

Interpretive Guidance for Prenatal Care

Guidance for Prenatal Standards (85-40 Regulations)

PCAP Standards	Interpretive Guidance
General Requirements	
PCAP shall act as "qualified provider."	Need to complete qualified provider agreement.
Facilitate enrollment into the Medicaid Program	Conduct presumptive eligibility on clients not already enrolled in Medicaid when entering prenatal care.
	Assist in completion of Medicaid application, and forward to Local Department of Social Services (LDSS).
	Develop system to track status of MA application until final determination made.
Subcontracts should be available for review by Department of Health staff.	Subcontracts should be easily retrievable to be reviewed on site visits. Subcontractors should provide care in accordance with Medicaid billing and PCAP standards.
Outreach	
Facilitate early entry into maternity services including the provision of on-site pregnancy screening;	Offer on-site pregnancy screening by appointment or walk-in basis. Review time lag for first prenatal appointment from when the client has a positive pregnancy test based on trimester of entry: If first trimester - visit should be within 3 weeks. If second trimester - visit should be within 2 weeks.
	Develop linkages with community-based resources (i.e., Public Health Nursing, WIC), communicate with regional network/Community Health Worker Program.
	Develop/distribute pamphlets, brochures, member newspaper article describing importance of early prenatal care. Include specific instructions for women who think they are pregnant, or need a pregnancy test.
	Document all outreach activities.
Risk Assessment	
Ongoing assessment of both maternal and fetal risk throughout the prenatal period. Such risk assessment shall include, but not be limited to, an analysis of individual characteristics affecting pregnancy, such as genetic, nutritional, psychosocial, and historical and emerging obstetrical and medical-surgical risk factors.	Use of one of the standardized prenatal care medical records is recommended (e.g., Hollister, POPRAS, ACOG). Other tools are acceptable if they adequately identify risk factors. Documentation should include identification of medical, obstetrical, nutritional, psychosocial, genetic and environmental risk factors.
This risk assessment shall be reviewed at each visit, linked to the plan of care and clearly documented in the medical record.	Assessment should be performed and documented at initial visit, and reviewed at each subsequent visit.

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		Risk Assessment should be reviewed/signed by MD/licensed midwife/Nurse Practitioner.
		Risk factors should be linked to plan of care. Documentation can be in the form of a problem list/corresponding plan.
		Develop criteria for determining high-risk pregnancies.
Development of Care Plan & Coordination of Care		
A care plan which addresses the proper implementation and coordination of all services required by the pregnant woman shall be developed, routinely updated and implemented jointly by the pregnant woman and her family where mutually agreeable to the woman and all appropriate members of the health care team.		Medical record should contain an individualized care plan reflecting multidisciplinary input. Care plan can be documented in a variety of ways: problem list intervention including referrals, tests and follow-up to address client needs; summary contained in progress or narrative notes; pre-developed algorithm/plan allowing for appropriate check-offs.
Care shall be coordinated to:		
a)	Encourage and assist the pregnant woman in obtaining necessary medical, nutritional, psychosocial, drug and substance abuse services appropriate to her identified needs and provide followup to ensure ongoing access to services;	Coordinate care with all disciplines (nutrition, social work) by discussing client cases on a weekly/monthly basis or through other means to ensure communication and coordination of care.
b)	provide the pregnant woman with an opportunity to receive prenatal or postpartum home visitation when the woman may derive medical or psychosocial benefits from such visits. The visit shall identify familial and environmental factors which may produce increased risk to the woman or fetus and the relevant findings shall be incorporated into the care plan;	Establish criteria for home visits Designate prenatal coordinator/nurse manager Develop mechanism (i.e., flow sheet) to ensure that all indicated care is rendered
c)	provide to or refer the pregnant woman for needed services;	Appropriate referrals include: 1. inpatient care 2. specialty physician services 3. genetic services 4. drug treatment services 5. dental services 6. home care 7. pharmaceutical and transportation 8. nutrition services
d)	encourage continuity of care and client followup including rescheduling of missed visits throughout the prenatal and postpartum period.	Transfer or co-management of high-risk patients, establish protocol to cover transfer for high risk patients from mid-level practitioner to obstetrician. Develop and implement a system to follow up and reschedule missed visits. Include follow up procedure for abnormal laboratory findings, referrals.

