material about the Newborn Screening Program. Because some women do not receive prenatal care, the same informational material, Important Information for Parents about the Newborn Screening Test (IIP), is also distributed upon admission to a licensed perinatal health facility for delivery. The California Newborn Screening Program supplies copies of this pamphlet at no cost to all health professionals who serve maternity patients, to hospitals that provide maternity and/or newborn care, to local health departments, and county birth registrars.

Resources for Genetic Screening

- A family history form for obtaining a history of genetic disorders is available from ACOG.
- For more information, prenatal diagnosis centers, and information on ordering materials for parents, see the https://www.cdph.ca.gov/Programs/CFH/DGDS/Pages/pns/healthcareprovider.aspx

Dental Care

Full scope Medi-Cal clients are automatically eligible for Denti-Cal, the dental component of Medi-Cal. Pregnancy related services may

be provided prenatally from the day that pregnancy is medically established and postnatally to the end of the month in which the 60-day period following termination of pregnancy ends. Beneficiaries are eligible to receive these services for 60 days postpartum, including any remaining days in the month in which the 60th postpartum day falls. Pregnant beneficiaries, regardless of aid code, and/or scope of benefits are eligible to receive all dental procedures listed in the Denti-Cal Manual of Criteria (MOC) that are covered by the Medi-Cal program so long as all MOC procedure requirements and criteria are met. For more information, please refer to 2014 Denti-Cal bulletin, Volume 30, number 17 located on the Medi-Cal Dental Provider Bulletins Archive at: https://www.denti-cal.ca.gov/Dental_Providers/Denti-Cal/Provider_Bulletins/Provider_Bulletins_Archive/.

The Medi-Cal Dental Program Provider Handbook is located here: https://www.denti-cal.ca.gov/DC_documents/providers/provider_handbook/handbook.pdf#page=80Helpful links:

- Medi-Cal Dental website: https://www.denti-cal.ca.gov/
- To select a Dental service plan: https://www.denti-cal.ca.gov/Beneficiaries/
- Beneficiary Outreach: https://www.denti-cal.ca.gov/Beneficiaries/Denti-Cal/Beneficiary_Flyers_Brochures/
- Find a dentist: https://www.denti-cal.ca.gov/Beneficiaries/Denti-Cal/Provider_Referral_List/
- Provider resources: https://www.denti-cal.ca.gov/Dental_Providers/
- Provider Bulletins

Refer your CPSP client to a dentist if she has not been to a dentist in the past six months or has any dental symptoms.

Locating Dental Referrals

To locate a participating dentist, go to the Denti-Cal website at: https://www.denti-cal.ca.gov/Beneficiaries/Denti-Cal/Provider_Referral_List/.

Some communities have publicly funded dental clinics. Call your local dental society, 211, or health department for information.

Beneficiaries - for assistance call 1-800-322-6384

Providers- for assistance call: 1-800-432-0507

Family Planning

The Department's Family P.A.C.T. (Planning, Access, Care, and Treatment) Program offers comprehensive family planning services to men and women whose income equals or falls below 200 percent of the federal poverty level and who have no other reproductive health care coverage (including private insurance and Medi-Cal).

Services offered include contraceptive counseling, pregnancy testing, female and male sterilization, limited infertility services, reproductive health counseling and education related to contraceptive methods, as well as screening and treatment for sexually transmitted infections, HIV testing and counseling, and screening for breast and cervical cancer.

Reimbursement to certified Family P.A.C.T. providers is based on Medi-Cal comparable rates. Billing is done on a fee-for-service basis on the same claim form used to bill other Medi-Cal services. CPSP providers must enroll separately in Family P.A.C.T. Also, CPSP patients are not eligible for Family P.A.C.T. as long as they have Medi-Cal coverage. CPSP patients who remain on full scope Medi-Cal (managed care or fee-for-service) receive family planning through Medi-Cal. Women on "pregnancy-only" Medi-Cal should be enrolled in Family P.A.C.T. after their CPSP postpartum care is completed in order to receive the full range of family planning services.

For more information on Family PACT services and providers in the area, including provider enrollment information, visit the website at: http://www.familypact.org/

Child Health and Disability Prevention Program

CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP offers a full range of health assessment services including physical examinations, immunizations, laboratory tests, vision and hearing screening, tuberculin skin testing, health education, and dental evaluation, and referrals for:

- Medi-Cal children and youth recipients from birth to age 21.
- Non-Medi-Cal children and youth from birth to age 19 years whose family income is equal or less than 200 percent of the federal income guidelines. All children and youth are eligible for health assessment based on the same schedule used for Medi-Cal children.

For more information on CHDP, visit the website at: http://www.dhcs.ca.gov/services/chdp/Pages/default.aspx

Developing Referral Resources

CPSP providers may need to help clients find resources beyond the scope of the CPSP services at their site. Most likely, a CPSP client is handling other issues in her life in addition to her pregnancy. When appropriate, a CPSP provider should help a client get necessary assistance by providing referrals to community agencies. Check with your local PSC to see if a comprehensive referral list is already developed.

Use the Community Resource Referral Checklist on page 6-10 to develop a site-specific referral list.

Developing a Referral List

- Develop and maintain a list of community services appropriate for client referrals. Include the following information for each service:
  - Type of service
  - Location
  - Contact person, phone
  - Brief description of the service and cost
  - Eligibility requirements
  - Medical interpreter service or language(s) used as appropriate
- Check the accuracy of referral information and update it periodically.

Locating Referral Agencies

- Check the internet for possible referral agencies in your county. Some headings to review include:
  - Immigrant and Refugee Services
  - Victim Assistance
  - Pregnancy/Family Planning Services
  - Child Care
  - Mental Health
  - Drug Abuse
  - Hotlines

Making Client Referrals

- Track client referrals. Note when a referral is recommended, and for what reason.
- Develop a system to follow through on completed referrals.
- Develop an agreement with the referral agency to promote coordinated care when appropriate (i.e., WIC, CHDP).

Community Resource Referral Checklist

Develop a community resource referral list to provide clients with referrals to needed services if your site does not provide the service. Include the following types of community services:

Health Department

- ❑ Black Infant Health Program (some counties)
- ❑ Adolescent and Family Life Program (AFLP) (some counties)
- ❑ Local Maternal, Child and Adolescent Health (MCAH) Program
- ❑ Home Visiting Programs (some counties)
- ❑ California Home Visiting Program (CHVP)
- ❑ Immunizations
- ❑ Tuberculosis services
- ❑ Human Immunodeficiency Virus (HIV) testing programs
- ❑ Sexually Transmitted Infection services
- ❑ Family planning services
- ❑ Public Health Nurses
- ❑ Tobacco education
- ❑ CHDP
- ❑ Abuse Prevention
- ❑ Mental Health Services
- ❑ Intimate Partner Violence Program
- ❑ Preconception Health
- ❑ Oral Health

Classes and Support Groups

- ❑ Pre- and post-natal exercise programs (not a benefit of Medi-Cal or CPSP)
- ❑ Childbirth preparation classes
- ❑ Infant care class
- ❑ Breastfeeding classes/support group
- ❑ Parenting classes
- ❑ Pregnancy/infant loss; Sudden Infant Death Syndrome (SIDS) support group

- ❑ Child safety classes
- ❑ CPR and first aid course
- ❑ Child abuse prevention and intervention groups

Substance Treatment

- ❑ Smoking cessation program
- ❑ California Smoker's Help Line 1-800-NOBUTTS (call for other languages)
- ❑ Recovery and 12-step programs (Alcoholics Anonymous, Narcotics Anonymous)
- ❑ Perinatal substance addiction services and programs

Teen Pregnancy

- ❑ Pregnant and parenting teen programs
- ❑ Adolescent Family Life programs

Education/Literacy

- ❑ Literacy and English as a Second Language programs
- ❑ Adult education/General Education Degree programs
- ❑ Community colleges

Libraries

- ❑ Some libraries offer adult literacy programs

Basic Needs

- ❑ Emergency resources: food, maternity and baby clothes, baby furnishings, utilities
- ❑ Women's shelter; domestic violence hotline
- ❑ Housing office
- ❑ WIC

Transportation

- ❑ Ride services
- ❑ Car seat loan program

Low Cost Health Insurance

These are programs for low-income pregnant women and their children not eligible for Medi-Cal.

- Medi-Cal Access Program (MCAP) - 1-800-433-2611 [formerly Access for Infants and Mothers (AIM)]
- Covered California - the Health Insurance Exchange for California. For more information, see the Web site at www.coveredca.com

Additional Perinatal Related Referrals

Local Maternal, Child and Adolescent Health Programs.

Each county and the cities of Berkeley, Long Beach, and Pasadena, has an MCAH Director and program that works to develop systems that protect and improve the health of California's women of reproductive age, infants, children, adolescents and their families.

Your PSC can provide information regarding programs available in your area.

California Diabetes and Pregnancy Program (CDAPP) Sweet Success

CDAPP Sweet Success provides comprehensive technical support and education to medical personnel and community liaisons to assist in promoting improved pregnancy outcomes for high-risk pregnant women with pre-existing diabetes and women who develop diabetes while pregnant, gestational diabetes mellitus. These medical providers who undergo standardized training and provide direct patient care to women with diabetes while pregnant become known as CDAPP Sweet Success Affiliates. The program's goal is to reduce maternal and infant morbidity and mortality for this high risk group to approximate the outcomes of the low–risk perinatal population. A statewide CDAPP Sweet Success Resource and Training Center is available to support and train our CDAPP Sweet Success Affiliates.

Please visit their website at https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/CDAPP.aspx

California Home Visiting Program

The California Home Visiting Program is designed for overburdened families who are at risk for adverse childhood experiences, including child maltreatment, domestic violence, substance abuse and mental illness. It is a preventive intervention focused on promoting positive parenting and child development. Home visiting services are offered in the family's home where teachable moments naturally arise. Working with pregnant and newly parenting women, home visitors build relationships as they:

- ❑ Teach parenting skills and model parenting techniques
- ❑ Provide referrals to address a range of family issues

- ❑ Screen children for developmental delays
- ❑ Promote early learning in the home

Please visit their website at https://www.cdph.ca.gov/Programs/CFH/DMCAH/CHVP/Pages/default.aspx

Black Infant Health Program

The California Black Infant Health (BIH) Program aims to improve health among African American mothers and babies and to reduce the Black:White disparities by empowering pregnant and mothering African American women to make healthy choices for themselves, their families, and their communities. Within a culturally affirming environment and honoring the unique history of African American women, the BIH Program uses a group-based approach with complementary client-centered case management to help women develop life skills, learn strategies for reducing stress, and build social support. BIH clients participate in weekly group sessions (10 prenatal and 10 postpartum) designed to help them access their own strengths and set health-promoting goals for themselves and their babies. In addition to helping clients reinforce the skills and knowledge they develop in the group sessions, one-on-one case management ensures that clients are connected with the appropriate community and social services to meet their needs. Each woman culminates her participation in the program by developing her own individual Life Plan to guide her continued progress after BIH.

Please visit their web site at https://www.cdph.ca.gov/Programs/CFH/DMCAH/BIH/Pages/default.aspx

Indian Health Program Clinics

The State Indian Health Program (IHP) promotes comprehensive medical, dental, and outreach services by funding clinics which provide quality services. Local clinics serve California American Indians both on reservations and in urban settings. Most clinics provide prenatal obstetric care and many are CPSP providers. In addition, many clinics have mental health services, drug and alcohol counseling, parenting classes, and social activities which respect the Native American culture. Clinics can provide or refer to traditional health or spiritual practitioners to complement medical prenatal care. Tribal clinics (on reservations) usually serve particular Indian communities and their families. Urban clinics are usually

open to all American Indians as well as the general population. Tribal organizations and clinics are listed in the phone book "yellow" pages and the local public health department can assist in locating available American Indian services and organizations.

Please visit their website at http://www.dhcs.ca.gov/services/rural/Pages/IndianHealthProgram.aspx

Adolescent Family Life Program

The Adolescent Family Life Program addresses the social, health, educational and economic consequences of adolescent pregnancy by providing comprehensive case management services to pregnant and parenting teens and their children. The AFLP emphasizes promotion of positive youth development, focusing on and building upon the adolescents' strengths and resources to:

- Improve the health of the pregnant and parenting teen, thus supporting the health of the baby
- Improve graduation rates
- Reduce repeat pregnancies
- Improve linkages and create networks for pregnant and parenting teens

Please visit their web site at https://www.cdph.ca.gov/Programs/CFH/DMCAH/AFLP/Pages/default.aspx

For More Information

To find out if there is a CDAPP, BIH, AFLP or IHP in your community, contact your local health department's PSC for information on how to access those that are available.

CPSP Training Opportunities

The MCAH Division of the California Department of Public Health sponsors training on how to implement CPSP.

Call your local PSC for more detailed information or visit the CPSP website at https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx

PSP Provider online and in-person training dates/locations: www.cce.csus.edu/cpsptraining

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Tool Kit

This chapter includes information to help you develop protocols, complete care plans, make needed referrals such as dental and WIC, and conduct quality review of CPSP administration and direct services.

For samples of assessment forms, care plans, and protocols, contact your local Perinatal Service Coordinator. For a list of local Perinatal Services Coordinators, visit the CPSP Web site at https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/Local-Directory.aspx

COMPREHENSIVE PERINATAL SERVICES PROGRAM

Initial CPSP Assessment
Instructions for Use

The initial CPSP assessment is designed to be completed by any qualified CPSP practitioner, as defined in Title 22, Section 51179.7. The provider may use a separate assessment and care plan, or may use a combined assessment and care plan form.

PURPOSE:

The initial assessment permits the CPSP practitioner to assess the client's strengths and identify her needs in the areas of nutrition, psychosocial, and health education. This information along with the information from the initial obstetric assessment is used, in consultation with the client, to develop an Individualized Care Plan (ICP).

PROCEDURES/PROCESS:

The initial assessment is to be administered by a qualified CPSP practitioner and not self-administered.

1. Familiarize yourself with the assessment questions and the client's medical history before completing the assessment.
2. The interview setting should be private and ideally have access to a phone.
3. At the beginning of the assessment, explain to the client that the purpose of the interview is to identify issues that may be of concern to her and to assist in their resolution.
4. Explain the confidentiality of the assessment process. Clarify that as a health practitioner you may be legally required to report information regarding child or elder abuse/neglect and in some circumstances, domestic violence.

   For more information on child and adult abuse, neglect, and intimate partner violence, refer to the following suggested websites for additional tools, forms, training and contact information below:

   To report suspected neglect or abuse for a child or adult, please see the Tool Kit for forms and contact the appropriate agency listed on this web page: http://www.cdss.ca.gov/Reporting/Report-Abuse/Child-Protective-Services/Report-Child-Abuse

   Child Abuse Mandated Reporter Training modules: http://mandatedreporterca.com/who/who.htm

   Futures Without Violence: http://www.futureswithoutviolence.org/
5. Focus on the client, do not read the questionnaire word-for-word. Engage the client in conversation about herself, family and environment and use this opportunity to establish rapport and gain information for the assessment.
6. Inform the client you will write notes while you are conducting the assessment.
7. Sensitive questions should be approached in an accepting, straightforward manner. Most clients are willing to answer, especially if they understand why the question is being asked. Explain that her responses are voluntary, and she may choose not to answer a specific question.

