Comprehensive Perinatal Services Program (CPSP)

CPSP Overview
Day 1

Trainers
• Paula Binner, MSW, LCSW
• Jean Floyd, BSN, PHN
• Thelma Hayes, MA, RD
• Jenny Morales, MSN, PHN
• Christian Murillo, MPH
• Joanne Roberts, BSN, PHN

Training Objectives
• Describe the 4 components of CPSP
• Explain the purpose of CPSP Orientation
• Explain how to use Provider Handbook, Steps to Take Guidelines, and Protocols
• Describe documentation guidelines
• Define Interconception Care

Objectives (cont.)
• Report an increased understanding of mandated reporting laws
• Identify ways to effectively communicate with patients

What does CPSP stand for?
• C Comprehensive
• P Perinatal
• S Services
• P Program

Definition
“Comprehensive perinatal services” means obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery.”

(Title 22, CCR, 51179)
### CPSP Program Goals
- To decrease the incidence of low birth weight in infants
- To improve pregnancy outcome
- To give every baby a healthy start in life
- To lower health care costs by preventing catastrophic & chronic illness in infants & children

### CPSP Program History
- Developed from the OB Access Project
- A perinatal demonstration project for 7000 low income women that operated from 1979 to 1982 in 13 California counties

### CPSP Program
- Reduced low birth weight rate by 1/3 and saved about $2 in short term NICU costs for every $1 spent
- CPSP was legislated in 1984 and added to Medi-Cal program in 1987

### Medi-Cal Managed Care
- 1997: CPSP included in Medi-Cal managed care
- All Medi-Cal Managed Care health plans are required to ensure that their pregnant patients have access to CPSP services

### Title 22 Regulations
- Title 22, California Code of Regulations (CCR), defines the CPSP program requirements
- A copy of regulations are in the CPSP Provider Handbook

### Who Can Become A CPSP Provider?
- Physician (OB/GYN, FP, GP, Pediatrician)
- Medical Group, any of whose members is one of the above physicians
- Certified Nurse Midwife
- Nurse Practitioner (family or pediatric)
- Clinic (hospital, community or county)
- Alternative Birth Center
CPSP Practitioners

• Physicians (MD, DO)
• Certified Nurse Midwives (CNM)
• Nurse Practitioners (NP)
• Physician Assistants (PA)
• Registered Nurses (RN)
• Licensed Vocational Nurses (LVN)

CPSP Practitioners (cont.)

• Social Workers (SW)
• Psychologists (PSY)
• Marriage and Family Therapist (MFT)
• Registered Dietitians (RD)
• Health Educators (HE)
• Certified Childbirth Educators (CCE)

CPSP Practitioners (cont.)

• Comprehensive Perinatal Health Workers (CPHW)
  *At least 18 years old
  *High School Diploma or GED
  *Minimum one year full time paid perinatal experience

CPSP in Los Angeles County (LAC)

• Statewide program: 58 counties + 3 cities
• All must follow Title 22 Regulations
• Some differences in different counties/cities
  o Forms

LAC CPSP Staff

• Public Health Nurses
  o Perinatal Services Coordinator (PSC)
  o 4 Assistant Coordinators

LAC Staff (cont.)

• Support Services Team:
  o Health Educator
  o Health Education Assistant
  o Registered Dietitian
  o Licensed Clinical Social Worker
• Staff Support
CPSP Scope of Services

Client Orientation

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

Initial Client Orientation

- What OB, CPSP, and other services will be provided
- Who will provide services
- Where to obtain services
- Client rights and responsibilities
- Danger signs and symptoms
  - What to do/who to call

Client Orientation

- Orientation to office policies
  - Office hours
  - Making and breaking appointments
- Opportunity to ask questions and express concerns about prenatal care, services, or information provided

Client Orientation

- Informed consent to procedures
  - Genetic testing, hospital registration
- Information about referrals
  - WIC, dental care, pediatric
- Can be ongoing throughout pregnancy
- Maximum time 2 hours per pregnancy
Client Orientation

