blue california Promise Health Plan	POLICY & PROCEDURE Medical Services	
Policy Title: Comprehensive Perinatal Services Program (CPSP)		
Policy No: 10.4.2.2	**Original Date: 11/97**	
Effective Date: 12/18	**Revision Date: 02/03, 05/07, 4/18, 12/18**	**Revision No: 4**
Department Head: **Date:**	**Medical Services/P&T Committee:** **Date:**	
P&P Committee: **Date:**	**Scope of Coverage:** **Population Health**	

PURPOSE:

To assure that all pregnant and post-partum patients are offered services that meet State comprehensive Perinatal Services Program standards. To establish mechanisms to refer pregnant and post-partum members to appropriate providers, and to track, monitor, authorize, and report the utilization of these services.

POLICY:

Pregnancy and Postpartum Services Overview

Pregnant members are to be provided comprehensive, multidisciplinary pregnancy and postpartum services with case coordination including obstetrics, risk assessment/ reassessments, health education, nutritional services, and psychosocial services in accordance with the most current standards or guidelines of the American College of Obstetrics and Gynecology (ACOG) are used as the minimum measure of quality for perinatal services.

Blue Shield Promise Health Plan shall implement a comprehensive risk assessment tool for all pregnant female Members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22, CCR, Section 51348. The results of this assessment shall be maintained as part of the obstetrical records and shall include medical/obstetrical, nutritional, (psychosocial, and health education needs risk assessment components.

The Comprehensive Prevention Services Program (CPSP) specifications of Title 22 of the California Code of Regulations and the provisions set forth below:

- ✓ Develop coordination policies and procedures.
- ✓ Provide in-service training to internal staff and participating providers.
- ✓ Identify strategic opportunities to share resources and maximize positive health outcomes.
- ✓ Exchange data for the purpose of evaluating perinatal trends.
- ✓ Develop joint quality improvement activities.
- ✓ Work to resolve problems on a local level.

Pregnancy Care

1. The initial prenatal visit must be available within (7) seven days of the initial referral or request for pregnancy-related services.
2. ACOG's Guidelines for Perinatal Care. (fourth edition), 1997,recommends the following examination schedule for woman with an uncomplicated pregnancy:
    a. Every four (4) weeks for the first 28 weeks.
    b. Every two (2) to three (3) weeks until thirty-six (36) weeks gestation.
    c. Weekly thereafter
    d. Postpartum, four (4) to eight (8) weeks after delivery.
3. The risk assessments (Medical/obstetrical, nutrition, psychosocial, and health education) are completed on all pregnant members at the initial prenatal visit, and at each subsequent trimester and post-partum. All identified risk conditions are followed up by interventions designed to ameliorate or remedy the condition or problem in a prioritized manner, which must be documented in the medical record.
4. Women with medical/obstetrical, nutrition, psychosocial, and health education risk may require closer surveillance. The obstetric provider according to the nature and severity of the risk and /or identified problems determines the appropriate interval between visits. **Recommended:** intervals for routine tests and as indicated tests for individual patients during pregnancy is as follows:

Time (Weeks Gestation)	Assessment / Service
Initial (as early as possible)	• Hemoglobin or hematocrit measurement • Urinalysis, including microscopic • Examination and infection screen • Blood Group and RH type determination • Antibody Screen • Rubella antibody titer measurement • Syphilis screen (VDRL/RPR) • Cervical cytology • Hepatitis "B" virus screen • HIV education, counseling, and voluntary testing • Tuberculosis testing • Chlamydia testing and gonorrhea culture • Blood pressure • Complete medical/obstetrical history including genetic risk assessment and review of systems complete physical examination • Orientation to CPSP prescription and/or dispensing 300-day supply of vitamins /mineral supplements as indicated counseling related to danger signs: what to do in an emergency, seat belt, safety, teratogens, smoking, alcohol, and other substance use • Referral to WIC