8. Ask questions and respond to answers in a non-judgmental manner. Be aware of your voice, body language, and attitudes.
9. If the client has limited English-speaking abilities and you are not comfortable in speaking her preferred language, arrange, if possible, to have another staff member with those language capabilities complete the assessment. If such a person is not available, the practice should have the ability to make use of community interpreting services on an as-needed basis. Telephone translation services should only be considered as a last resort for very limited situations.
10. When the assessment is completed, pay particular attention to the answers that indicate risks (these are often shaded); they are ones most likely to need interventions and/or be included on the ICP. Generally they will require follow-up questions by the practitioner to determine the actual need and appropriate intervention. Answers to non-shaded responses and/or open-ended questions are important in that they provide additional information about the client's strengths, living situation, and resources that will be important to consider when developing a care plan.
11. At the completion of the interview, summarize the needs that have been identified, and assist the client in prioritizing them. Work with her to set reasonable goals that she wishes to accomplish.

DOCUMENTATION

- Make sure all questions are answered. If the question does not apply, write "N/A" (not applicable); if the client declines to answer, so note.
- All notes and answers on the assessment should be legible.
- All problems identified during the assessment should indicate some level of follow up that may range from a problem noted on the ICP to notations on the assessment form and/or narrative that indicate immediate intervention provided or that the issue is not one that the client chooses to address at this time.
- All assessments should be dated and signed with first initial, last name, and CPSP title of the person completing the assessment.
- Time spent in minutes should be noted at the end of the assessment; indicate only time spent face-to-face with the client, not time spent in phone calls, charting, etc. unless the client is present during these activities.
- Document direct supervision of care provided by CPHWs and care provided by other practitioners as defined in your office protocols.

Guidelines for Developing CPSP Enhanced Services Protocols

When developing site-specific protocols for CPSP enhanced services, provide answers to the six questions outlined below. Provide a general protocol for routine CPSP services such as orientation, CPSP staffing, assessment, writing care plans, making referrals, reassessments, supervision, case coordination, case conferencing, and postpartum care. Most providers find it helpful to write protocols using their assessment forms as a guide, and write protocols to describe the actions to take when the assessment identifies a risk condition.

WHAT

- Identify the procedure, service, or intervention.
- Indicate what staff is to do; the expectation for the content of the intervention. (Some are specified by Title 22.)
- Describe the written documentation expected and form(s) to use, as applicable.
- Indicate the Medi-Cal billing code(s) for the service or procedure.

WHO

- Identify the staff who will conduct each procedure or provide the service or intervention.
- Identify who will receive a service or procedure (i.e., all clients, pregnant teens, etc.), as applicable.
- Include others who may participate in a procedure or service (i.e., other staff, client's support person), as applicable.
- Indicate how a physician will supervise services and how this is documented. If a non-physician provider, indicate the arrangements for referral to a physician.

WHEN

- Indicate when the procedure or service is to be offered or provided; also, how often, the frequency or interval at which a procedure or intervention is to be offered or provided, as applicable. For example: …each trimester …at ____ wks. gestation …each visit …at first visit …before/after the initial OB exam …following initial assessments …at postpartum visit.

WHERE

- Indicate where the service or procedure will take place (i.e., in a confidential setting, a specific room), as applicable.
- Indicate where to refer a client when services are off site (i.e., classes, WIC, CHDP).
- Indicate where client should be referred for risk conditions (i.e., drug/alcohol/smoking counseling, diabetes control).
- Indicate where to document the information obtained from the client (i.e. Client Chart)
- Indicate the coordination and continuity of care between providers from antepartum, intrapartum and postpartum, as appropriate.

HOW

- Based on the capability of staff and level of training, provide necessary detail on how to provide or conduct the procedure, service, or intervention. For example:
  - Methods or tools to use such as film, video, group or one-on-one
  - A specific teaching tool
  - Description of any preferred teaching or interview techniques
- Include specific procedures to follow when making a client referral.
- Include specific instructions for completing forms, as needed.

WHY

- Indicate the reason for completing the service, procedure, or intervention. For example:
  - Title 22 statute
  - ACOG guidelines
  - Other rationale/background needed to further explain the service, procedure, or intervention to staff

CPSP Protocol Worksheet

Topic: _____

Provider: _____

Approved by: _____ Date: _____

WHAT?

What is the staff to do? What is the content of the service? What written documentation is needed? Indicate appropriate forms to use and billing codes to enter for the procedure.

WHO?

Which practitioner(s) will provide the service or intervention? Who will be offered or receive this service? Who else may participate in the service?

WHEN?

When is the service to be provided? Indicate the frequency or interval at which the service is to be provided.

WHERE?

Where will the client receive the service? Where is the service to be documented?

HOW?

How does a physician personally supervise CPSP services and directly supervise CPHWs? How is this documented?
Title 22, Section 51179.5 states: "Personal supervision" means evaluation, in accordance with protocols, by a licensed physician, of services performed by others through direct communication, either in person or through electronic means.

WHY?

What is the reason for providing this service?

CPSP Enhanced Services Protocol Checklist

Develop site-specific CPSP protocols for the procedures and interventions identified below.

Routine CPSP Procedures

- ❑ Client orientation
- ❑ Initial assessments
- ❑ Individualized Care Plan
- ❑ Case coordination
- ❑ Dispensing vitamins
- ❑ Registration and orientation to group classes
- ❑ Orientation to HIV test and HIV risk – see SB 889 for requirements regarding counseling and testing
- ❑ Routine referrals: WIC, Genetic Screening, Dental, Family Planning, CHDP
- ❑ State how personal supervision of CPSP services by a licensed physician occurs and is documented
- ❑ State how direct supervision to a CPHW by a physician is met

Routine CPSP Interventions

- ❑ Nutrition interventions
- ❑ Health Education interventions
- ❑ Psychosocial interventions
- ❑ Group interventions

Interventions Based on Assessment/Reassessments

- ❑ Smoking cessation
- ❑ Drug or alcohol services
- ❑ Diabetes education
- ❑ Domestic violence
- ❑ Other _____

_____

_____

CPSP protocols should answer the "what, who, when, where, how, and why" questions outlined on pages 7-9 and 7-10.

Reassessments

- ❑ Nutrition
- ❑ Health Education
- ❑ Psychosocial

Postpartum Reassessments

- ❑ Nutrition
- ❑ Health Education
- ❑ Psychosocial

Postpartum Education

- ❑ Nutrition
- ❑ Health Education
- ❑ Psychosocial Support

EXAMPLE

Sample Strengths and Problems List for Developing the Individualized Care Plan

SAMPLE STRENGTHS LIST

1. High School Education
2. Support System
3. Motivated
4. Emotionally Stable
5. Wanted/Accepted/Planned
6. Adequate Shelter/Clothing
7. Employed
8. Financially Stable
9. Adequate Transportation
10. Adequate Food
11. Refrigerator
12. Ability to Cope
13. Experience/Knowledge of Pregnancy/Delivery/Infant Care/Parenting
14. Family or friend that has successfully breastfed
15. Previous positive experience breastfeeding
16. Ability to Comprehend and Make Decisions
17. Interest/Willingness to Participate in Individual/Group Classes

SAMPLE PROBLEM/NEED LIST

Obstetric:

1. Hx of C-section/uterine surgery
2. Hx of incompetent cervix
3. Hx of < 2500 gram infant
4. Hx of >4000 gram infant
5. Hx of stillbirth
6. Hx of preterm birth (< 36 weeks) or SGA (Wt_____)
7. Hx of neonatal death
8. Hx of fetal anomaly
9. Hx of DES exposure
10. Hx of hospitalization(s)
11. Preg. interval < 1 year
12. Genetic risk
13. Hypertension/chronic
14. Pregnancy induced hypertension
15. Cardiovascular disorders
16. Diabetes, pre-existing, Type 1
17. Diabetes, pre-existing, Type 2
18. Diabetes, gestational this pregnancy
19. Hx gestational diabetes
20. Insulin/diet controlled diabetes
21. Chronic renal disease
22. GI disorders
23. Seizure disorder
24. Hypo/Hyperthyroid
25. Pulmonary Disease
26. Hepatitis B (date pos. test_____)
27. Dysplasia/Gyn malignancy
28. Anemia/Hemoglobinopathy
29. Multiple gestation
30. Rh hemolytic disease
31. HIV risk
32. STD: _____
33. Vaginal bleeding started @ _____ weeks
34. HX of previous lactation failure
35. Breast exam findings, such as breast surgery
36. Substance use/abuse _____
    Alcohol (_____ drinks/week)
    Cigarettes (_____cigs/day)
    Smokeless tobacco _____
    Illicit drugs(s) _____

Nutrition:

1. Overweight (BMI > 24.5)
2. Underweight (BMI < 18.5)
3. Obese (BMI > 30)
4. Insufficient weight gain
5. Excessive weight gain > 6.5 lb/mo
6. Plans to fast
7. Anemia
8. Gestational diabetes/ high blood glucose
9. Diabetes
10. High blood pressure
11. Nutrition related discomforts (Nausea, vomiting, constipation etc.)
12. Currently breastfeeding
13. History of low birth weight infant
14. History of infant weighing > 9 lb.
15. History of eating disorder
16. Taking unapproved supplements (specify) _____
17. Unhealthy changes in eating habits (specify) _____
18. Inadequate diet (specify) _____
19. Eats risky foods (fish, soft cheeses, etc)
20. Pica
21. Other unusual or restrictive diet (specify) _____
22. Inadequate food preparation or storage resources
23. Food insecurity
24. Insufficient physical activity
25. Excessive intake of non nutritious foods (i.e. soda, caffeine, sugar)
26. Insufficient intake of a particular food group (specify) _____
27. Excessive intake of a particular food group (specify) _____
28. No family or friends that have successfully breastfed
29. Fears related to breastfeeding

SAMPLE PROBLEM/NEED LIST

Psychosocial:

1. Excessive worries/fears regarding damage to self during pregnancy; fears related to fetus; fear of dying during labor; fears about inability to parent, etc.
2. Extreme difficulty or resistance to complying with medical recommendations or restrictions
3. Severe emotional problems, depression, anxiety or mental health issues
4. Previous pregnancy loss; fetal demise, TAB, SAB, miscarriage, etc.
5. Pregnancy complicated by detection of fetal anomaly
6. Previous psychosocial history of depression; suicidality; psychosis; hospitalization
7. Substance use (smoking; alcohol; prescription, over-the-counter, and street drugs; home remedies)
8. History or current indication of domestic violence
9. Frequent somatic complaints for which no diagnosis can be found
10. Excessive difficulty coping with crisis that interferes with self-care
11. Ambivalence, rejection, or denial of pregnancy after 20 weeks gestation
12. Perception that pregnancy will cause the mother permanent physical harm or damage
13. Unrealistic positive or negative feelings about pregnancy/motherhood/parenthood
14. Lack of resources for pregnancy, labor and delivery, and parenting (i.e., lack and financial resources, medical insurance, transportation, food, clothing, shelter for self and newborn)
15. Relationship conflict or absence of a support person
16. Reproductive coercion or birth control sabotage
17. Domestic violence
18. Possible current perinatal depression
19. Anxiety
20. Fears related to breastfeeding

Health Education:

1. Noncompliance with medical advice
2. Failed appointments
3. Age less than 17 or greater than 35
4. Late initiation of prenatal care
5. Primigravida or multi-gravida with five or more pregnancies
6. Previous pregnancy problems
7. Occupational risk
8. History of preterm labor
9. Mental disabilities
10. Physical disabilities (speech problems, severe hearing, or vision problems)
11. Inability to read or write or low reading level
12. Incompatible language between client and provider
13. Low education level
14. Low motivation level
15. Negative attitude about pregnancy
16. Fears related to breastfeeding
17. Little or no experience with U.S. health care
18. Lack of social support structure
19. Inability to reach decisions or comprehension difficulties
20. Extreme anxiety or emotional problem (fear, denial, excessive shyness)
21. Conflict scheduling class times
22. Transportation issues
23. Family problems/abuse
24. Economic/housing problems
25. Combination of other medical conditions, behaviors, barriers to learning and/or other factors

How to Apply for Medi-Cal (handout)

You can apply for Medi-Cal benefits or you can apply for CalWORKS, which includes Medi-Cal and a cash grant.

Find out if you are eligible for CalWORKS on this website: www.benefitscal.org

To apply for Medi-Cal or other health insurance:

- Fill out an application on the Covered California Web site at www.coveredca.com (this is the fastest way)
- Call Covered California at 1-800-300-1506
- Go to the County Welfare office (address below)
- Fill out a paper application and mail it to Covered California

If you don't have a computer, you can make an appointment to use a computer at any public library.

Applications are available in many languages.

If you apply with a paper application, mail it to Covered California, P.O. Box 989725, West Sacramento, CA 95798-9725. If you apply on line, the office will automatically receive it. An eligibility worker at the County social services office will determine your eligibility.

Write the name and address of the County social services office, your Medi-Cal eligibility worker's name and telephone number below. If you have any questions about your Medi-Cal eligibility, be sure to call this person.

County Office _____
County Office Address_____
Eligibility Worker's Name_____
Phone # _____
Supervisor's Name_____
Phone # _____

What You Need to Have

You need the following information to apply for Medi-Cal:

- ❑ **Identification**: Take a birth certificate, driver's license, California ID card, student ID, marriage license, or green card. Take identification for yourself and each family member living with you.
- ❑ **Social Security Number**: If you are a citizen or legal resident of the U.S., or you have applied or are applying for amnesty, take

your Social Security number. Also take the Social Security number **of each family member living with you. If you are applying for restricted benefits, you will need to give your Social Security number only, if you have one**.

- ❑ **Proof of Residency**: Take proof that you live in California, such as rent or mortgage receipts, utility bills, California vehicle registration or driver's license, proof of child's enrollment in school, or a State ID Card.
- ❑ **Proof of Income** (if any): If you have income, take pay stubs, income tax forms, or a letter from an employer. **Take income information for each family member living with you.**
- ❑ **Proof of Property** (if any): If you own property, take a bank statement, tax assessment, or some other proof of property ownership. If you are applying for Medi-Cal benefits only for your pregnancy, you may not have to provide this evidence.
- ❑ **Proof of Pregnancy**: Take a signed statement from your doctor or clinic showing your due date.

If you do not have all of the information available, submit your application anyway. Covered California will call you in 10-15 days to tell you what to do. If you go to the office, you can give your Medi-Cal eligibility worker the information at another visit and you can also ask your eligibility worker for help in getting the information.

It may take up to 45 days to hear whether your application has been approved.

Notice of Action

If You Are Approved

- You will receive a Benefits Identification Card (BIC) in the mail. (Exception: Those approved for Minor Consent Services will receive a paper card at the welfare office. If you have an immediate need, you may get a paper card first, then a BIC in the mail).
- Take this card to your provider to help pay for early, regular prenatal care.
- Do not throw the BIC away, even if you are no longer eligible for Medi-Cal.