- No consent needed to participate in CPSP
- Patient has the right to decline
  - Document “patient declines” and reason
  - Re-offer at next trimester

Initial Assessment

To gather baseline data and ask questions designed to identify issues affecting:

- The client’s health and pregnancy
- The client’s readiness to take action
- Resources needed to address the issues

Areas of Initial Assessment

- Personal Information
- Economic Resources and Housing
- Transportation
- Current Health Practices
- Pregnancy Care
- Educational Interests
- Nutrition
- Coping Skills

CPSP Components

- Obstetrical (OB) Care
  - Obstetrical Services
    - Prenatal care
  - Intrapartum (delivery) care
  - Postpartum Care
OB Care

• Content of visits are in accordance with current American Congress of Obstetricians & Gynecologists (ACOG) Guidelines for Perinatal Care, and

• Clinic follows ACOG schedule for frequency of visits

Initial OB Assessment

• Initial pregnancy-related exam is billed with code of (Z1032)

• Includes comprehensive history and physical exam

Initial CPSP Assessment

• Health Education
• Nutrition
• Psychosocial
• Provide her with information that will help her make informed choices during her pregnancy.

Late Entry

• Initial assessment may occur in 1st, 2nd or 3rd trimester (whenever client enters for care)

• If client enters care in 2nd trimester (wks of GA), date initial assessment in the “initial” space and enter “N/A” in the 2nd trimester.

• Reassessment must occur in the following trimester.

• All questions must be asked (unless N/A) and recorded for the appropriate weeks.

Initial CPSP Assessment

• Assessment information used to develop Individualized Care Plan

• ICP developed from identified problems/risks (shaded areas of assessment/reassessment)  
> Problems/risks are prioritized with patient
Initial Health Education

• Is used to identify the client’s learning needs as they relate to her pregnancy

• Must contain the following required components

Initial Health Education

• Current health practices
• Past experience with health care delivery systems
• Prior experience with and knowledge about pregnancy, prenatal care, delivery, postpartum self care, infant care & safety
• Client’s expressed learning needs
• Formal education & reading level

Initial Health Education

• Learning methods most effective for the client
• Educational needs related to diagnostic impressions, problems, and/or risk factors identified by staff
• Languages spoken & written
• Mental, emotional, or physical disabilities that may affect learning
• Mobility/residency

Initial Health Education

• Religious/cultural influences that impact perinatal health should be identified

• Client and family or support person’s motivation to participate in the educational plan should be determined and encouraged

Initial Nutrition Assessment

• Encourage sound nutrition practices
• Identify women at risk for a poor pregnancy outcome
• Identify who can benefit from nutritional intervention
• Involve four (4) required components
Frequently Asked Questions

• What is healthy eating for me and my baby?
  - Eating for two? - Food intake - Weight gain?
• Will everything about my routine change?
  - Exercise - Favorite foods - Morning coffee
• Why do I sometimes feel so bad?
  - Morning sickness - Swelling - Constipation
• The baby has arrived. Now what?
  - Weight loss - Breastfeeding

Initial Nutrition Assessment

• Anthropometric (height & weight)
• Biochemical (lab tests and values)
• Clinical (previous & current OB/Medical risks)
• Dietary (food intake)

Anthropometric

• Height and weight
• Weight history
• Pre-pregnant weight
• Record weights on grid at each OB visit
• Postpartum weight

Weight Categories for Pre-pregnancy Weights

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Twins</th>
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<tbody>
<tr>
<td>Underweight</td>
<td>28 – 40 lbs.</td>
<td>N/A</td>
</tr>
<tr>
<td>Normal weight</td>
<td>25 – 35 lbs</td>
<td>37-54 lbs</td>
</tr>
<tr>
<td>Overweight</td>
<td>15 – 25 lbs</td>
<td>31-50 lbs</td>
</tr>
<tr>
<td>Obese weight</td>
<td>11 – 20 lbs</td>
<td>25-42 lbs</td>
</tr>
</tbody>
</table>