	• Referral to Department of Health Services (DHS) – certified genetic services if indicated comprehensive nutrition, psychosocial, and health education risk assessment (ideally at initial visit, but within four (4) weeks of initial visits, development of an individualized care plan.
8 – 18 weeks	• Ultrasound if indicated amniocentesis if indicated Chorionic villus sampling if indicated.
16-18 weeks	• Maternal serum alpha-fetoprotein (by California law, must be offered to all pregnant women entering prenatal care prior to the 20th completed weeks of gestation.
27 weeks	• Re-assessment of nutritional, psychosocial and health education needs.
26-28 weeks	• Diabetes screening.
28 weeks	• Repeat antibody test for un-sensitized RH-negative patients • Prophylactic administration of Rho (D) immune globulin if needed.
32 -36 weeks	• Ultrasound if indicated • Repeat testing for sexually transmitted disease, if indicated • Repeat hemoglobin or hematrocrit if indicated • Family planning counseling/plan offer • HIV tests again if previously refused or continued high-risk health behaviors.
By 39 weeks	• Re-assessment of nutrition, psychosocial and health education needs • Inquiry related to member's plan for Pediatric Services provide information about Child Health and Disability Prevention (CHDP) Program.
Every Prenatal Visit	• Urine checks for glucose and protein. • After quickening, report of fetal movement, blood pressure, weight, uterine size, fetal heart rate, edema, • Leopold's maneuvers interval history. Opportunity for questions. • Continual risk assessment and revision of the individualized Care Plan and referral as indicated.
Postpartum – 4-8 weeks following delivery.	<u>Physical exam to include:</u> 1. Breast examination. 2. Recto vaginal evaluation. 3. Bi-manual examination of the uterus and adnexa. 4. Weight, blood pressure. 5. Abdominal examination. 6. Interval history/adaptation to newborn. 7. Discussion of normal symptoms vs. warning of postpartum depression. 8. Family adaptation.

	9. Immunization status (especially rubella for non-immune women). 10. Breastfeeding inquiries. 11. Counseling regarding future health and pregnancies (gestational diabetes, vaginal birth after cesarean, genetic anomalies, hypertension, etc.) Laboratory data as indicated (hgb if anemic on discharge from hospital, etc.) 12. Family planning counseling/prescription. 13. Well child care (CIIDP) inquiry/referral. 14. Re-assessment of nutrition, psychosocial, and health education needs-revise or close Individual Care Plan as indicated. CPSP support services are available to members for up to (60) days postpartum. 15. Medical, gynecological, nutritional, psychosocial, and/or health education needs/problems persisting beyond this period are communicated to the members PCP for further follow-up and service coordination. This is accomplished by the transfer of a copy of the Individualized Care Plan, which clearly indicates unresolved problems/needs, and interventions to date, from the perinatal provider to the PCP.

At Risk Pregnancy/Postpartum Conditions

A. Identification of risk factors is critical to minimizing maternal and neonatal morbidity and mortality. The obstetric provider is responsible for identifying women with high risk of a poor pregnancy outcome conditions and providing appropriate referrals to perinatal specialists, coordinating other medically necessary services, and making appropriate referrals to public health programs, social services and community support agencies at any time during the pregnancy when high risk indicator are identified.

. The obstetric provider is responsible for personal supervision of the members Individualized Care Plan to ensure that all identified risk conditions are followed-up with interventions expected to ameliorate or remedy the condition or problem in a prioritized manner. This supervision is the obstetric responsibility whether the support services (nutrition, psychosocial and health education) assessment and interventions are accomplished in his/her practice or are carried out at another location.

A Case Manager is available to assist to provider with the coordination of services. The Health Plan CM will ensure the Member will have access to genetic screening with appropriate referrals, and appropriate hospitals within the provider network to provide necessary high-risk pregnancy services.

PROCEDURES:

A. The provision of the full scope of CPSP services to pregnant members is the responsibility of the OB providers and will endeavor to link pregnant members to participating CPSP providers.
    1. CPSP providers are responsible for complying with Tower Health policies, procedures and standards including the use of approved assessment and documentation tools.

B. Health Care workers who perform CPSP support services assessment and interventions meet Title 22, California Code of Regulations (CCR), Section 51179.7 standards for Comprehensive Perinatal Practitioners which include:
    1. Physician
        a. General Practice
        b. Family Practice
        c. Pediatric Practice
        d. Obstetric/Gynecology Practice
    2. Certified Nurse Midwife
    3. Registered Nurse Licensed by the Board of Registered Nursing, and one year experience in the field of maternal and child health.
    4. Nurse Practitioner
    5. Physician Assistant
    6. Social Worker
        a. Baccalaureate Degree or higher in social work or social welfare from a college, or, university with a social work degree program accredited by the Council on social Work Education, and;
        b. Who has one (1) year experience in the field of maternal and child health, or;
        c. Masters Degree in psychology or Marriage, Family and Child Counseling and;
        d. Has one (1) year of experience in the field of maternal and child health.
    7. Health Educator Baccalaureate Degree or higher in Community or Public Health Education, and (one) year of experience in the field of maternal and child health.
    8. Childbirth Educator Licensed Registered Nurse with (one) year experience in a program which complies with ACOG's "Guidelines for Childbirth Education" (198 1), or certified by the American Society for Psycho prophylaxis in Obstetrics, Bradley, or the International Childbirth Education Association.
    9. Dietitian Registered or eligible to be registered by the Commission on Dietetic Registration with (one) year experience in the field on maternal and child health.
    10. Comprehensive perinatal health worker
        a. At least eighteen (18) years of age.
        b. High School graduate or equivalent
        c. One year of full-time paid practical experience in providing perinatal care.
        d. Provides service in a clinic that is either licensed or exempt from licensure, and under direct supervision of comprehensive perinatal practitioner (1-9 above)
    11. Licensed Vocational Nurse with one (1) year experience in the field of maternal and child health.
    12. Reimbursement Case Coordination (see attachment A).