If You Are Denied

If you feel the denial is wrong, you have the right to appeal the denial. Instructions for filing an appeal are on the back of the denial letter.

If you are re-applying, you may not get retroactive coverage for any month that you were already denied. For more information about the application process, please see the 'Ways to Apply for Medi-Cal' website at: http://www.dhcs.ca.gov/services/medi-cal/Pages/ApplyforMedi-Cal.aspx

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WIC referral forms for providers are located at: https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/HealthCareProviders.aspx

WIC Referral form for Pregnant Women

https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph247c.pdf

State of California—Health and Human Services Agency

California Department of Public Health—WIC Program

WIC REFERRAL FOR PREGNANT WOMEN

Health Care Provider: Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits since program eligibility requirements must be met.

Patient's name (last, first)	Address (street, city, ZIP code)	Telephone number	Birthdate (MM/DD/YY)

WOMAN'S CURRENT (PRENATAL)

Height _____ ins. Measurement date _____

Weight _____ lbs. _____

Hemoglobin _____ gm/dl. Blood test date _____

and/or

Hematocrit _____ %

Est. date confinement _____

Date last preg. ended _____

Gravida _____ Para _____

Pregravid weight _____ lbs.

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN:

- ☐ Diabetes
- ☐ Multiple Pregnancy
- ☐ Hypertension
- ☐ Tuberculosis _____ +PPD _____ INH
- ☐ Previous poor pregnancy outcome / history (specify):
- ☐ Other current or historical conditions (specify):

LOCAL WIC AGENCY

PLEASE LIST ANY CURRENT MEDICATIONS / SUPPLEMENTS PRESCRIBED:

IMPRESSIONS/COMMENTS:

Name of physician/health care provider/group/clinic	Telephone number

IMPORTANT: Must be signed by health care provider

Date

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

This institution is an equal opportunity provider.

CDPH 247C Rev 04/17 | #930028

Postpartum WIC referral form

https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph247b.pdf

State of California—Health and Human Services Agency

California Department of Public Health—WIC Program

WIC REFERRAL FOR POSTPARTUM/BREASTFEEDING WOMEN

Health Care Provider: Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits since program eligibility requirements must be met.

Patient's name (last, first)	Address (street, city, ZIP code)	Telephone number	Birthdate (MM/DD/YY)

WOMAN'S CURRENT (After Delivery)

Height _____ ins.

Weight _____ lbs. _____ Measurement date

Hemoglobin _____ gm/dl.

and/or

Hematocrit _____ % _____ Blood test date

PREGNANCY OUTCOME

Delivery date _____

	Full-term	Preterm (37 wks.)	Sm. Gest. Age	Fetal Loss	Stillbirth	Sex	Birth weight	Birth length
1.	☐	☐	☐	☐	☐			
2.	☐	☐	☐	☐	☐			

Please describe any medical conditions affecting the infant(s):

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN.

- ☐ C-Section
- ☐ Diabetes
- ☐ Hypertension
- ☐ Tuberculosis
- ☐ Other conditions occurring during this pregnancy for delivery (specify):
- ☐ Other current or historical medical conditions (specify):

_____ +PPD _____ INH

LOCAL WIC AGENCY

PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:

IMPRESSIONS/COMMENTS:

Name of physician/health care provider/group/clinic	Telephone number:

IMPORTANT: Must be signed by health care provider — Date

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

This institution is an equal opportunity provider.

CDPH 247B Rev 04/17 I #930028

Pediatric WIC referral form

Infant (only need to complete Section 1 for the initial referral, or the mother can bring the baby's birth certificate).

https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph247a.PDF

State of California—Health and Human Services Agency

California Department of Public Health—WIC Program

Pediatric Referral

WIC Agency:

WIC ID#:

SECTION I: ***Complete this section to assist the patient with WIC eligibility, WIC services, and appropriate referrals. Whenever a therapeutic formula is prescribed, complete both Sections I and II.***

PATIENT NAME: (First) (Last)				DATE OF BIRTH:
CURRENT HEIGHT/LENGTH: (within 60 days) inches	CURRENT WEIGHT: (within 60 days) lbs oz	CURRENT BMI: (within 60 days) BMI percentile: %	MEASUREMENT DATE:	BIRTH WEIGHT / LENGTH: lbs oz inches

HEMOGLOBIN OR HEMATOCRIT TEST is required every 12 months when normal and every 6 months when abnormal.

Hemoglobin (gm/dl) or Hematocrit (%)	Lab Result Date

LEAD TEST (recommended at 1–2 years of age): _____ mcg/dL

IMMUNIZATIONS are up-to-date:

☐ Yes ☐ No ☐ Not available

BREASTFEEDING ASSESSMENT (birth to 12 months):

☐ Fully breastfeeding ☐ Never breastfed ☐ Feeding breastmilk & formula ☐ Discontinued breastfeeding (Date: _____)

This is completed when therapeutic formula is prescribed.

https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph247a.PDF

SECTION II: ***Complete ALL boxes below when therapeutic formula is prescribed. Incomplete information may delay issuance of WIC foods.***

DIAGNOSIS:

☐ Prematurity ☐ GERD or reflux ☐ Food allergy: _____
☐ Failure to thrive ☐ Dysphagia ☐ Other: _____

FORMULA / MEDICAL FOOD: _____

DURATION: _____ months **AMOUNT:** _____ oz / day

This prescription is: ☐ New ☐ Refill

NOTE: At 1 year of age, the patient will receive 13 quarts of cow's milk in addition to therapeutic formula unless *Do Not Give* is checked for cow's milk (see WIC Food Restrictions).

COMMENTS:

WIC FOOD RESTRICTIONS: The patient will receive WIC foods in addition to the formula prescribed. Please check all foods listed below that are NOT appropriate for the diagnosis.

Category	WIC Foods	Do Not Give	Restriction / Comment
Infants (6–12 mo)	Baby cereal		
	Baby fruit / vegetable		
Children (1–5 yr)	Cow's milk		
	Cheese		
	Eggs		
	Peanut butter		
	Whole grains *		
	Cereal		
	Beans		
	Vegetables / fruits		
	Juice		
	Yogurt		

*** whole wheat bread, corn/wheat tortilla, brown rice, barley, bulgur, or oatmeal**

HEALTH COVERAGE: ***Refer patient to their health plan or Medi-Cal for a medically necessary formula or medical food.***
WIC only provides these products when they are NOT a covered benefit by the patient's health plan or by Medi-Cal.

Provide patient's health insurance information:	**Check action taken:**
Private insurance: _____ Medi-Cal managed care: _____ Other: _____	☐ Submitted justification to health plan
Regular Medi-Cal (fee-for-service): ☐ Yes ☐ No	☐ Submitted justification to pharmacist

If the patient requires a therapeutic formula and does NOT have health insurance, check ALL boxes below that apply:

☐ Gave formula samples
☐ Referred to Medi-Cal
☐ Referred to WIC

QUESTIONS: Call 1-888-942-9675 or 1-800-852-5770.
Health Professionals: Go to www.wicworks.ca.gov; click Health Care Professionals; then click WIC contacts for MDs.

COMMENTS:

HEALTH PROFESSIONAL NAME	**HEALTH PROFESSIONAL SIGNATURE**	**MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP**
PHONE NUMBER	**TODAY'S DATE**	

The information above is only for use by the intended recipient and contains confidential information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original form. **This institution is an equal opportunity provider and employer.**

CDPH 247A Rev 03/16 | #930029

Oral Health Referral Form for Pregnant Women*

PATIENT NAME
DOB
PRIMARY CARE PROVIDER

Patient ID / Addressograph

Date: _____ Referred to: _____

Reason for referral: ☐ Routine ☐ Bleeding gums ☐ Pain ☐ Other _____

Weeks' gestation *(at time of referral)*: ___ Estimated delivery date: _____ Patient Phone: _____

Primary language spoken: _____

☐ This patient is cleared for routine evaluation and dental care, which may include but is not limited to:

- Dental X-rays as needed for diagnosis *(with abdominal and neck lead shield)*
- Oral health examination
- Dental prophylaxis
- Scaling and root planing
- Restoration of untreated caries
- Extraction
- Standard local anesthetic *(lidocaine with or without epinephrine)*
- Analgesics (if needed): acetaminophen and/or acetaminophen with codeine *(Nonsteroidal anti-inflammatory drugs are not recommended during pregnancy)*
- Antibiotics (if needed and no known allergies): penicillin, amoxicillin, cephalosporin, clindamycin, erythromycin— not estolate form *(Cipro and tetracycline are not recommended during pregnancy.)*

Significant Medical Conditions:
☐ NONE ☐ YES *(e.g., heart condition, liver disease, kidney disease, etc.)*

_____
_____
_____

Known Allergies: ☐ NONE ☐ YES

Drug(s)/Reactions(s): _____
_____
_____
_____

Current Medications: ☐ NONE
☐ Prenatal vitamins ☐ Iron ☐ Calcium
☐ OTHERS *(Attach updated list of active Rx)*

_____
_____
_____

Any Precautions: ☐ NONE ☐ SPECIFY *(List if any coments or instructions)*

_____
_____
_____

Prenatal care provider *(print name)*: _____

Phone/pager: _____ Fax #: _____

Signature: _____ Date: _____

Dentist: Please fax information back (to prenatal care provider, fax # above) after initial dental visit:

Exam date: _____ ☐ Normal exam/recall ☐ Missed appointment

☐ Needs additional treatment visits for: ☐ Caries ☐ Periodontitis ☐ Referral to oral surgery ☐ Other _____

Comments: _____
_____
_____

Dentist signature: _____ Date: _____

Phone: _____

*Adapted from San Francisco General Hospital and Trauma Center, Community Health Network

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State of California
Office of Emergency Services
(www.oes.ca.gov)

MANDATED SUSPICIOUS INJURY REPORT

CAL OES 2-920

For copies of this form or assistance in completing the Cal OES 2-920, please contact the
California Clinical Forensic Medical Training Center:
(916) 930-3080 or
Contact Us @ www.ccfmtc.org

SUSPICIOUS INJURY REPORT

STATE OF CALIFORNIA
California Office of Emergency Services

Cal OES 2-920

Confidential Document

Penal Code Section 11160 requires that if any health practitioner, within their scope of their employment, provides medical services for a wound or physical injury inflicted as a result of assaultive or abusive conduct, or by means of a firearm, shall make a telephone report immediately or as soon as possible. They shall also prepare and submit a written report within 2 working days of receiving the information to a local law enforcement agency. This is the official form (Cal OES 2-920) for submitting the written report.

This form is used by law enforcement only and is confidential in accordance with Section 11163.2 of the Penal Code. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts.

Part A: PATIENT WITH SUSPICIOUS INJURY			
1. Name of Patient (Last, First, Middle)	2. Birth Date	3. Gender ☐ M ☐ F	4. SAFE Telephone Number ( )
5. Patient Address (Number and Street / Apt – **No P.O. Box**) City State Zip			
6. Patient Speaks English ☐ Yes ☐ No If No, identify language spoken:_____	7. Date and Time of Injury Date: Time: ☐ am ☐ pm ☐ unknown		
8. Location / Address Where Injury Occurred, if Available. Check here if unknown: ☐			
9. Patient description of the incident. Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident. ☐ Additional Pages Attached			
10.Name of Suspect, if Identified by the Patient	11. Relationship to Patient. ☐ No Relationship		
12. Suspicious Injury Description. Include a brief description of physical findings, lab tests completed or pending, and other pertinent information. ☐ Additional Pages			

Part B: REQUIRED – AGENCIES RECEIVING PHONE AND WRITTEN REPORTS		
13. Law Enforcement Agency Notified By Phone (Mandated by PC 11160)	14. Date and Time Reported Date: Time: am pm	
15. Name of Person Receiving Phone Report (First and Last)	16. Title	17. Phone Number ( )
18. Law Enforcement Agency Receiving Written Report (Mandated by PC 11160)	19. Agency Incident Number	

Part C: PERSON FILING REPORT		
20. Name of Health Practitioner (First and Last)	Title	Telephone
21. Employer's Name		Phone Number
22. Employer's Address (Number and Street) City State Zip		
23. HEALTH PRACTITIONER'S SIGNATURE:	26. Date Signed:	

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS — Street — City — Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ❒ YES ❒ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

❒ LAW ENFORCEMENT ❒ COUNTY PROBATION ❒ COUNTY WELFARE / CPS (Child Protective Services)	AGENCY		
ADDRESS — Street	City	Zip	DATE/TIME OF PHONE CALL
OFFICIAL CONTACTED - TITLE			TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street — City — Zip	TELEPHONE ( )		
PRESENT LOCATION OF VICTIM	SCHOOL	CLASS	GRADE
PHYSICALLY DISABLED? ❒ YES ❒ NO	DEVELOPMENTALLY DISABLED? ❒ YES ❒ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME
IN FOSTER CARE? ❒ YES ❒ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ❒ DAY CARE ❒ CHILD CARE CENTER ❒ FOSTER FAMILY HOME ❒ FAMILY FRIEND ❒ GROUP HOME OR INSTITUTION ❒ RELATIVE'S HOME		TYPE OF ABUSE *(CHECK ONE OR MORE)* ❒ PHYSICAL ❒ MENTAL ❒ SEXUAL ❒ NEGLECT ❒ OTHER (SPECIFY)
RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ❒ YES ❒ NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ❒ YES ❒ NO ❒ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street — City — Zip	HOME PHONE ( )	BUSINESS PHONE ( )	
NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street — City — Zip	HOME PHONE ( )	BUSINESS PHONE ( )	

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street — City — Zip	TELEPHONE ( )		
OTHER RELEVANT INFORMATION			

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ❒ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

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Developing a Quality Assurance (QA) Plan

Your QA plan should include the following:

Overview

- Who receives CPSP services
- Philosophy of services

Purpose of the Plan

- Access, maintain, or improve the standards of CPSP services
- Assure appropriate care according to protocols, assessment forms, and ICP

Goals and Objectives

- Validate quality of care
- Assess quality of care
- Identify and implement strategies for problem resolution
- Identify trends, barriers and how to address these
- Improve care by evaluating interventions and modify as necessary
- Communicate findings and improvement plans to appropriate persons

Authority and Responsibility

- Who is responsible for the program
- Who participates in the program
- Who communicates findings

Scope of Care and Major Clinical Functions

- Who are the services provided to
- Where are the services provided
- Description of the services
- Who provides the services (kinds of staff and individual services)
- Where are protocols (and for whom)

Aspect of Care

- How will you identify what services are to be monitored: occur frequently, effective large numbers of clients, serious consequences, trends

Monitoring and Evaluating

- Methodology
- Who will identify problems/topics to monitor
- How often will the monitoring be done
- How will information be gathered (chart review, personal observation, client satisfaction reports, stated concerns, logs, statistics)
- Indications for corrective action
- Standards used (CPSP, ACOG)

Indicators

- What aspects of care are to be monitored

Reporting Structure

- To whom will the monitoring information be reported

Program Evaluation

- How often will the Quality Assurance Plan be evaluated

Note: The local Perinatal Services Coordinators have the right to conduct quality assurance activities with their network providers as part of the California Department of Public Health, Maternal Child and Adolescent Health Division's monitoring authority over CPSP, stipulated under the Welfare and Institutions Code 14134.5 (i).