*Recommended Rate of Weight Gain

<table>
<thead>
<tr>
<th>Weight Category</th>
<th>1st Trimester</th>
<th>2nd/3rd Trimester (Per month)</th>
</tr>
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<tbody>
<tr>
<td>Underweight</td>
<td>------</td>
<td>4 lbs or more</td>
</tr>
<tr>
<td>Normal</td>
<td>------</td>
<td>3-4 lbs</td>
</tr>
<tr>
<td>Overweight</td>
<td>------</td>
<td>about 2 lbs</td>
</tr>
<tr>
<td>Obese</td>
<td>------</td>
<td>Varies</td>
</tr>
</tbody>
</table>

*IOM, 2009 Weight Gain During Pregnancy*
Biochemical
Review and record nutrition-related lab values
✓ Hgb/Hct
✓ Urine
✓ Glucose
✓ Proteins
✓ Ketones
✓ Mean Corpuscle Volume (MCV)

Clinical
Assess and Record Nutrition Related Clinical Conditions
✓ Acute & Chronic Diseases
✓ High parity; Multiple Gestation
✓ Anemia; Age <17
✓ Substance Use (alcohol, drugs, tobacco)
✓ Previous Low or High Birth Weight
✓ Others ………………

Dietary
ASSESS
Discomforts / Cravings
• Food & Beverage
  – Eating Patterns / Allergies
  – Availability / Preparation
  – Safety / Storage / OTC Meds
• Eating Disorders / Vegetarian
• Infant Feeding Plan
• Food Intake: Quantity & Quality
• WIC Participation

Daily Food Guide for Pregnant/Breastfeeding Women

<table>
<thead>
<tr>
<th>Food Groups</th>
<th>Recommended Minimum Servings – Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meat / Protein Foods</td>
<td>3</td>
</tr>
<tr>
<td>Milk Products</td>
<td>3</td>
</tr>
<tr>
<td>Breads, Cereals &amp; Grains</td>
<td>7</td>
</tr>
<tr>
<td>Fruits and Vegetables: Vitamin C-rich</td>
<td>1</td>
</tr>
<tr>
<td>Fruits and Vegetables: Vitamin A-rich</td>
<td>1 (2-3 per week)</td>
</tr>
<tr>
<td>Fruits and Vegetables: Others</td>
<td>3</td>
</tr>
<tr>
<td>Unsaturated Fats</td>
<td>3</td>
</tr>
</tbody>
</table>
What are some psychosocial issues that a woman may experience during her pregnancy?

Psychosocial services help patients understand and deal effectively with biological, emotional, and the social stressors of pregnancy.

Overall Aim: Healthy moms and babies

Assessment required to contain the following:

- Personal adjustment to pregnancy
- Wanted or unwanted pregnancy
- Acceptance of pregnancy

- Substance use, abuse or dependency
- Housing/household situation
- Current status including social support system
Initial Psychosocial

• Substance use, abuse or dependency
• Housing/household situation
• Current status including social support system

Initial Psychosocial

• Education
• Employment
• Financial and material resources

Initial Psychosocial

• History of previous pregnancies
• General emotional status and history
• Patient’s goals for herself in this pregnancy

Psychosocial Assessment

• The psychosocial process assists the patient with:
  o Community resources
  o Emotional concerns
  o Crisis intervention

Initial Psychosocial

• Let’s discuss . . .
  • What psychosocial issues listed are high risk, moderate risk and low risk ?
Importance of Relationship

Let’s discuss . . .

• Think about the first time you went to a new doctor for medical appointment. . .
• Was there anything provider did that made you comfortable to share information?