C. Ancillary Programs: Ancillary programs which may provide services within specific components of comprehensive perinatal services include those listed below.
   1. Geneticists
   2. Other Medical Services
   3. Public Health Services
   4. Family Planning Services
   5. Substance Abuse Prevention Services
   6. Community Based Organization
   7. Community Outreach Services
   8. Agencies providing transportation
   9. Domestic Violence Units
   10. Child Protective Services
   11. Local Diabetes and Pregnancy Programs
   12. WIC
   13. CHDP
   14. Translation Services
   15. Women's Center
   16. Respite Care Services
   17. Dental Services

D. Blue Shield Promise Health Plan will ensure that all pregnant women have access to care in accordance with this procedure. The required services include:
   1. Client orientation
   2. Obstetrical services
   3. Nutrition, psychosocial and health education support services initial assessments.
   4. Formal assessments based on initial stratification, throughout pregnancy and in the postpartum period.
   5. Development of an Individualized Care Plan to include planned interventions as indicated by the assessments, and outcome objectives for each of the four (4) categories with revision as needed, but at least for each subsequent trimester and postpartum.
   6. Case coordination
   7. Vitamin and mineral supplementation
   8. Referral to women, infants and children (WIC) Supplemental Nutrition Program.
   9. Provision of or referral for dental, genetic, family planning and well child care (CHDP) services, as indicated.

E. CPSP providers are responsible for providing all support services as listed above in addition to recommending appropriate referrals to the obstetric provider for support services. Additionally, the contracted CPSP support service provider is responsible for trimester and postpartum reassessments, provision of or arrangement for appropriate nutrition, psychosocial, and Health Education interventions, individualized Care Plan revision, and Case Coordination including

organizing case conferences when appropriate. CPSP support services to the pregnant patient must include the following components:

1. Obstetric Provider Responsibilities including:
   - ✓ Provide for all obstetrical care including ante-partum, intra-partum, and post-partum care.
   - ✓ Bill for all Obstetric Care (if applicable).
   - ✓ Prescribe prenatal vitamins to be distributed through and billed for by
   - ✓ CPSP provider.
   - ✓ Refer all pregnant members to the CPSP support services provider.
   - ✓ When indicated, referrals to Registered Dietitians, Social.
   - ✓ Workers, Health Educators or other support services providers are accomplished using procedures established by participating provider group.
   - ✓ Fee-for-Service Providers contracted directly with Blue Shield Promise Health Plan.
   - ✓ Obtain authorization for referrals through Blue Shield Promise Health Plan's Utilization Management Department.
   - ✓ Provide a copy of all ante-partum exams, labor and delivery experience and postpartum exam to CPSP support services provider to be included in CPSP chart.
   - ✓ Include copies of all assessments; re-assessments, Individualized Care Plan, and other documentation related to interventions provided by CPSP support services provider in the medical chart.

2. Responsibilities of CPSP Support Services Provider including:
   - ✓ Provide the CPS orientation.
   - ✓ Provide initial support services assessment, develop Individualized Care Plan, and provide trimester and postpartum re-assessments.
   - ✓ Provide and coordinate interventions, case coordination services to pregnant members enrolled in CPSP upon referral from the named obstetric provider.
   - ✓ Bill for all CPSP services, including case coordination where applicable and as arranged with Tower Health participating provider.
   - ✓ Provide copy of assessments, re-assessments, and intervention documentation on monthly basis to Obstetric Provider for inclusion in Obstetric Medical Record.
   - ✓ Bill for distribution of prenatal vitamins and mineral upon delivery of three-hundred (300) day supply to patient as prescribed by Obstetric Provider, include copies of Obstetric exams, labor and delivery experience and postpartum exam in CPSP chart as received from Obstetric Provider.

