Orange County

Comprehensive Perinatal Services Program

Perinatal Protocols

Name of CPSP Site

Address

Date

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CPSP PROTOCOL SIGNATURE PAGE
CPSP Site

The undersigned have reviewed and approved the attached CPSP protocols:

_____

name and credentials typed:

CPSP Supervising Physician

Date: _____

_____

Pamela E. Brett, LCSW

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Date: _____

_____

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Health Education Consultant

Date: _____

_____

Nutrition Consultant

Date: _____

INSERT MOST RECENT STAFF ROSTER HERE

CPSP Protocols Introduction

The Alameda County Comprehensive Perinatal Services Program (CPSP) Perinatal Protocols

- were developed by Alameda County Department of Public Health's Perinatal Services Program and **may not be altered without permission**. If you wish to make any changes, contact the Alameda County Perinatal Services Coordinator.
- follow the Combined Perinatal Assessment and Individualized Care Plan forms (initial, reassessment and postpartum) developed by Alameda County Department of Public Health's Perinatal Services Program and approved by California State Health Services CPSP staff in 2010.
- reference the *Comprehensive Perinatal Services Program Steps to Take (STT) Guidelines* (2001) **NOTE:** individual guidelines are dated from 1997-2007, depending on when they were last revised.
- are site-specific.
- should be updated to reflect changes in clinic staffing and policies.

Client Orientation Protocol

Purpose:

- To inform the patient about her pregnancy care and available CPSP services
- To obtain the client's agreement to participate in CPSP services
- To review danger signs and symptoms

Procedure:

1. Client orientation will be provided to each new prenatal client at the time of the positive pregnancy test, at first obstetric visit or before the initial CPSP assessment. If the patient has transferred care from another CPSP provider, repeat the client orientation to inform the patient of practices at this site.

2. Confidentiality is a critical component of the CPSP. In the partnership of her care, it is the health care team's responsibility to keep confidential the information that the woman provides. Her responsibility is to be truthful and honest in her answers. Limits of the patient's confidentiality should be outlined such as mandatory reporting laws for child abuse, domestic violence, etc. She should be informed other members of the health care team will share the information among themselves so that they can deliver the best care possible.

Practitioner: The client orientation will be conducted by practitioners at your location.

Documentation:

1. Follow STT *Documentation* Guidelines.

2. The initial client orientation should be documented on pregnancy test counseling form, initial combined assessment form or progress note. Subsequent orientation should be documented in a progress note titled "CPSP Orientation." Each entry must include the name and title of the practitioner, date and minutes spent.

3. All orientation services should also be recorded on the CPSP Flow Sheet and Billing Summary (see appendix) indicating the number of units, date and initials of the person who provided the service.

4. If the client declines to participate in CPSP, a note must be made in the client's medical record which includes any particular reason the client gives for declining services.

Content:

1. Initial Client Orientation must be individual, face-to-face and last a minimum of 15 minutes.

2. At the initial Client Orientation, a CPSP practitioner will review with the client a copy of *Welcome to Prenatal Care* (see appendix) which contains all the required elements.

3. Review the handout *Pregnant? Steps for a Healthy Baby: You Can Help Prevent Miscarriage, Birth Defects or Illness* (see appendix.)

4. Throughout the pregnancy, orientation should be done for procedures such as AFP testing, ultrasound, stress testing, amniocentesis, etc., as these issues arise. The procedures should be explained, who will do them, and why they are important. Any pre- or post-instructions should be reinforced.

5. The client should also receive a full orientation to the hospital where she is expected to deliver, including any tours available, pre-admission information requested by the hospital and routine practices of the hospital.

6. Provide postpartum orientation to services and referrals; for example, lactation support services, on-going primary care for the patient.

7. For additional information on Client Orientation see the *CPSP Provider Manual* pages 2-3 and 2-4.

Initial Assessment Protocol

Purpose:

- to help the patient have a healthy baby by identifying her strengths, as well as problems and learning needs that affect the pregnancy
- to develop an individualized care plan to address those needs and build on those strengths

Procedure:

1. The initial assessment is conducted as soon as possible in the patient's prenatal care, ideally within 4 weeks of entry to care. If the woman enters prenatal care in the second or third trimester, start with the initial assessment and "catch up" with the trimester assessments in subsequent visits. If the patient transfers from another CPSP provider and she has already had an initial assessment, it should be repeated.

2. Follow procedures outlined in STT *Assessment* Guidelines.

3. At the completion of the assessment, summarize the needs that have been identified and assist the client in prioritizing them. Work with her to set reasonable goals and document them on her Individualized Care Plan that follow the assessment questions.

4. Refer to the *Resource Guide for Men, Women, Children and Teens* (*Alameda County)* (see appendix) for community referrals or call the Alameda County Public Health Clearinghouse 1-888-604-INFO (4636) during business hours for health and other referrals.

Practitioner: The initial assessment will be conducted when by practitioners at your location

Documentation:

1. Follow STT *Documentation* Guidelines.

2. Make sure there is documentation for every question. If the question does not apply, indicate that by choosing or writing "N/A". If the client chooses not to answer a question, note that: "declines to answer."

3. All notes and answers on the assessment should be legible and in English. The completed assessment tool must be included as a part of the client's medical record.

4. Write a brief explanation to each question that says "describe" or has a colon (:) followed by a line such as "WIC, site: _____" or "type of work: _____."

5. All problems identified during the assessment should indicate some level of follow-up. Interventions should be indicated on the patient's individualized care plan. A progress note may be used in addition to the assessment form for a high risk patient.

6. All assessments should be dated and signed with at least the first initial, last name, and title of the person completing the assessment.

7. If the initial assessment is completed by a CPHW (Comprehensive Perinatal Health Worker) including MA's (Medical Assistants), it should be co-signed by an obstetric medical provider (MD, CNM, PA or NP).

8. Use only those abbreviations your facility has approved.

9. Time spent in minutes should be noted at the end of the assessment; indicate only time spent face-to-face with the client.

10. The assessment should also be recorded on the CPSP Flow Sheet and Billing Summary (see appendix) indicating the number of units, date and initials of the person who provided the service.

11. If the client does not want to participate in the initial assessment a note must be made at the end of the assessment form which states that the patient declines the service. No other support service assessments or interventions may be billed if an initial assessment has not been completed. The patient can be offered the initial assessment at a subsequent visit. The patient may also decline to answer certain assessment questions. A note should be made in the margin indicating the patient's choice; do not simply leave the assessment questions blank.

Content:

The 2010 Alameda County Initial Perinatal Assessment and Individualized Care Plan has received approval from California State Department of Health Services and Alameda County's Medi-Cal managed care programs and **MAY NOT BE ALTERED**. If you wish to make any changes, contact the Alameda County Perinatal Services Coordinator.

The form is to be completed by the CPSP practitioner and never by the patient herself. The words on the assessment form are **not** meant to be read word-for-word. The assessor should use language appropriate to the patient's culture and education to ask about the topics included in the form. The first page of each section contains assessment questions related to that area such as psychosocial, health education or nutrition. If a need or problem is identified during the assessment, it will need to be noted on the second page of each section which includes the individualized care plan for that area. This is where the CPSP practitioner records any actions taken, handouts reviewed and referrals made for that particular issue.

The Protocols are generally organized in the following manner: 1) the question as it appears on the Initial Perinatal Assessment and Individualized Care Plan form, 2) instruction on how to record the patient's answer 3) reference to the appropriate section of the *Comprehensive Perinatal Services Program Steps to Take (STT) Guidelines* (2001). **NOTE:** individual guidelines are dated from 1997-2007, depending on when they were last revised.

Orientation completed, per protocol:
If the initial client orientation is done at the same time as the initial assessment by the same CPSP practitioner, it can be documented here. Record minutes spent here **and** at the end of the assessment. If the initial client orientation was provided by a different CPSP practitioner or on a previous day, indicate 0 minutes. Do not leave this line blank.