Important aspects of interviewing and assessing:

• She comes to trust you
• She can tell you what is happening in her life
• She won’t be judged, criticized, ignored, laughed at or labeled

Importance of Relationship

• May need extra time to process what you are asking, may not be sure how much to share on first visit
• You are patient’s partner in maximizing her care and cannot make her do anything

Key Points for Interviewing

• Setting should assure confidentiality
• Keep all notes, lists, or charts involving the patient in a locked space when not in use
• Have a phone and resource list available

Key Points for Interviewing

• Ask open-ended questions
• If asked in a sensitive, straightforward manner, most patients are willing to answer
• Many patients are relieved to discuss problems with a helpful, caring person
Key Points for Interviewing

- Try to put the patient at ease by explaining the purpose of the assessment
- Adopt a non-judgmental, accepting, relaxed attitude
- Be aware of your own attitudes & ways your own personal history affects your ability to serve your patients

Listening

- Verbal
- Non-verbal

Non-Verbal Listening

- Body language
  - Communicate without words: heart rate, perspiration, labored breathing
  - Facial expressions and eye movements

Listening Styles

- **Passive/not listening**: noise in background
- **Pretend listening**: responsive listening, using nods, smiles, uhum, yes of course
- **Biased listening**: selective listening, disregarding/dismissing the patient’s views
- **Misunderstood listening**: unconsciously overlaying own interpretations, making things fit when they don't

Listening Styles

- **Attentive listening**: personally-driven fact gathering, analysis
- **Active listening**: understanding feelings, gathering facts for variety of purposes
- **Empathic listening (empathy)**: understanding, checking facts and feelings, helping with patients needs uppermost

Empathy

- *The ability to put oneself in the shoes of another person and experience events and emotions the way that person experienced them*
  
  Batson
Empathy

- Listen with full attention
- Consider cultural/ethnic aspects
- See and feel from patient’s viewpoint
- Summarize to verify understanding

(Listening Types by Allen Campbell)

Empathy

- Empathic listening aligns us with patient
- Empathy and trust are crucial for effective understanding and communication
- Become a partner in assisting patient to meet goals for this pregnancy and beyond

Psychosocial High Risk Situations

- Seek help from supervisor, consultant, medical provider before patient leaves office
- Train all staff before crisis occurs
- Provider may designate you assist patient in accessing referrals **

MANDATED REPORTING IN CPSP

Mandated Reporting

- Inform patient that you are a mandated reporter at the beginning of the assessment
- Clearly understand situations that must be reported to authorities

Mandated Reporting

Must report when you suspect:

- A child, elder, or dependent adult has been harmed or in danger of being harmed
- A patient has injuries that you suspect are from assault as the result of violence, including intimate partner violence
**Mandated Reporting**

- Patient is a danger to self, others, or gravely disabled call PMRT (psychiatric mobile response team) or law enforcement
- Makes a serious threat to kill another person
- Patient suffering from injury by firearm
- Seek help from supervisor and document what happened and authorities you’ve contacted

**Mandated Reporting**

- Intimate Partner Violence

  - Health Practitioners required to report if provide medical services to patient suspected of suffering from physical injury due to abuse/assault
    - Any Health Care Team Member can complete report

**Mandated Reporting**

- Intimate Partner Violence
  - Must report even if patient states different story or denies abuse
  - You DO NOT have to inform patient that you are reporting, BUT THIS MUST BE REPORTED

**Legal Responsibilities**

- IPV Reporting
  - Telephone law enforcement immediately or as soon as possible
  - Document in medical chart verbal/written reports have been made
  - Written report submitted within 48 hrs includes:
    - Name and location of injured person
    - Character and extent of injuries
    - Name and location of perpetrator

**Liability Issues for Reporting**

- Reporting
  - Immunity with reporting as long as no evidence of bad faith reporting
- Not Reporting
  - Misdemeanor charges
  - $1000 fine
  - Six months in jail
  - Subject to civil suit

**Reporting Sexual Abuse**

- When coerced, or in any other way not voluntary
- Based on age difference between partners
  - Do I need to get the age of minor’s sexual partner for reporting purposes?
  - What if I’m not sure whether to report?
- Let’s Discuss . . .
LUNCH

CPSP Scope of Services

Orientation
Initial and Ongoing

Initial Assessments in
- ob, - psychosocial,
- health ed, and nutrition

ICP
(care plan)

Postpartum Assessment
& Care Plan

Reassessment

Interventions

Resources

• Provider Handbook

• CPSP Prenatal Protocols and Postpartum Protocols

• Steps to Take Guidelines (STT)