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Nutrition Services		
Establish and implement program of nutrition screening and counseling which includes:		Develop nutrition risk assessment tool which screens for specific nutritional risk conditions at initial visit. Can be documented as part of risk assessment or as a discrete tool.
a)	Individual nutrition risk assessment	Nutrition assessment can be self-administered with professional review or completed by clinical staff (RN, LPN). Clients with nutrition risk factors should be referred to a registered dietician or nutritionist for counseling/followup monitoring.
b)	arrangements for services with funded nutrition programs available in the community including provision for enrollment of all eligible women and infants in the Supplemental Food Program for Women, Infants and Children (WIC), at the initial visit;	Ensure referrals to WIC for women not already enrolled. Develop mechanism (tool) to track WIC enrollment.
c)	provision of basic nutrition education and counseling for each pregnant woman	Provide basic nutrition education including appropriate dietary intake, and weight gain. Can be documented on health education tool. Discuss infant feeding choices with emphasis on breastfeeding. Document all nutrition services in the client record.
Health Education		
Health and childbirth education services shall be given to each pregnant woman based on an assessment of her individual needs.		Evidence that risk-appropriate health education was provided to each patient should be documented in the medical record.
		A checklist format or notation in the progress notes is recommended for documentation.
		Health education can be presented in a group setting or on an individual basis using videos, printed material, classes.

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	Health education should be based on assessment of individual women's needs considering language and cultural factors. The following topics shall be provided as needed:
	<ol style="list-style-type: none"> 1. orientation to procedures at medical facilities and at the expected site of birth; 2. rights and responsibilities of the pregnant woman; 3. signs of complications of pregnancy; 4. physical activity, exercise and sexuality during pregnancy; avoidance of harmful practices and substances including alcohol, and other drugs, including non-prescribed medications and nicotine; 5. occupational concerns; 6. risk of HIV infection and risk reduction behavior; 7. benefits of prenatal HIV testing and universal HIV testing of newborns through newborn screening program; 8. signs of labor; 9. labor and delivery process; 10. relaxation techniques in labor; 11. obstetrical anesthesia and analgesia; 12. preparation for parenting including infant development and care and options for feeding. Encourage breastfeeding, discuss advantages to mother and infant; Note: HIV positive women should be advised not to breastfeed. 13. the newborn screening program with the distribution of newborn screening educational literature, and 14. family planning; 15. Medicaid eligibility for infant up to one year of age.
Psychosocial Assessment	
A psychosocial assessment shall be conducted on each client	Psychosocial assessment should include screening for economic, social, psychological and emotional problems as well as past or present domestic violence or sexual assault.
	Can be documented as part of overall risk assessment or on a separate tool.
	Develop criteria for referral of women with psychosocial risk factors.
	Develop criteria and protocol to ensure women and screened for and receive services for postpartum depression
	Followup on referrals (flow sheet, phone calls tickler system) document follow up activities in record.

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Prenatal Diagnostic and Treatment Services		
a)	an initial comprehensive assessment including history, review of systems, and physical examination.	Prenatal care protocols must be in place which specify content of care, as well as including level of practitioner and schedule of visits. Protocols should be based on client risk status and consistent with ACOG/85.40 guidelines. Adherence to protocols should be documented in prenatal record.
b)	standard laboratory tests and procedures;	There should be evidence that risk-appropriate laboratory tests/special procedures were performed. Can be documented on prenatal record tool or separate laboratory sheet in the client record.
c)	needed special laboratory tests as indicated by comprehensive assessment and initial or preliminary test findings;	Documented evidence that abnormal lab/test results are followed by a reporting procedure, client notification and followup. Counseling for Alpha-fetoprotein (AFP) and offer of testing.
d)	evaluation of risk;	Ongoing evaluation of risk at each visit.
e)	establish arrangements for availability of after hours and emergency consultation and care for pregnant women.	Detailed protocol regarding after hours consultation should be documented in procedure manual. Notify clients and all affected staff regarding these arrangements. Clients should be able to telephone clinical or trained triage staff after hours for appropriate support and medical guidance, thereby avoiding unnecessary trips to the emergency room.
f)	develop and implement written agreements with planned sites of delivery which address, at a minimum: 1) a system for sharing medical records	Establish arrangements for referral of women/newborns to appropriate alternate care sites for medically indicated care (i.e., refer high risk women to appropriate level of care facility). Develop written agreements with planned delivery sites which address: prebooking, scope of services, prenatal record transfer, sharing of delivery/birth outcome information.