Note: The quality assurance activities conducted by PSCs may include site visits to perform the following: chart review of CPSP implementation and documentation of services, desk or administrative review, and qualitative review of service delivery such as staff interviews and observation.

Note: The forms used by the PSCs to perform QA activities with the providers may undergo periodic revisions according to their local needs and CPSP program requirements.

EXAMPLE

COMPREHENSIVE PERINATAL SERVICES PROGRAM

Administrative Review Tool

Provider:_____

Staff Present/Title: _____

Perinatal Services Coordinator: _____

Date: _____

Indicators	Yes	No	N/A	Comments
A. Application current/changes have been submitted to PSC				
1. All staff delivering care have been approved by PSC (on application)				
2. Description of practice current (note changes)				
3. Antepartum/intrapartum/postpartum agreements current				
4. Delivery hospitals current				
5. OB assessment form used (e.g. ACOG, other)				
6. Approved assessment forms on file with PSC.				
a. Nutrition (Note dietary assessment form used)				
b. Psychosocial				
c. Health Education				
d. Trimester Reassessments				
e. Postpartum assessment				
B. Group classes				
1. Sign in sheets				
2. Lesson plans				
C. Physical layout—pt. confidentiality				
D. Staff resources				
1. Current handbooks/ manuals (check date)				
a. CPSP Provider Handbook				
b. Steps to Take Manual				
c. Medi-Cal Provider Manual (on-line) Medi-Cal Bulletins (on-line)				
2. Protocols available, current and accessible for all staff, aligned w/ assessment forms.				
a. Protocols state how provider supervises care and documents this.				
b. Protocols describe orientation, which includes all items required: detailed information on services to be provided, who will provide services, where to obtain services, when the services will be delivered, patient rights and responsibilities, identifying an emergency (danger signs), and what to do in an emergency.				

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COMPREHENSIVE PERINATAL SERVICES PROGRAM
Administrative Review Tool

Indicators	Yes	No	N/A	Comments
c. Mandatory referrals in place (WIC, CHDP, Family Planning, Genetic Diseases, Dental)				
d. High risk referral mechanisms in place (RD, GDM, perinatologist)				
e. Protocols describe flow of care (intake, orientation, assessment, reassessment, postpartum, case coordination), including requiring initial assessments to be completed within 4 weeks of the initial visit.				
f. Protocols signed by MD and qualified discipline/ consultants or previously approved protocols customized to site and signed by provider				
g. Protocols require sending prenatal record or summary to delivery doctor/hospital				
h. Protocols require obtaining copy of delivery record for CPSP chart.				
3. Staff demonstrates appropriate use of STT and protocols.				
4. Training				
a. At least one staff member has attended				
Note: Inform of upcoming local, online and state trainings				
E. Does provider take Medi-Cal Managed Care? List plans, review MCMC chart as well as FFS charts:				
1. Medical Groups or Independent Practice Associations (list)				
F. Optional items:				
1. Perinatal Resource Directory—If PSC develops this, could offer as a resource to the office				
2. Prenatal care health education materials reviewed (if using other than STT)				
3. Language appropriate for population				
4. Culturally/linguistically appropriate materials				
5. Internal QA/CQI process—Is this present?				
6. Presumptive eligibility * if no, give provider info, discuss barriers, encourage to apply				
G. Billing (optional)				
1. NPI matches Medi-Cal				
2. Provider address matches Medi-Cal				
3. Charge document has correct CPSP codes				
4. Services billed match documentation				
5. Refer billing questions to Medi-Cal billing representative				

DRAFT

COMPREHENSIVE PERINATAL SERVICES PROGRAM
Administrative Review Tool

Notes:
Issues:
Provider to develop corrective action plan with due date, action required, person responsible.

PSC signature: _____

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EXAMPLE

Chart ID number: _____

COMPREHENSIVE PERINATAL SERVICES PROGRAM
Chart Review Tool

CPSP Provider: _____ Date:_____

Clinic Staff Present (List all staff present and title): _____

Perinatal Services Coordinator: _____

ITEMS	FINDINGS/NOTES
1. Week started prenatal care	
2. Number of OB visits/follows ACOG recommended schedule	
3. Client Orientation is documented. (51348.d.1)	
4. Using approved assessment forms, initial, trimester and PP assessments completed.	
a. Nutrition Assessment	
■ Diet evaluation used: 24 hr. recall	
■ Food frequency questionnaire	
■ Weight every visit; plotted on correct grid	
■ Initial (within 4 weeks of initial visit)	
■ Second Trimester	
■ Third Trimester	
■ Postpartum	
b. Psychosocial Assessment	
■ Initial (within 4 weeks of initial visit)	
■ Second Trimester	
■ Third Trimester	
■ Postpartum	
c. Health Education Assessment	
■ Initial (within 4 weeks of initial visit)	
■ Second Trimester	
■ Third Trimester	
■ Postpartum	
5. All documentation includes time in minutes	
6. All entries signed with name and CPSP title	
7. Appropriate use of STT or other materials	
8. An individual care plan is in place that:	
a. Identifies client strengths	
b. Addresses identified OB, health ed, psychosocial, nutrition needs.	
c. Care plan updated each trimester and postpartum	List dates

SAMPLE

COMPREHENSIVE PERINATAL SERVICES PROGRAM
Chart Review Tool

ITEMS	FINDINGS/NOTES
9. Follow up on risks/issues identified in care plan	
10. Appropriate referrals documented including but not limited to:	
a. WIC	
b. Genetic Services	
c. CHDP/Well Child Pediatric Care	
d. Family Planning	
e. Dental	
11. Appropriate follow up of other referrals	
12. Who does case coordination?	
13. Dispensed or prescribed vitamin & mineral supplement	
14. Physician supervision documented per protocol	
15. Delivery record in chart (use to obtain birth outcome data, follow up if LBW, preterm, elective delivery before 39 wks, c-section)	Gender ❑ Male ❑ Female Birth weight _____lb. _____oz. Gestational age _____weeks Delivery method ❑ vaginal ❑ cesarean Feeding method: ❑ Breast ❑ Formula ❑ Combination

Corrective Action Plan:

Issue	Action Required	Person Responsible	Target Date

SAMPLE

COMPREHENSIVE PERINATAL SERVICES PROGRAM

Multi-Chart Review Tool

CPSP Provider: _____ Date: _____

Clinic Staff Present (List all staff present and title): _____

Perinatal Services Coordinator: _____

ITEMS	FINDINGS			
	1	2	3	4
1. Week started prenatal care				
2. Number of OB visits/follows ACOG recommended schedule				
3. Client Orientation is documented. (51348.d.1)				
4. Using approved assessment forms, initial, trimester and PP assessments completed.				
a. Nutrition Assessment				
▪ Diet evaluation used: 24 hr. recall				
▪ Food frequency questionnaire				
▪ Weight every visit; plotted on correct grid				
▪ Initial (within 4 weeks of initial visit)				
▪ Second Trimester				
▪ Third Trimester				
▪ Postpartum				
b. Psychosocial Assessment				
▪ Initial (within 4 weeks of initial visit)				
▪ Second Trimester				
▪ Third Trimester				
▪ Postpartum				
c. Health Education Assessment				
▪ Initial (within 4 weeks of initial visit)				
▪ Second Trimester				
▪ Third Trimester				
▪ Postpartum				
5. All documentation includes time in minutes				
6. All entries signed with name and CPSP title				
7. Appropriate use of STT or other materials				

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COMPREHENSIVE PERINATAL SERVICES PROGRAM

Multi-Chart Review Tool

ITEMS	FINDINGS/NOTES			
	1	2	3	4
8. An individual care plan is in place that:				
a. Identifies client strengths				
b. Addresses identified OB, health ed, psychosocial, nutrition needs.				
c. Care plan updated each trimester and postpartum				
9. Follow up on risks/issues identified in care plan				
10. Appropriate referrals documented including but not limited to:				
a. WIC				
b. Genetic Services				
c. CHDP/Well Child Pediatric Care				
d. Family Planning				
e. Dental				
11. Appropriate follow up of other referrals				
12. Who does case coordination?				
13. Dispensed or prescribed vitamin & mineral supplement				
14. Physician supervision documented per protocol				
15. Delivery record in chart (use to obtain birth outcome data, follow up if LBW, preterm, elective delivery before 39 wks, c-section)	Gender ❑ M ❑ F Birth weight: _____lb. _____oz. Gestational age: _____weeks Delivery method: ❑ vaginal ❑ cesarean Feeding method: ❑ Breast ❑ Formula ❑ Combination	Gender ❑ M ❑ F Birth weight: _____lb. _____oz. Gestational age: _____weeks Delivery method: ❑ vaginal ❑ cesarean Feeding method: ❑ Breast ❑ Formula ❑ Combination	Gender ❑ M ❑ F Birth weight: _____lb. _____oz. Gestational age: _____weeks Delivery method: ❑ vaginal ❑ cesarean Feeding method: ❑ Breast ❑ Formula ❑ Combination	Gender ❑ M ❑ F Birth weight: _____lb. _____oz. Gestational age: _____weeks Delivery method: ❑ vaginal ❑ cesarean Feeding method: ❑ Breast ❑ Formula ❑ Combination

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Corrective Action Plan:

Issue	Action Required	Person Responsible	Target Date

Appendix

The Codes/Regulations

The California Code of Regulations link is located at: https://oal.ca.gov/publications/ccr/

The Pathway to find the CPSP Title 22 regulations is:

Title 22. Social Security

- Division 3. Health Care Services
  - Subdivision 1. California Medical Assistance Program
    - Chapter 3. Health Care Services
      - Article 2. Definitions (Refs & Annos) – 51179-51179.9
      - Article 3. Standards for Participation (Refs & Annos) 51249
      - Article 4. Scope and Duration of Benefits (Refs & Annos) 51348 – 51348.2
      - Article 7. Payment for Services and Supplies (Refs & Annos) 51504

Medi-Cal Managed Care Policy Letter 12-003

Guidelines for Preconception and Interconception Care

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TITLE 22 **MEDICAL ASSISTANCE PROGRAM**

§51001

(Register 88, No. 15-4-9-88) (P. 1238.77)

CHAPTER 3. HEALTH CARE SERVICES
Article 1.3. General Provisions

51001. Beneficiary.

As used in this Chapter, the term "beneficiary" means any person certified as eligible for services under the Medi-Cal program. NOTE: Authority cited: sections 10725 and 14124.5, Welfare and Institutions Code. Reference: Sections 14000 and 14005, Welfare and Institutions Code.

HISTORY:

1. Amendment filed 6-5-67 as an emergency; effective upon filing. Certificate of Compliance filed 6-9-67 (Register 67, No. 23).
2. Amendment filed 6-22-87; operative 7-22-87 (Register 87, No. 27).

51002. Beneficiary Billing.

(a) A provider of service under the Medi-Cal program shall not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service, except to:

(1) Collect payments due under a contractual or legal entitlement pursuant to Section 14000(b) of the Welfare and Institutions Code.

(2) Bill a long-term care patient for the amount of his liability.

(3) Collect co-payment pursuant to Welfare and Institutions Code Section 14134. NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code; Section 133.5 of Chapter 102, Statutes of 1981; and Section 2 of Chapter 237, Statutes of 1981. Reference: Section 14134, Welfare and Institutions Code.

HISTORY:

1. Amendment filed 1-18-74; effective thirtieth day thereafter (Register 74, No. 3). For prior history, see Register 72, No. 5.
2. Amendment filed 8-8-78; effective thirtieth day thereafter (Register 78, No. 32).
3. New subsection (2) (3) filed 11-17-81 as an emergency; effective upon filing (Register 81, No. 47). A certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3-17-82.
4. Certificates of Compliance transmitted to OAL 3-16-82 and filed 4-16-82 (Register 82, No. 16).

51003. Prior Authorization.

(a) "Prior authorization", "reauthorization", or "approval" means authorization granted by a designated Medi-Cal Consultant in advance of the rendering of a service, unless otherwise specifically stated, after appropriate medical, dental or other review. The responsibilities of the Medi-Cal Consultant shall not be delegated, except to the extent provided under Sections 51013 and 51014.

(b) Retroactive approval of requests for prior authorization may be granted only under the following conditions:

(1) When certification of the Medi-Cal beneficiary's eligibility by the county welfare department was delayed;

(2) When "other coverage" (i.e., Medicare or other health insurance programs) denied payment of a claim for services;

TITLE 22 **MEDICAL ASSISTANCE PROGRAM**

§51001

(Register 88, No. 15-4-9-88) (P. 1238.78)

(3) When communication with the Medi-Cal Consultant could not be established and provision of the required service should not have been delayed; under this condition the request for retroactive authorization must be received by the Medi-Cal Consultant within 10 working days after the service is provided or initiated.

(4) When a patient does not identify himself to the provider as a Medi-Cal beneficiary by deliberate concealment or because of physical or mental incapacity to so identify himself;

(A) The request for retroactive authorization shall be accompanied by a statement from the provider certifying that the patient did not identify himself and the date the patient was so identified, provided such date is within one year after the month is which service was rendered.

(B) The request for retroactive authorization shall be submitted within 60 days following the certified date of beneficiary identification.

(5) When the Department determines that the provider was prevented from submitting a timely request for reauthorization because of a reason that meets one of the criteria specified in paragraph (A), (B) or (C). The provider shall submit factual documentation deemed necessary by the Department with the reauthorization request. Any additional documentation requested by the Department shall be submitted within 60 days of the request. The documentation shall verify that the late submission was due to:

(A) A natural disaster which has:

1. Destroyed or damaged the provider's business office or records.
2. Substantially interfered with a provider's agent's processing of the provider's Treatment Authorization Requests (TARs).

(B) Delay caused by other circumstances beyond the control of the provider which have been reported to the appropriate law enforcement or fire agency when applicable. Circumstances which shall not be considered beyond the control of the provider include but are not limited to:

1. Negligence by employees.
2. Misunderstanding of program requirements.
3. Illness or absence of any employee trained to prepare TARs.
4. Delays caused by the United States Postal Service or any private delivery service.

(6) When the Department has imposed postservice prepayment audits as set forth in Section 51159(b), for emergency services pursuant to Section 51056(b) (2), by requiring providers to utilize the procedures for obtaining authorization on a retroactive basis.

(c) "Reauthorization" means authorization of a request received by the Medi-Cal Consultant before the expiration of the previous authorization for a service being rendered.

(d) All authorization requests shall include adequate information and justification for the service requested for the beneficiary.

