

Oklahoma State Department of Health Maternal and Child Health Service

Maternity Program Policy and Procedures Manual

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Maternity Program Policy and Procedures Manual

The policies and procedures necessary to provide maternity services to clients are based on the American College of Obstetricians and Gynecologist (ACOG) Standards and other sources of best practice guidance.

Clinic personnel are responsible for ensuring that care provided through the Maternity Program meet the standards set forth in the Maternity Program Policy and Procedures Manual, September 2006.

As the Women's Health Medical Consultant, I have reviewed and approved this manual for use in the Oklahoma State Department of Health (OSDH) sponsored maternity clinics.

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10/4/06
Date

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FOREWORD

I. Federal

With the establishment of the Children's Bureau in 1912, this country recognized the special vulnerability of women, infants and children. In 1935, the unique social, emotional, physical and developmental needs of these populations were further recognized and prioritized for the nation with passage of Title V as part of the nation's Social Security Act.

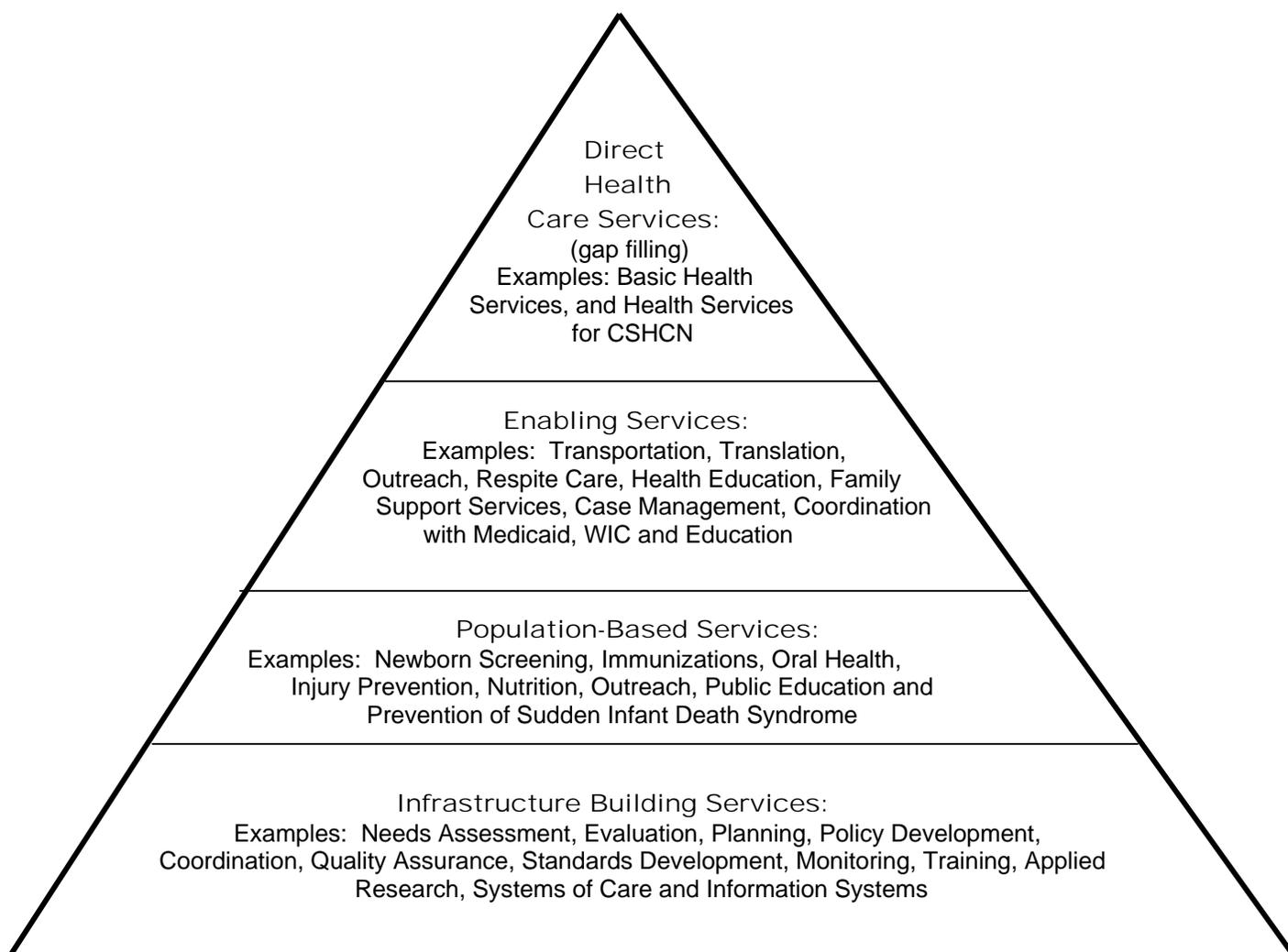
Title V of the Social Security Act is a federal funding commitment to support the efforts of individual states toward improving the well being of women, infants and children. States may apply annually to receive federal Title V monies in the form of a block grant. The Title V Maternal and Child Health (MCH) Block Grant is matched by state monies and used to develop and enhance health systems targeted at improving the health status of the MCH population. More specifically, the Title V MCH Block Grant targets pregnant women, mothers and infants; children; and, children with special health care needs.

The Maternal and Child Health Bureau (MCHB) administers Title V funding and is a national partner agency in the development of state programs and initiatives affecting maternal and child health and welfare. The MCHB was established in 1990 within the Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS).

The mission of the MCHB is to provide national leadership, in partnership with key stakeholders, to improve the physical and mental health, safety and well-being of the MCH population which includes all of the nation's women, infants, children, adolescents, and their families, including fathers and children with special health care needs.

Title V activities and services are targeted to those at risk of poor health outcomes, with inadequate or no health insurance, or with an otherwise limited availability of quality health services. The conceptual framework for the services of the Title V MCH Block Grant is envisioned as a pyramid with four tiers of services and levels of funding that provide comprehensive services. The pyramid also displays the uniqueness of the Title V MCH Block Grant, which is the only federal program that consistently provides services at all levels of the pyramid. Infrastructure building and population-based services provide the broad foundation upon which enabling and direct health care services rest. The MCH health services pyramid provides a framework for understanding programmatic directions and resource allocation by the MCHB and its partners.

MCH Pyramid of Health Services



Infrastructure building services are the base of the MCH pyramid of health services and form its foundation. These activities are directed at improving and maintaining the health of the MCH population by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, information systems and systems of care.

Population-based services are preventive interventions and personal health services developed and available for the entire MCH population of the state rather than for individuals in a one-on-one situation. Disease prevention, health promotion and statewide outreach are major components. Common among these services are newborn screening, immunizations, oral health, injury prevention, nutrition, outreach, public education, and prevention of Sudden Infant Death Syndrome (SIDS). These services are generally available whether the mother or child receives care in the private or public health care system and whether insured or not.

Enabling services are services that allow for, or provide access to, and/or result in the derivation of benefits from the array of basic health care services that include such things as transportation, translation services, outreach, respite care, health education, family support services, case management and coordination of care with Medicaid, the Women, Infants and Children Supplemental Nutrition Program (WIC) and Education. These services are specifically required for the low income, disadvantaged geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals the enabling services are essential, for without them, access to health services is not possible.

Direct health care services are those health services generally delivered one-on-one between a health professional and a client in an office or clinic that may include primary care physicians, advanced practice nurses, public health nurses, social workers, nutritionists and dentists. In addition, health professionals for children with special health care needs may include subspecialty physicians, audiologists, occupational therapists, physical therapists and speech and language therapists.

National and state outcome and performance measures provide indicators of the effectiveness of program activities intended to improve the health status of the MCH population. All states utilizing Title V funds are required to report their progress toward core national outcome and performance measures developed by the MCHB. Additionally, states are required to establish performance measures reflecting their particular needs.

II. State

At the federal level, MCHB holds the State of Oklahoma accountable for administration of the Title V MCH Block Grant. Under Oklahoma statute, the Oklahoma State Department of Health (OSDH) and the Oklahoma Department of Human Services (OKDHS) share the administration of the Oklahoma Title V Program.

The Maternal and Child Health Service (MCH), within the OSDH, is responsible for services provided with Title V funds to pregnant women, mothers, infants and children. The Children with Special Health Care Needs (CSHCN) Program, within the OKDHS, is responsible for administering services to children with special health care needs. As required in Section 505 of the Social Security Act, a minimum of 30 percent of the total funding received by Oklahoma is used for preventive and primary care of children; 30 percent is used for health care needs of children with special health care needs; and, no more than 10 percent is used for administrative costs. Remaining funds used for services have historically and continue to be prioritized in Oklahoma for services to pregnant women and mothers.

The mission of MCH is to provide state leadership, in partnership with key stakeholders, to improve the physical and mental health, safety, and well being of the Oklahoma MCH population.

MCH services are directed toward meeting the national and state performance measures using the four levels of core public health service. Emphasis is placed on infrastructure building and population-based services as the foundation with enabling services provided to facilitate access to services and direct health care services provided only as gap filling. Federal and state funds are used at the state, regional, county and community levels to provide Title V services to impact national and state outcome and performance measures.

III. County

In addition to the federal Title V MCH Block Grant received by Oklahoma, state statute specifies that county and city-county departments of health have a responsibility to provide MCH programs. This supports the federal, state and local partnership in assuring funding for and availability of services.

In Title 63 O.S. § 1-206 Functions of Health Departments, a county department of health, a district department of health, a cooperative department of health, and a city-county department of health **shall**, in their respective jurisdictions: maintain programs for disease prevention and control, health education, guidance, **maternal and child health**, including school health services, health in the working environment, nutrition and other matters affecting the public health.

