

HEALTH PLAN OF SAN JOAQUIN			
Subject: Prenatal Care			
Department: Medical Management Utilization			Policy #: UM42
Applies to: Medi-Cal / Healthy Families / Healthy Kids			Scope: UM
Effective Date:	Revised Date:	Approved by: <i>Signature on file</i> (Title of Sr. Exec. responsible)	

POLICY

- A. Members of the Health Plan of San Joaquin may self refer for Prenatal care. Health Plan of San Joaquin shall cover and ensure the provision of all Medically Necessary services for pregnant women, and will ensure that the network contracted Obstetricians follow the most current American College of Obstetrics and Gynecologists (ACOG) and Comprehensive Perinatal Services Program (CPSP) standards as the minimum standards for antepartum care.
- B. Members may access and obtain OB services from Certified Nurse Midwife (CNM), who will practice within their scope of practice and refer to the obstetrician all cases outside the scope of their practice. If there are no contracted CNM's, the members may access and obtain OB care from an out of area CNM and HPSJ will reimburse services provided to Members at no less than the applicable Medi-Cal fee-for-service (FFS) rate.
- C. The Health Plan of San Joaquin's contracted Obstetricians and CNM, shall utilize, with all their prenatal cases, an assessment tool which includes medical/obstetrical, nutritional, psychosocial, and health education needs and a risk assessment component. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components.
- D. (This is a Procedure/Guideline)Health Plan of San Joaquin participating physicians and CNM shall inform HPSJ members presenting for obstetrical care of the availability of Comprehensive Perinatal Services Program (CPSP) and how to access such services as soon as pregnancy is determined. The Health Plan of San Joaquin will, through periodic surveys of pregnant and post-partum members verify that appropriate education and information is being provided by the Obstetrician. Deficiencies will be addressed to individual providers and, when necessary, through CPSP provider training. Participation of the member in the CPSP program is voluntary. Plan members who are evaluated as high risk will be counseled as to the positive outcome benefits possible through participation in CPSP.

PROCEDURE (basic obstetrical, nutritional, health)

E. Scheduling and tracking appointments

1. Providers will schedule Pre-natal appointment within one (1) week of members request for an appointment.
 - a) Patients who fail to keep a scheduled first prenatal appointment will be followed up immediately by a phone call.
 - No phone response will be followed by a letter within one week of missed appointment

F. Continued inability to reach the patient within two weeks will be referred by the member's physician to the Health Plan of San Joaquin Member Services Representative for follow-up assistance.

1. Return visits should be determined by a woman's individual needs and risk factors. Women with active medical or obstetric problems should be seen more frequently at intervals determined by the nature and severity of the problem A woman with an uncomplicated pregnancy should be seen;
 - a) Every 4 weeks for the first 28 weeks of pregnancy
 - b) Every 2 – 3 weeks until 36 weeks gestation,
 - c) Weekly thereafter.

G. Antepartum Health Assessment

1. The main components of basic antepartum health assessment include:
 - a) Follow up appointments according to the interval of antepartum care
 - b) Risk Assessment
 - c) Physical examination and interpretation of findings
 - d) Routine laboratory assessment
 - e) Assessment of normal pregnancy progress,
 - f) Specialty referral consultations consistent with antepartum care, plus fetal diagnostic testing (e.g. biophysical tests, amniotic fluid analysis, basic ultrasound);
 - g) Psychosocial support, including, genetic testing and consultation, nutrition assessment, health education, care coordination,
 - h) Specialty network panel with expertise in management of medical and obstetric complications, including peri-natologists.

H. Initial Risk Assessment

1. Providers will perform an initial risk assessment Risk assessment and re-assessment will occur at the following intervals,
 - a) The first prenatal visit
 - b) Within four weeks of entry into care
 - c) At least once every trimester
 - d) At the post partum visit

I. Initial Prenatal visit

1. During the initial prenatal visit the member will receive a complete initial nutrition, psychosocial and health education assessment which will include;
 - a) Nutrition evaluation including;
 - b) Anthropometric
 - c) Biochemical
 - d) Clinical and
 - e) Dietary
 - f) Health Education evaluation;
 - Prior experience with and knowledge of pregnancy, prenatal care, delivery, postpartum self care, infant care, safety.
 - Current health practices, including use of drugs, over-the-counter medications, tobacco, alcohol and caffeine and health promoting/risk reduction behaviors;
 - Religious/cultural influences that impact upon Perinatal health;
 - Formal education and reading level;
 - Learning methods most effective for the client;
 - Languages spoken and written;
 - Past experience with health care delivery systems;
 - Mental, emotional, or physical disabilities that affect learning;
 - Client's expressed learning needs;
 - Client and family or support person's motivation to participate in the educational plan;
 - Mobility/residency;
 - Educational needs related to diagnostic impressions, problems, and/or risk factors identified by staff.