3. The individualized Care Plan must comply with the following requirements:
   - ✓ Obstetrical component includes the prevention and/or resolution of obstetrical/medical problems.
   - ✓ Nutrition component includes the prevention and/or resolution of nutrition problems
   - ✓ The support and maintenance of strengths and habits oriented toward optimal

nutrition status, and the goals to be achieved.

- ✓ Psychosocial component includes the prevention and/or resolution of psychosocial problems; the support and maintenance of psychosocial strengths; and the goals to be achieved.
- ✓ Health Education component includes the member's health education strengths, the prevention and/or resolution of health education problems and/or needs and medical conditions and health promotion/risk reduction behaviors; the goals to be achieved via health educator intervention; and health education interventions based on the member's needs, interests, and capabilities.
- ✓ Examples of client strengths include, but are not limited to: Ability to comprehend and make decisions
- ✓ Ability to cope
- ✓ Adequate shelter/clothing Adequate transportation Emotionally stable Employed
- ✓ Experience/knowledge or labor and delivery
- ✓ Experience/knowledge of infant care
- ✓ Financially stable
- ✓ Positive compliance and self-esteem
- ✓ High School Education
- ✓ Interest/willingness to participate in individual/group classes
- ✓ Motivated
- ✓ Access to refrigerator/stove Social Support System Thinking of the Future
- ✓ Wanted /accepted/planned pregnancy

4. Care lst Health Plan Case Managers are available to coordinate care with other Case Management agencies such as Black Infant Health, Prenatal Care, Guidance, Public Health Nursing, and Adolescent Family Life/Cal-Learn Programs, to ensure appropriate resources are available to the member and to avoid duplication of services.

5. The local Perinatal Services/CPSP Coordinator ensures that all DRS/certified CPSP Providers receive all DRS-sponsored CPSP updates, as well as a copy of the CPSP enhancement, "Steps to Take" materials, which provide information helpful to CPSP approved staff members to effectively assess. Provide interventions (for common pregnancy conditions and discomforts, not for high-risk situations) and appropriately refer pregnant members.

ACCESS TO CARE

1. Blue Shield Promise Health Plan UM/Case Manager evaluates access to perinatal related services by reviewing selected claims and encounter data. Utilizing this data, Blue Shield Promise Health Plan’s Health Educator indentifies opportunities to indentify members early in their pregnancy and link them to appropriate perinatal programs and services including CPSP.

2. Access to pre-natal care is an important factor in achieving health birth outcomes. Blue Shield Promise Health Plan recognizes that the lack of transportation is a barrier to access to health care for many low-income women. Blue Shield PromiseHealth Plan attempts to coordinate transportation.

GENETIC SCREENING, COUNSELING AND REFERRAL

Screening and Counseling

Pregnant Blue Shield Promise members will be provided genetic screening, counseling, and referral as needed. This history obtained during initial evaluation should be reviewed to detect signs of possible genetic disorder risk including those listed below:

- ✓ Maternal age (mother 35 or older)
- ✓ Previous offspring with chromosome aberration
- ✓ Chromosome abnormality in either parent
- ✓ Family history of sex linked condition
- ✓ Neural tube defect
- ✓ Ancestry indicating risks for Tay-Sachs, beta telamessemia or alpha thalessemia
- ✓ Inborn errors of metabolism

Women at increased risk 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 justiy referral. Whatever the situation, counseling is obligatory before antenatal diagnostic studies are performed. Genetic counseling, whether done by the obstetrician or by the medical geneticists, is defined as a communication process that deals with the occurrence, or risk of occurrence, of a genetic disorder in a family. In this process, one or more appropriately trained persons attempt to help the individual and /or family to:

- ✓ Comprehend medical facts, including the diagnosis, the probable course of the disorder and the available management. Appreciate the way in which heredity contributes to the disorder and the available management.
- ✓ Appreciate the way in which heredity contributes to the disorder and the risk of occurrence in specified relatives.
- ✓ Understand the options for dealing with the risk of recurrence.
- ✓ Choose the course of action that seems appropriate in view of the risk and the family goals, and act in accordance with the decision.
- ✓ Make the best possible adjustment to the disorder in an affected family member and to the risk of recurrence in another family member.

The key elements in this are diagnosis, communication, and options. When a genetic disorder has been diagnosed in a family member, the counselor communicates 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 allows couples to make an informed decision.