STATE PROGRAM ADMINISTRATION

I. Program Philosophy

Collaborative partnerships are the key to facilitating improvement in perinatal outcomes and providing high quality perinatal services. The Maternity Program collaborates with national, state and community-based partners to decrease maternal and infant mortality and morbidity rates, increase access to quality prenatal, postpartum and infant health services, and encourage education and outreach efforts to women who are at risk for poor perinatal outcomes. Deliberate efforts are made to alleviate those situations that negatively impact the physical, mental and emotional health of all pregnant women and infants.

II. Definitions

- A. **Contract Agency**
Refers to those agencies that provide maternity services with local, state and federal funds under a negotiated, written agreement with the Maternal and Child Health Service (MCH), Oklahoma State Department of Health (OSDH).
- B. **Service Site**
Refers to those locations where maternity services are actually provided by OSDH county health departments.

III. Goals and Objectives

The Maternal and Child Health Bureau (MCHB) requires states to conduct a comprehensive state needs assessment every five years with reviews and updates occurring during the interim years. Information from these assessments is used to identify state priorities and performance measures that are monitored on an annual basis.

IV. Policy and Procedure Development

State policies and procedures are developed to comply with federal and state laws and regulations. They are developed in collaboration with medical consultants as well as federal, state and community-based partners. Policies and procedures are developed in accordance with nationally recommended standards and guidelines as approved by the American College of Obstetrics and Gynecology, (ACOG), the United States Preventative Health Task Force and the United States Public Health Service. Public input is sought and considered in the development and revision of policies and procedures. Policies and procedures are reviewed annually with needed changes

approved by MCH staff, the Women's Health Division Medical Director, OSDH Office of General Counsel and Commissioner of Health.

V. Reporting

- A. MCH is required yearly to report to the MCHB through the Title V MCH Block Grant Application. Target activities are described and data are provided to demonstrate impact on national and state outcome and performance measures. All service sites and contract agencies must provide data for the completion of the application.
- B. The Title V MCH Block Grant Application and Annual Report is available for public comment upon request to MCH and/or via a link on the OSDH web site (<http://www.health.state.ok.us/program/mchs/index.html>).

VI. Public Input

Public input is integral to the development and implementation of the Title V MCH Block Grant Application. MCH obtains public input throughout each year from sources such as families, coalitions (public and private), service providers, the OSDH web site, and state, regional and community partners.

VII. Training and Technical Assistance

- A. Oklahoma has the opportunity annually to request technical assistance through the Title V MCH Block Grant Application. In addition, as need arises during the year, technical assistance can be requested by contacting the MCHB.
- B. MCH collaborates with a variety of agencies and programs to co-sponsor, develop and provide trainings and educational opportunities for health care providers throughout the year. Notices of training events are distributed through conventional mail and electronic mail.
- C. Technical assistance for a contract agency or service site may be obtained from the Maternity Program by contacting MCH, Women's Health Division, at (405) 271-4476 or by completing the technical assistance request at <http://www.health.state.ok.us/program/mchs/ta.asp>.

SERVICE SITE AND CONTRACT AGENCY RESPONSIBILITIES

I. Clinic Governance

- A. Service sites and contract agencies must be an incorporated agency governed by a Board of Directors or a facility operating under the auspices of a state/federal agency.
- B. Each service site and contract agency must have written documentation of its source of authority (e.g., charter, constitution and by-laws, statutes, etc.).
- C. All service sites and contract agencies must appoint a Medical Director whose qualifications, authority and duties are defined in writing.
- D. All service sites and contract agencies must appoint an executive/administrative director whose qualifications, authority and duties are defined in writing.
- E. All contract providers must appoint a chief financial officer whose qualifications, authority and duties are defined in writing.
- F. All service sites and contract agencies must have an updated organizational chart setting forth the operational components.

II. Administrative and Legal Requirements

- A. Each service site and contract agency must assure compliance with all applicable state and federal statutes regarding the protection of human subjects involved in research, development and related activities (*Code of Federal Regulations, Title 45, Public Welfare, Part 46*).
- B. Compliance with local, state and federal safety guidelines must be assured by each service site and contract agency.
- C. Each service site and contract agency must keep a record of the appropriate licensure and certification of each professional serving clients in the maternity clinic. These records must be available for review during site visits.

III. Overview of Services

- A. Priority for services are women with income at or below 185% of the Federal Poverty Level (FPL). Maternity services should be provided by a multidisciplinary team and coordinated within the community.

- B. Service sites and contract agencies must designate a time for maternity clinic services and utilize a client appointment system.
- C. During the initial visit, the client must be assessed for risk status and reevaluated at each visit thereafter. Clients identified as high risk must be referred for risk appropriate care and/or consultation.
- D. All maternity clients must be referred to appropriate education and counseling including childbirth education, parenting classes and health education to improve perinatal outcomes.
- E. Prenatal services must be coordinated with the private medical community and hospitals to provide inpatient and intrapartum care for clients and facilitate referrals or obtain consultation when appropriate or necessary.
- F. Clients must be counseled by health care providers on the importance of making delivery and pediatric care arrangements and are referred to the appropriate care providers. Copies of client records must be transferred at 36 weeks gestation to the hospital and physician who have accepted the responsibility of intrapartum care.

IV. Provision of Services

- A. Access to Care
 - 1. Barriers to maternity services accessibility should be identified for the target population.
 - 2. Services should be provided upon request of the individual. Referral from other providers is not required.
 - 3. Services must be provided without regard to religion, race, ethnicity, color, national origin, creed, handicapping condition, marital status, age, or sexual orientation.
 - 4. Prenatal care appointments should be available within two weeks of request. Appointments for problems may need to be scheduled before the initial visit.
 - 5. No client should have to wait in the clinic longer than 30 minutes to receive care.
 - 6. Plans must be developed to provide services to clients for whom lack of transportation is a barrier to care.
 - 7. Adequate parking facilities should be available.
 - 8. Hours of service should be convenient for the majority of the target population. The days and hours that the service site or contract clinic is open must be posted in the waiting area and at the front door of the clinic in a location visible to the public from the outside.
 - 9. Facilities must be accessible to individuals with disabilities.
 - 10. Bilingual/interpreter services must be provided.

- B. Maternity care must be respectful of individual dignity, integrity, cultural diversity and right to self-determination. Care must be provided in a manner which will insure the right of confidentiality. Clients may refuse certain aspects of care which may be recommended by clinic staff. Clients who decide to refuse services should have thorough documentation in the medical record of subjective information, dates of contact and names of professional staff involved.
- C. Appointments for prenatal care should be scheduled using the following guidelines:
 - 1. The initial visit should include risk assessment, laboratory work, physical exam and enrollment in the Women, Infants and Children Supplemental Nutrition Program (WIC).
 - 2. An initial physical examination must be conducted by a physician or advanced practice nurse including documentation. Thirty minutes should be allowed per client, two clients scheduled each hour of clinic time.
 - 3. Return visits should be scheduled at a rate of 3-4 clients each hour of clinic time.
 - 4. Schedules should be designed to reflect optimum use of personnel and consideration of no show patterns to enhance clinic efficiency.
- D. Service sites and contract agencies may provide services to high-risk clients who are unable to obtain care in the community. A Care Coordinator must be identified for all high-risk clients. Consultation with the local physician providing maternity support to the clinic, or an obstetrician/gynecologist must occur on a regular basis. A plan of care must be developed to ensure that the client receives the most appropriate care available.
- E. Service sites and contract agencies may consider other models of care provision such as Centering Pregnancy Care. Review and approval of an alternative model must be received from the Maternal and Child Health Service (MCH) before implementation.

V. Personnel

- A. Each service site and contract agency must assure that staff members receive orientation and continuing education appropriate to their professional and service needs.

B. Multidisciplinary Team

Each service site and contract agency should have a multidisciplinary team based on the size and composition of the maternity caseload. Maternity team members must:

1. Receive orientation and training and provide services according to the Maternity Policy and Procedure Manual.
2. Review and utilize referral and consultation guidelines within the community.
3. Meet regularly to plan and coordinate the care rendered to assure quality and continuity.
4. Participate in case staffing of maternity clients in order to monitor, evaluate, and revise the individualized care plan as appropriate. Case staffing may occur through the use of pre or post clinic conferencing or at other times when the multidisciplinary team members are available to meet.

C. The multidisciplinary team should consist of the following:

1. Physician
 - a. Qualifications: The physician must be a doctor of medicine, obstetrics and gynecology or osteopathy and licensed to practice in the State of Oklahoma with clinical experience providing maternity services.
 - b. Role: The physician(s) involved in the maternity clinic will be responsible for reviewing protocols and guidelines prior to providing overall medical direction for maternity clinical/medical services. These services include direct medical care for clients, medical backup to the advanced practice nurse(s), and signing of the *Advanced Practice Approved Orders*.
2. Advanced Practice Nurse (APN)
 - a. Qualifications: The APN must be a registered nurse licensed in the State of Oklahoma who has completed a formal nurse practitioner education program with a specialty in women's health or family, is certified by a national certification body in the respective field, and is recognized as an advanced practice nurse by the Oklahoma Board of Nursing. A nurse practitioner with a specialty in adult health may provide maternity services once written confirmation of experience in providing maternity services is demonstrated. This role may also be assumed by a certified nurse midwife (CNM), clinical nurse specialist (CNS) or a physician's assistant (PA). A CNM is a registered nurse, licensed in the State of Oklahoma and certified by the American College of Nurse Midwives; a CNS is certified by the Oklahoma Board of Nursing and possesses specialized training in obstetrics, and a PA is certified by the Oklahoma State Board of Medical Licensure and Supervision and possesses specialized training in obstetrics.