- g) Psychosocial
 - Review of history from previous notes in medical records;
 - Current situation (patient’s point of view);
 - Substance use and abuse;
 - Housing/household;
 - Education/employment;
 - Financial/material;
 - Summary of assessment;
 - Immediate action taken.
2. During the first Pre-natal visit each member will be assessed to identify potential risk factors and to develop an Initial Care Plan that will facilitate coordination of care. In accordance with Title 22, CCR, section 5134 8.2, Participating providers will inform HPSJ members of the CPSP program and that participation is voluntary.
 3. Plan members who are evaluated as high risk will be counseled as to the positive outcome benefits possible through participation in CPSP.
 4. If CPSP is refused by the Plan member, no further CPSP components will be completed following the initial assessments.
 5. An Individual Care Plan (ICP) shall be implemented for each member, which will be revised throughout the antepartum and postpartum care to facilitate the coordination of care.
 6. The member’s obstetrician, or certified nurse midwife, (CNM) is responsible to ensure that an ICP is initiated upon the patient’s first contact with the physician as a new pregnancy.
 7. Patients transferring from another physician, or CNM, will require that the provider, or CNM secure a copy of the ICP, or to initiate a new ICP. Document clinical observations and services on the form. The date on the form should reflect the date of entry into care with this physician
 8. The Individual Care Plan will be kept within the medical record and developed by a comprehensive Perinatal Practitioner(s) in consultation with the patient and practitioners in the areas of:
 - a) Nutrition
 - The prevention and/or resolution of nutrition problems;
 - The support and maintenance of strengths and habits oriented toward optimal nutritional status;
 - The goals to be achieved via nutrition intervention.

- b) Psychosocial
 - The prevention and/or resolution of psychosocial problems;
 - The support and maintenance of strengths in psychosocial functioning;
 - The goals to be achieved via psychosocial interventions;
 - c) Health Education
 - Health education strengths;
 - 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;
 - The goals to be achieved via health education interventions;
 - Health education interventions based on the patient’s identified needs, interests, and capabilities.
9. The Individual Care Plan shall include, for each component, the identification and documentation of;
- a) Risk conditions/problems,
 - b) Interventions, and
 - c) Outcome information documented for each re-assessment
10. The ICP shall also clearly identify parties responsible for carrying out proposed interventions. Practitioners who assist in keeping the ICP are those involved in case management of the member, eg; physician, nurse, nutritionist, social worker, health educator, physician assistant. Practitioners must date and initial their assessments, recommendation and interventions.
11. Health Plan of San Joaquin members exhibiting any of the following Common Pregnancy conditions/issues will require interventions and referrals to the appropriate requiring multi-disciplinary management;

Unintended or unwanted pregnancy	Psychosocial
Teenager pregnancy	Psychosocial
Fear of physicians, hospitals and medical personnel	Health Education
Language barriers	Health Education
Lack of basic reproductive awareness	Health Education
Housing and transportation problems	Psychosocial

Domestic violence	Psychosocial
No previous contact with health care systems	Health Education
HIV positive	Psychosocial
Nutritional	
Substance use	Psychosocial
Multiple gestation	Health Education
Psychosocial	
Nutritional	
Need for bed rest during pregnancy	Health Education
Psychosocial	
Previous receipt of unfriendly health care services	Health Education
Cultural /religious beliefs	Health Education

12. Common Postpartum Conditions/Issue Requiring Multidisciplinary Management

Postpartum blues, postpartum depression	Psychosocial
Housing, food, transportation problems	Psychosocial
Lack of basic parenting skills and role models	Health Education
Breastfeeding difficulties	Health Education
Sexual pain/difficulties	Health Education
Severe anemia	Nutritional

J. High Risk Conditions Requiring Specialty Care

1. Pregnant HPSJ members will be provided genetic screening, counseling and referral as needed. The member's obstetric provider will contact the member's PCP if he or she feels there is a need for medical geneticist assessment and counseling. The PCP, in consultation with the obstetric physician, will authorize the requisite referrals. (From UM 43)
2. The following referral matrix for High Risk Pregnancy is a partial list of high risk obstetric factors, derived from the history or physical examination which increases pregnancy risks and may necessitate further evaluation, consultation or referral:

REFERRAL MATRIX-HIGH RISK PREGNANT WOMEN

Refer to the following provider when patients present with;

Perinatal Specialists	Social Worker	Registered Dietician	MPH
Diabetes	No support system	Poor nutritional status	Multiple barriers to learning:
Hypertension	Family abuse	Daily diarrhea	Developmentally disabled
Cardio Vascular Problems	Financial problems	Very over weight = >135%	Limited English speaking
Hepatitis	No food in house	Under weight = <90%	Impaired ability to understand
Tuberculosis	Psychiatric problems	Vomiting more than 2 times daily in 2nd and 3rd trimester	Little or no education
Pre-term Labor	History of CPS involvement	2nd and 3rd Trimester	Functionally illiterate
Pre-Eclampsia	Abuse	Excess weight gain = >8# per month	Apathetic resistant
HIV+	Child	Inadequate weight gain <1#/mo. in very over weight	
Renal Disease	Sexual	<2#/mo in all other	
Blood Disorders	Chemical	Severe anemia	
Genetic Problems	Family	hypovolemia	
Cancer	Non-Compliance	GTT 3/hour	
Multiple Gestation	Late entry into care	Fast > 1.5 mg/dl	
Epilepsy		1 hr > 190	
Asthma		2 hr > 165	
		3 hr > 145	
		Gestational diabetes	
		Aids	
		Cancer, 15 yrs or less, Anorexia, nervosa, Bulimia, Compulsive eating	

REFERENCE

- A Title 22, CCR, Sections 51348, 51240, 51345, 51345.1
- B American College of Obstetrics and Gynecology (ACOG)
- C DHS Contract Exhibit A, Attachment 10, Provision 6.
- D DHS Contract Exhibit A, Attachment 9. Provision 3, 4 & 7
- E HPSJ P&P UM43 - Comprehensive Perinatal Service Program (CPSP)

Executive Approval Chief Executive Officer

Created by/Date	Revised by/Date	Revised by/Date	Revised by/Date	Revised by/Date	Revised by/Date
2-1-96	03-28-03	4/06 per DHS M. Jordan RN	06/08 M. Papasan	Reviewed by J. Scott 10/08	

Original with signature on file in the office of the Compliance Officer Date:

HEALTH PLAN OF SAN JOAQUIN		
Subject: Comprehensive Prenatal Services Program (CPSP)		
Department: Medical Management		Policy #: UM 43
Applies to: Medi-Cal		Scope: UM
Effective Date: 2/96	Revised Date: 06/08	Approved by: Medical Director

PURPOSE

The Comprehensive Perinatal Services Program integrates nutrition, psychosocial and health education services with basic obstetric services. This multidisciplinary approach to the delivery of prenatal care is based on the recognition that providing these services from conception through 60 days following delivery contributes significantly to improved pregnancy outcomes. The delivery of CPSP services is a Medi-Cal benefit pursuant to Title 22, California Code of Regulations (CCR), Section 51348.

POLICY

Participating physicians are required to inform pregnant HPSJ members of the availability of CPSP services and how to access such services as soon as pregnancy is determined. Member will be informed that participation in CPSP is voluntary. Plan members who are evaluated as high risk will be counseled as to the positive outcome benefits possible through participation in CPSP. If CPSP is refused by the Plan member no further CPSP components will be completed following the initial assessments. Members that enroll in the CPSP program will have their risk status assessed by the OB provider using the comprehensive risk assessment tool, attachment A, or an ACOG approved tool.

Results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components.

PROCEDURE

- A. Each pregnant HPSJ member enrolled in CPSP will receive a complete initial nutrition, psychosocial and health education assessment at the first prenatal visit or within four weeks of the first prenatal visit (see Attachment A) As a result of the assessment, referrals to the appropriate specialist, including perinatologists and genetic screening and counseling will be made. This assessment will include:
- B. **Nutrition**
 - 1. Anthropometric

2. Biochemical
3. Clinical, and
4. Dietary data

C. Health Education

1. Prior experience with and knowledge of pregnancy, prenatal care, delivery, postpartum self care, infant care, and safety;
2. Current health practices, including use of drugs, over-the-counter medications, tobacco, alcohol and caffeine and health promoting/risk reduction behaviors;
3. Religious/cultural influences that impact upon perinatal health;
4. Formal education and reading level;
5. Learning methods most effective for the client;
6. Languages spoken and written;
7. Past experience with health care delivery systems;
8. Mental, emotional, or physical disabilities that affect learning;
9. Client's expressed learning needs;
10. Client and family or support person's motivation to participate in the educational plan;
11. Mobility/residency;
12. Educational needs related to diagnostic impressions, problems, and/or risk factors identified by staff.