(e) Authorization may be granted only for Medi-Cal benefits that are medically necessary and do not exceed health care services received by the public generally for similar medical conditions. The "Manual of Criteria for Medi-Cal Authorization" published by the Department in January 1982, last amended in March 1988 and herein incorporated by reference in its entirety, shall be the basis for the professional judgments of Medi-Cal consultants in their decision on authorizations for services or conditions listed in the Manual. Such authorization shall be valid for the number of days specified in this chapter. The consultant may grant authorization for up to a maximum of one year when the treatment as authorized is clearly expected to continue unmodified for up to or beyond one year.

TITLE 22 **MEDICAL ASSISTANCE PROGRAM**

§51001

(Register 88, No. 15-4-9-88) (P. 1239)

(f) Authorization may be granted only for the lowest cost item or service covered by the program that meets the patient's medical needs.

(g) A provider may appeal the decision of Medi-Cal Consultant on a TAR. Such an appeal shall be received by the administrator of the Medi-Cal field office which denied the initial request within 60 calendar days from the date of provider notification of the Medi-Cal Consultant's decision.

(1) The appeal shall be submitted in writing to the administrator of the local Medi-Cal field office.

(2) If the administrator of the local Medi-Cal field office finds no basis for altering the original decision of the Medi-Cal consultant, the provider shall be informed in writing, within 60 calendar days of receipt of the appeal, of the local Medi-Cal field office administrator's decision, the basis therefore, and the provider's right to resubmit the appeal to the Field Services Headquarters.

(3) An appeal to the Field Services Headquarters shall be initiated within 30 calendar days from the date of provider notification of the local Medi-Cal field office administrator's decision. The Department shall act on the appeal and inform the provider directly of the Department's decision, and the basis therefore, within 60 calendar days from the receipt of the appeal submitted to the Field Services Headquarters. NOTE: Authority cited: Section 10725, 1405, 15124.5, 14132.5, 14133, Welfare and Institutions Code; and Sections 208.3 and 1267.7, Health and Safety Code; and Section 57(c), chapter 328, Statutes of 1982. Reference: Sections 14053, 14087, 14103.6, 14132, 14132.5, 14133, 14133.1, 14133.25 and 14133.3, Welfare and Institutions Code.

HISTORY:

1. Editorial correction of subsection (e) filed 3-29-84 as an emergency; designated effective 4-1-84 (Register 84, No. 15).
2. Editorial correction of HISTORY NOTE No. 1 (Register 85, No. 27). For prior history, see Register 84, No. 2.
3. Amendment of subsection (e) field 7-2-85; designated effective 8-1-85 pursuant to Government Code Section 11346.2(d) (Register 85, No. 27).
4. Amendment of subsection (b) (3) filed 8-13-85; effective thirtieth day thereafter (Register 85, No. 33).
5. Amendment of subsection (e) filed 11-15-85; effective thirtieth day thereafter (Register 85, No. 46).
6. Amendment of subsection (e) filed 1-17-86; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 86, No. 3).
7. Amendment of subsection (e) filed 6-3-86 as an emergency; effective upon filing (Register 86, No. 23). A Certificate of compliance must be transmitted to OAL within 120 days or emergence language will be repealed on 10-1-86.
8.. Amendment of subsection (e) refilled 11-3-86 as an emergency; effective 10-1-86 (Register 86, No. 45). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1-29-87.
9. Change without regulatory effect of subsection (a) (Register 86, No. 49).
10. Amendment of subsection (e) filed 11-12-86; effective thirtieth day thereafter (Register 86, No. 49).
11. Certificate of Compliance including amendment of subsection (e) as to 11-3-86 order filed 1-20-87 (Register 87, No. 4).
12. Amendment of subsection (e) filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days of emergency language will be repealed on 6-17-87.
13. Amendment of subsection (e) refilled 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on will be repealed on 10-15-87.
14. Certificate of Compliance filed 9-17-87 (Register 87, No. 38).
15. Amendment of subsection (e) filed 10-27-87 as an emergency; operative 10-27-87 (Register 87, No. 44). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 2-24-88.
16. Certificate of Compliance including amendment of subsection (e) transmitted to OAL 2-24-88 and filed 3-22¬88 (Register 88, No. 15).

TITLE 22 **MEDICAL ASSISTANCE PROGRAM**

§51050

(Register 87, No. 44-10-31-87) (P. 1244.4)

Article 2. Definitions

51051. Provider of Services.

(a) "Provider of services" means any individual, partnership, clinic, group, association, corporation, institution, or public agency designated in (b) below, meeting applicable standards for participation with the Medi-Cal program.

(b) Providers of services are:

Acupuncturists
Assistive Device and Sick Room Supply
Dealers Audiologists
Blood Banks
Child Health and Disability Prevention
Providers Christian Science Facilities
Christian Science Practitioners
Clinical Laboratories
Comprehensive Perinatal Providers
Dental School Clinics
Dentists
Dispensing Opticians
Hearing Aid Dispensers
Home Health Agencies
Hospices
Hospital Outpatient Departments
Hospitals
Intermediate Care Facilities
Intermediate Care Facilities for the Developmentally Disabled
Nurse Anesthetists
Nurse Midwives
Nurse Practitioners
Occupational Therapists
Ocularists
Optometrists
Orthotists
Organized Outpatient Clinics
Outpatient Heroin Detoxification Providers
Pharmacies/Pharmacists
Physical therapists Physicians
Podiatrists
Portable X-ray Services
Prosthetists Providers of Medical Transportation
Psychologists
Rehabilitation Centers
Renal Dialysis Centers and Community Hemodialysis Units
Rural Health Clinics
Short-Doyle Medi-Cal Providers Skilled Nursing Facilities
Speech Therapists

NOTE: Authority cited: Sections 10725, 14100.1, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14100.1, 14105, 14115.6, 14124.5, 14132, 14132.4, and 14134.5, Welfare and Institutions Code.

TITLE 22 **MEDICAL ASSISTANCE PROGRAM**

§51051

(Register 88, No. 15-4-9-88) (P. 1245)

HISTORY:

1. Amendment of subsection (b) filed 6-23-77; effective thirtieth day thereafter (Register 77, No. 26). For prior history, see Register 76, No. 2.
2. Amendment of subsection (b) filed 8-1-78 as an emergency; effective upon filing (Register 78, No. 31).
3. Certificate of Compliance transmitted to OAL 11-28-78 and filed 11-29-78 (Register 78, No. 48).
4. Amendment filed 3-2-79; effective thirtieth day thereafter (Register 79, No. 9).
5. Amendment of subsection (b) filed 4-30-81; effective thirtieth day thereafter (Register 81, No. 18).
6. Amendment of subsection (b) filed 12-21-83; effective thirtieth day thereafter (Register 83, no. 52).
7. Amendment of subsection (b) filed 8-13-86; effective upon filing (Register 86, No. 33).
8. Amendment of subsection (b) filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.
9. Amendment of subsection (b) refilled 6-5-87; operative 6-17-887 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.
10. Amendment of subsection (b) filed 7-23-87; operative 8-22-87 (Register 87, No. 31).
11. Certificate of Compliance as to 6-5-87 order filed 9-17-87 (Register 87, No. 38).
12. Amendment of subsection (b) filed 10-27-87 as an emergency; operative 10-27-87 (Register 87, No. 44). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 2-24-88.
13. Certificate of Compliance transmitted to OAL 2-24-88 and filed 3-22-88 (Register 88, No. 15).

TITLE 22 **MEDICAL ASSISTANCE PROGRAM**

§51179

(Register 87, No. 38-9-19-87) (P. 1262.14)

51179. Comprehensive Perinatal Services.

"Comprehensive perinatal services" means obstetric, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery. NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 1434.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.

2. New section refilled as an emergency 6-5-87; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.

3. Certificate of Compliance including amendment filed 9-17-87 (Register 87, No. 38).

TITLE 22 **MEDICAL ASSISTANCE PROGRAM**

§51179.1

(Register 87, No. 38-9-19-87) (P. 1262.14.1)

51179.1. Comprehensive Perinatal Provider.

"Comprehensive perinatal provider" means any general practice physician, family practice physician, osterician/gynecologist, pediatrician, a group, any of whose members are one of the above-named physicians, or any preferred provider organization, organized outpatient clinic, or any other clinic holding a valid Medi-Cal provider number, approved by the Department to provide comprehensive perinatal services. NOTE: Authority cited: Section 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 14134.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.
2. New section refilled as an emergency 6-5-87; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.
3. Certificate of Compliance field 9-17-87 (Register 87, No. 38).

51179.2. Comprehensive Perinatal Nutrition Services.

"Comprehensive perinatal nutrition services" means direct patient care nutrition services provided by any qualified professional as specified in Section 51179.7, pursuant to protocols as defined in Section 51179.10. NOTE: Authority cited: section 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 14134.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.
2. New section refilled 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.
3. Certificate of Compliance including amendment filed 9-17-87 (Register 87, No. 38).

51179.3. Comprehensive Perinatal Psychosocial Services.

"Comprehensive perinatal psychosocial services" means direct patient care psychosocial services provided by any qualified professional as specified in Section 51179.7, pursuant to protocols as defined in Section 51179.10. NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 14134.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.
2. New section refilled 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.
3. Certificate of Compliance including amendment filed 9-17-87 (Register 87, No. 38).

TITLE 22 **MEDICAL ASSISTANCE PROGRAM**

§51179.4

(Register 87, No. 38-9-19-87) (P. 1262.14.2)

51179.4. Comprehensive Perinatal Health Education Services.

"Comprehensive perinatal health education services" means direct patient care health care education services provided by any qualified professional as specified in Section 51179.7, pursuant to protocols as defined in Section 51179.10. NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 14134.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.
2. New section refilled 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.
3. Certificate of Compliance including amendment filed 9-17-87 (Register 87, No. 38).

51179.5. Personal Supervision.

"Personal supervision" means evaluation, in accordance with protocols, by a licensed physician, of services performed by others through direct communication, either in person or through electronic means. NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132, and 14134.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will repealed on 6-17-87.
2. New section refilled 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.
3. Certificate of Compliance including amendment filed 9-17-87 (Register 87, No. 33).

51179.6. Case Coordination.

"Case coordination" means organizing the provision of comprehensive perinatal services, and includes, but is not limited to, supervision of all aspects of patient care including antepartum, intrapartum, and postpartum. NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132, and 14134.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.
2. New section filed 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.
3. Certificate of Compliance wiled 9-17-87 (Register 87, No. 38).

51179.7. Comprehensive Perinatal Practitioner.

(a) "Comprehensive Perinatal Practitioner" means any one of the following:

(1) A physician who is either:

(A) A general practice physician, or

(B) A family practice physician, or

(C) A pediatrician, or

(D) An obstetrician-gynecologist.

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(Register 87, No. 38-9-19-87) (P. 1262.14.3)

(2) A Certified Nurse Midwife as defined in Section 51170.2.

(3) A Registered Nurse who is licensed as such by the Board of Registered Nursing and who has one year experience in the field of maternal and child health.

(4) A Nurse Practitioner as defined in Section 51170.3.

(5) A Physician's Assistant as defined in Section 51170.1.

(6) A social worker who either:

(A) Holds a Master's Degree or higher in social work or social welfare from a college or university with a Social Work Degree program accredited by the Council on Social Work Education and who has one year of experience in the field of Maternal and Child Health, or

(B) Holds a Master's Degree in psychology or Marriage, Family and Child counseling and has one year of experience in the field of Maternal and Child Health, or

(C) Holds a Baccalaureate Degree in social work or social welfare from a college or university with a Social Work Degree program accredited by the Council on Social Work Education and who has one year experience in the field of Maternal and Child Health.

(7) A health educator who either has:

(A) A Master's Degree (or higher) in Community or Public Health Education from a program accredited by the Council on Education for Public Health and who has one year of experience in the field of Maternal and Child Health, or

(B) A Baccalaureate Degree with a major in Community or Public Health Education and who has one year of experience in the field of Maternal and Child Health.

(8) A childbirth educator who is:

(A) Licensed as a Registered Nurse by the Board of Registered Nursing and has one year experience in a program which complies with the "Guidelines for Childbirth Education" (last published in 1981), herein incorporated by reference in its entirety and available from the American College of Obstetricians and Gynecologists, 600 Maryland Avenue, South West, Suite 300 East, Washington, D.C., 20024-2588 or

(B) A Certified Childbirth Educator who has completed a training program and is currently certified to teach that method of childbirth education by the American Society for Psychoprophylaxis in Obstetrics, or Bradley, or the International Childbirth Education Association.

(9) A dietitian who is registered, or is eligible to be registered by the Commission on Dietetic Registration, the credentialing agency of the American Dietetic Association, with one year of experience in the field of perinatal nutrition.

(10) A comprehensive perinatal health worker who:

(A) Is at least 18 years of age, is a high school graduate or equivalent, and has at least one year of full-time paid practical experience in providing perinatal care;

(B) Provides services in a clinic that is either licensed or exempt from licensure under Section 1200 et seq. and 1250 et seq. of the Health and Safety Code, under the direct supervision of a comprehensive perinatal practitioner as defined in Section 51179.7(a)(1).

(11) A licensed vocational nurse who is licensed under Section 2516 of the Business and Professions Code and who has one year of experience in the field of Maternal and Child Health.

(12) A licensed midwife as defined in Section 51191.

Note: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code; and Section 20, Health and Safety Code. Reference: Sections 14053, 14132 and 14134.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.

2. New section refiled 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.

3. Certificate of Compliance including amendment filed 9-17-87 (Register 87, No. 38).

4. Change without regulatory effect adopting new subsection (a)(12) and amending Note filed 6-20-2016 pursuant to section 100, title 1, California Code of Regulations (Register 2016, No. 26).

51179.8. Individualized Care Plan.

"Individualized Care Plan" means a document developed by a comprehensive perinatal practitioner(s) in consultation with the patient. The plan consists of four components; obstetrical, nutritional, health education, and psychosocial. Each component includes identification of risk conditions, prioritization of needs, proposed interventions including methods, time frames, and outcome objectives, proposed referrals and staff persons' respective responsibilities, based on the results of assessments. NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 14134.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency: effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days of emergency language will be repealed on 6-17-87.

2. New section refiled 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.

3. Certificate of Compliance including repealer of former Section 51179.8, and renumbering and amendment of Section 51179.9 to Section 51179.8 filed 9-17-87 (Register 87, No. 38).

51179.9. Protocol.

"Protocol" means written procedures for providing psychosocial, nutrition, and health education services and related case coordination. Protocols shall be approved by the Comprehensive Perinatal Provider as defined in Section 51179.7(a) (1) and the Comprehensive Perinatal Practitioners as defined in Sections 51179.7(a) (6) (A) or 51179.7(a) (6) (B), and Section 51179.7(a) (7) (A) and Section 51179.7(a) (9). Protocols shall be developed, approved, and adopted within six months of the effective date of provider approval as a Comprehensive Perinatal Provider. NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 14134.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.

2. New section refiled 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.

3. Certificate of Compliance including renumbering of former Sections 51179.9 to Sections 51179.3, and renumbering and amendment of Section 51179.10 to Section 51179.9 filed 9-17-87 (Register 87, No. 38).