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HIV Services	
DOHM (AI 99-01) is the standard of care for HIV services.	
<ul style="list-style-type: none"> a. Provide all pregnant women with HIV counseling and education; b. Offer the pregnant woman confidential HIV testing; and c. provide the HIV positive woman and her newborn infant the following services or make the necessary referrals for these services; <ul style="list-style-type: none"> 1. management of HIV disease; 2. psychosocial support; 3. case management to assist in coordination of necessary medical, social and addictive services. 	<p>HIV pretest counseling should be provided to all prenatal clients.</p> <p>Clinical recommendation of testing as early in their prenatal care as possible. Discussion should include benefits of testing, such as availability of ZDV therapy for reducing transmission of HIV to infant, and that newborns will be HIV tested at birth.</p> <p>HIV posttest counseling must be provided to all women who are HIV tested.</p> <p>Medical record should contain entries that: HIV pretest counseling was provided, decision on testing; HIV test results, posttest counseling.</p> <p>Women who are HIV positive should receive indicated referrals for antiretroviral therapy.</p> <p>For HIV positive women, documentation should reflect receipt of appropriate care.</p>
Records and Reports	
<p>Create and maintain records and reports that are complete, legible, retrievable and available for review. Such records and reports shall include:</p> <p>A comprehensive prenatal care record for each pregnant woman which documents the provision of care and services required by this section and which is maintained in a manner consistent with medical record confidentiality requirements.</p>	<p>Comprehensive prenatal care record should be maintained on each client. Entries should be complete, legible and accurately reflect provision of laboratory testing and special procedures.</p> <p>Records should be maintained in a manner which safeguards confidentiality requirements.</p> <p>Develop/implement system to track trimester of entry, Low birth weight (LBW) infants, number of prenatal visits, postpartum rate of return, number of c/sections, Vaginal Births After Cesarean Section (VBACs), and number of women choosing to breastfeed, number of teenagers.</p> <p>PCAP annual report should be accurately completed and submitted within expected time frame.</p>

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Internal Quality Assurance	
<p>Develop and implement written policies and procedures establishing an internal quality assurance (IQA) program to identify, evaluate, resolve and monitor actual and potential problems in patient care.</p>	<p>Implement IQA activities focusing on prenatal care within system wide QA program.</p> <p>Develop policies/procedures establishing internal quality assurance plan for prenatal care program.</p> <p>Recommend IQA should be multidisciplinary and review issues such as nutrition, psychosocial, educational methods, care coordination, risk assessment, and HIV services.</p> <p>Have periodic QA meetings to discuss prenatal issues.</p>
<ul style="list-style-type: none"> a. a documented and filed prenatal chart audit performed periodically on a statistically significant number of current prenatal client records. b. an annual written summary evaluation of all components of such audits. c. a system for determining patient satisfaction and for resolving patient complaints. d. a system for developing and recommending corrective actions to solve identified problems. e. a followup process to assure that recommendations and plans of correction are 	<p>Prenatal chart audits should be performed using 85.40 indicators.</p> <p>A tool to conduct chart audit should be developed</p> <p>Prepare written summary evaluation of audit findings on an annual basis. Maintain audit summary on file.</p> <p>Develop system for determining patient satisfaction with prenatal program and resolving patient complaints. Recommend administering patient satisfaction survey during client's third trimester or at the postpartum visit.</p> <p>Documentation should include: summary reports of chart audit findings; analysis of outcome statistics; analysis of patient satisfaction survey results with recommendations to correct identified problems.</p> <p>All followup is done in a timely manner.</p>
Postpartum Services	
<p>Coordinate with the neonatal care provider to arrange for the provision of pediatric care services and patient services.</p>	<p>Stress importance of postpartum/pediatric visit to the mother during third trimester visits.</p>

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<p>A postpartum visit with a qualified health professional shall be scheduled and conducted in accordance with medical needs but no later than eight weeks after delivery. For the interim, furnish each women with a means of contacting the provider in case postpartum questions or concerns arise.</p>	<p>Develop strategies to encourage client to return for postpartum visit (i.e., incentives). Implement missed visit policy for "no-shows."</p> <p>Provide home visits to assess needs (e.g., adjustment to parenting, feeding, etc.) as indicated. Refer to Care Coordination section for additional guidance. Contents of home visit should be documented in the record.</p> <p>Postpartum visit should be scheduled no later than eight weeks post delivery. Submit mechanism to schedule/followup on postpartum visit. Arrangements for pediatric care should be made</p> <p>Develop arrangements for client to contact provider between delivery and scheduled postpartum visit.</p>
Postpartum Visit Components	
<ul style="list-style-type: none"> a. Identify any medical, psychosocial, nutritional, alcohol treatment and drug treatment needs of the mother or infant that are not being met; b. Refer the mother or other infant caregiver to resources available for meeting such needs and provide assistance in meeting such needs where appropriate; c. Assess family planning needs and provide advice and services or referral where indicated; d. Provide preconception counseling as appropriate and encourage a preconception visit prior to subsequent pregnancies for women who might benefit from such visit; e. Refer infants to preventive and special care 	<p>Establish protocol to provide all postpartum components of care (i.e., identify needs of woman/infant, necessary referrals, family planning etc.).</p> <p>Postpartum documentation should include: delivery outcome, maternal physical exam, health status of mother/infant including medical, nutritional, psychosocial needs with referrals.</p> <p>Use a standardized medical record with postpartum section or separate postpartum visit tool outlining indicated components of care.</p>

Source: New York State Department of Health;
<http://www.health.state.ny.us/nysdoh/perinatal/en/guidance.htm>