Psychosocial

Pregnancy information

1. **DOB:** Record the patient's birth date.

   Age: Record the patient's current age.
   If the patient is a teen, follow STT *Teen Pregnancy and Parenting* Guidelines, circle Y on the "Teen parent" section of the Psychosocial Individualized Care Plan and indicate interventions. Consult the *Resources for Pregnant Teens in Alameda County* (see appendix) for referrals to community programs for adolescents.

   You are **not** required to ask the teen under 18 the age of the baby's father. However, if she tells you the age of the father of her baby, consult *When Mandated Reporters Must Report Sexual Activity by Minors in California* (see appendix) for guidance on whether or not you need to make a report to Children's Protective Services. The medical provider is responsible for making the report. Follow STT *Child Abuse and Neglect* Guidelines and submit the *Suspected Child Abuse Report* form (see appendix) to County Department of Social Services where the patient resides.

EDC: (estimated date of confinement)
Record the patient's estimated date of delivery; if unknown, write "unknown".

Wks. Gestation: Record the **best estimate** of the number of weeks gestation of the current pregnancy.

If the patient entered prenatal care late (after 16 weeks), circle Y on "Late entry to care" section of the Psychosocial Individualized Care Plan and indicate interventions.

Grav: Record how many times the patient has been pregnant.

Para: Record how many times the patient has delivered a live child.

TAB: Record the number of (induced) therapeutic abortions.

SAB: Record the number of spontaneous abortions (miscarriages or stillbirths).

2. **Problems with previous pregnancies:** Check N/A if this is patient's first pregnancy or No if the patient's previous pregnancy was normal.

   If she had problems in a previous pregnancy, briefly describe e.g., "diabetes" or "preterm labor."

3. **Current medical problems:** If the patient is experiencing medical problems with this pregnancy, check Yes and briefly describe e.g., "high blood pressure" or "seizure disorder." Circle Y on "Current medical problems" section of the Psychosocial Individualized Care Plan and indicate interventions.

4. **Planned pregnancy:** If this is an unplanned pregnancy, check No and briefly describe e.g., "failed birth control" or "didn't think she could get pregnant."

5. **Wanted pregnancy:** Check Yes if patient accepts the pregnancy and plans to continue prenatal care and raise the child. Then proceed to question # 6.

   If the patient has an unwanted pregnancy, check No. If she is before 20 weeks gestation, explore the issue of abortion and/or adoption following STT *Unwanted Pregnancy*. If she is later in her pregnancy, explore the patient's attitude towards adoption. Check Yes if she is interested in either an abortion or adoption. Describe your discussion briefly, e.g., "will discuss TAB with medical provider" or "wants referrals to adoption agencies." Circle Y on "Unwanted pregnancy" section of the Psychosocial Individualized Care Plan and indicate interventions.

   Inform the patient about the state safe surrender law. A parent who is unable or unwilling to care for their newborn can safely surrender the baby within three days of birth. All that is required is that the baby be given to an on-duty employee of a hospital or safe surrender site such as fire stations. A confidentially coded ID bracelet will be put on the baby's ankle and a matching bracelet offered to the surrendering person, to help connect the parent to the baby if the parent wants the baby back. For more information: *http://www.babysafe.ca.gov*

6. **Previous pregnancy loss/infant death:** Check N/A if this is the patient's first pregnancy. If yes, describe briefly e.g., "stillbirth of son in 2008" or "three first trimester miscarriages." Circle Y on "Previous pregnancy/infant loss" section of the Psychosocial Individualized Care Plan and indicate interventions.

7. **FOB/partner accepts pregnancy:** If the father of the baby (FOB) or the mother's current partner does not accept the pregnancy, check No and briefly describe e.g., "denies paternity" or "broke off relationship when pregnancy was announced." Refer to STT *Emotional/Mental Health Concerns* Guidelines if needed. Circle Y on "FOB/partner does not accept pregnancy" section of the Psychosocial Individualized Care Plan and indicate interventions.

Family/Support System

8. **Members of household (not including patient):**
   Number of adults:
   Relationship to patient:
   Indicate the number of adults in the household **not** including the patient and relationship to her e.g., "husband" or "parents-in-law."
   Number of children:
   Relationship to patient:
   Indicate the number of children in the household and relationship to patient e.g., "8-month-old son John" or "nieces and nephews." Names of household members are optional.

9. **Patient's children all live with her:** Check N/A if the patient has no living children. If any do not reside with her, check No and provide a short description of the circumstances, e.g., "3-year old son in foster care since birth due to mother's drug use," "12-year old daughter cared for by maternal grandmother in Guatemala since 2006 due to mother's emigration" or "sons ages 6 and 4 in custody of their father in Stockton since divorce in 2009." Circle Y on "Not all patient's children live with her" section of the Psychosocial Individualized Care Plan and indicate interventions.

10. **Patient turns to for emotional support:** Check all the people who help when the patient has a problem, is feeling sad or needs advice. If she feels that she has no one to turn to, check "No one" and give a brief description, e.g., "here for 2 months from China; little social support." Refer to STT *Emotional/Mental Health Concerns* Guidelines if needed. Circle Y on "Poor emotional/social support" section of the Psychosocial Individualized Care Plan and indicate interventions.

    If the patient shows emotional or physical signs of depression, refer to STT *Depression* Guidelines. Review the patient handout *Are You Feeling Sad, Alone or Crying a Lot?* (see appendix).

Emotional Concerns

11. **Currently having any personal or family problems:** Check Yes if the patient has any difficulties that cause her concern, such as recent death, illness, separation, divorce, (un)employment, immigration, children with school problems, etc. Briefly describe, e.g., "mourning death of mother 3 months ago," or "child with severe learning disabilities." Follow STT Guidelines *Financial Concerns*, *Legal/Advocacy Concerns*, *New Immigrant*, and *Parenting Stress* as indicated. Circle Y on "Current family problems/stressors" section of the Psychosocial Individualized Care Plan and indicate interventions.

12. **Often feels down, depressed of hopeless:** If the patient answers yes to this question, refer to STT *Depression* Guidelines. Review the patient handout *Are You Feeling Sad, Alone or Crying a Lot?* (see appendix). Circle Y on "Current/past emotional problems" section of the Psychosocial Individualized Care Plan and indicate interventions.

    Often feels irritable, restless or anxious: If the patient answers yes to this question, refer to STT *Emotional or Mental Health Concerns*. Circle Y on "Current/past emotional problems" section of the Psychosocial Individualized Care Plan and indicate interventions.

13. **Lost interest or pleasure in doing things she used to enjoy:** If the patient answers yes to this question, she may be depressed. Refer to STT *Depression* Guidelines. Review the patient handout *Are You Feeling Sad, Alone or Crying a Lot? (*see appendix). Circle Y on "Current/past emotional problems" section of the Psychosocial Individualized Care Plan and indicate interventions.

Consult with the medical provider before the client leaves the office for additional evaluation and referral to appropriate resources if you are concerned about the safety of the patient.

14. **Ever seen a counselor for personal or family problems:** If yes, briefly describe when and why e.g. "as a teen following rape; student health services 2008" or "currently seeing private therapist for depression." Circle Y on "Current/past emotional problems"" section of the Psychosocial Individualized Care Plan and indicate interventions.

> Consult with your supervisor immediately before the client leaves the office if the patient may be a danger to herself or others. The medical provider is responsible for appropriate evaluation, referral and mandatory reporting as needed.

If needed, use the resource guide *Mental Health Services in Alameda County For Women and Families Low Cost, Sliding Scale Fees* (see appendix).

15. **Currently receiving services from local agency such as case management, counseling, etc.** If yes, briefly describe e.g., "case management from Brighter Beginnings," "client of Black Infant Health Program" or "drug treatment services from Second Chance," circle Y on Receiving services from local agency" section of the Psychosocial Individualized Care Plan and indicate interventions. You **do not need** to list programs such as WIC, Food Stamps, CalWORKS, Medi-Cal, etc.