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§51249

(Register 88, No. 15-4-9-88) (P. 1264.7)

Article 3. Standards for Participation

51249. Application Process for Comprehensive Perinatal Providers.

(a) Except where a capitated health system contract entered into by Department provides otherwise, to become a comprehensive perinatal provider as defined in Section 51179.1, the Medi-Cal enrolled provider shall complete and submit a Department approved application form entitled Application for Certification As A Comprehensive Perinatal Provider Under Medi-Cal to the local health department or designated State agent for review. The designated agent may include counties or other non-profit organizations as designated by the Director of the Department. Applications shall be available from the local Comprehensive Perinatal Services Program Coordinator or the State Maternal and Child Health Brance, 714 P Street, Sacramento, CA 95814

(b) The department shall utilize the following criteria in evaluating application.

(1) Provider's ability to provide the services specified in Section 51348 through the provider's own service or through subcontractors.

(2) Training and experience of providers rendering services specified in Section 51348.

(3) Quality of care rendered by providers as evidenced by history of:

(A) Revocations, suspensions, or restrictions by a licensing authority.

(B) The extent of training received in the provision of comprehensive perinatal care which has been approved by the State.

(c) The Department shall have responsibility for the final decision and for notifying the provider of acceptance or rejection of the application.

(d) The Department shall:

(1) Within 60 calendar days from receipt of the application, inform the applicant in writing that the application is complete and acceptable or that the application is deficient and what specific information or clarification is necessary.

(2) Within 60 calendar days from receipt of an application which is complete upon initial submission, reach a decision to approve or deny the applicant for participation as a

comprehensive perinatal provider.

(3) Within 60 calendar days from receipt of any information or clarification necessary to make an application complete, reach a decision to approve or deny the applicant for

participation as a comprehensive perinatal provider.

(4) Send written notification to be applicant upon approval or denial for participation as a comprehensive perinatal provider. The written notification of the denial shall contain the basis for the denial.

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§51249

(Register 88, No. 15-4-9-88) (P. 1264.8)

(e) An applicant whose application has been denied shall have 30 calendar days from the date of the receipt of written notification of the denial to submit a written appeal to the Department. This written appeal shall contain factual statements as to why the applicant meets the criteria which have been cited as the basis for the denial of the application. The Department shall issue a written decision within 60 calendar days of receipt of the applicant's appeal. NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 14134.5, Welfare and Institutions Code; and Section 15376(a) and (b), Government Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.

2. New section refiled 6-5-87 as am emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.

3. Certificate of Compliance including amendment of subsection (a) filed 9-17-87 (Register 87, No. 38).

TITLE 22 **MEDICAL ASSISTANCE PROGRAM**

§51348

(Register 88, No. 24-6-11-88) (P. 1294.2.12)

Article 4. Scope and Duration of Benefits

51348. Comprehensive Perinatal Services.

(a) Comprehensive perinatal services, as defined in Section 51179, are covered to the extent specified in this section. Prior authorization is required for nutrition, psychosocial and health education services, which exceed the Maximum Frequency amounts as set forth in Section 51504.

(b) Except where a capitated health system contract entered into by the Department provides otherwise, obstetric services in addition to all necessary medical care shall include, but are not limited to:

(1) A written assessment of each patient's obstetric component.

(2) Preparation of the individualized care plan obstetric status.

(c) Except where a capitated health system contract entered into by the Department provides otherwise, nutrition services shall include but are not limited to:

(1) Written assessments of each patient's nutritional status.

(A) A complete initial nutrition assessment shall be performed at the initial visit or within four weeks thereafter and shall include: authropometric data, biochemical data, clinical data, and dietary data.

(B) A nutrition reassessment using updated information shall be offered to each client at least once every trimester and the individualized care plan revised accordingly.

(2) Preparation of the individualized care plan nutritional component that address:

(A) The prevention and/or resolution of nutrition problems.

(B) The support and maintenance of strengths and habits oriented toward optimal nutritional status, and;

(3) Dispensing, as medically necessary, prenatal vitamin/mineral supplement to each client.

(4) Treatment and intervention directed toward helping the patient understand the importance of, and maintain good nutrition during pregnancy and lactation, with referrals as appropriate.

(5) Postpartum reassessment, development of a care plan, and interventions.

(d) Except where a capitated health system contract entered into by the Department provides otherwise, health education services shall include, but are not limited to:

(1) Client orientation including, but not limited to provision of detailed information regarding the services to be provided, what to do in case of an emergency, and:

(2) Written assessment of each patient's health education status.

(A) A complete initial education assessment shall be performed at the initial visit or within four weeks thereafter and shall include an evaluation of: current health practices; past experience with health care delivery systems; prior experience with and knowledge about pregnancy, prenatal care, delivery, postpartum self-care, infant care, and safety; client's expressed learning need; formal education and reading level; learning methods most effective for the client; educational needs related to diagnostic impressions, problems, and/or risk factors identified by staff; languages spoken and written; mental, emotional, or physical disabilities that affect learning; mobility/residency; religious/cultural influences that impact upon perinatal health; and client and family or support person's motivation to participate in the educational plan.

(B) An education reassessment using updated information shall be offered to each client every trimester and the individualized care plan revised accordingly.

(3) Preparation of the individualized care plan health education component that addresses:

(A) Health education strengths.

(B) The prevention and/or resolution of health education problems and/or needs and medical conditions and health promotion/risk reduction behaviors which can be ameliorated and/or resolved through education.

(C) The goals to be achieved via health education interventions.

(D) Health education interventions based on the patient's identified needs, interests, and capabilities, and particularly directed toward assisting the patient to make appropriate, well-informed decisions about her pregnancy delivery, and parenting, with referrals, as appropriate.

(4) Postpartum assessment, development of care plan, an interventions.

(e) Except where a capitated health care system contract entered into by the Department provides otherwise, psychosocial services shall include, but are not limited to:

(1) Written assessments of each patient's psychosocial status.

(A) A complete initial assessment of psychosocial functioning shall be performed at the initial visit or within four weeks thereafter and shall include review of: current status including social support system; personal adjustment to pregnancy; history of previous pregnancies; patient's goals for herself in this pregnancy; general emotional status and history; wanted or unwanted pregnancy, acceptance of the pregnancy; substance use and abuse; housing/household; education/employment; and financial/material resources.

(B) A psychosocial reassessment using updated information shall be offered to each client every trimester, and the individualized care plan revised accordingly.

(2) Preparation of the individualized care plan psychosocial component that addresses:

(A) The prevention an/or resolution of psychosocial problems.

(B) The support and maintenance of strengths in psychosocial functioning, and:

(C) The goals to be achieved via psychosocial interventions.

(3) Treatment and intervention directed toward helping the patient understand and deal effectively with the biological, emotional, and social stresses of pregnancy with referrals, as appropriate.

(4) Postpartum reassessment, development of a care plan, and interventions.

(f) Review and revision of the care plan shall occur during the antenatal, intrapartum, and postpartum periods on a regular basis and will be based on repeated and ongoing assessments and evaluation of the client's status.

(g) Nutrition, psychosocial, and health education services ad defined in Sections 51179.2, 51179.3, and 51179.4 shall be provided by a comprehensive perinatal practitioner as defined under Section 51179.7.

(h) Each Comprehensive Perinatal Provider shall perform the duties of, or shall have on staff or employ or contract with one or more comprehensive perinatal practitioners as defined in Section 51179.7, to provide interdisciplinary services.

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§51348.1

(Register 88, No. 24-6-11-88) (P. 1294.2.14)

(i) Each Comprehensive Perinatal Provider shall inform the beneficiary what services will be provided, who will provide these services, where to obtain the services, when the services will be delivered, and procedures to follow in case of emergency.

(j) The Comprehensive Perinatal Provider shall refer patients, as appropriate, to services not specifically made part of comprehensive perinatal services, as defined in Section 51179. These services shall include, but are not limited to, those provided by the following programs: Women, Infants, and Children Supplemental Foods, Child Health and Disability Prevention, Family Planning, Genetic Disease, and Dental.

(k) The Comprehensive Perinatal Provider shall complete and forward to the Department, upon request, a Perinatal Data Form in a format prescribed by the Department for each patient served. NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 14134.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.
2. New section refiled 6-5-87 as an emergency; operative 6-17-87 (register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.
3. Certificate of Compliance including amendment filed 9-17-87 (Register 87, NO. 38).

51348.1. Comprehensive Perinatal Standards of Care.

(a) Services shall be provided in conformance with:

(1) "Standards for Obstetric-Gynecologic Services, Sixth Edition", herein incorporated by reference in its entirety and available from the American College of Obstetricians and Gynecologists, 600 Maryland Avenue, South West, Suite 300 East, Washington D.C., 20024¬2588.

(2) Newborn Screening Regulations as set forth in Title 17, California Administrative Code, Section 6500 et seq.

(3) Hemolytic Disease of the Newborn Requirements as set forth in Title 17, California Administrative Code, Section 6510 et seq. NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 14134.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.
2. New section refiled 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.
3. Certificate of Compliance filed 9-17-87 (Register 87, No. 38).

51348.2. Patient Rights.

Patient participation in the comprehensive perinatal services program shall be voluntary. Each eligible patient shall be informed about the services available in the program, the potential risks and benefits of participation, and alternative obstetric care if she chooses not to participate in the program.

Prior to the administration of any assessment, drug, procedure, or treatment, the patient shall be informed of potential risks or hazards which may adversely affect her or her unborn infant during pregnancy, labor, birth or postpartum and the alternative therapies available to her. The patient has a right to consent or refuse the administration of any assessment, drug, procedure or treatment.

(c) The patient has the right to be treated with dignity and respect, to have her privacy and confidentiality maintained, to review her medical treatment and record with her physician or practitioner, to be provided explanations about tests and clinic procedures, to have her questions answered about her care, and to participate in the planning and decisions about her management during pregnancy, labor and delivery.

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14053, 14132 and 14134.5, Welfare and Institutions Code.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.

2. New section refiled 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.

3. Certificate of Compliance filed 9-17-87 (Register 87, No. 38).

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§51503.2

(Register 88, No. 20-5-14-88) (P. 1300.2.4.2)

51504. Comprehensive Perinatal Services.

(a) Except where a capitated health system contract entered into by the Department provides otherwise, reimbursement for comprehensive perinatal obstetric, nutrition, psychosocial, and health education services shall be made only to comprehensive perinatal providers defined in Section 51179.1.

(b) Except where a capitated health system contract entered into by the Department provides otherwise, reimbursement for comprehensive perinatal obstetric, services shall not exceed the maximum allowances for similar services established in Sections 51503, 51509 or 515093.1, whichever is applicable, plus the following amounts.

(1) An additional $50.00 shall be allowed for the initial comprehensive medical office visit when provided within 16 weeks of the last menstrual period.

(2) An additional $100.00 in total shall be allowed for the tenth and all subsequent prenatal office visits when billing occurs on a "by-visit" basis.

(c) Except where a capitated health system contract entered into by the Department provides otherwise, reimbursement for pathology services shall not exceed the maximum a allowances established in Section 51529.

(d) Except where a capitated health system contract entered into by the Department provides otherwise, reimbursement of comprehensive perinatal nutrition, psychosocial, and health education services shall not exceed the maximum allowances listed in this section. Reimbursement shall be claimed only for time spent rendering covered patient care services while in direct personal contact with the patient. Reimbursement shall not be claimed for similar services provided under the Maternal and Child Health program.

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(Register 88, No. 20-5-14-88) (P. 1300.2.5)

(e) Reimbursement for the combined perinatal assessment procedure listed in subsection (1) shall be allowed only when all three indicated assessments and the initial comprehensive medical examination have been performed.

(1) Maximum allowances for comprehensive perinatal nutrition, psychosocial, and health education assessment:

Procedure Code		Maximum Allowance
Z6500	Initial comprehensive nutrition, psychosocial, and health education assessments and development of care plan, first 30 minutes each assessment (total of 90 minutes), including ongoing coordination of care.	$135.83

(2) Maximum allowances for comprehensive perinatal nutrition services:

Z6200	Initial nutrition assessment and development of care plan, first 30 minutes	$16.83
Z6202	Initial nutrition assessment and development of care plan, each subsequent 15 minutes (Maximum of 1 1/2 hours)	8.41
Z6204	Follow-up antepartum nutrition assessment, treatment and/or intervention, individual, each 15 minutes (Maximum of 2 hours)	8.41
Z6206	Follow-up antepartum, nutrition assessment, treatment, and/or intervention, group, per patient, each 15 minutes (Maximum of 3 hours)	2.81
Z6208	Postpartum nutrition assessment, treatment, and/or intervention, including development of care plan, individual, each 15 minutes (Maximum of 1 hour)	8.41
S0197	Prenatal vitamin-mineral supplement, 1 unit (30-day supply) (Maximum 10 units)	3.00

(3) Maximum allowances for comprehensive perinatal psychosocial services:

(4) Maximum allowances for comprehensive perinatal health education services:

Z6300	Initial psychosocial assessment and development of care plan, first 30 minutes	$16.83
Z6302	Initial psychosocial assessment and development of care plan, each subsequent 15 minutes (Maximum of 1 1/2 hours)	8.41
Z6304	Follow-up antepartum psychosocial assessment, treatment and/or intervention, individual, each 15 minutes (Maximum of 3 hours)	8.41
Z6306	Follow-up antepartum psychosocial assessment, treatment and/or intervention, group, per patient, each 15 minutes (Maximum of 4 hours)	2.81
Z6308	Postpartum psychosocial assessment, treatment, and/or intervention, including development of care plan, individual, each 15 minutes (Maximum of 1 1/2 hours)	8.41

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(Register 88, No. 20-5-14-88) (P. 1300.2.6)

Procedure Code		Maximum Allowance
Z6400	Client orientation, each 15 minutes (Maximum of 2 hours)	8.41
Z6402	Initial health education assessment and development of care plan, first 30 minutes	16.83
Z6404	Initial health education assessment and development of care plan, each subsequent 15 minutes (Maximum of 2 hours)	8.41
Z6406	Follow-up antepartum health education assessment, treatment, and/or intervention, individual, each 15 minutes (Maximum of 2 hours)	8.41
Z6408	Follow-up antepartum health education assessment, treatment, and/or intervention, group, per patient, each 15 minutes (Maximum of 2 hours)	2.81
Z6410	Perinatal education, individual, each 15 minutes (Maximum of 4 hours)	8.41
Z6412	Perinatal education, group, per patient, each 15 minutes (Maximum of 18 hours)	2.81
Z6414	Postpartum health education assessment, treatment, and/or intervention, including development of care plan, individual, each 15 minutes (Maximum of 1 hour)	8.41

<General Materials (GM) - References, Annotations, or Tables>

Note: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14075, 14077, 14105 and 14134.5, Welfare and Institutions Code; Statutes of 2000, Chapter 52, Items 4260-101-0001 and 0890. Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14075, 14077, 14105 and 14134.5, Welfare and Institutions Code; Statutes of 2000, Chapter 52, Items 4260-101-0001 and 0890.