Individualized Care Plan (ICP)

• Systematic way to prioritize problems, plan interventions, and track progress

• Coordinates care by all staff

• Serves as a self-management tool for the client

ICP Requirements

• Identification of risks

• Proposed interventions

• Outcome information

• Staff responsible

• Strengths

• Timeframe

• Developed in consultation with the patient

Individualized Care Plan (ICP)

• Includes obstetrical, health education, nutrition, and psychosocial risks throughout pregnancy and postpartum
Individualized Care Plan (ICP)

- All problems identified in assessments and reassessments should be addressed
- Staff & patient perceptions may differ
- Update ICP throughout pregnancy and postpartum

Individualized Care Plan (ICP)

- Summary of the assessment process
- Must be done with the patient present
- Useful tool for case conferences
- All team members should review and ensure accuracy of plan and consistency of messages

Individualized Care Plan (ICP)

- The ICP:
  - is not a progress note
  - is a brief summary of patient problems and interventions
- For high risk patients, details of interventions and referrals should be described in a progress note

CPSP Scope of Services

- Orientation
- Initial Assessments in -ob, -psychosocial, -health ed, and nutrition
- Postpartum Assessment & Care Plan
- Interventions
- ICP (care plan)
- Reassessment

Interventions

- Actions intended to reduce or eliminate risks
- Education, counseling, referrals, procedures
- Individual or group

Reassessments

- Identify new risks
- Re-evaluate risks in previous trimesters
- Face-to-face with the client
Reassessments

• Must be done each trimester and postpartum and must include:
  • **Nutrition assessment**
    - Including Perinatal Food Frequency Questionnaire or 24 Hour Diet Intake
  • **Health Education**
  • **Psychosocial**

Postpartum Assessment

• Review prenatal assessments, delivery record, and ICP
• Complete a postpartum assessment for:
  - Health Education
  - Nutrition
  - Psychosocial

Postpartum ICP

• Update existing ICP
• Note problems which have resolved since delivery
• Add new problems from postpartum assessment
Interconception Care

• Interconception = between pregnancies
• The postpartum assessment and ICP are the first steps toward interconception care

Case Coordination

• Implementation of a system for planning & ensuring the provision of comprehensive perinatal services to the patient
• The formal system of record keeping
• Communication among staff & other providers
• The involvement of all aspects of patient care & all practitioners

STT Scavenger Hunt Activity

CPSP Documentation and Billing
Documentation and Billing Overview

- Only state-approved providers may bill
- Services must be provided by an approved CPSP practitioner
- Date of service must be between conception and end of the month in which the 60th postpartum day occurs

Billed using the appropriate procedure code
- Only services as specified in the CPSP regs
- If it’s not documented the assumption is that no service was provided

Documenting CPSP Services

Forms in Chart:
- Client Orientation Checklist (optional)
- Initial Assessment/Reassessment Forms
- Individualized Care Plan (ICP)
- Perinatal Food Frequency Questionnaire (PFFQ)
  - one per trimester and postpartum

Appropriate weight gain grid
- Based on pre-pregnancy weight
- Postpartum assessment and postpartum ICP
- Progress Note
  - For documentation of services/education

Reporting Application Changes

- Notify local CPSP office of any changes
  - Required forms
    - Initial assessments, reassessments, pp assessment
    - Individualized Care Plan
  - Staff
  - General Description of Practice
  - Agreements for delivery or CPSP support services

A brief description of the service provided
- First initial, last name & CPSP title
- The date of service
- The length of time in minutes
- The service provided must be done with the client present (“face to face”)
Group Education Documentation

- A group consists of two or more patients
- Group education is optional
- Must submit a lesson plan to local CPSP office
- Must have a sign in sheet for all classes

Group Education Documentation

- Use of videos
  - Cannot be the entire class
  - Must be appropriate to content of class
  - Approved practitioner must be present throughout video

Group Education Documentation

- Lesson plan on file in provider office
- Sign in sheets on file
  - Do not keep copies in patient charts
  - Title of class, date, name/title of instructor, total class time in minutes, signatures of attendees
- Document attendance in client chart: name of class, date, actual time client spent