- b. Role: The APN provides prenatal and postpartum care under approved orders signed by the maternity clinic physician. County or clinic specific orders must be reviewed and approved by MCH.
- 3. Clinic Coordinator
 - a. Qualifications: The clinic coordinator must be a registered nurse licensed in the State of Oklahoma and designated to coordinate the maternity clinic.
 - b. Role: The maternity clinic coordinator:
 - 1) Works under the medical direction of the maternity clinic physician.
 - 2) Supervises completion of the history, nutrition and psychosocial assessment areas of the prenatal record according to the written instructions; completes required initial and interim prenatal lab; and, makes referrals to WIC, Department of Human Services (OKDHS), Children First or others.
 - 3) Coordinates clinic personnel, records and supplies.
 - 4) Coordinates multidisciplinary team members in case staffing of maternity clients in order to monitor, evaluate and revise the individualized care plan as appropriate.
 - 5) Assures that appropriately timed lab work is performed and recorded in the designated areas of the prenatal record.
 - 6) Coordinates referrals made by the physician or advanced practice nurse.
 - 7) Coordinates follow-up of missed appointments and high-risk clients in accordance with a defined tracking system.
 - 8) Monitors or initiates quality assurance activities.
 - 9) Coordinates client education (individual or group).
 - 10) Assures prenatal records are sent at 36 weeks estimated gestational age to the physician and hospital of client's planned delivery (early copies may also be sent to hospitals where requested).
 - 11) Coordinates follow-up of clients through the delivery and postpartum periods.
 - 12) Acts as contact person for maternity issues and works within the community to integrate maternity services and elicit community support.
- 4. Clinic Nurse
 - a. Qualifications: The clinic nurse must be a registered nurse licensed in the State of Oklahoma.
 - b. Role: The clinic nurse:
 - 1) Works with other team members under the medical direction of the maternity clinic physician.

- 2) May perform laboratory tests, obtain weight, height and blood pressure, draw blood specimen(s), and assist in the exam room.
 - 3) May perform prenatal education and counseling regarding medical care, educational issues and referrals.
5. Patient Care Assistant (PCA)
- a. Qualifications: The PCA has basic knowledge of the community and is able to communicate effectively with culturally and ethnically diverse populations. The PCA must function under professional medical or nursing supervision.
 - b. Role: The PCA:
 - 1) Provides outreach to the community attempting to identify persons in need of prenatal care and facilitating their entry into early prenatal care.
 - 2) Arranges, coordinates, monitors and advocates for services needed by the client.
 - 3) Contacts clients to follow-up on missed appointments and assists in the tracking of clients.
 - 4) Makes home visits to deliver messages or reschedule appointments.
 - 5) Helps schedule clinic appointments, sets up exam rooms and assists with examinations.
 - 6) Links the client to systems that provide needed services, resources and opportunities, which ensure high quality care.
6. Clerk/Receptionist
- a. Qualifications: The clerk has basic clerical skills, has received instruction in handling maternity clinic schedules, records and telephone calls.
 - b. Role: The clerk/receptionist:
 - 1) Facilitates entry into prenatal care by giving accurate information and helping the client enroll in clinic.
 - 2) Records data on records, answers phone calls and questions, assists in record preparation for referrals, sends requests for copies of previous medical record, and schedules return appointments.

7. Care Coordinator

a. Qualifications: Staff members who meet the following education and experience criteria may be designated as Care Coordinators:

- 1) **Social Worker** licensed by the Oklahoma State Board of Social Workers and possessing a master's degree in social work, or an unlicensed master's level social worker who has one year of health or social service experience and is directly supervised by a Licensed Clinical Social Worker.
- 2) **Registered Nurse (RN)** licensed by the Oklahoma Board of Nursing and possessing either a master's or bachelor's degree in nursing or those with an associate's degree in nursing and two years experience in community health, care management or perinatal care.
- 3) **Advanced Practice Nurse (APN)** licensed by the Oklahoma Board of Nursing and certified by a national certification body with one year of experience in community health, care management or perinatal care.
- 4) **Physician's Assistant (PA)** licensed by the Oklahoma State Board of Medical Licensure and Supervision with one year of experience in perinatal care and one year of community health or care management experience.
- 5) **Certified Nurse Midwife (CNM)** licensed by the Oklahoma Board of Nursing and certified for the practice of nurse-midwifery from the American College of Nurse-Midwives or American College of Nurse-Midwives Certification Council Incorporated.
- 6) **Clinical Nurse Specialist (CNS)** holds Master's Degree in Nursing with minimum of two semesters of supervised advanced clinical practice and licensed by the Oklahoma Board of Nursing.

b. Role: A care coordinator:

- 1) Is responsible, in part, for coordinating the activities of the individualized care plan and for locating and coordinating the services necessary to assure that the client's needs, as identified through the comprehensive risk assessment, are addressed.
- 2) Works with the at-risk client and the multidisciplinary team to monitor, evaluate and revise the care plan as appropriate.
- 3) Maintains current knowledge and regularly interacts with perinatal health care providers and social and health related resources within the community.

8. Dentist

a. Qualifications: The dentist must be licensed to practice dentistry in the State of Oklahoma.

b. Role: The dentist:

- 1) Provides prevention, diagnosis and treatment of disease, injuries, and malformation of the teeth, jaws and mouth.
 - 2) Provides direct supervision of dental auxiliary personnel.
9. Dental Hygienist
- a. Qualifications: The dental hygienist must be licensed as a registered dental hygienist in the State of Oklahoma.
 - b. Role: The dental hygienist performs preventive and therapeutic dental services under the direct supervision of a dentist. The employer, educational preparation and the regulations of the State Dental Practice Act may determine the range of duties.
10. Nutritionist
- a. Qualifications: The nutritionist/dietitian must have a Bachelor of Science degree, be registered by the American Dietetic Association and licensed as a dietitian in the State of Oklahoma.
 - b. Role: The nutritionist:
 - 1) Provides nutrition assessment and counseling specific to the pregnant woman.
 - 2) Develops a nutrition care plan.
 - 3) Participates in staff meetings regarding case management of the client.
 - 4) Is available for consultation when problems are identified.
11. Social Worker
- a. Qualifications: The social worker must be a Licensed Clinical Social Worker (LCSW). A Master of Social Work (MSW) or a Bachelor of Social Work (BSW) may be accepted provided the degree is from a program accredited by the Council on Social Work Education and that supervision and consultation are available from a Licensed Clinical Social Worker.
 - b. Role: The social worker:
 - 1) Provides assurance that psychosocial and health needs are met.
 - 2) Provides services that include, but are not limited to, psychosocial assessment, counseling, referrals for resources, consultation, advocacy and care coordination, and other services as needed.
 - 3) Participates in clinic interdisciplinary staffing.
 - 4) Is available for referral and consultation as problems/needs arise.
 - 5) Works in the community service delivery system to assure that the system functions to meet client need.
12. Health Educator
- a. Qualifications: The health educator must possess a Bachelor degree in Health Education, Health Promotions, Community Health, Kinesiology and Health Studies, Health Behavior, or Nursing. A bachelor or master degree in another field with an

- official transcript demonstrating completion of 12 semester hours (or equivalent quarters) of coursework with specific preparation addressing areas of responsibility of health educators as defined by the National Commission of Health Education Credentialing can substitute for specific degree requirement.
- b. Role: The health educator develops, implements and evaluates a variety of health education programs for the community targeted at increasing the awareness of preconceptual health, prenatal health and behaviors that negatively impact maternal and child health.
13. Other: Other health specialists may include a genetic counselor, child development specialist, lactation consultant, prepared childbirth educator, and others.
14. Volunteers
- a. Qualifications: Volunteers must receive appropriate orientation, training, and ongoing supervision depending upon the services provided by the volunteer. Volunteers may be identified with groups such as LaLeche League, prepared childbirth instructors, churches, civic organizations, and may be a valuable resource committed to meeting community as well as individual needs or concerns.
 - b. Role: Volunteers may:
 - 1) Enhance services by assisting in routine clinic tasks.
 - 2) Provide child care.
 - 3) Assist with increasing community awareness of clinic services.
 - 4) Translate for clients with limited English proficiency.

VI. Serving Populations with Limited English Proficiency (LEP)

- A. The Title VI Civil Rights Act of 1964, 42 U.S.C Section 2000d *et. seq.* states, "No person in the United States shall on the ground of race, color or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."
- B. Service sites must ensure that language assistance is provided in accordance with the Oklahoma State Department of Health (OSDH) Policy: Minority and English Proficiency Populations.
- C. Contract agencies must develop and implement written policies to ensure that minorities and populations with (LEP) have meaningful access to services. This includes, but is not limited to:
 - 1. Hiring bilingual staff trained and competent in the skill of interpreting.

2. Hiring staff interpreters trained and competent in the skill of interpreting. The number of interpreters should reflect the population served.
 3. Arranging for formal volunteer services from community members who are trained and competent in the skill of interpreting.
 4. Contracting for the use of a telephone language interpreter service.
- D. Using family members or untrained interpreters is inappropriate unless specifically requested by the individual. Prior to utilizing a family member or untrained interpreter, the interpreter must have a briefing on privacy requirements. Requiring the individual to bring an interpreter or charging for interpreter services is in violation of the Title VI Civil Rights Act of 1964. Any request by an individual with LEP will be documented appropriately.