HISTORY:

1. New section filed 2-17-87 as an emergency; effective upon filing (Register 87, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 6-17-87.
2. New section refiled 6-5-87 as an emergency; operative 6-17-87 (Register 87, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-15-87.
3. Certificate of Compliance including amendment of subsection (d) filed 9-17-87 (Register 87, No. 38).
4. Amendment of subsection (b) filed 5-9-88 as an emergency; operative 5-15-88 (Register 88, No. 20). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9-12-88.
5. Certificate of Compliance including amendment of subsection (b)(2) transmitted to OAL 9-1-88 and filed 10-3-88 (Register 88, No. 42).
6. Amendment of subsections (e)(1)-(e)(4) filed 9-25-92 as an emergency; operative 10-1-92 (Register 92, No. 40). A Certificate of Compliance must be transmitted to OAL 1-25-93 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 9-25-92 order transmitted to OAL 1-22-93 and filed 3-9-93 (Register 93, No. 11).
8. Amendment of subsections (e)(1)-(2) and (e)(4), new subsection (f) and amendment of Note filed 7-16-2002; operative rates for services provided on or after 8-1-2000 pursuant to Stats. 2000, c. 52, Items 4260-101-0001 and 0890 (Register 2002, No. 29).
9. Certificate of Compliance as to 7-16-2002 order, including repealer of subsection (f), transmitted to OAL 11-12-2002 and filed 12-24-2002 (Register 2002, No. 52).19

WELFARE AND INSTITUTIONS CODE
COMPREHENSIVE PERINATAL SERVICES PROGRAM WI 14134.5

14134.5. All of the following provisions apply to the provision of services pursuant to subdivision (u) of Section 14132:

(a) "Comprehensive perinatal provider" means any general practice physician, family practice physician, obstetrician-gynecologist, pediatrician, certified nurse midwife, a group, any of whose members is one of the above-named physicians, or any preferred provider organization or clinic enrolled in the Medi-Cal program and certified pursuant to the standards of this section.

(b) "Perinatal" means the period from the establishment of pregnancy to one month following delivery.

(c) "Comprehensive perinatal services" shall include, but not be limited to, the provision of the combination of services developed through the Department of Health Services Obstetrical Access Pilot Program.

(d) The comprehensive perinatal provider shall schedule visits with appropriate providers and shall track the patient to verify whether services have been received. As part of the reimbursement for coordinating these services, the comprehensive perinatal provider shall ensure the provision of the following services either through the provider's own service or through subcontracts or referrals to other providers:

(1) A psychosocial assessment and when appropriate referrals to counseling.

(2) Nutrition assessments and when appropriate referral to counseling on food supplement programs, vitamins and breast-feeding.

(3) Health, childbirth, and parenting education.

(e) Except where existing law prohibits the employment of physicians, a health care provider may employ or contract with all of the following medical and other practitioners for the purpose of providing the comprehensive services delineated in this section:

(1) Physicians, including a general practitioner, a family practice physician, a pediatrician, or an obstetrician-gynecologist.

(2) Certified nurse midwives.

(3) Nurses.

(4) Nurse practitioners.

(5) Physician assistants.

(6) Social workers.

(7) Health and childbirth educators.

(8) Registered dietitians.

The department shall adopt regulations which define the qualifications of any of these practitioners who are not currently included under the regulations adopted pursuant to this chapter. Providers shall, as feasible, utilize staffing patterns which reflect the linguistic and cultural features of the populations they serve .W&I Codes Page 13

(f) The California Medical Assistance Program and the Maternal and Child Health Branch of the State Department of Health Services in consultation with the California Conference of Local Health Officers shall establish standards for health care providers and for services rendered pursuant to this subdivision.

(g) The department shall assist local health departments to establish a community perinatal program whose responsibilities may include certifying and monitoring providers of comprehensive perinatal services. The department shall provide the local health departments with technical assistance for the purpose of implementing the community perinatal program. The department shall, to the extent feasible, and to the

extent funding for administrative costs is available, utilize local health departments in the administration of the perinatal program. If these funds are not available, the department shall use alternative means to implement the community perinatal program.

(h) It is the intent of the Legislature that the department shall establish a method for reimbursement of comprehensive perinatal providers which shall include a fee for coordinating services and which shall be sufficient to cover reasonable costs for the provision of comprehensive perinatal services. The department may utilize fees for service, capitated fees, or global fees to reimburse providers.

However, if capitated or global fees are established, the department shall set minimum standards for the provision of services including, but not limited to, the number of prenatal visits and the amount and type of psychosocial, nutritional, and educational services patients shall receive. Notwithstanding the type of reimbursement system, the comprehensive perinatal provider shall not be financially at risk for the provision of inpatient services. The provision of inpatient services which are not related to perinatal care shall not be subject to the provisions of this section.

Inpatient services related to services pursuant to this subdivision shall be reimbursed, in accordance with Section 14081, 14086, 14087, or 14087.2, whichever is applicable.

(i) The department shall develop systems for monitoring and oversight of the comprehensive perinatal services provided in this section. The monitoring shall include, but shall not be limited to, collection of information using the perinatal data form.

(j) Participation for services provided pursuant to this section shall be voluntary. The department shall adopt patient rights safeguards for recipients of the comprehensive perinatal services.

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State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 26, 2012

MMCD POLICY LETTER 12-003
SUPERSEDES POLICY LETTER 12-001 AND 96-01

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: OBSTETRICAL CARE-PERINATAL SERVICES

PURPOSE

This Policy Letter (PL) supersedes the Medi-Cal Managed Care Division's (MMCD) PLs 12-001 and 96-01. This revised PL corrects recent errors in PL 12-001 that were not consistent with the Medi-Cal managed care health plan provider credentialing process.

In order to assure optimum perinatal care and pregnancy outcomes for Medi-Cal managed care enrollees (Members), Medi-Cal managed care plans (Plans) must meet the provisions set forth in this PL.

POLICY

All Plans must ensure initiation of prenatal care as soon as possible and must not require prior authorization for basic prenatal care or preventive services. Plans must inform Members of childbearing age of the availability of comprehensive perinatal services and how to access such services as soon as pregnancy is determined.

- Plans are required to cover and ensure the provision of all medically necessary services for pregnant women. Plans must ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

- Plans are also required to implement a comprehensive risk assessment tool for all pregnant Members that is comparable to ACOG and the Comprehensive Perinatal Services Program (CPSP) standards (California Code of Regulations, Title 22, Section 51348). Individualized care plans must be developed to include obstetrical, nutrition, psychosocial, and health education interventions when indicated by identified risk factors.

Medi-Cal Managed Care Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

- Plans are required to apply their provider credentialing standards to all prenatal care providers. The Plan's prenatal care or obstetrical providers and non-physician medical practitioners, as defined in plan contracts, are exempt from the requirement of certification as Medi-Cal CPSP providers (Title 22, Section 51249 and 51179.7).

- Plans must ensure that pregnant women at high-risk of poor pregnancy outcomes are referred to appropriate specialists, including perinatologists, and that they have access to genetic screening with appropriate referrals. The Plans must also ensure that appropriate hospitals are available within the provider network to provide necessary high-risk pregnancy services.

- Plans are required by contract to execute a subcontract or Memorandum of Understanding (MOU) with local health departments in the area of Maternal and Child Health (MCH).

Additional Resource: Comprehensive Perinatal Services Program

CPSP integrates nutrition, psychosocial, and health education services with basic obstetrical services. This multidisciplinary approach to the delivery of prenatal care is based on the recognition that providing these services from conception through 60-days after the month following delivery contributes significantly to improved pregnancy outcomes.

The California Department of Public Health, Maternal, Child and Adolescent Health (MCAH) Program oversees CPSP and the statewide system of perinatal care. Plans can contact their local health agency MCAH director or their perinatal services coordinator for further information and resources. Information about CPSP and provider training courses is available at:
http://www.cdph.ca.gov/programs/CPSP/Pages/default.aspx.

Please contact your MMCD contract manager for questions about this PL.

Sincerely,

ORIGINAL SIGNED BY MARGARET TATAR

Margaret Tatar, Chief
Medi-Cal Managed Care Division

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 30, 2015

ALL PLAN LETTER 15-017

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVISION OF CERTIFIED NURSE MIDWIFE AND ALTERNATIVE BIRTH CENTER FACILITY SERVICES

PURPOSE:
The purpose of this All Plan Letter (APL) is to clarify for all Medi-Cal managed care health plans (MCPs) their responsibilities to meet federal requirements for access to Certified Nurse Midwife (CNM) services and alternative or freestanding birth centers.[1]

BACKGROUND:
The Medi-Cal Provider Manual defines Alternative Birthing Centers (ABCs) as, "specialty clinics authorized to bill Medi-Cal for Comprehensive Perinatal Services Program (CPSP), obstetrical, and delivery services." For a full list of Current Procedural Terminology codes that have been approved for use by ABCs, see the Medi-Cal Provider Manual.[2]

In addition, Section 1905 of the Social Security Act (Title 42 United States Code [U.S.C] Section 1396d(l)(3)(B)) defines the following:

(B) The term "free standing birth center" as a health facility –
(i) that is not a hospital;
(ii) where childbirth is planned to occur away from the pregnant woman's residence;
(iii) that is licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and
(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the state shall establish.

[1] "Alternative or freestanding birth center services" as defined in Title 42 United States Code, Section 1396d (l)(3)(B), is an alternative to traditional, hospital-based maternity care.
[2] The section of the Provider Manual, "altern 1," is available at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/altern_m00o03.doc.

Among several important provisions targeted to the care of pregnant women that the Patient Protection and Affordable Care Act (referred to as ACA) mandates are payments for facility services to birth centers across the United States (Section 2301). Both Section 2301 of the ACA and Section 1905 of the Social Security Act (Title 42 U.S.C. Section 1396d) require states that recognize freestanding or ABCs to provide coverage for freestanding birth center facility services and services rendered by certain professionals providing services in a freestanding birth center, to the extent the state licenses or otherwise recognizes such providers under state law. Also per ACA Section 2301 and Section 1905 of the Social Security Act (Title 42 U.S.C. Section 1396d (l)(2)(C)), "a state shall provide separate payments to providers administering prenatal, labor and delivery or postpartum care in a freestanding birth center…such as nurse midwives and other providers of services such as birth attendants recognized under state law, as determined appropriate by the secretary."

A CNM is a Non-Physician Medical Practitioner who is licensed as a Registered Nurse and certified as a nurse midwife by the California Board of Registered Nursing. A CNM may be employed by a Medi-Cal provider or be an independent Medi-Cal provider. Primary care services rendered by a CNM must be performed under the general supervision of a physician. A physician's co-signature or countersignature is not required for care provided by CNMs. CNMs must practice in collaboration with a physician and surgeon who have current practice or training in obstetrics and gynecology. Licensed (non-nurse) midwives are not currently allowed to enroll as independent Medi-Cal providers; [3] this APL pertains to the services of CNMs.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including APLs and Dual Plan Letters. DHCS's readiness review process includes a review of each MCP's delegation oversight. MCPs must receive prior approval from DHCS for each delegate.

POLICY:
Pursuant to the MCP contract, MCPs are required to provide access to CNM services, as defined in Title 22, California Code of Regulations (CCR), Section 51345 and Certified Nurse Practitioner (CNP) services, as defined in Title 22, CCR, Section 51345.1, and must inform Medi-Cal beneficiaries that they have a right to obtain out-of-plan CNM services. If there are no CNMs or CNPs in the MCP's provider network, the MCP must reimburse out-of-network CNMs or CNPs for services provided to beneficiaries at no less than the applicable Medi-Cal fee-for-service (FFS) rates. For birthing centers, the MCP is required to reimburse no less than the applicable Medi-Cal FFS rate.[4]

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[3] Medi-Cal Provider Manual, Non-Physician Medical Practitioners, non ph, pages 16-18, is available at: http://files.medi-cal.ca.govpublications/masters-mtp/part2/nonph_m00o03o11.doc.
[4] Select the appropriate boilerplate contract at http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. Go to Exhibit A, Attachment 9,

In October 2012, the Centers for Medicare and Medicaid Services approved the Department of Health Care Services' (DHCS') State Plan Amendment (SPA) 11-022, which added freestanding birth centers and professional services to the California State Plan.[5] SPA 11-022 did not change the scope of services as defined in Welfare and Institutions Code, Section 14148.8, or the requirement that alternative birth center facilities must be certified CPSP providers. Therefore, MCPs and any subcontracting Independent Physician Associations must provide coverage for freestanding birth center facility services and services rendered by certain professionals providing services in a freestanding birth center. DHCS encourages MCPs to contract directly with providers in their networks for these services. If that is not a possibility, MCPs must arrange to provide such services through out-of-network providers, per contractual and regulatory requirements.[6]

If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah C. Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Care Services

Section 7 for County Organized Health System (COHS) plans, and Attachment 9, Section 8 for Two Plan and Geographic Managed Care (GMC) plans.

[5] SPA 11-022 is available at: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Recent%20Amendment%20SPA%2011-022.pdf.

[6] Select the appropriate boilerplate contract at http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. Go to Exhibit A, Attachment 8, Section 7 for COHS, and Attachment 8, Section 8 for Two Plan and GMC. In addition, see Section 2301 of the Patient Protection and Affordable Care Act, http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

Guidelines for Preconception and Interconception Care

Every Woman California
Preconception Health Council of California

General Factors and Recommendations

Alcohol & Drugs

Ask: When was the last time you had more than 3 drinks in one day? (Positive= in the past 3 months) How many drinks do you have per week? (Positive= more than 7) Have you used drugs other than those required for medical reasons (illicit or prescription drug misuse) in the past year?

Advise: Pregnancy should be delayed until individuals are alcohol and drug free.

Refer: Do a brief intervention to address hazardous or harmful use of alcohol or drugs. Refer for more intensive treatment if indicated.

Counsel: No amount of alcohol is considered safe during pregnancy. Alcohol is the leading known cause of intellectual disabilities and birth defects in the U.S. If a woman is pregnant, planning to get pregnant or at risk of getting pregnant (i.e., not using contraception), she should not drink alcohol. Illicit drug use is associated with pregnancy loss (miscarriage, stillbirth, neonatal death), birth defects, SIDS, IUGR, LBW, preterm birth, neonatal abstinence syndrome, developmental and behavioral problems.

Chlamydia

Ask: Women under 26 years of age if they have been screened for Chlamydia in the past year.

Advise: Annual screening of sexually active women under 26 years of age. Increased risk women of ANY age should be screened annually or more often based on sexual behaviors.

Refer: As needed for screening and treatment if not available in your practice.

Counsel: Risk factors for Chlamydia infection include history of GC, Chlamydia, or PID in the past 2 years, more than 1 sexual partner in the past year, a new sexual partner within 90 days, and reason to believe that a sex partner has had other partners in the past year.

Other STIs & Other Infectious Diseases

Ask: Women about their sexual history and the use of injection drugs by themselves or their partners.

Advise: Women at risk for gonorrhea, HIV, TB, syphilis and hepatitis B and C should be screened and treated.

Refer: As needed for screening and treatment if not available in your practice.