Domestic Violence

16. **Ever emotionally, physically or sexually abused by a partner or someone close to you:** If yes, describe and indicate if the abuse occurred as a child or an adult e.g., "battered by former husband" or "molested as a child by uncle."

    If the client is under 18 years and has been a victim of abuse in the past that has never been reported, refer to STT *Child Abuse and Neglect* Guidelines section "When Past Abuse is Discovered."

17. **Within the last year ever been hit, slapped, kicked, pushed, shoved, forced to have sex by partner or ex-partner:** If yes, briefly describe the situation including the last time abuse occurred, how often this is a problem and have there been any injuries e.g., "hit by husband in the stomach last weekend; patient concerned about the baby" or "ex-boyfriend was abusive when he drank; no longer together." Follow STT *Spousal/Partner Abuse* Guidelines, circle Y on "Current domestic violence" section of the Psychosocial Individualized Care Plan and indicate interventions.

> If there are current injuries, inform your supervisor immediately. The medical provider is responsible for appropriate evaluation, referral and mandatory reporting as needed. The medical provider may designate staff to make the report.

Follow STT *Spousal/Partner Abuse* Guidelines, consult the *Domestic Violence Resource Guide for Alameda County* and circle Y on "Current domestic violence" section of the Psychosocial Individualized Care Plan and indicate interventions.

18. **Afraid of partner or ex-partner:** If yes, describe patient's fears and plans for safety. Follow STT *Spousal/Partner Abuse* Guidelines, consult the *Domestic Violence Resource Guide for Alameda County* and circle Y on "Current domestic violence" section of the Psychosocial Individualized Care Plan and indicate interventions.

19. **Guns or other weapons in the home:** If yes, indicate what weapons are in the home and how they are stored e.g., "husband keeps loaded revolver in nightstand" or "hunting rifle in locked cabinet." Circle Y on "Weapons in the home" section of the Psychosocial Individualized Care Plan and indicate interventions.

Inform your supervisor and the medical provider immediately before the client leaves the office if the client is in immediate danger.

Employment/Finances

20. **Source of financial support:** Check all that apply and give a brief description e.g., "housekeeper 3 days a week" or "housepainter." Indicate any financial problems e.g., "laid off 2 months ago; receiving unemployment benefits."

    If the client has financial problems, follow STT *Financial Concerns* and *Legal/Advocacy Concerns* Guidelines circle Y on "Financial problems" section of the Psychosocial Individualized Care Plan and indicate interventions.

Housing

21. **Type of housing:** Check the appropriate box and describe if "other" such as "homeless shelter" or "car." Indicate any problems e.g., "landlord refuses to fix leak in roof" or "received eviction notice last week." Circle Y on the "Housing problems" section of the Psychosocial Individualized Care Plan and indicate interventions.

If the patient is homeless and you are unable to find emergency shelter, inform your supervisor immediately before the client leaves the office. The medical provider is responsible for appropriate evaluation and referrals.

22. **Goals for this pregnancy:** Indicate what the patient's goals are for herself during this pregnancy. This is a subjective question; any response is acceptable. You can ask the question in a variety of ways, e.g., "Have you any plans for yourself after the baby is born?" or "Is there something you're working on to achieve for yourself in the future?" Many women will answer that their goal is a healthy baby. With some prompting, they may mention career plans or other personal goals. This question can indicate the assessor's interest and concern in the patient as an individual, not just as a pregnant patient.

Psychosocial Individualized Care Plan

After completing the psychosocial assessment questions, you need to address the patient's risks and concerns on the next page. Circle N if there is no problem. Circle Y if there is a problem and note what STT Guidelines were used, actions taken and referrals given. If the patient is high risk and you need to make additional notes, use a progress note labeled "CPSP Initial Psychosocial Assessment." Sign the progress note with your title and date; record the time spent on the assessment form (not on the progress note) in the space provided.

Health Education

23. **English language:** Check off whether her spoken English is good, fair or poor. Ask her to read a short, easy phrase from a pamphlet (such as *Welcome to Pregnancy Care*) to see if her English reading is good, fair or poor. Check "non-reader" if she is not able to read at all.

    If the patient is English-speaking but a poor or non-reader, follow STT *Low Literacy* Guidelines and check "difficulty in reading" on the Barriers to Learning section at the bottom of the next page. Tailor your health education services to her reading ability.

24. **Other language:** If she speaks a language other than English, indicate the language in the space provided. Ask her how well she speaks it (good, fair or poor). Ask if she feels this is her primary language, and in what language she prefers to receive services. If you can provide services in her primary language, test her ability to read by asking her to read a short, easy phrase in that language from a pamphlet. Check the appropriate box for her reading ability (good, fair or poor). Check "non-reader" if she is not able to read at all in this language.

If the patient is a poor or non-reader in her native language, follow STT Guidelines *Low Literacy, Cross-Cultural Communication, No Language in Common with Staff* and *Using Interpreters* as needed. On the next page, under Barriers to Learning check "difficulty in reading."

25. **Likes to learn by:** Ask how she likes to learn about new things. If she is slow to respond, prompt her by reading off the options on the form, and check all that apply. Tailor your health education services to her preferred learning style such as using more videos if she prefers those.

26. **Last grade completed:** Indicate the last grade completed in school. This gives some idea of her level of functioning. You may want to ask where she attended school (which country). If she completed high school or a GED, check "12th or over."

    If she has graduated from high school or has higher education, check "completed 12th grade or more" under Health Education Strengths on the next page.

27. **Any disabilities that affect ability to learn?** Tell the patient that you ask all clients about disabilities so that you can provide appropriate services. Ask if she has any mental, emotional, physical (hearing or vision) or learning disabilities that affect her ability to learn. If she answers Yes, describe the disability in the area provided and discuss with her ways she can be accommodated to benefit from the health education services. If her disability, such as vision, has been adequately corrected so that it doesn't interfere with her learning, you don't need to check Yes.

    If the patient has any disabilities that affect her ability to learn, go to the Barriers to Learning on the next page and check "mental/emotional disability affecting learning" and/or "vision/hearing problems (uncorrected) affecting learning."

28. **Born in the United States:** If not born in the United States, indicate the patient's country of birth and the length of time living in U. S., circling either "months" or "years." If she has been in this country a short length of time, she may need more orientation.

29. **Ever used health care services in the U. S.?** If she answers No, ask her if she has specific questions or concerns you can help her with and note in space provided. If she has used health care services in another country, note that in the space provided such as "been to hospital emergency room." Go to the Barriers to Learning on the next page and check "little experience with Western health care."

30. **Dental check-up within past 12 months:** If no, indicate the last time she had dental care. If she has not had a dental exam in more than a year, fill out a *Prenatal Dental Referral Prescription* (see appendix) for medical provider to sign and make a dental referral. Circle Y on the "Dental care/problems" section of Patient's Educational Needs and note your interventions. Refer to STT *Oral Health During Pregnancy* Guidelines.

31. **Any dental problems:** If yes, briefly describe problems she has with her teeth or gums. Fill out a *Prenatal Dental Referral Prescription* (see appendix) for medical provider to sign and make a dental referral. Circle Y on the "Dental care/problems" section of Patient's Educational Needs and note your interventions. Refer to STT *Oral Health During Pregnancy* Guidelines

32. **Transportation to the clinic:** Indicate how the patient gets to the clinic. If she does not have a reliable way to get to her appointments, circle Y "Lack of transportation" section of Patient's Educational Needs. Help her identify alternatives for transportation and check in with her throughout her pregnancy to see that it does not prevent her participation in prenatal care.

33. **Knows how to wear a seat belt when pregnant?** Encourage the client to wear a seat belt every time she rides in a vehicle. If she doesn't know how to wear one during pregnancy, check No and indicate your interventions on the next page under Patient's Educational Needs "Seat belt use" section. Review the patient *handout What's the Right Way To Wear My Seat Belt?* (see appendix.)