VII. Needs Assessment

- A. Service sites and contract agencies must conduct a needs assessment every three years with a review of the assessment in the interim years that provides data regarding uninsured and underinsured clients' abilities to access services.
- B. Assessing the maternity services and activities that are presently available in the community and to whom the services are provided is an important first step in determining community needs. There may be a particular population for whom care is lacking or completely unavailable. When community or county demographic data are compared to that of the client population, an assessment of services may be made to determine if they are being administered to the appropriate population.
- C. Information from the needs assessment should be used to target services to areas and populations of greatest need. Information not already available through existing needs assessments may be obtained from MCH. The assessment should include the following components:
 1. Geographic description of the county including a discussion of potential geographic, topographic, and other related barriers to service.
 2. Demographic description of the service area including objective data pertaining to:
 - a. Total population
 - b. Distribution by age, by race, and by sex
 - c. Poverty status of populations to be served
 - d. Birth rates by age and race/ethnicity
 - e. Maternal and infant mortality rates
 - f. Low birth weight rates
 - g. Perinatal and adolescent health outcome measures by race/ethnicity
 - h. Other reproductive health care resources for low-income women
 - i. Location of low-income women in the community

- j. Cultural and linguistic needs
 - k. Intimate partner violence
 - l. Percentage of pregnant women who received first trimester prenatal care
 - m. Percentage of pregnant women who received poor or inadequate prenatal care
 - 3. Description of existing services and need for additional maternity services to meet community/cultural needs.
 - 4. Rates of sexually transmitted infections (STI's) and HIV prevalence including perinatal infection rates in the geographic service area.
 - 5. Identification and descriptions of linkages with other resources related to perinatal health.
 - 6. Identification and descriptions of high priority populations and target areas.
- D. Demographic data may be obtained annually from the Health Care Information Service. Data by county on STI and HIV rates can be obtained from www.health.state.ok.us/program/hivstd/epi/epi.htm. This data may serve as an overall view of specific counties and identify areas for further assessment.

VIII. Community Education

- A. Community education and information are an important component of the services provided by the program. Community educational efforts are provided to inform the public of the importance of early prenatal care, to encourage those in need to seek services, to educate women about healthy life styles before, during and after pregnancy, and to develop a supportive community environment. Outreach and information about the availability of care are part of this educational effort.
- B. All printed materials for client education must be reviewed by a multidisciplinary team for readability, medical accuracy and cultural sensitivity. All proposed printed materials for distribution to the general public and clients must receive peer review consideration and review from MCH. These materials include: reports, flyers, posters, brochures/pamphlets, newsletters and reprints of any that are listed.
- 1. Send all materials to MCH Administration, Attention: Suzanna Dooley. MCH Administration will assure that the appropriate MCH Division(s) receives the materials for review by program staff and that a timely response is forwarded back to the submitter.
 - 2. All materials must acknowledge support of the appropriate federal grant. For maternity, the Title V MCH Block Grant is to be referenced.

IX. Program Evaluation

- A. Each service site and contract agency must implement a clinic evaluation system which reports the profile of clients seeking services, their satisfaction with the level of care, barriers to obtaining care and steps taken to address elimination of barriers.
- B. Members of the community should participate in the development, implementation and evaluation of the services provided.

X. Statewide Emergency or National Disaster

- A. Follow existing visit standards for required services.
- B. Waive any fees for service if a client is determined homeless.
- C. Develop plans of care to assure clients receive the most appropriate care available including coordination with medical community and hospitals.
- D. Health care providers must evaluate clients for risk status to ensure appropriate care. Consultation with and/or referral to other health care providers should be based on the risk status.

QUALITY IMPROVEMENT/QUALITY ASSURANCE

The Maternity Program strives to assure provision of high quality maternity services in an efficient manner. While the methods of measuring the quality of services are constantly evolving, a variety of techniques are used.

I. Comprehensive Program Review

A. Purpose

1. To assure adherence to maternity policy and procedures
2. To provide technical assistance for facilitating and ensuring the provision of quality maternity services
3. To provide a forum to discuss local issues or concerns and engage in open dialogue to address those issues or concerns

B. Process

1. Program reviews are conducted every four years as part of the Maternal and Child Health Service (MCH) comprehensive program review process for service sites and contract agencies.
2. MCH staff will provide notification of the program review and a copy of the program review tools to the service site or contract agency at least 4 weeks prior to the onsite visit.
3. All findings from the program review will be noted in a final written report. The report is to be completed and forwarded to the service site or contract agency Administrator within forty-five (45) days of completion of the program review.
4. For all findings that result in “Requirements”, the Administrator of the service site or contract agency must develop a written response to be forwarded to MCH within 45 days identifying the corrective action(s) taken or planned to address correcting each finding.
5. For any finding(s) that require immediate resolution, MCH will work with the Administrator of the service site or contract agency to assure resolution occurs immediately and will note actions(s) taken in the initial report of the program review sent to the Administrator.
6. Additional site visits may be scheduled to ensure service sites or contract agencies are making progress toward correcting program review findings.
7. If a service site fails or refuses to correct findings (requirements) after ongoing technical assistance and support from MCH, the Deputy Commissioner of Community Health Services will be notified in writing of the situation so that administrative action can be initiated. If a contract agency fails or refuses to correct findings (requirements) after ongoing technical assistance and support from MCH, administrative actions will be initiated to terminate the contract.

II. Annual Program Monitoring

A. Purpose

1. To assure ongoing adherence to maternity policy and procedure
2. To identify technical assistance needs for facilitating and ensuring the provision of quality maternity services

B. Process

1. Service sites must complete an annual self-assessment of MCH services no later than July 1 of each year. The Administrator of the service site must sign and forward the self-assessment to MCH. The self-assessment will be reviewed by MCH with follow-up with the service site accomplished by MCH as indicated.
2. Contract agencies will receive an annual onsite visit to assure compliance with all terms and conditions of the contract. A written report of the annual onsite visit will document any findings(s) requiring corrective action. Action(s) taken or to be taken by the contract agency to address a finding(s) must be documented in writing and forwarded to MCH within 45 days of receiving the written site visit report. Failure or refusal to address findings after ongoing support and technical assistance from MCH will result in initiation of administrative processes to terminate the contract.

III. Medical Record Audit

A. Purpose

To assure appropriate and accurate documentation of maternity services

B. Process

1. Medical records for maternity clients must be audited on a quarterly basis.
2. Service sites and contract agencies should select one indicator as the focus of each quarterly medical audit.
Suggested audit topics:
 - a. Clients are offered Maternal Serum Alpha-Fetoprotein screening (MSAFP) or if past screening date, provide screening information for future pregnancies.
 - b. All clients are tested for HIV and results properly recorded.
 - c. All clients receive a risk assessment.
 - d. Prenatal education and counseling are appropriately offered and documented.
 - e. All clients who use tobacco products receive appropriate counseling and support to quit. These interventions are appropriately documented.
 - f. Pre-examination education is appropriately documented.

EQUIPMENT AND SUPPLIES

I. Equipment

Dopplers and other selected equipment needs of service sites may be requested individually by calling the MCH Women's Health Division at (405) 271-4476. Service sites are responsible for purchasing replacement bulbs and batteries. Contract agencies must have and maintain equipment needed to provide maternity services.

II. Ordering Supplies and Medications

- A. Supplies and medications are available to service sites that have maternity clinics. Contract agencies may requisition certain supplies and medications as specified by their contract. Service sites may access a complete catalog of supplies on Public Folders/Pharmacy.
- B. Maternity medications and supplies **must** be listed on two separate *Supply Order Form(s)*.
 - 1. Maternity supply items (with the corresponding catalog number) **must** be listed on ODH Form 15, *OSDH Supply Order Form* and faxed to Oklahoma State Department of Health (OSDH) Shipping and Receiving, 405-271-7350.
 - 2. Maternity medications **must** be listed on a separate *Supply Order Form* and faxed to the Pharmacy at 405-271-7350.
- C. Rho-D Immune Globulin is available for uninsured clients only. Order Rho-D Immune Globulin for each Rh negative client between 24-28 weeks. Place client's name, date of birth, and estimated date of confinement on the order form. Rho-D Immune Globulin is very expensive and usually short dated.
- D. The following practices must be implemented to keep dated stock from becoming outdated:
 - 1. Restrict orders to quantities of supplies to last only three months
 - 2. Rotate stock. When new supplies are received, move the older products forward and place new supplies behind them.
 - 3. Return items that cannot be used three months before the expiration date to the OSDH Central Office, Shipping and Receiving, so they can be used by another clinic before becoming outdated. Enclose a packing slip stating reasons for returning item.

III. Ordering Pamphlets

An assortment of health education publications are available for service sites and contract agencies. Publications can be ordered from OSDH Shipping and Receiving for use with maternity clients by using *Supply Order Form*, ODH Form 15. You may call Shipping and Receiving at (405) 271-4330 to request a current *Forms and Publications Catalog*.

Maternity Supply Catalog
Medications

<u>Catalog No.</u>	<u>Description</u>	<u>Unit</u>
FPMAT 022	Ampicillin Capsules 500 mg (28/Btl).....	Bottle
FPMAT 006	Amoxicillin 500 mg (21/Btl).....	Bottle
FPMAT 015	Clotrimazole Cream.....	Tube
MAT 002	Docusate Sodium Succinate 100 mg (20/Btl).....	Bottle
FPMAT 003	Erythromycin Stearate 250 mg (56/Btl).....	Bottle
FPMAT 004	Ferrous Sulfate 325 mg (100/Btl).....	Bottle
MAT 013	Glucose Tolerance Screening Beverage (100 gm/Btl).....	Bottle
MAT 014	Glucose Tolerance Screening Beverage (50 gm/Btl).....	Bottle
FPMAT 009	Macrobid 100 mg (14/Btl).....	Bottle
MAT 024	Metronidazole 250 mg (21 Tabs/Btl).....	Bottle
FPMAT02	Miconazole.....	Tube
MAT 010	Prenatal Vitamins (100/Btl).....	Bottle
MAT 011	RH Immune Globulin (RhoGam) (must include patient name, DOB and EDC).....	Each