D. Psychosocial

1. Review of history from previous notes in medical record;
2. Current situation (patient's point of view);
3. Substance use and abuse;
4. Housing/household;
5. Education/employment;
6. Financial/material;
7. Summary of assessment;
8. Immediate action taken.

E. Genetic Screening, Counseling and Referral

1. Women at increased risk of a poor pregnancy outcome may or may not need formal genetic counseling. Sometimes, the problem is relatively uncomplicated, for example, the obstetrician can readily explain the well-known relationship between advanced maternal age and chromosomal abnormalities. In other cases, complexities may justify referral. Whatever the situation, counseling is obligatory before antenatal diagnostic studies are performed.

2. Genetic counseling, whether done by the obstetric physician or by the medical geneticist, is defined as a communication process that deals with the occurrence, or the risk of occurrence, of a genetic disorder in a family.
3. Pregnant HPSJ members will be provided genetic screening, counseling, and referral as needed. (This needs to be added to UM 42 (Prenatal Care) also.
4. In this process, one or more appropriately trained persons will attempt to help the individual or family:
 - a) Comprehend the medical facts, including the diagnosis, the probable course of the disorder and the available management;
 - b) Appreciate the way in which heredity contributes to the disorder and the risk of occurrence in specified relatives;
 - c) Understand the options for dealing with the risk of recurrence;
 - d) Choose the course of action that seems appropriate in view of the risk and the family goals, and act in accordance with that decision; and
 - e) Make the best possible adjustment to the disorder in an affected family member and to the risk of recurrence in another family member.
5. The key elements in this definition are diagnosis, communication, and options. When a genetic disorder has been diagnosed in a family member, the counselor will communicate to the family a range of available options; the counselor's function is not to dictate a particular course of action, but to provide information that will allow couples to make an informed decision.

F. Procedure for Genetic Referral

1. The member's obstetric provider will contact the member's PCP if he or she feels there is need for medical geneticist assessment and counseling. The PCP, in consultation with the obstetric physician, will authorize the requisite referrals. This needs to be added to UM 42 (Prenatal Care) too.

G. Postpartum Evaluation

The routine postpartum care visit should be accomplished 4-8 weeks after delivery, although this interval may be modified if warranted by the needs of the patient. This postpartum review should include:

1. Internal history, including questions regarding breastfeeding;
2. Physical examinations;
3. Laboratory data as indicated;
4. Family planning counseling;

5. Nutritional, health education and psychosocial re-assessments;
6. Review of immunizations including against rubella;
7. Encouragement to return regularly for examinations.

H. Guidelines for Postpartum Nutrition Assessment

1. Identify any nutritional risk factors which may compromise the health of the client or her infant following the delivery;
2. Identify and support the strengths/habits which promote good nutrition status following pregnancy and during breastfeeding;
3. Make timely and appropriate nutrition interventions for each client;
4. Integrate postpartum nutrition care with obstetrical, psychosocial, and health education services.

I. Post -Partum Psychosocial Re-Assessments

1. The Psychosocial re-assessment will be performed at the postpartum visit. Comprehensive Perinatal psychosocial services will be directed toward helping the patient to understand and deal effectively with the biological, emotional, and social challenges of the postpartum period.

J. Plan Oversight

1. The Health Plan will, through periodic surveys of pregnant and postpartum members verify that appropriate education and information is being provided by the obstetrician. Deficiencies will be addressed to individual providers and, when necessary, through CPSP provider training.

REFERENCE

- A. Title 22, CCR, Sections 51348 and 51348.2
- B. DHS Contract Exhibit A, Attachment 10, Provision 6
- C. HPSJ P&PUM 42 – Prenatal Care

Executive Approval

Chief Executive Officer

Created by/Date	Revised by/Date	Revised by/Date	Revised by/Date	Revised by/Date	Revised by/Date
Feb. 1996	4/2006 M.Jordan RN	01/2008 M. Papasan	Reviewed by J. Scott 10/08		