Genetic referral

The member's obstetric provider contacts the member's Primary Care Physician when there is a need for medical geneticist assessment and counseling. The Primary Care Physician, in consultation with the obstetric physician, authorizes or requests authorization for the requisite referrals. If referred to a geneticist the diagnostic and counseling program may include:

- ✓ Ultrasound examination for visualization of fetal size and anomalies.
- ✓ Amniocentesis for withdrawal of fluid for genetic evaluation of presence of neural tube defect.
- ✓ Karyotyping
- ✓ Genetic Counseling
- ✓ Other procedures as deemed necessary by the Primary Care Physician, OB Gynecologist and Geneticist.

Intra-partum Care

A. Pregnant members are informed of a designated facility for delivery. The choice of facility is based on risk appropriateness as well as contractual arrangements. This information should be re-confirmed as reinforced with the member during the course of pre-natal care. The obstetric providers will forward a copy of the member's prenatal care records to the designated facility per facility procedures.

B. Women at high-risk pregnancies are directed to a facility with advanced obstetrics and neonatal care units. If the need for NICU services in anticipated (pre-maturity), known as congenital anomaly, low estimated fetal weight, diabetic pregnancy maternal cardiac or other disease, etc.). High-risk members must be instructed to deliver in a hospital with an appropriate level CCS designated NICU with the capacity to provide risk appropriate care for their delivery and children.

C. Studies have shown that infants requiring Neonatal Intensive Care (NICU) whom are born in (not transferred to after delivery) hospitals able to provide such care have fewer complications. The following conditions require specialized care and Tower Health members should be directed to go to, or transferred pre-natally to a facility with California Children

Health members should be directed to go to, or be transferred pre-natally to a facility with a California Children's Service (CCS) designated (NICU) with the capacity to provide risk appropriate care for their delivery and newborn.

1. Maternal/ Obstetrical Complications
    a. Intermediate, Community or Regional NICU designation recommended.
    b. Premature rupture of membranes, 32-34 weeks gestation.
    c. Premature labor, thirty-six (36) weeks, but thirty-two weeks gestation, unknown dates with estimated fetal weight 2.000 grams.
    d. Trauma requiring intensive care of surgical correction or requiring a procedure that may result in the onset of premature labor.
    e. Acute abdominal emergencies.
    f. Pre-eclampsia, eclampsia, or other hyperstension complication.

g. Third trimester bleeding.
h. Multiple gestation thirty-four (34) weeks gestation and all three (3) fetuses.

2. Medical Complications
   a. Infectious heart
   b. Disease – Diabetes
   c. Mellitus
   d. Thyrotoxicosis
   e. Renal disease with deteriorating function or increased hypertension
   f. Hepatic disease
   g. Drug overdose
3. Fetal Conditions
   a. Anomalies that may require surgery
   b. Congenital anomalities requiring specialized new born care.
   c. Erythroblastosis requiring intrauterine transfusion
4. Neonatal conditions where transport may be indicated.
   a. Gestational less than 32 weeks or weigh less than 1500 grams.
   b. Persistent respiratory stress.
   c. Seizures refractory to usual treatment
   d. Congenital malformations requiring special diagnosis procedures or surgical care.
   e. Sequelae of hypoxia persisting beyond (2) hours, with evidence of multi-system involvement.
   f. Cardiac disorders that require special diagnostics procedures or surgery sepsis.

Postpartum Evaluation

A. Each member is to receive a postpartum nutritional assessment two (2) or four (4) weeks after deliver. This assessment will:
   - ✓ Identify any nutritional risk factors which may compromise the health of the client or her infant following the delivery.
   - ✓ Identify and support the strengths/habits which promote good nutrition status following pregnancy and during breast feeding.
   - ✓ Make timely and appropriate nutrition interventions for each client Integrate postpartum nutrition care with obstetrical, psychosocial, and health education services, including development of nutrition care plan and WIC referral when appropriate.

B. The routine postpartum care visit should be accomplished between twenty-one (21) days fifty-six days after the delivery, although this interval may be modified if warranted by the needs of the patient. This postpartum review should include:
   - ✓ Internal history, including questions regarding breast feeding

- ✓ Physical examinations Laboratory data as indicated Family planning counseling
- ✓ Nutritional, health education and psychosocial re-assessments Review of immunizations including rubella immunization Encouragement to return regularly for examinations
- ✓ Psychological assessment
- ✓ Health education assessment