Supplies

MAT 016	Aquasonic Gel.....	Each
FPMAT 021	Benzalkonium Wipes (100/Bx).....	Box
FPMAT 182	Chek-Stix (controls for Multi-Stix 7-SG - 50/Btl).....	Bottle
FPMAT 147	Capes (100/Cs).....	Case
FPMAT 148	Cover Slips (144/Bx).....	Box
CHR 010	Fingerstick Lancets (200/Bx).....	Box
FPMAT 012	Gloves, Sterile, Small (For IUD/IUS Insertion/Sterile Exams)...	Pair
FPMAT 013	Gloves, Sterile, Medium (For IUD/IUS Insertion/Sterile Exams)	Pair
FPMAT 014	Gloves, Sterile, Large (For IUD/IUS Insertion/Sterile Exams)...	Pair
FPMAT 149	Gloves, Non-sterile, Small (100/Bx).....	Box
FPMAT 150	Gloves, Non-sterile, Medium (100/Bx).....	Box
FPMAT 157	Gloves, Non-sterile, Large (100/Bx).....	Box
FPMAT 183	Gowns (50/Cs).....	Case
***	Group B Strep Transport Media.....	Tube
LAB 025	Group B Strep Transport Media (call lab to order).....	Kit
FPMAT 161	KOH Solution.....	Bottle
FPMAT 163	Lens Paper (50/Pad).....	Pad
FPMAT 164	Lubricant (KY Jelly).....	Tube
CHR 030	Microscope Slides (Frosted One End – 72/Bx).....	Box
FPMAT 020	Multistix 7-SG (100/Btl).....	Bottle
FPMAT 166	Povidone Iodine.....	Bottle
FPMAT 167	Prescription Labels (500/Roll).....	Roll

FPMAT 168	Saline Solution (0.9% 5 ml/Btl).....	Bottle
FPMAT 169	Sheets (Drapes).....	Case
FPMAT 107	Speculum, Graves, Small.....	Each
FPMAT 108	Speculum, Graves, Medium.....	Each
FPMAT 109	Speculum, Graves, Large.....	Each
FPMAT 110	Speculum, Pederson, Small.....	Each
FPMAT 111	Speculum, Pederson, Medium.....	Each
FPMAT 112	Speculum, Pederson, Large.....	Each
FPMAT 179	Speculum, KleenSpec, Small (20/Box).....	Box
FPMAT 180	Speculum, KleenSpec, Medium (20/Box).....	Box
FPMAT 181	Speculum, KleenSpec, Large (15/Box).....	Box
FPMAT 171	Table Paper, 18".....	Roll
FPMAT 118	Tourniquet.....	Each
FPMAT 082	Trichloroacetic Acid (TCA) (80-90%).....	Bottle
FPMAT 172	Urine Cups (100/Bx).....	Box
***	Urine Culture Kits.....	Kit

*** Contract Lab Supply Kit

FACILITIES AND ACCESSIBILITY

I. Accessibility for Handicapped Persons

- A. The Rehabilitation Act of 1973 (Public Law 93-112) requires that all programs and activities of a recipient of federal funds be accessible to handicapped persons.
- B. Definition of Handicapped Person
The Rehabilitation Act defines handicapped as:
 - 1. Any person who has a physical or mental impairment which substantially limits one or more major life activities.
 - 2. Any person who has a record of such an impairment.
 - 3. Any person who is regarded as having an impairment.
- C. Compliance
Service sites and contract agencies should refer to the Checklist for Existing Facilities, developed by the Office of Handicapped Concerns to assess their compliance with Americans with Disabilities Standards. This document may be obtained from Maternal and Child Health Service (MCH).

II. Scheduling

- A. Clinic Scheduling
 - 1. Clients should be scheduled for their first prenatal visit during the first trimester.
 - 2. Open access scheduling should be used to decrease appointment waiting times and no-show rates.
- B. Clients should be surveyed at regular intervals to evaluate the acceptability and the accessibility of clinic hours (see Quality Improvement/Quality Assurance).

III. Client Appointments

- A. Appointments should be staggered during the clinic session matching client arrival to staff availability.
- B. Clients should be moved from one area to another as little as possible so that clients have fewer opportunities to wait or to miss services.

- C. Clients should be seen as close to their appointment time as possible. Clients should be seen in appointment order (if more than one client has the same appointment time, the client with the earliest arrival is seen first).
 - D. All walk-ins should be seen after all clients with appointments.
 - E. Clients who are more than 15 minutes early for an appointment should be treated as walk-ins until their appointment time.
 - F. Clients who are more than 15 minutes late for an appointment should be treated as walk-ins.
 - G. A client emergency should be an exception to these policies.
- IV. Open Access Scheduling
- A. Every effort should be made to see clients within two weeks from date of request.
 - B. Begin by offering some clients appointments on the day they call in.
 - C. If clients do not want to be seen on the day they call, schedule an appointment of their choosing.
 - D. Make sure each provider has an appointment load that is manageable based on patient mix and time spent in the office.
 - E. Develop plans for how the clinic will handle times of extreme demand or provider absence.
 - F. Reduce future demand by maximizing today's visit. Be sure to accomplish referrals, lab work and other needs at the time the client is seen.

FINANCIAL MANAGEMENT

I. Introduction

Contract agencies must develop and implement financial policies and procedures that are in compliance with federal and state guidelines. The following policies and procedures pertain ONLY to service sites.

II. Demographics

A. Service sites must utilize the Public Health Oklahoma Client Information System (PHOCIS). The Demographic, Financial and Insurance modules must be completed on each client.

1. The Demographic section of the module documents demographic information, including address and contact information for all service sites. This module is a part of the client's record and should be completed when the first continuing service record is opened for a client. The Demographics Report from this module must be printed, signed by the client and placed in the client's medical record.
2. The Financial module reflects the income declaration of the client. Income should be based on gross earnings (before taxes) and include all household income, i.e. overtime, tips, pensions, alimony, child support, etc.

Note: This information will be an indicator whether the client may qualify for Medicaid.

If the income meets eligibility criteria, the client should be encouraged to complete a Sooner Care Health Benefits Application (SC-1 or SC-1-SV). The application can be completed at the health department or at the local Oklahoma Department of Human Service (OKDHS) office. Presumptive Eligibility (PE) forms can also be completed to assure the client gets Medicaid coverage as of the date the application is completed.

Note: The OKDHS prefers completion of the SC-1 or SC-1-SV application in place of the PE forms.

- a) OKDHS Website – forms page
<http://www.okdhs.org/forms/Default.asp?cotent=frmMed&id=13>
- b) SC-1 (English):
<http://www.okdhs.org/forms/forms2/sc-1.pdf>
- c) SC-1-SV (Spanish):
<http://www.okdhs.org/forms/forms2/SC-1-SV.pdf>

- d) Presumptive Eligibility (English):
<http://www.okdhs.org/forms/forms2/MA-PE-1.pdf>
<http://www.okdhs.org/forms/forms2/MA-PE-2.pdf>
 - e) Presumptive Eligibility (Spanish):
<http://www.okdhs.org/forms/forms2/MA-PE-1-SV.pdf>
<http://www.okdhs.org/forms/forms2/MA-PE-2-SV.pdf>
3. The Insurance module reflects whether the client has private insurance, Medicaid, Medicare or is uninsured. It is recommended that the client show their Medicaid, Medicare and/or insurance card at the time they check in. This will allow staff an opportunity to accurately record the name and numbers into the insurance module as they are reflected on the cards.
- B. Information on the Demographic, Financial and Insurance module is to be completed by the staff member who does the initial intake on clients admitted for a service, which requires a continuing service record. Each section of the module should be updated at every visit. A new Demographics Report must be printed any time the client's financial information changes or at six months interval if no changes have occurred.

The client's self-declared income is used to determine potential eligibility for Medicaid. However, if the client has furnished proof of income to an OSDH program that requires such proof, and then declares an income that is less than the proven income, the staff person assisting the client should ask the client to explain the reason for the lower self-declared income. The staff person will record the reason for the lower income on the printed Demographics Report. The client will then sign the Demographics Report below the written explanation.

III. Billing

- A. Please refer to pages 9-12 of the *Electronic Data System (EDS) Manual* to review detailed instructions for billing Medicaid on the Web:
<http://www.okhca.org/Provider/Billing/manual/documents/chap11.pdf>.

Billing should be based on the appropriate CPT codes for maternity care and delivery. Service sites should refer to the current crosswalk for billing codes to be used for maternity services. The crosswalk is found in the Public Folders under PHOCIS/Billing & Coding. Service sites should refer billing questions to their assigned Records Consultant.

- B. Postpartum Visits
- 1. Medicaid provides postpartum coverage for 60 days following delivery of Medicaid eligible clients. Postpartum services are also available

within 60 days of delivery to those clients who are not eligible for Medicaid and do not have insurance coverage.

2. If a visit is scheduled more than 60 days post delivery, the client must be scheduled for a family planning visit.
3. Cost for family planning supplies provided during the 60-day postpartum period must be billed to Medicaid as applicable or be paid by the client using the family planning fee schedule.

IV. Common Error Codes Used On Claims Denied

- A. The billing information for maternity claims is taken from the Billing/Charge/Data (BCD) Slip. All maternity claims are to be submitted to the Oklahoma Health Care Authority via the Electronic Data System (EDS). Use Provider Number 100726700A to submit a claim for a maternity visit.
- B. Common Error Codes Used on Denied Claims
A list of all Medicaid billing error codes and descriptions listed on provider remittance statements is available to view or print on the OHCA web site at http://www.okhca.org/provider/billing/ec/error_codes.asp.

In order to assist Medicaid service providers throughout the state, the Oklahoma Health Care Authority (OHCA) has a provider web page devoted to providing up-to-date information regarding the provider enrollment process, contracts, fee schedules, Medicaid policy, frequently asked billing questions, pharmacy program information, Health Insurance Portability and Accountability Act (HIPAA), and abuse reporting. The OHCA provider web page can be accessed through <http://www.okhca.org/provider/provider.asp>.

V. Claim Status Report

- A. By Client:
This report allows the user to view the status of claims that have been submitted for a specific client. Only users with authorized access to the EDS may obtain this report.
 1. Log into the website and choose the appropriate provider for the claims to be viewed.
 2. Click on CLAIMS; then CLAIMS INQUIRY.
 3. Enter the client's Medicaid number in the CLIENT ID field.
 4. Claim Status: Choose the claim type you wish to review. Types include any status, denied, paid, suspended and resubmit. Selecting ANY STATUS will show all claims for the client.
 5. Enter a FROM DATE and THRU DATE to narrow the field of search. Leave these fields blank for a list of all claims.
 6. Click on the SEARCH button.