Counsel: See STD Treatment Guidelines (cdc.gov/std/treatment/2010/default.htm) or TB Treatment Guidelines (cdc.gov/tb/publications/guidelines/Treatment.htm) for risk factors.

Environmental/ Occupational Exposures

Ask: Do you have household, environmental, or workplace exposures to known or potentially hazardous chemicals or materials including pesticides?

Advise: Avoid such exposures prior to and during pregnancy.

Refer: Refer women with soil and/or water hazard concerns to the local health department for soil and water testing. Refer women with household or workplace exposure concerns to an occupational medicine specialist for modification of exposures (ctispregnancy.org) and (prhe.ucsf.edu).

Counsel: Consider household, environmental and occupational exposures. Recommend that women avoid BPA and phthalates, lead, and mercury. Refer to Birth Defects Monitoring Program (cdph.ca.gov/programs/CBDMP/).

Family & Genetic History

Ask: Personal or family history of genetic disorders, congenital malformations, intellectual disabilities, and ethnicity of woman and partner.

Refer: Refer to geneticist if indicated. Assess for genetic disorders, congenital malformations, intellectual disabilities, and ethnicity of woman and partner. Refer to March of Dimes checklist: (marchofdimes.com/Your_family_health_historypreconceptionprenatal.pdf)

Folic Acid

Ask: Do you take folic acid supplements or a multivitamin with folic acid?

Advise: All women who are planning pregnancy or at risk of becoming pregnant should take 0.4 mg (400 mcg) of folic acid daily. This can be done with a folic acid tablet or a multivitamin with folate.

Counsel: Preconception intake of folic acid is crucial because neural tube development is essentially complete by 4 weeks after conception (6 weeks after last menstrual period). This can reduce severe anomalies by 46%. Women with a seizure disorder or history of neural tube defects should take 4.0 mg/day. Obese women should take at least 1.0 mg/day.

Immunizations

Ask: Have you been vaccinated for influenza, MMR, varicella, TDP, HPV and Hepatitis B?

Advise: Completion of all necessary vaccine series before becoming pregnant.

Refer: As needed for vaccination services not available in your practice.

Counsel: See CDC vaccination guidelines: (cdc.gov/vaccines/recs/schedules/downloads/adult/adult-schedule-bw.pdf)

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These guidelines are considered a resource, but do not define the standard of care in California. Readers are advised to adapt the guidelines and resources based on their facility's level of care and patient population and are advised not to rely solely on the information presented here. Guidelines can be found at: (Everywomancalifornia.org)

Mood Disorder

Ask 1: Over the past 2 weeks, have you felt down, depressed or hopeless? Over the past 2 weeks, have you felt little interest or pleasure in doing things? If yes, use validated screening tool such as Edinburgh Postpartum Depression scale or PHQ-9.

Ask 2: In the past month, for more days than not, have you been bothered by feeling overly anxious, nervous, worried, irritable, or overwhelmed? If yes, screen for panic disorder, agoraphobia and obsessive-compulsive disorder.

Refer 1: To Postpartum Support International (1-800-844-4PPD or postpartum.net).

Refer 2: To specialist if indicated.

Oral Health & Routine Dental Care

Ask: When was the last time you went to the dentist?

Advise: To brush teeth and floss at least twice a day.

Refer: To see dentist at least once a year.

Counsel: Poor oral health in adults is associated with cardiovascular disease, diabetes, and respiratory diseases, all of which can increase the risk of complications during pregnancy. Children of mothers with poor oral health are more likely to develop dental caries at an early age and this can lead to developmental problems, pain, problems eating and speaking, low self-esteem, and school absenteeism.

Periodontal Disease

Ask: Do you have sore or bleeding gums, sensitive or loose teeth, a bad taste or smell in your mouth?

Advise: To brush teeth and floss at least twice a day.

Refer: To see a dentist, or if severe, a periodontist.

Counsel: Periodontal disease in pregnant women is associated with adverse pregnancy outcomes including low birthweight, preterm birth, preeclampsia, and gestational diabetes. In fact, 18% of LBW and PTB may be attributable to periodontal disease.

Relationship Health

Ask 1: Within the last year, has your partner hit, slapped, kicked, choked, or otherwise physically hurt you? Are you afraid of your partner?

Ask 2: Within the past year, has your partner forced you to participate in unwanted sexual activities? Does your partner interfere with your birth control or refuse to wear condoms ?

Advise 1: Controlling or violent relationships can impact your health as well as the health of your children. You are not alone; help is available.

Advise 2: It can be stressful to worry about being pregnant when you don't want to be. There are methods of birth control that your partner doesn't have to know about.

Refer: Offer information about community resources, National DV Hotline (1-800-799-SAFE).

Counsel: Assess other behavioral health issues (depression, substance abuse) and refer to mental health specialist if indicated.

Reproductive History

Ask 1: How many cesarean sections have you had?

Ask 2: Did you have gestational diabetes with any prior pregnancy?

Ask 3: Do you have a history of preterm delivery, stillbirth, recurrent pregnancy loss or uterine anomaly?

Advise 1: Women with prior cesarean delivery should be counseled to wait at least 18 months before next conception.

Advise 2: Postpartum women with a history of gestational diabetes should be screened for diabetes using a 2 hr. OGTT with a 75 gm glucose load. After the postpartum period, perform HbA1c every 1-3 years.

Advise 3: Evaluate for modifiable risk factors prior to conception, e.g. medical, lifestyle, and environmental risks for preterm birth, diagnosis of thrombophilia, or surgical correction of uterine anomalies.

Refer 2: For treatment if HbA1c > 6.5%.

Refer 3: To specialist if indicated.

Counsel 1: There is a significant increase in morbidity and mortality with > 3 C/S.

Counsel 2: Good control of blood sugars is essential prior to conception (See section on Diabetes).

Counsel 3: Discuss possible treatment options for next pregnancy, e.g., progesterone therapy, cerclage, timely treatment of recurrent UTIs or cervical/vaginal infections,etc., if applicable.

Smoking

Ask: Do you currently smoke or use any form of tobacco?

Advise: Quit for your health and the health of your family.

Refer: To (1-800-NO-BUTTS) or access other community-based resources.

Counsel: Smoking accounts for the highest proportion of preventable problems in pregnant women and it is also important to avoid second-hand smoke. Smoking is associated with increased risk of miscarriage, cleft lip with or without cleft palate, premature rupture of membranes, preterm delivery, abruption, intra-uterine fetal demise, low birthweight, and SIDS.

Guidelines for Preconception and Interconception Care

Every Woman California
Preconception Health Council of California

Specific Health Conditions

Asthma

Counsel: Women with poor control of their asthma should use contraception until it is well controlled.

Tests: Confirm diagnosis with PFTs if not already done; intermittent SOB may have cardiac origin. See NHLBI Guidelines for Diagnosis and Management of Asthma, July 2007.

Contraindicated Medications: No restrictions.

Contraception:** All methods are considered to be safe. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

Cardiovascular Disease

Counsel: Pregnancy is a stressor on the cardiovascular system. Discuss potentially life-threatening risks with pulmonary hypertension, Eisenmenger syndrome, prior myocardial infarction, or cardiomyopathy. Contraception should be strongly recommended when pregnancy is contraindicated.

Tests: Consult with a cardiac specialist. Any history of cardiac murmur needs echocardiogram; any history of palpitations/fainting needs EKG. See CA Heart Disease and Stroke Prevention Program (cdph.ca.gov/programs/cvd).

Contraindicated Medications: Find an alternate medication for ACE inhibitors and Coumadin beyond 6 weeks gestation. Statins.

Contraception:** Avoid: estrogen-containing methods in women with multiple risk factors for arterial CV disease, history of heart attack, and most women with a history of post-partum cardiomyopathy. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

Depression

Counsel: Screening prior to pregnancy allows for treatment with behavioral therapy with or without medication and control of symptoms that may help prevent negative pregnancy and family outcomes. Patients controlled on SSRIs should be warned that relapse rates are 75% if medication is discontinued.

Tests: Use PHQ-9 or other validated test to diagnosis and monitor patient. See MacArthur Initiative on Depression and Primary Care Tool Kit (depression-primarycare.org/clinicians/toolkits/).

Contraindicated Medications: Paroxetine, lithium.

Contraception:** All methods are considered to be safe. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

Diabetes

Counsel: Three-fold increased risk of birth defects, which may be reduced with good glycemic control prior to conception. Women with poor glycemic control should use effective birth control.

Tests: Patients should demonstrate good control of blood sugars with HbA1c < 6.5 prior to conception. Assess for retinopathy, renal disease, and cardiac disease. See Basic Guidelines for Diabetes Care (caldiabetes.org).

Contraindicated Medications: ACE inhibitors, statins.

Contraception:** Avoid: estrogen-containing methods in women with diabetic nephropathy, retinopathy, neuropathy, or diabetes of >20 years duration. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

HIV

Counsel: HIV may be life-threatening to the infant if transmitted. Antiretroviral therapy can reduce the risk of transmission, but the risk is still ~2%.

Tests: Refer to specialist. See updated Guidelines for Treatment of Adults and Adolescents (aidsinfo.nih.gov/Guidelines/). Call HIV Perinatal Hotline for questions (888-488-8765).

Contraindicated Medications: Efavirenz (Sustiva®).

Contraception:** Some antiretroviral drugs may reduce the efficacy of hormonal methods. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization (whqlibdoc.who.int/hq/2012/WHO_RHR_12.08_eng.pdf).

Hypertension

Counsel: Increased maternal and fetal risk during pregnancy, especially for preeclampsia. Discuss importance of finding alternative to ACE inhibitor prior to pregnancy.

Tests: Women with HTN for several years should be assessed for ventricular hypertrophy, retinopathy and renal disease. Consult a cardiac specialist if indicated.

Contraindicated Medications: ACE inhibitors.

Contraception:** Avoid estrogen-containing methods in women with severe hypertension (systolic >160, diastolic >100). Estrogen oral contraceptive pills should be avoided in women over 35. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

Intimate Partner Violence and/or Reproductive Coercion

Counsel: Increased risk of unintended pregnancy, abortion, repeat pregnancy, STIs, preterm labor, obstetric complications, pregnancy-related mortality, postpartum depression, smoking in pregnancy, drug use in pregnancy.

Tests: Acknowledge the trauma and assess the immediate safety of woman and her children while assisting the woman in development of safety plan. Offer information about community resources, National DV Hotline (1-800-799-SAFE). Refer to social services or mental health specialist. In CA, reporting is mandatory if practitioner treats woman or provides medical care for injuries resulting from DV or abuse.

Contraception:** Use methods that are hidden or less likely to be controlled by partner (DMPA, implant, EC). Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

Underweight

Counsel: (BMI ≤ 18.4) Counsel patients that they are at risk for an IUGR infant. Encourage healthy eating.

Tests: Assess for eating, malabsorption and/or endocrine disorder.

Contraception:** All methods are considered to be safe. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

Overweight

Counsel: (BMI=25.0-29.9) and one additional risk factor.

Tests: Additional risk factors: physical inactivity, waist circumference >35 inches, FH of DM, HTN, CVD, dyslipidemia, history of gestational diabetes or a previous 9 lb baby, PCOS, IGT or high risk ethnicity (African American, Native American, Latina, Asian American or Pacific Islander).

Contraindicated Medications: Test for glucose intolerance with HbA1c or a 2 hr OGTT with a 75 gm glucose load.

Contraception:** All methods are considered to be safe. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

Obesity

Counsel: (BMI ≥ 30) Increases the risk for birth defects, spontaneous abortion, pre-eclampsia, gestational diabetes, prematurity, cesarean delivery, incision complications, postpartum infection, thromboembolic disease, perinatal death, maternal death, and childhood obesity. Offer specific strategies to decrease caloric intake and increase physical activity.

Tests: Screen for diabetes with HbA1c or 2 hr OGTT with a 75 gram glucose load except in patient with Roux-en-Y gastric bypass surgery (OGTT will cause dumping syndrome). A patient who has undergone bariatric surgery needs to have PCC with her surgeon.

Contraindicated Medications: Weight loss medications should not be used during pregnancy.

Contraception:** Combined OCs and progestin only pills may have higher failure rates in women who have had bariatric surgery with a malabsorptive procedure. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

Renal Disease

Counsel: Counsel to achieve optimal control (serum Cr <1.4 mg/dL) of condition prior to conception. Discuss potentially life-threatening risks during pregnancy. After transplant, wait 12-18 mo and until comorbid risk factors under control (no or minimal proteinuria, absence or well-controlled HTN, stable serum Cr < 1.4, no graft rejection).

Tests: Consult with renal specialist.

Contraindicated Medications: Find alternative for ACE inhibitors if at risk of pregnancy.

Contraception:** Safe: Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

Seizure Disorder

Counsel: Counsel on potential effects of seizures and seizure medications on pregnancy outcomes. Patients should take 4 mg of folic acid per day for at least 1 month prior to conception.

Tests: Whenever possible, monotherapy in the lowest therapeutic dose should be prescribed.

Contraindicated Medications: Valproic acid (Depakote®), lithium. Topiramate. (Topamax®)

Contraception:** Phenytoin, carbamazepine, barbiturates, primidone, toprimate, oxcarbazepine, and lamotrigine may decrease contraceptive efficacy of some hormonal methods. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

SLE & Other Autoimmune Diseases

Counsel: Disease should be in good control prior to pregnancy.

Tests: Evaluate for renal function and end-organ disease. Consult with rheumatologist.

Contraindicated Medications: Cyclophosphamide and Methotrexate.

Contraception:** Avoid estrogen-containing methods in women with SLE with positive (or unknown) antiphospholipid antibody. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

Thyroid Disease

Counsel: Women with hypothyroidism should increase their levothyroxine by 30% as soon as pregnancy is confirmed. Iodine intake of 150 mcg/day.

Tests: TSH should be < 3.0 prior to pregnancy. Free T4 should be normal.
See:(thyroidguidelines.net/pregnancy)

Contraindicated Medications: Radioactive iodine.

Contraception:** All methods are considered to be safe. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

Thromboembolic Disease

Counsel: Counsel patient that inherited thrombophilias and the antiphospholipid syndrome, as well as history of thrombosis increase the risk for venous thromboembolism during pregnancy and postpartum. Many of these patients will require anticoagulation during pregnancy and postpartum.

Tests: If patient with history of venous thromboembolism has not had work-up, test for inherited thrombophilias and the antiphospholipid syndrome.

Contraindicated Medications: Coumadin beyond 6 wk. GA.

Contraception:** Avoid estrogen-containing methods in women with history of DVT/PE (on or off of anticoagulant medications) with an increased risk of recurrence. Copper IUD and LNG IUD, ETG implant, DMPA, sterilization.

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These guidelines are considered a resource, but do not define the standard of care in California. Readers are advised to adapt the guidelines and resources based on their facility's level of care and patient population and are advised not to rely solely on the information presented here. Guidelines can be found at: (Everywomancalifornia.org)

** U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 (cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm)

Acknowledgment: These guidelines were adapted from the HealthTeamWorks (founded as the Colorado Clinical Guidelines Collaborative) Guidelines for Preconception and Interconception Care (Dec 2009).