34. **Previous knowledge/experience with:**
Check Yes for any topic she knows about or has experience with and take this into account when planning her health education services. On the next page under Health Education Strengths, check "some experience with pregnancy/delivery/infant care."

35. **Person to share in prenatal education:** If no, encourage her to involve a support person by sharing educational materials after her appointments. If yes, on the next page under Health Education Strengths check "social support for prenatal education."

36. **Who gives advice about being pregnant:** Check all that apply. Write in any others that are not on the list under "other."

37. **What are the most important things they have advised:** Briefly describe the advice she has been given e.g., "don't eat spicy foods" or "get plenty of sleep." If she is following advice that may be harmful to the pregnancy, make a note of it here. Turn to the next page to the Patient's Educational Needs and circle Y "problematic customs/practices" and coordinate care with the medical provider.

38. **Exposed to dangers at work or home:** If yes, circle Y in the "Exposed to Dangers" section of the Patient's Educational Needs and indicate your interventions. Review the handout *Pregnant? Steps for a Healthy Baby: You Can Help Prevent Miscarriage, Birth Defects or Illness* (see appendix.)

Coordinate care with the medical provider who will evaluate the risk to the patient.

39. **Did your parents have problems with drugs or alcohol:** If yes, describe the patient's response. Follow STT *Perinatal Substance Abuse* Guidelines. On the next page, note your interventions on Patient's Educational Needs under "Parent/partner drug/alcohol use" section.

40. **Does your partner have any problem with drugs or alcohol:** Check N/A if the patient does not have a partner. If yes, describe the patient's response. On the next page, note your interventions on the Patient's Educational Needs "Parent/partner drug/alcohol" use section.

41. **Before you knew you were pregnant, how much beer/wine/liquor did you drink?** If she consumed any alcohol, fill in the blanks with the amount and type of alcohol and circle the frequency (per day, week, month) e.g. "was drinking 2 glasses wine per day" or "was drinking 4 beers per week."

    Then ask about her current alcohol use since she found out she was pregnant. Indicate her current use e.g., "currently drinking 1 beer per week." If she has stopped drinking, put a 0 in the space for currently drinking, circle Y in the "Patient recently quit alcohol use" section of the Patient's Educational Needs and indicate your interventions.

    If the patient is a current alcohol user, ask about binge drinking with the question: **How many times a week do you drink a lot at one time (4 or more drinks in about two hours?** Indicate her response.

    Follow STT *Drug and Alcohol Use* and *Perinatal Substance Abuse* Guidelines. If she has not quit drinking, circle Y in the "Patient current alcohol use" section of the Patient's Educational Needs and indicate your interventions.

If the client is not interested in cutting down on her drinking or is binge drinking, refer to the medical provider for additional evaluation, patient education and referral to appropriate resources.

42. **Before you knew you were pregnant, how much did you smoke?:** If she smoked any cigarettes, list the amount such as "Yes, smoked 20 cigarettes/day." Then indicate how much she is currently smoking **since** she found out she was pregnant e.g., "10/day."

    Currently: Check the appropriate box to describe the patient's current tobacco use. Follow STT *Tobacco Use* Guidelines.

    If the patient has quit smoking since she found out she was pregnant, circle Y on the "Patient recently quit smoking" section of the Patient's Educational Needs and indicate your interventions.

    If she has cut down or continues to smoke the same amount, circle Y on "Patient currently smoking" section of Patient's Educational Needs. Indicate your interventions referring to the *Tobacco Cessation Resources List (Alameda County)* (see appendix) if needed.

If the client is not interested in cutting down on her smoking, refer to the medical provider for additional evaluation, patient education and referral to appropriate resources.

43. **Exposed to 2nd hand smoke at home/elsewhere:** If yes, indicate the number of hours a day she is exposed to smoke. Follow STT *Secondhand Tobacco Smoke.* On the next page, note your interventions on the Patient's Educational Needs "Second-hand Smoke" section.

44. **Before you knew you were pregnant, how much did you usually use marijuana and other drugs:** Other drugs may include cocaine, crack, PCP, methamphetamines, heroin, prescription painkillers etc. Fill in the blanks with the amount and type of drugs and circle the frequency (per day, week, month) such as "was using 2 joints pot per day " or "was using PCP twice a month."

    Currently using: Then ask about her current drug use since she found out she was pregnant. Fill in the blanks with the amount and type of drugs and circle the frequency (per day, week, month) such as "currently using 2 joints pot per week " or "currently snorting meth 3 times a day."

    If she has stopped using any drugs, put a 0 in the space for currently using, circle Y in the "Patient recently quit drug use" section of the Patient's Educational Needs and indicate your interventions.

    Follow STT *Drug and Alcohol Use* and *Perinatal Substance Abuse* Guidelines. If she has not quit using, circle Y in the "Patient current drug use" section of the Patient's Educational Needs and indicate your interventions. Use *Substance Abuse Resources in Alameda County Primarily for Pregnant Women and Parents with Children* (see appendix) for suggested referrals.

If the client is currently abusing legal or illegal substances that may be harmful to her pregnancy, refer to the medical provider for additional evaluation, patient education and referral to appropriate resources.

Health Education Individualized Care Plan

After completing the health education assessment questions, ask the client if she would like education on any of the topics listed under the top section "**Patient Interested in Learning**" of the Health Education Individualized Care Plan. Note what STT Guidelines were used, STT or other handouts reviewed with the patient, actions taken and referrals given.

In the next section of the Health Education Individualized Care Plan, address the **Patient's Educational Needs** that were identified during the assessment. Circle N if the item is not a need for the client. Circle Y if there is a need to address the issue with the client at this visit. Note what STT Guidelines were used, STT or other handouts reviewed

with the patient, actions taken and referrals given.

If the patient has extensive health education needs, issues or risks and you need to make additional notes, use a progress note labeled "CPSP Initial Health Education Assessment." Sign the progress note with your title and date; record the time spent on the assessment form (not on the progress note) in the space provided.

Barriers to Learning: Based on the health education assessment questions, check all of the patient's barriers to learning. Check "none" if there are no barriers to learning.

Health Education Strengths: Based on the health education assessment questions, check all of the patient's health education strengths.

Nutrition

45. **Weight pre-pregnancy:** Ask the woman for her best guess of her weight before this pregnancy.

    If she doesn't know her pre-pregnant weight:
    - Use her weight at the current visit along with her height to determine which weight gain chart to use; most women will not change an entire BMI category.
    - Plot the current weight on the 0 line and watch for her rate of gain in the following visits.

    Height: Weigh the patient *without* shoes.

    Weight gain category:
    Use the appropriate weight gain grid based on her pre-pregnant weight.
    - Underweight
    - Normal
    - Overweight
    - Obese

46. **Today's weight:** For best results, use the same scale at each patient visit.

    Weight gain to date this pregnancy: Subtract the patient's pre pregnant weight from her current weight. This number will be positive if she has gained weight and negative if she has lost weight.

    Recommended weight gain range: Check the recommended weight gain**.**
    - Underweight
    - Normal
    - Overweight
    - Obese

47. **Weight gain plotted on appropriate grid:** Refer to STT *Weight Gain During Pregnancy* Guidelines for additional information on plotting her weight gain correctly.

CPSP regulations require that the patient be weighed at **each** prenatal appointment.

48. **Reviewed patient's *My Healthy Weight Gain.*** Use the handout *My Healthy Weight Gain* (see appendix) to educate the patient.

49. **Current weight gain appropriate**: If the patient's current weight gain is adequate as plotted on the weight gain grid, check Yes. If not, check whether it is "excessive" or "inadequate." Circle N on "Weight gain appropriate"

section of the Nutrition Individualized Care Plan and indicate interventions. Refer to STT *Weight Gain During Pregnancy* Guidelines.

Alert the medical provider in the situations outlined in the "Referral" section of the STT *Weight Gain During Pregnancy* Guidelines.