7. To print, click on the PRINTER icon on the task bar.

B. By County:

This report allows the user to view the status of claims that have been submitted for payment. All claims submitted for payment must show the county number in the Patient Account Field. This allows the data system to identify the county of origin for the claim. This report cannot identify and display claims that do not contain the county number. Only users with authorized access to the EDS may obtain this report.

1. Log into the website and choose the appropriate provider for the claims to be viewed.
2. Click on CLAIMS; then CLAIMS INQUIRY.
3. Enter the county health department number in the PATIENT ACCOUNT NUMBER field.
4. Claim Status: Choose the CLAIM TYPE you wish to review.
5. Enter a FROM DATE and THRU DATE to narrow the field of search. Leave these fields blank for a list of all claims.
6. Click on the SEARCH button.
7. To print, click on the PRINTER icon on the task bar.

Note: If the Patient Account Number field was left blank when the claim was submitted, those claims will not be listed.

RECORDS AND FORMS

I. Medical Records

- A. Maternity client records are confidential as required by medical ethics and by federal and state statutes. It is the responsibility of each service site and contract agency employee to maintain complete and total confidentiality of any and all client information collected, filed or stored by the service site or contract agency.
- B. Measures to assure client confidentiality include:
 - 1. Provide privacy when requesting personal information (Demographic Profile or equivalent, health history, current problem).
 - 2. Never leave a client in a room with any other client's records.
 - 3. Place client record on desks or in holders so that the name cannot be seen.
 - 4. Never call out the client's full name in the waiting area.
 - 5. Secure records by lock when not in use.
 - 6. Obtain mailing information during the initial interview that can be used for confidential contact. Document contact information in the Public Health Oklahoma Client Information System (PHOCIS) and in the client's chart.

II. Client Confidentiality

All clients must be assured confidentiality and safeguards provided against the invasion of personal privacy. Service sites must follow Oklahoma State Department of Health (OSDH) Health Insurance Portability and Accountability Act (HIPAA) policy. Contract agencies must develop written policies and procedures to assure compliance with federal HIPAA regulations.

III. Release of Medical Records

- A. Release of Confidential Information
Service sites must use the Authorization for Release of Confidential Information, ODH Form 206, to obtain authorization for release of client records to agencies or parties other than health care professionals or covered entities conducting certain administrative or financial transactions, such as submitting claims for reimbursement and being reimbursed.

- B. Contract agencies must develop written policies and procedures for obtaining authorization to release confidential information or records to agencies or parties other than health care professionals.
- C. **Release of Minor's Medical Record**
The medical record of a minor must not be released to anyone (including the minor's parent or guardian) without the client's personal written consent.
- D. **Requests for Medical Records**
Any request for a client's maternity record from anyone other than the client must be reported to the Clinic Administrator immediately.

IV. Guidelines for Prenatal Documentation

- A. A record must be opened for any person who receives one or more required maternity service(s), including, but not limited to:
 - 1. Counseling or medical services for prenatal care.
 - 2. Postpartum services.
- B. When a record is opened for the first time, the data should be recorded in the Public Health Oklahoma Client Information System (PHOCIS) Demographic Profile, Financial Module, Client Appointment Module, and Personal Health Module.
- C. The prenatal record must accurately reflect the progress and care given during the prenatal period. The prenatal record must identify problems that develop during pregnancy and assess risk factors both initially and throughout the pregnancy. Clear and comprehensive documentation of prenatal care helps to ensure that clients will receive appropriate care and services during the intrapartum and postpartum periods.
 - 1. All vaginal exams must be documented.
 - 2. All laboratory values must be clearly visible.
 - 3. Complications or changes in risk status must be easily found on the prenatal form.
 - 4. All medications given throughout the prenatal course must be documented on the prenatal record.
 - 5. Immunizations must be reviewed and properly documented with dates.
- D. All education provided to the client throughout her pregnancy must be documented in the appropriate area.
- E. Routine maternity visits must have documentation of the following: fundal height in centimeters, fetal presentation, fetal heart rate, assessment of fetal movement, assessment of preterm labor signs/symptoms, blood pressure, weight, urine albumin, urine glucose and provider initials.

- F. Documentation of Contacts Other Than Face-to-Face
All contacts made with a client or with another provider in reference to a client must be documented. This includes encounters both in the clinic and outside the clinic setting, as well as telephone contacts. Documentation must be signed and dated.
 - G. Client Information
 - 1. Information in the PHOCIS Demographics Module and Financial Module must be updated every six months.
 - 2. The clinic record must also be updated whenever a change in the information is identified.
- V. Consent Forms
- A. Instructions for Consent for Service
 - 1. Informed consent means the voluntary, knowing assent from the individual for whom any procedure is to be performed, or medication provided.
 - 2. Service sites are to use *Consent for Services*, ODH Form 303C with the *Maternity Fact Sheet*, ODH Form P-474. The *Consent for Services*, ODH Form 303C is not to be signed until a clinic staff member has reviewed the *Maternity Fact Sheet* with the client and is assured that the client understands the services to be offered and agrees to receive them.
 - 3. Documentation of client receipt of Maternity Fact Sheet and review by staff must be documented in the client's medical record.
 - 4. The consent form must be signed prior to the time that a client actually receives a maternity service.
 - 5. The original of any signed consent form must be part of the client's record and kept at the clinic site. The consent form is subject to the same rules of confidentiality that apply to medical information.
 - 6. A copy of the OSDH Privacy Statement must be given to the client.
 - 7. Contract agencies must implement written policies and procedures to obtain and document informed consent and provision of privacy statement.
 - B. A client is considered capable of giving informed consent unless a court has deemed them otherwise. Mentally handicapped clients may still be capable of giving informed consent.
 - C. Minors (under age 18) seeking maternity services may self-consent for services and must always sign the consent form.

- D. When a person other than the client gives consent for maternity services, this does not entitle the person giving consent the right of access to the client's record unless otherwise authorized by law.
- VI. Maternity Record Card
- A. All maternity clients should be given a *Maternity Record Card*, ODH Form 320, at the first prenatal visit. The *Maternity Record Card* serves as a summary of their prenatal care in the event they need to see a health care provider without the benefit of transfer of records.
 - B. Discuss the use of the *Maternity Record Card* with the client and the importance of bringing the card to each clinic appointment on the *Maternity Record Card*.
 - C. Document follow-up visits, laboratory results, medications used, other test results and any problems that occur during the prenatal period.

VII. Sterilization

Service sites and contract agencies **must** provide sterilization information upon request of the client 21 years of age and older. Department of Health and Human Services (DHHS), Public Health Services publication, *Information for Women*, ODH Form P683, and *Information for Men*, ODH Form P500 are available in English and Spanish.

SERVICE GUIDELINES

I. Privacy

- A. Clients **must** have privacy at the clinic for the following activities:
 - 1. Stating reasons for coming to clinic
 - 2. Providing personal information, including financial data and information for the medical history
 - 3. Discussing problems and questions with clinic staff
 - 4. During physical exams
 - 5. During lab testing
- B. Staff **must** ask every client how best to contact her if follow-up is needed and record that information in her chart. Always respect the client's desire not to be contacted in certain ways or at certain times.
- C. Charts **must not** be left where other clients can see them.
- D. Clients **must not** be discussed in front of other clients, and all conversations about clients shall be confined to what is professionally necessary, and only among staff with "need to know."
- E. Information about clients **should** not be provided over the telephone and **shall** only be provided to appropriate individuals.

II. Initial Visit

- A. At the initial visit the following should be completed:
 - 1. Health history
 - 2. Physical examination
 - 3. Review of systems
 - 4. Baseline laboratory testing
 - 5. Nutritional assessment
 - 6. Psychosocial assessment
 - 7. Assessment of specific risk factors, including oral health, genetic and environmental

This information forms the obstetrical database upon which the health care professionals and the client develop an individualized care plan. History taking is an ideal time to assess the client's knowledge of health and to provide counseling on lifestyle changes that can enhance both the health of the client and the health of the fetus.

- B. The health history should include:
1. Menstrual history
 2. Past pregnancy history
 3. Medical history
 4. Symptoms since last menstrual period
- C. The initial physical examination should preferably be performed at the initial visit by the physician; however, this should not delay care. An advanced practice nurse may perform the initial physical examination and initiate care until the physician is able to see the client.
1. The initial physical examination must include:
 - a. Blood pressure, pulse, weight, and height
 - b. Evaluation of skin, eyes, ears, nose, dentition, gums, oral hygiene, throat, thyroid, heart, lungs, breasts, and extremities
 - c. Abdominal examination including inspection, auscultation, palpation
 - d. Abdominal/uterine examination must include height of fundus, presenting part when applicable, position and fetal heart rate, vaginal examination for signs of pregnancy, position, size and consistency of uterus, condition of cervix, and speculum visualization of cervix and vagina
 - e. Estimate of gestational age (in weeks) must be documented at the initial visit and during subsequent visits
 - f. An estimate of pelvic measurements and morphology rectal examination
 2. Complete *Maternity Record Card*, ODH Form 320 and provide to client at initial visit. Instruct the client to bring the card at each visit. The *Maternity Record Card* is not an official medical record.
- D. Laboratory testing includes tests to determine the basic health status of the mother and the presence of health problems/concerns that may affect maternal and fetal health. See *Laboratory* section.
- E. Each pregnant woman must have a nutrition assessment. Those women found to have nutrition risk factors should be referred to a nutritionist. The nutrition component includes screening for specific nutritional deficiencies, cultural practices and nutritional patterns. The following risks indicate the need for nutrition referral:
1. Pre-pregnancy Body Mass Index (BMI) <19.8 or >26.0 (See Prenatal Weight Gain Grid)
 2. Anemia
 3. Metabolic disorder
 4. Eating disorder
 5. Inadequate intake of protein, calcium and/or calories