Billing Basics

- Only face-to-face service is billable
- Cannot bill services marketed as “free” to community
- Obstetrical services
  - By visit
  - Global – at least 4 ob visits and provided total ob care for patient
- CPSP support services – by visit billing only

Billing Basics

- In accordance with the instructions in the Medi-Cal Billing Manual for Medi-Cal OB/CPSP
- www.medi-cal.ca.gov
- Submit claims within 6 months of service
- Contact Medi-Cal Telephone Service Center (TSC) at 1-800-541-5555

CPSP Billing

- Support services billed in 15-minute units
- Minimum 8 minutes
- Range for units
**CPSP Billing**

<table>
<thead>
<tr>
<th>UNITS</th>
<th>TIME (MIN.)</th>
<th>RANGE (Min.)*</th>
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<tbody>
<tr>
<td>1</td>
<td>15</td>
<td>8-22</td>
</tr>
<tr>
<td>2</td>
<td>30</td>
<td>23-37</td>
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<tr>
<td>3</td>
<td>45</td>
<td>38-52</td>
</tr>
<tr>
<td>4</td>
<td>60</td>
<td>53-67</td>
</tr>
</tbody>
</table>

*Range = Time ± 7 minutes
Ex: 2 units = 30 minutes (30-7=23 and 30+7=37)

**CPSP Reimbursement**

- Individual services $33.64/hr 23 hrs
- Group classes $11.24/pt/hr 27 hrs
- Case Coordination $85.34 in Z6500
- Prenatal vitamins $30 300-day supply

*TAR required for additional units of service
^Rates are for fee-for-service Medi-Cal only; do not apply to FQHC or Managed Care
Use of Billing Modifiers

• No modifiers required for CPSP support services
• Non-physician medical practitioners (CNM, NP, PA) must use correct modifier for medical services
• Multiple modifier (99) used when CNM, NP, PA do initial prenatal exam with early entry bonus (Z1032-ZL)

Use of Billing Modifiers

• Billing ZL modifier when Z1032 done by non-MD
  ○ Bill as Z1032-99
  ○ CNM 99 = SB + ZL
  ○ NP 99 = SA + ZL
  ○ PA 99 = U7 + ZL

CPSP Billing

• Z1032 is billable separately, even with global
• Client Orientation (Z6400) is billed separately from Initial CPSP Assessment time
• Avoid “cookie cutter” documentation
  ○ Risk conditions
  ○ Minutes
  ○ Make sure documentation justifies billing

Federally Qualified Health Centers (FQHC)

• Documentation the same as fee-for-service
• Do not spread out services on multiple days
• Bill using Code 01 for all services
• Group classes – bill for one patient only
• Same maximum service allowances as ffs
FQHC Billing

- Treatment Authorization Request (TAR)
  - Do not submit to M/C
  - Document TAR requirements and keep in chart
  - Cannot provide additional prenatal visits
  - Use CPSP Billing Summary Form

Medi-Cal Managed Care and CPSP

- Three different Managed Care Models in CA
  - Geographic Managed Care
  - County-Organized Health System
  - Two-Plan
- Los Angeles is a Two-Plan County
  - LA Care
  - Health Net

Medi-Cal Managed Care

- LA Care and Health Net
  - Subcontract with other health plans (Blue Cross, Care 1st, Molina, etc.)
- IPAs and Medical Groups
- Providers

Medi-Cal Managed Care

- READ YOUR CONTRACT!
- CPSP is a managed care benefit
- All managed care enrollees eligible
- Reimbursement method varies by contract
  - Capitation or separate fee-for-service rate
  - Do not bill Medi-Cal for managed care clients
  - May need prior authorization for high risk referrals

Electronic Health Records

- CPSP should be part of any EHR
- Handouts
  - EHR Resource List
  - Functionality Basics

Medi-Cal Fraud

Medi-Cal Fraud Reporting

1-800-822-6222
Questions?

Post-Test & Training Evaluation