50. **Completed the Perinatal Dietary Assessment with patient's *My Healthy Eating Plan:*** Refer to the CPSP Perinatal Dietary Assessment (PDA) Instructions (see appendix).

51. **Number of times per day usually eats:** Indicate how many times a day she usually eats, including meals and snacks. If she eats less than 3 times a day, circle Y on "Eats less than 3 times/day" section of the Nutrition Individualized Care Plan and indicate interventions. Refer to STT *Stretching Your Food Dollar* and *Financial Concerns* Guidelines if she has food access problems.

52. **Allergic to foods:** If yes, list the foods, circle Y on "Food allergies" section of the Nutrition Individualized Care Plan and indicate interventions. Follow STT *Lactose Intolerance* if she says she has trouble digesting milk products.

53. **Foods or food groups avoided:** If yes, list and note reason e.g., "vegetarian; eats eggs and dairy" or "doesn't like milk; gives her a stomach ache." If she avoids major food groups, circle Y on "Avoids major food groups" section of the Nutrition Individualized Care Plan and indicate interventions. Refer to STT *Vegetarian Eating* if needed.

Alert the medical provider in the situations outlined in the "Referral" section of the STT *Vegetarian Eating* Guidelines.

54. **Eats raw or undercooked eggs/seafood/meat,** If yes, list the foods, amounts and frequency and follow STT Guidelines *Food Safety.* On that section of the Nutrition Individualized Care Plan, circle Y and indicate interventions.

55. **Eats deli meats or hot dogs:** If yes, list which meats, amounts and frequency, and follow STT Guidelines *Food Safety.* On that section of the Nutrition Individualized Care Plan, circle Y and indicate interventions.

56. **Eats soft cheeses such as feta, blue cheese, queso de crema, asadero, queso fresco or panela:** If yes, list which cheeses and follow STT Guidelines *Food Safety.* On that section of the Nutrition Individualized Care Plan, circle Y and indicate interventions.

57. **Eats more than 12 oz. of fish each week:** If yes, list which fish, amounts, and frequency, and follow STT Guidelines *Food Safety* On that section of the Nutrition Individualized Care Plan, circle Y and indicate interventions.

58. **Eats fish caught by friends or family:** If yes, list which fish and the source, quantity, and frequency, and follow STT Guidelines *Food Safety.* On that section of the Nutrition Individualized Care Plan, circle Y and indicate interventions. Check the California state Office of Environmental Health Hazard Assessment OEHHA's website http://www.oehha.ca.gov/fish.html to get up-to-date advisories on chemicals found in fish caught in local waterways.

59. **Food or non-food cravings:** If yes, note type of craving, the frequency and amount e.g., "eats a tray of ice cubes a day." Circle Y on "Food, non-food cravings" section of the Nutrition Individualized Care Plan and indicate interventions. Follow STT *Pica* if needed.

Alert the medical provider if patient does not agree to avoid unsafe non-food items.

60. **Current discomforts:** If yes, note any current discomforts that the patient is experiencing. Describe the frequency and severity of the discomforts e.g., "vomiting three times a day." Follow STT *Nausea and Vomiting, Heartburn,* and *Constipation* Guidelines if needed. Circle Y on "Current discomforts" section of the Nutrition Individualized Care Plan and indicate interventions.

Alert the medical provider in the situations outlined in the "Referral" section of the *Nausea and Vomiting, Heartburn,* and *Constipation* Guidelines.

61. **Nutrition-related medical conditions:** These may include chronic illness such as diabetes, hypertension, etc. that may need nutrition intervention. Briefly describe the medical condition, e.g., "gestational diabetes in last pregnancy." Follow STT *Gestational Diabetes* if needed. Circle Y on "Nutrition-related medical conditions" section of the Nutrition Individualized Care Plan and indicate interventions. Coordinate care with the medical provider.

    Diabetic patients with the following risk factors _____ will be referred to _____ for medical management and to _____ for nutrition services.

62. **Knowledge or experience with breastfeeding:** Check all the items that describe her knowledge and/or experience. Circle either "positive", "none" or "negative" to describe her personal experience with breastfeeding a previous baby. Leave the personal experience blank if she has never breastfed.

63. **Planning to breastfeed:** Indicate the patient's response. Follow STT Health Education *Infant Feeding Decision-Making* and STT Nutrition *Breastfeeding* Guidelines for Early Pregnancy. Indicate interventions in the "Breastfeeding/infant feeding education" section of the Nutrition Individualized Care Plan.

64. **Currently taking prenatal vitamins:** If not currently taking vitamins, check No, needs vitamins Follow STT *Prenatal Vitamins and Minerals, Iron and Calcium* Guidelines. Indicate interventions in the "Breastfeeding/ infant feeding education" section of the Nutrition Individualized Care Plan.

65. **Currently taking:** If yes, check the substance and write the type, amount and frequency in the space provided e.g.,"Ex-Lax daily for the last 2 weeks." Circle Y on "Medicines/supplements/home remedies" section of the Nutrition Individualized Care Plan and indicate interventions.

Consult with the medical provider if the patient may be taking substances harmful to her or the baby's health.

66. **Already enrolled in WIC?** If yes, indicate the WIC site where she is receiving services. If no, check "No, needs referral." If the patient declines a WIC referral, make a brief note. Indicate interventions in the "Food Access" section of the Nutrition Individualized Care Plan.

67. **Ever run out of food:** If yes, describe how frequently this happens e.g., "Food stamps run out every month and family eats at soup kitchen" or "parents skip dinner 2 times a week so the children can eat." Indicate interventions in the "Food Access" section of the Nutrition Individualized Care Plan.

If the patient does not have any food in the house, make a referral for emergency food before the client leaves the office.

68. **Access to a working kitchen:** If no, comment if the patient has an alternate way to cook food and a refrigerator to store food e.g., "uses hot plate to prepare most meals." Circle Y on "Food preparation/storage problem" section of the Nutrition Individualized Care Plan and indicate interventions. Refer to STT *Cooking and Food Storage* Guidelines.

69. **Physically active at least 3 times each week:** If yes, list type and frequency of activity e.g., "walks her dog every day about 6 blocks." If patient is a heavy exerciser such as running 5 miles daily, see STT Health Education *Stay Active When You Are Pregnant* for guidance.

    If patient does not engage in physical exercise at least 3 times a week, describe patient's reasons e.g., "too tired after working all day." Indicate interventions in the "Physical activity" section of the Nutrition Individualized Care Plan.

Consult with the medical provider if there are any questions about what exercise is safe for the client.

Nutrition Individualized Care Plan
After completing the nutrition assessment questions, you need to address the patient's risks and dietary issues. Circle N if the item is not a problem for the patient. Circle Y if there is a problem. Note what STT Guidelines were used, STT patient handouts reviewed, actions taken and referrals given. If the patient is high risk and you need to make additional notes, use a progress note labeled "CPSP Initial Assessment."

Labs: Note results of lab tests. Make a note if certain labs are not available and the plan to obtain them. Positive results should be brought to the medical provider's attention.

Completed by: The last section is important for proper documentation and billing. All entries must be legible.

Signature: the person conducting the assessment should sign with their first name or initial and last name.

Title: credentials, e.g., RD, RN, MD, MSW, LVN, MPH; Comprehensive Perinatal Health Workers including MA's (Medical Assistants) should sign "CPHW."

Date: date of assessment.

Orientation Minutes: Enter the total time spent **face-to-face** with the patient doing individual patient orientation to CPSP at the time of the initial assessment. If orientation was done at another time (at the time of the positive pregnancy test, for example) and/or by another staff member, put 0 minutes.

Other Minutes: Enter the total time spent **face-to-face** with the patient doing the combined psychosocial, health education and nutrition assessment.

Reviewed by: The supervising medical provider (MD, CNM, PA, or NP) should co-sign the initial assessment form if the assessment has been done by a CPHW (Comprehensive Perinatal Health Worker) including MA's (Medical Assistants).

Signature :of the supervising medical provider.