6. A weight gain of three pounds or less by 16 weeks, six pounds or less by 20 weeks, nine pounds or less by 24 weeks and 13 pounds or less by 30 weeks.
- F. The psychosocial assessment must be performed in a standardized format using uniform criteria. The assessment is an on-going process which is re-evaluated/reviewed at each visit and formally repeated early in the third trimester.
1. The psychosocial component includes screening for social, economic, psychological and emotional concerns and problems.
 2. Women who have one or more of the following psychosocial risk factors should receive further assessment by the social worker. In absence of a social worker, contact the Regional Technical Social Work Supervisor in your area for consultation and local resources for:
 - a. Lack of basic resources.
 - b. Emotional or psychiatric conditions such as anxiety or depression, any diagnosed mental illness, suicide ideation or attempt, phobias, grief or any unusual behavior.
 - c. Developmental disability.
 - d. Adolescent under age 18.
 - e. Social/behavioral concerns such as: violence/abuse/sexual assault (current or historical), alcohol, tobacco and/or other drug use, lack of emotional support (may be due to loss or conflict), or current involvement with legal system.
 - f. Undesired pregnancy.
 - g. Other risks, conditions or complications that could pose significant risk for poor pregnancy outcome.
- G. Clients should be assessed to determine risk factors for genetic disorders or exposure to harmful substances. Clients with the following risk factors should be referred for genetic counseling and possible prenatal diagnostic procedures:
1. Advanced maternal age (mother 35 years or older at delivery)
 2. Previous offspring or family personal history of birth defects or genetic disorders
 3. Three or more unexplained pregnancy losses
 4. Exposure to x-ray, alcohol, drugs or other environmental hazards
 5. Seizure disorders or insulin-dependent diabetes prior to pregnancy
 6. Couples who are both carriers of sickle cell trait
 7. Family history of mental retardation
 8. Family history of neural tube or ventral wall defect
 9. Abnormal maternal serum α -fetoprotein (MSAFP) screening
 10. Consanguinity (first cousins or closer)
 11. Couples who are both carriers for cystic fibrosis

III. Subsequent Visits

- A. Return visits should be planned with the client according to her needs. The minimal plan should include:
 - 1. Visits once every four weeks up to twenty-eight weeks of pregnancy.
 - 2. Visits once every two weeks from twenty-eight weeks to thirty-six weeks of pregnancy.
 - 3. Visits once weekly from thirty-seven weeks of pregnancy to term.
- B. Laboratory data and prenatal visit measurements such as blood pressure, maternal weight, fundal height, fetal heart rate and urine screening results should also be entered on the medical record and the *Maternity Record*, ODH Form 320 at each visit. Developing problems or concerns and plans should be documented in the medical record.
- C. Health promotion and anticipatory guidance should be provided at each maternity visit. Research has shown that women who are given specific strategies to address their risk factors are able to reduce those risk factors and the impact on themselves and the fetus. A review of educational topics is presented in the Health Promotion Section.
- D. All pregnant women should be assessed for smoking, alcohol consumption, drug use, and domestic violence during the initial exam, and as needed thereafter to determine “at risk” status in the last half of pregnancy. Smoking, alcohol consumption and other drug use may fluctuate over a nine-month period. A negative response at intake does not mean a woman has continued to abstain throughout her pregnancy.
- E. Pregnant women identified as being Rh negative should receive RHO-D Immune Globulin at 28 weeks gestation. The benefits and risks should be explained and documented.
- F. A review of the client's history and physical findings must be repeated at 32 and 36 weeks of gestation to finalize decisions regarding referral for delivery care. Examination by the maternity clinic physician is preferred.

IV. Ultrasounds

- A. Routine ultrasound examination is not recommended for each woman who is pregnant. The following indications should be used to decide need for ultrasound examination:
 - 1. Need for determination of correct gestational age such as a size/date discrepancy of greater than three weeks, uncertain last normal menstrual period or previous cesarean section

2. Suspected placental abnormality, for example, placenta previa, abruptio placenta or vaginal bleeding of unknown etiology
 3. Suspected ectopic pregnancy or hydatidiform mole
 4. Suspected multiple gestations
 5. Suspected fetal death
 6. Suspected polyhydramnios or oligohydramnios
 7. Determination of fetal presentation
 8. Suspected uterine abnormality or pelvic mass
- B. Comprehensive ultrasound (previously level II) indications include:
1. Evaluation of specific suspected fetal malformations
 2. Evaluation of previously identified problems on basic scan
 3. Evaluation of previously identified fetal anomalies, placental anomalies, and amniotic bands
 4. Genetic scans
 5. Evaluation of fetus of a woman with advanced maternal age or diabetes
 6. Evaluation of fetus with heart problems
 7. Fetal Doppler flow studies
- C. Clients requiring multiple ultrasound examinations must be under the care of, or co-management of, a physician for their pregnancy. The Maternity Program must be contacted for approval of ultrasounds beyond the one basic ultrasound. The Maternity Program does not provide funds for comprehensive ultrasounds. **Clients must be informed that they may be responsible for payment beyond the one basic ultrasound.**

V. Coordination of Care

- A. Coordination of the individualized obstetrical plan of care activities shall be implemented or arranged for the purpose of locating and coordinating the services necessary to assure that the client's needs, as identified through the risk assessment, are addressed. Care coordination shall include collaboration with the client and the health care team to monitor, evaluate and revise the plan of care as appropriate. Each clinic should designate a qualified staff member to provide care coordination services.
- B. The physician and/or other members of the health care team should discuss with the client a proposed plan of obstetrical care. Every pregnant woman will have an individualized plan of obstetrical care that will:
1. Be developed with the participation of the pregnant woman.
 2. Be based on the client's individual risk status as identified by the initial risk assessment and the ongoing assessments performed during routine visits.
 3. Provide for a schedule of prenatal care visits consistent with the client's risk status and based on the recommendations of the American College of

- Obstetricians and Gynecologists (ACOG) for frequency and content of the visits.
4. Contain information regarding the results of laboratory tests and procedures as well as the clinical implications of these results.
 5. Reflect a coordination of prenatal diagnostic and treatment services, nutrition and treatment services, psychosocial services as indicated, and monitoring of progress and follow-up.
 6. Contain information regarding nutritional risk factors, needs and the interventions implemented to address these needs. Individualized nutritional counseling should be provided by qualified professional staff based on the client's nutritional risk status. All eligible women should be referred to the Women, Infants and Children Supplemental Nutrition Program (WIC) at the initial visit and/or any other community resources/services that are needed, such as Children First (C1).
 7. Contain information regarding psychosocial needs and/or problems such as substance abuse.
 8. Contain information regarding identified health education needs and planned interventions, as well as the need for home visits appropriate to address needs and risks identified in the risk assessments.
 9. Be routinely monitored, evaluated and revised by the health care team to reflect the client's current health care needs and risk status.
 10. Include relevant information exchanged between the primary care provider and other providers of care, including the exchange of information with the delivery site.

VI. Consultation and/or Referral

Definitions

Consultation: Request for an opinion or advice. A consultation is a type of service provided by a provider whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another provider or other appropriate source. The 3 R's of Consultations: (1) Request (2) Render (3) Report.

Referral: A transfer of client management to another provider. The referring provider should state on the referral form, "client is being referred for evaluation & treatment." "Referring" should not be used unless transfer of care is the intent.

A. Collaborative Management

Communities faced with a lack of providers, increasing uninsured clients, providers who are unwilling to accept Medicaid clients or similar situations may consider a collaborative management process. Collaborative management must include frequent consultations with the local physician providing maternity support of the clinic or obstetrician/gynecologist (OB/GYN) to identify and implement a management plan for clients who require additional intervention.

- B. Examples of conditions requiring consultation and/or referral to the appropriate professional (OB/GYN, family practice physician, perinatologist, maternal fetal medicine physician, etc.) are as follows:
1. Risk factors by history:
 - a. Clients under 15 years or more than 35 years of age
 - b. High parity (greater than five)
 - c. One or more previous premature labors or history of low birth weight infants (less than 2,500 grams)
 - d. Excessively large previous infants (greater than 4,000 grams)
 - e. Previous Cesarean section or uterine operations
 - f. Previous significant dystocia
 - g. Three or more unexplained pregnancy losses
 - h. Previous stillbirth or neonatal loss
 - i. Suspected incompetent cervix
 - j. Medical indication for termination in previous pregnancy
 - k. Previously diagnosed abnormalities of the genital tract
 - l. Previous history of need for special neonatal care
 - m. Previous infant or a family history with known or suspected birth defect(s) including genetic disorders
 - n. Severe emotional problems and or depression associated with previous pregnancy or delivery
 - o. Chronic medical disease such as heart disease, neurological, endocrine or metabolic disorder
 - p. Significant psychosocial problems
 - q. Gestational diabetes mellitus
 - r. Smoking
 2. Risk factors which develop or are present in early pregnancy:
 - a. Battering or abuse
 - b. Gestational diabetes
 - c. Psychiatric disorder
 - d. Marked nutritional abnormality or abnormal stature
 - e. Malignancy
 - f. Non-responding urinary tract infections
 - g. Suspected ectopic pregnancy
 - h. Suspected missed abortion or trophoblastic disease
 - i. Severe hyperemesis
 - j. Exposure to potential teratogens
 - k. Positive serologic test for syphilis
 - l. Pregnancies complicated by medical disease (endocrine, renal, cardiac, hypertensive, etc.)
 - m. Anemia not responsive to iron therapy
 - n. Positive antibody screen
 - o. Abnormal cervical/vaginal cytological studies
 - p. Overt rejection or denial of the pregnancy
 - q. Dental problems