Title: medical provider credentials, e.g., MD, CNM, PA, or NP.

Date: date of the co-signing.

Reassessment Protocol

Purpose:

- to reassess the client's strengths and needs in relation to infant care and parenting skills and her personal health
- to develop an individualized care plan to build on her strengths and address those needs

Procedure:

1. A reassessment is conducted once per trimester.

2. At the completion of the reassessment, summarize the needs that have been identified and assist the client in prioritizing them. Work with her to set reasonable goals and document them on her Individualized Care Plan.

Practitioner: The reassessment will be conducted by practitioners at your location.

Documentation:

1. Follow STT *Documentation* Guidelines and instructions for the Initial Assessment Protocol.

2. The reassessment should also be recorded on the CPSP Flow Sheet and Billing Summary (see appendix) indicating the number of units, date and initials of the person who provided the service.

3. If the client does not want to participate in the reassessment, a note must be made at the end of the form which states that the patient declines the service.

Content:

The 2010 Alameda County Reassessment and Individualized Care Plan has received approval from California State Department of Health Services and Alameda County's Medi-Cal managed care programs and **MAY NOT BE ALTERED**. If you wish to make any changes, contact the Alameda County Perinatal Services Coordinator.

The Protocols are generally organized in the following manner: 1) the question as it appears on the Reassessment and Individualized Care Plan form, 2) instruction on how to record the patient's answer 3) reference to the appropriate section of the *Comprehensive Perinatal Services Program Steps to Take (STT) Guidelines* (2001).

Review previous assessments and individualized care plans to provide follow up of unresolved issues. The patient may have also new problems, issues or concerns.

EDC (estimated date of confinement)**:**
Record the patient's estimated date of delivery; if unknown, write "unknown".

Wks. Gestation: Record the **best estimate** of the number of weeks gestation of the current pregnancy.

Check 2nd Trimester if the assessment takes place between 14 and 28 weeks and 3rd trimester if between 29 and 40 weeks. Check Other if reassessment takes place in addition to trimester reassessments and indicate the weeks gestation.

Psychosocial

1. **Current medical problems?** If the patient is experiencing medical problems with this pregnancy, briefly describe, circle Y on the Psychosocial Individualized Care Plan, indicate interventions plan and coordinate care with the medical provider.

2. **Has emotional/social support?** If she feels that she has no one to turn to, briefly describe, circle Y on the Psychosocial Individualized Care Plan and indicate interventions. Refer to STT *Emotional/Mental Health Concerns* if needed.

3. **Current family problems/stressors?** If the patient has any difficulties that cause her concern, briefly describe, circle Y on the Psychosocial Individualized Care Plan and indicate interventions. Follow STT Guidelines *Financial Concerns, Legal/Advocacy Concerns, New Immigrant, Parenting Stress* as indicated.

4. **Currently receiving services from a local agency such as case management, counseling, etc.?** If yes, briefly describe, circle Y on the Psychosocial Individualized Care Plan and indicate interventions.

5. **Mental Health Concerns?** If yes, briefly describe, circle Y on the Psychosocial Individualized Care Plan and indicate interventions. If the patient shows emotional or physical signs of depression, refer to STT *Depression* Guidelines. Review the patient handout *Are You Feeling Sad, Alone or Crying a Lot?* (see appendix)

Consult with your supervisor immediately before the client leaves the office if the patient may be a danger to herself or others. STT Guidelines *Emotional or Mental Health Concerns* and *Depression* as indicated. The medical provider is responsible for appropriate evaluation, referral and mandatory reporting as needed.

If needed, use the resource guide: *Mental Health Services in Alameda County For Women and Families Low Cost, Sliding Scale Fees* (see appendix).

6. **Current domestic violence?** If yes, briefly describe the situation and follow STT *Spousal/Partner Abuse* Guidelines. Circle Y on the Psychosocial Individualized Care Plan and indicate interventions.

If there are current injuries, inform your supervisor immediately before the client leaves the office. The medical provider is responsible for appropriate evaluation, referral and mandatory reporting as needed. The medical provider may designate staff to make the report.

7. **Financial/housing/transportation problems?** If the client has these problems, follow STT Guidelines *Financial Concerns* and *Legal/Advocacy Concerns*, circle Y on the Psychosocial Individualized Care Plan and indicate interventions.

If the patient is homeless and you are unable to find emergency shelter, inform your supervisor immediately before the client leaves the office. The medical provider is responsible for appropriate evaluation and referrals.

8. **Has health insurance for her own health care in the future**? Find out if the patient will continue to have insurance coverage after the postpartum Medi-Cal eligibility ends. If she will no longer be covered and your site participates in the Alameda County Medically Indigent Services Program (CMSP), refer her to a financial eligibility worker to enroll. If your clinic does not offer CMSP services, refer her to Alameda County Health Care Service Agency for help in signing up for CMSP. Services are free, available in many languages and for people with all immigration statuses. Call 1-800-422-9495 to make an appointment.

9. **Preparation for the baby:** Discuss with all clients preparations for the baby. Indicate interventions on the Psychosocial Individualized Care Plan. Follow STT Guidelines *Financial Concerns* if needed.

   Other risk or concern: Briefly describe any other psychosocial (social, emotional or financial) problem identified by the patient or yourself and indicate interventions on the Psychosocial Individualized Care Plan.

Psychosocial minutes spent: record the time spent on the psychosocial reassessment in the space provided.

Health Education

10. **Questions on body changes during pregnancy/baby's growth?** Provide health education for the patient regarding any questions or concerns she has about body changes during pregnancy or the growth of the baby. Indicate what was discussed on the Health Education Individualized Care Plan.

11. **Danger signs, preterm labor, kick counts**: Discuss with all patients Refer to STT Guidelines *Preterm Labor* and *Kick Counts* and indicate your interventions on the Health Education Individualized Care Plan.

12. **Dental care/problems?** If she has not had a dental exam in more than a year or has dental problems, circle Y on the Health Education Individualized Care Plan and note interventions.

13. **Needs information on seat belt use, safe lifting?** If she does not wear a seatbelt every time she rides in a motor vehicle, teach her how to wear a seatbelt during pregnancy and encourage her to use one every time. Refer to STT *Safe Exercise and Lifting* Guidelines if needed. Indicate your interventions on the Health Education Individualized Care Plan.

14. **Exposed to dangers?** (STT HE Cautions, Cause for Concern and/or Workplace and Home Safety) If the patient is exposed to dangers, review page 2 of the handout *Pregnant? Steps for a Healthy Baby: You can help prevent miscarriage, birth defects or illness*. Note your interventions on the Health Education Individualized Care Plan..

15. **Uses alcohol or drugs?** Follow STT *Drug and Alcohol Use* and *Perinatal Substance Abuse* Guidelines if the patient uses alcohol or other drugs. Indicate your interventions on the Health Education Individualized Care Plan.

If the client is currently abusing legal or illegal substances that may be harmful to her pregnancy, refer to the medical provider for additional evaluation, patient education and referral to appropriate resources.

Use *Substance Abuse Resources in Alameda County Primarily for Pregnant Women and Parents with Children* (see appendix) for suggested referrals.

16. **Smokes?** If she continues to smoke, circle Y on the Health Education Individualized Care Plan and indicate your interventions. "Patient currently smoking" section of Patient's Educational Needs. Indicate your interventions referring to the *Tobacco Cessation Resources List (Alameda County)* (see appendix) if needed. Follow STT *Tobacco Use* Guidelines. Offer health education materials such as *You Can Quit Smoking (Support and Advice* patient handout (see appendix).

If the client is not interested in cutting down on her smoking, refer to the medical provider for additional evaluation, patient education and referral to appropriate resources.

17. **Exposed to second-hand smoke?** Follow STT *Secondhand Tobacco Smoke* Guidelines and note your interventions on the Health Education Individualized Care Plan.

18. **Labor and delivery plans:** Discuss with all patients plans for labor and delivery and indicate your interventions on the Health Education Individualized Care Plan.

19. **Plans for future children?** Discuss with all patients their plans for more children after the birth of this baby. Ask how many children total does she want? How far apart does she want them to be? What are her plans to achieve these goals? What contraceptive method does she choose? Where does she go for her family planning needs? Make a referral if she does not have a family planning provider.

20. **Has primary care provider for her regular medical check ups?** If she does not have a primary care provider, make a referral to _____so she will have access to preventative health care. If your site does not offer primary care, advise patient to call the Alameda County Public Health Clearinghouse 1-888-604-INFO (4636) for referrals.

21. **Any health problems that need follow up postpartum?** If she will need medical care for ongoing health problems such as diabetes, hypertension, obesity, depression, etc. after the postpartum period, encourage her to make an appointment with her primary care provider. This provider can refer her to specialists for her chronic health conditions.

22. **Has pediatric provider?** Discuss the patient's options for pediatric care and indicate your interventions on the Health Education Individualized Care Plan.

23. **Questions about newborn care/illness?** Provide health education and answer patient's questions regarding care of the newborn using STT *Infant Safety and Health* Guidelines. Indicate your interventions on the Health Education Individualized Care Plan.

    Other patient interests/needs? Provide health education and answer patient's questions regarding other perinatal topics; if needed consult the medical provider or other staff member. Indicate your interventions on the Health Education Individualized Care Plan.

Nutrition

24. **Weight gain plotted at this visit:** The patient should be weighed at this visit and her weight gain plotted on the appropriate grid.

CPSP regulations require that the patient be weighed at **each** prenatal appointment.

25. **Perinatal Dietary Assessment completed at this visit:** This needs to be completed before the nutrition reassessment is done.

26. **Weight gain recommended:** Review the patient's weight gain recommendations referring to STT *Weight Gain During Pregnancy* Guidelines and her weight gain grid. Indicate interventions on the Nutrition Individualized Care Plan.

27. **Weight gain appropriate?** If yes, circle Y and refer to STT *Weight Gain During Pregnancy* Guidelines. Indicate interventions on the Nutrition Individualized Care Plan.

Alert the medical provider in the situations outlined in the "Referral" section of the *Weight Gain During Pregnancy* Guidelines.

28. **Eats less than 3 times a day?** Ask her how many times a day she usually eats, including meals and snacks. If she eats less than 3 times a day, circle Y and indicate interventions on the Nutrition Individualized Care Plan. Refer to STT *Stretching Your Food Dollar* and *Financial Concerns* Guidelines if she has food access problems.

29. **Current discomforts?** If the patient has common discomforts, circle Y on the Nutrition Individualized Care Plan and follow STT *Nausea and Vomiting, Heartburn,* and *Constipation* Guidelines if needed. Indicate any interventions on the nutrition care plan.

Alert the medical provider in the situations outlined in the "Referral" section of the *Nausea and Vomiting, Heartburn,* and *Constipation* Guidelines.

30. **Nutrition-related medical conditions?** If the patient has diabetes, hypertension or other nutrition-related conditions, circle Y on the Nutrition Individualized Care Plan and indicate interventions. Coordinate care with the medical provider. Refer to STT *Gestational Diabetes* Guidelines if needed.

31. **Breastfeeding/infant feeding education:** All patients should receive education on breastfeeding and other infant feeding options. Follow STT *Breastfeeding* Guidelines and indicate interventions on the nutrition care plan.

32. **Takes prenatal vitamins?** Ask the patient if she is taking her prenatal vitamins following STT *Prenatal Vitamins and Minerals, Iron and Calcium* Guidelines. Give a prescription or dispense vitamins to a patient who needs vitamins. Indicate interventions on the Nutrition Individualized Care Plan.

33. **Food access:** Ask all patients If yes, circle Y and refer to STT *Stretching Your Food Dollar* and *Financial Concerns* Guidelines. Indicate interventions on the Nutrition Individualized Care Plan.

If the patient does not have any food in the house, make a referral for emergency food before the client leaves the office.

34. **Food preparation/storage problem?** If yes, circle Y, refer to STT *Cooking and Food Storage* Guidelines and indicate interventions on the Nutrition Individualized Care Plan.

35. **Physical activity?** Ask all patients the type and frequency of her physical activity. Encourage the patient to exercise at least 3 times a week. Refer to STT *Safe Exercise and Lifting* Guidelines and indicate interventions on the Nutrition Individualized Care Plan.

Consult with the medical provider if there are any questions about what exercise is safe for the client.

Other risk/dietary issue? Provide education and answer questions on the patient's other nutrition concerns. Indicate interventions on the Nutrition Individualized Care Plan.

Labs: Note results of lab tests. Make a note if certain labs are not available and the plan to obtain them. Positive results should be brought to the medical provider's attention.

Perinatal Reassessment Additional Notes: Use this space if you need to make additional notes for any of the preceding assessment sections.

Completed by: The last section is important for proper documentation and billing. All entries must be legible.

Signature: the person conducting the assessment should sign with their first name or initial and last name.

Title: credentials, e.g., RD, RN, MD, MSW, LVN, MPH; Comprehensive Perinatal Health Workers including MA's (medical assistants) should sign "CPHW."

Date: date of assessment.

Minutes spent: Look back at the minutes spent in each of the areas (psychosocial, health education and nutrition) and record here.

Postpartum Assessment Protocol

Purpose:

- to assess the client's strengths and needs in relation to infant care and parenting skills and her personal health
- to develop an individualized care plan to build on her strengths and address those needs

Procedure:

1. The CPSP postpartum assessment is conducted at approximately ____ weeks after delivery.

2. At the completion of the assessment, summarize the needs that have been identified and assist the client in prioritizing them. Work with her to set reasonable goals and document them on her Individualized Care Plan that follow the assessment questions.

Practitioner: The initial assessment will be conducted by practitioners at your location.

Documentation:

1. Follow STT *Documentation* Guidelines and instructions for the Initial Assessment Protocol.

2. The postpartum assessment should also be recorded on the CPSP Flow Sheet and Billing Summary indicating the number of units, date and initials of the person who provided the service.

3. If the client does not want to participate in the postpartum assessment, a note must be made at the end of the form stating that the patient declines the service.

Content:

The 2010 Alameda County Postpartum Assessment and Individualized Care Plan has received approval from California State Department of Health Services and Alameda County's Medi-Cal managed care programs and **MAY NOT BE ALTERED**. If you wish to make any changes, contact the Alameda County Perinatal Services Coordinator.

The Protocols are generally organized in the following manner: 1) the question as it appears on the Postpartum Assessment and Individualized Care Plan form, 2) instruction on how to record the patient's answer 3) reference to the appropriate section the *Comprehensive Perinatal Services Program Steps to Take (STT) Guidelines* (2001).

If possible, review the delivery record for relevant information prior to conducting the postpartum assessment. Also, review previous assessments and individualized care plans to provide follow up of unresolved issues.

Psychosocial

Baby/Delivery:

1. **Baby's DOB:** Record the date of the baby's birth.

2. **Name:** Record the baby's name. Check M for male or F for female.

3. **Weight at birth:** Record the baby's birthweight and circle either pounds or grams.

4. **Length at birth:** Record the baby's length at birth and circle either inches or centimeters.

5. **Weeks gestation:** Record the length of the pregnancy in weeks.

Risk/Concerns:

Review the list of risk and concerns circling N or Y. Use the appropriate STT Guidelines and indicate your interventions on the Psychosocial Individualized Care Plan.

6. **Multiple births:** If yes, give the name, sex and birthweight of the other babies. Follow STT *Multiple Births-Twins and Triplets* and indicate interventions on the Psychosocial Individualized Care Plan.

7. **Problems with delivery:** If yes, briefly describe and indicate interventions on the Psychosocial Individualized Care Plan.

8. **Patient has current medical problems:** If yes, briefly describe and indicate interventions on the Psychosocial Individualized Care Plan.

9. **Baby has current medical problems:** If yes, briefly describe and indicate interventions on the Psychosocial Individualized Care Plan. Follow STT *Birth Defects* Guidelines if needed.

10. **Patient coping with demands of the baby:** If no, briefly describe and indicate interventions on the Psychosocial Individualized Care Plan. Follow STT Guidelines *Parenting Stress, Emotional Concerns,* and *Depression* if needed.

11. **Family members adjusting to the baby:** If no, briefly describe and indicate interventions on the Psychosocial Individualized Care Plan.

12. **Patient experiencing postpartum emotional problems:** If the patient shows emotional or physical signs of depression, refer to STT *Depression* Guidelines. Review the patient handout *Are You Feeling Sad, Alone or Crying a Lot?* (see appendix). Briefly describe and indicate interventions on the Psychosocial Individualized Care Plan. If needed, use the resource guide: *Mental Health Services in Alameda County For Women and Families Low Cost, Sliding Scale Fees* (see appendix).

> Consult with your supervisor immediately before the client leaves the office if the patient may be a danger to herself or others. STT Guidelines *Emotional or Mental Health Concerns* and *Depression* as indicated. The medical provider is responsible for appropriate evaluation, referral and mandatory reporting as needed.

13. **Current family problems/poor emotional/social support:** If yes, briefly describe and indicate interventions on the Psychosocial Individualized Care Plan. Follow the appropriate STT Guidelines.

14. **Needs help in finding childcare**: If yes, briefly describe and indicate interventions on the Psychosocial Individualized Care Plan.

15. **Needs essential baby supplies**: If yes, briefly describe and indicate interventions on the Psychosocial Individualized Care Plan.

16. **Has health insurance for her own health care in the future**? Find out if the patient will continue to have insurance coverage after the postpartum Medi-Cal eligibility ends. If she will no longer be covered and your site participates in the Alameda County Medically Indigent Services Program (CMSP), refer her to a financial eligibility worker to enroll. If your clinic does not offer CMSP services, refer her to Alameda County Health Care Service Agency for help in signing up for CMSP. Services are free, available in many languages and for people with all immigration statuses. Call 1-800-422-9495 to make an appointment.

17. **Has primary care provider for her regular medical check ups?** If she does not have a primary care provider, make a referral to _____ so she will have access to preventative health care.

18. **Any health problems that need follow up?** Discuss with the patient if she will need medical care for ongoing health problems such as diabetes, hypertension, obesity, depression, etc. that will require further care after the postpartum period. Encourage her to see her primary care provider to help with specialist referrals for her chronic conditions.

Other risk or concern: Briefly describe any other psychosocial (social, emotional or financial) problem not listed above. Refer to the appropriate STT Guidelines and indicate interventions on the Psychosocial Individualized Care Plan.

Psychosocial minutes spent: Indicate the number of minutes spent conducting the psychosocial postpartum assessment and interventions on the bottom of the page and again on page 2.

Health Education:

19. **Questions about body changes after pregnancy:** Provide health education to the patient regarding any questions or concerns she has about body changes following pregnancy. Indicate what was discussed on the Health Education Individualized Care Plan.

20. **Plans for future children?** Discuss with all patients their plans for more children after the birth of this baby. Ask how many children total does she want? How far apart does she want them to be? What are her plans to achieve these goals? What contraceptive method does she choose? Does she have family planning appointment scheduled? Encourage the patient to keep her appointment.

21. **Has appointment with pediatric provider:** List the baby's pediatric provider or indicate referral given on the Health Education Individualized Care Plan.

22. **How is the baby being fed?** All patients should receive education on breastfeeding and other infant feeding options. Follow STT *Breastfeeding* Guidelines and indicate interventions on the Nutrition Individualized Care Plan.

23. **Questions about newborn care?** Provide basic information on infant care. Encourage the mother to make a list of questions for the baby's pediatric provider.

24. **Infant safety:** Provide health education and answer patient's questions regarding safety of the newborn using STT *Infant Safety and Health* Guidelines. Indicate your interventions on the Health Education Individualized Care Plan.

25. **Questions about newborn immunizations, health:** Provide health education and answer patient's questions illness of the newborn using STT *Infant Safety and Health* Guidelines. Encourage the mother to make a list of questions for the baby's pediatric provider. Indicate your interventions the Health Education Individualized Care Plan.

Other interest or need: Provide health education and answer patient's questions regarding other perinatal topics; if needed, consult the medical provider or other staff member. Indicate your interventions on the Health Education Individualized Care Plan.

Health education minutes spent: Indicate the number of minutes spent conducting the health education postpartum assessment and interventions at the end of the section and again at the bottom of the page.

Nutrition:

26. **Completed the Perinatal Dietary Assessment with patient's *My Healthy Eating Plan*.** This needs to be completed before the postpartum nutrition assessment is done.

27. **Total Weight gain:** Record the patient's total weight gain during pregnancy and today's weight. Help the patient make reasonable goals to reach a healthy postpartum weight. Encourage regular physical activity such as walking. Review with the patient *My Healthy Weight Loss.*

28. **Eats less than 3 times a day:** Ask her how many times a day she usually eats, including meals and snacks. If she eats less than 3 times a day, circle Y and indicate interventions on the Nutrition Individualized Care Plan. Refer to STT *Financial Concerns* Guidelines and patient handout *Stretching Your Food Dollar* and if she has food access problems.

29. **Vitamins**: Ask the patient if she is still taking her prenatal vitamins. Encourage her to take a vitamin pill daily with 400 micrograms of folic acid. Indicate interventions on the Nutrition Individualized Care Plan.

Other risk or dietary issue: Provide education and answer questions on the patient's other nutritional concerns. Indicate interventions on the Nutrition Individualized Care Plan.

Nutrition minutes spent: Indicate the number of minutes spent conducting the nutrition postpartum assessment and interventions at the end of the section and again at the bottom of the page.

Completed by: The last section is important for proper documentation and billing. All entries must be legible.

Signature: the person conducting the assessment should sign with their first name or initial and last name.

Title: credentials, e.g., RD, RN, MD, MSW, LVN, MPH; Comprehensive Perinatal Health Workers including MA's (medical assistants) should sign "CPHW."

Date: date of assessment.

Minutes spent: Look back at the minutes spent in each of the areas (psychosocial, health education and nutrition) and record here.

Perinatal Health Education Class Protocol

Purpose:

- to provide perinatal health education in a group setting.
- to provide an opportunity for patients to learn from each other and discuss pregnancy-related issues.

Procedure:

3. Perinatal education classes will be offered in addition to individual CPSP assessments.
4. Patients will be referred to classes based on their health education needs and interests.
5. Patient's support person may be encouraged to attend the class with the patient.
6. At the beginning of each class, have patients sign-in (see appendix for sample sign-in sheet).
7. At the end of each class, note the "minutes spent" for each patient beside their name on the sign-in sheet

Practitioner: The perinatal education classes will be conducted by practitioners at your location.

Documentation:

5. Follow STT *Documentation* Guidelines.

6. Two or more CPSP clients make up a class; the patient's support person, such as a partner, may attend a class, but is not billable.

7. Perinatal education classes should be documented both:
   - on a patient sign in sheet that also includes the name and date of the class and the signature and title of the CPSP practitioner conducting the class (to be kept on file), and
   - in each patient's chart including the name, date and length of the class in minutes and the signature and title CPSP practitioner conducting the class. These items will be documented in a progress note or perinatal class form.

8. Class outlines describing the content of each perinatal education class must be kept on file.

9. All perinatal education classes should also be recorded on the CPSP Flow Sheet and Billing Summary (see appendix) indicating the number of units, date and initials of the person who provided the service.

10. Only face-to-face class time is billable.

Content:

See Alameda County Perinatal Services *Perinatal Health Education Class Lesson Plans* in appendix, or other lesson plans.

Alameda County
Comprehensive Perinatal Services Program

Appendices