3. Risk factors that develop in late pregnancy:
 - a. Third trimester uterine bleeding
 - b. Polyhydramnios or oligohydramnios
 - c. Fetal demise
 - d. Thromboembolic disease
 - e. Multiple pregnancies
 - f. Need for fetal maturation studies
 - g. Inappropriate fetal growth for gestational age
 - h. Persistent abnormal presentation (any presentation other than cephalic)
 - i. Postdate pregnancy
 - j. Premature rupture of membranes
 - k. Premature labor
 - l. Induction of labor
 - m. Tumor or other obstruction of birth canal
 - n. Suspected fetopelvic disproportion
 - o. Active genital herpes
 - p. Abnormal glucose tolerance test
 - q. Verbalized unrealistic expectations of the baby

- C. The following are examples of conditions requiring consultation and/or referral to an OB/GYN, maternal fetal medicine specialist, or perinatologist:
 1. Preeclampsia
 2. Isoimmune disease
 3. Intrauterine growth retardation
 4. Signs of labor at less than 34 weeks gestation
 5. Anticipated need for neonatal surgery
 6. Incompetent cervix
 7. Major complications that may significantly alter the usual management:
 - a. Diabetes
 - b. Cardiopulmonary disease
 - c. Renal disease
 - d. Malignancy
 - e. Severe, nonresponding infection
 - f. Neurologic disorders
 - g. Metabolic/endocrine disease
 - h. Abnormal cytologic studies
 - i. Diagnosed major fetal malformation
 - j. HIV seropositivity

- D. Emergency situations should be appropriately handled depending on the type and severity. Refer to *Maternity Medical Referrals* in the Appendix.

VII. Assessment of Fetal Activity

- A. Maternal assessment and monitoring of fetal activity after 28 weeks gestation has been shown to decrease the incidence of stillbirths and fetal deaths.
- B. All clients should be instructed to monitor fetal movement using *The Cardiff “Count to Ten” Fetal Activity Chart*, ODH Form 319-B, beginning at 28 weeks. Instruct clients to begin counting fetal movements at the same time every day. *The Cardiff “Count to Ten” Fetal Activity Chart* instructions recommend 9:00 a.m. The start time can be adjusted to conform to the client’s schedule. Reassuring fetal activity will be demonstrated by marking ten fetal movements in any six-hour period. Counting should stop for the day once ten fetal movements are felt within a six-hour period. Clients should be instructed to count any movement felt, regardless of intensity or location. It is not the strength of the movement that indicates a well oxygenated fetus, but the presence of movement.
- C. Instructions for use of *The Cardiff “Count to Ten” Fetal Activity Chart* should include discussion of normal variations of fetal activity throughout the day. Four fetal states have been identified in the last trimester. Term and near term fetuses spend approximately 25% of their time in quiet sleep state and 60 to 70% of their time in active sleep state. Research has shown that infants with normal oxygenation patterns should not go any longer than 75 minutes without movement.
- Women who are experiencing polyhydramnios, excess amniotic fluid, or who have an anterior placenta may experience more difficulty feeling fetal movements. Fetal movements may be felt to the side, posterior or as fluttering, floating like movements. Encourage clients with polyhydramnios or an anterior placenta to count all movements regardless of intensity or location.
- D. Clients who do not feel ten movements by 9:00 p.m. should write in the total number of movements in the bottom section of the chart, below the double line. Clients who feel less than 10 movements for two days in a row should be instructed to contact the clinic. These women should be referred to a physician immediately for follow-up testing such as a non-stress, contraction stress test or biophysical profile. The Maternity Program does not provide for these tests. **The client must be informed of their responsibility for payment.**
- E. Clients who feel no movement for one day should be instructed to contact the clinic immediately. These clients should be referred immediately to a physician.

VIII. Women Choosing Not To Parent

- A. Women who are planning to place an infant for adoption should receive the same assessment, services, education and counseling as women who are choosing to parent.
 - 1. Referrals to the WIC program should be made. Prominently mark on the referral that the client has chosen not to parent and is planning to place the child for adoption.
 - 2. Visit schedules should remain the same.
 - 3. Social work services should be made available to the client throughout her pregnancy. Coordination with the adoption resources will assist in ensuring coordination of care.
- B. Staff providing services must be sensitive to, and supportive of, the client's choice not to parent the infant. Services **must** be provided in a nonjudgmental and supportive manner.

IX. Postpartum Care

- A. All women should have a postpartum visit at four to six weeks postpartum. The postpartum period is defined as the 60 days following delivery.
- B. The four to six weeks' examination should be comprehensive including physical and psychosocial elements. Appropriate family planning services should be offered. If family planning services are provided, service sites and contract agencies must follow *Family Planning Policy and Procedures Manual*.
- C. All postpartum clients should be assessed for postpartum depression through observation of weight loss, sleeplessness, anorexia and inability to care for herself and/or her infant. Clients will often express guilt or embarrassment over perceived inadequacies as a mother. Do **NOT** ask the client if she is depressed. Non-threatening assessment can begin by asking:
 - 1. "How do you feel things are going?"
 - 2. "How are things with the baby?"
 - 3. "Are you feeling like you expected?"
- D. A follow-up plan on all postpartum clients includes:
 - 1. Referral and follow-up in the family planning clinic.
 - 2. Referral to WIC as appropriate.
 - 3. Referral to other social services as appropriate.

X. Preconception/Interconception Care

All women returning for a postpartum checkup should receive education regarding their specific genetic, nutrition, medical, social and life style risk factors. In doing so, risks can

be discovered and corrected, or at least minimized, before a subsequent pregnancy occurs. The importance of spacing pregnancies should be discussed.

XI. Transfer of Clients

- A. Clients have the option of transferring maternity services to another provider. Complete ODH Form 206, *Authorization to Release Confidential Information*.
1. Copies of the prenatal record, copies of progress notes, prenatal weight gain grid, laboratory reports and other pertinent documents can be mailed or faxed to the provider, or hand carried by the client.
 2. If the client will not be returning to the clinic for postpartum care, the medical record should be closed.

- d. Previous infant greater than 4,000 grams
 - e. History of previous unexplained stillbirth
 - f. Poor obstetrical history (i.e. spontaneous abortions or congenital anomalies)
 - g. Recurrent glycosuria not explained by dietary intake
 2. Hematocrit/Hemoglobin
 3. Antibody screen on Rh negative clients at risk for antibody change (i.e. those who have received blood products)
 4. GC/Chlamydia, RPR/STS, HIV (positive screen during first trimester or high risk behaviors)
- D. 35-37 weeks gestational age: Vaginal culture for Group B Streptococci
- E. Glucose screens may be delayed for clients who present for prenatal care within four weeks of the regularly scheduled screening interval of 24-28 weeks.
- F. Additional laboratory tests to be provided by the maternity clinic when indicated include:
1. Antibody identification and titer
 2. Blood chemistry panel
 3. CBC and platelet count
 4. Glucose Tolerance Test (GTT) 100 gram
 5. Thyroid panel
 6. Urine culture and susceptibility
 7. Vaginal wet preparations
 8. Hemoglobin A1C
 9. Ferritin
- G. Other prenatal or medical tests may also be indicated. The maternity clinic may arrange for the tests but the client will be required to assume responsibility for payment. These include, but are not limited to, the following:
1. Anemia profile
 2. Amniocentesis
 3. Amniotic fluid alpha-fetoprotein (AFAFP)
 4. Biochemical enzyme assays
 5. Cordocentesis
 6. DNA analysis
 7. EKG
 8. Oxytocin challenge test
 9. Nonstress test
 10. PT, PTT and FSP
 11. Tuberculin skin test (PPD)
 12. Toxoplasmosis, rubella, cytomegalovirus
 13. X-ray (chest)
 14. 24-hour urine analysis
 15. Cystic Fibrosis

II. Maternal Serum Alpha-Fetoprotein (MSAFP) Screening

- A. All clients **must** be given information regarding the MSAFP screening. Screening is performed between 15 to 22 weeks gestation. Please refer to *PHN Guidelines and Orders: Maternal Serum Alpha-fetoprotein/Human Chorionic Gonadotropin Screening*.
- B. Clients entering care **before** 22 weeks gestation **must** be offered the MSAFP screening. Medicaid payment for testing is available for those eligible. Clients not eligible for Medicaid will be required to submit a money order in the amount of \$41.78 made payable to NTD Laboratories.
- C. Clients entering care **after** 22 weeks gestation should be informed of the availability of the screening test for future pregnancies.
- D. NTD Laboratories contact information:
 - NTD Laboratories
 - 403 Oakwood Road
 - Huntington Station, NY 11746
 - Phone: (631) 425-0800
 - FAX: (631) 425-0811

III. Vaginal Wet Preparations

Certain physical conditions identified either by history or physical examination may be evaluated by microscopic viewing of slide preparations. Staff members who have OSDH documented microscope training and are included in listed personnel at a maternity clinic site may perform such tests when indicated.

HEALTH PROMOTION

EDUCATION

Research has shown that perinatal outcomes are most improved with education and health promotion. The prenatal period is a time when women may be motivated to learn and implement lifestyle changes that can improve the health of the fetus, themselves, and their families. Education and counseling information should be targeted at issues the client views as important. Information should be given in a nonjudgmental manner, with printed materials at the reading level and in a language the client can read. Topics to be covered during prenatal visits should provide anticipatory guidance and should be selected based on client interests and gestational age.

Please refer to the current *Public Health Nursing (PHN) Guidelines and Orders* for treatment guidelines for folic acid, anemia, gonorrhea/chlamydia, MSAFP, preterm labor and urinary tract infections.

BREASTFEEDING

I. Education

- A. Women planning to parent should be advised that breastfeeding is unequalled as a way of providing food for the health, growth and development of infants and has been shown to have significant advantages for women and infants.
- B. The following information should be provided early in prenatal care and repeated frequently (at least once each trimester):
 - 1. Human milk is the only food that provides all nutrients for the first six months of life.
 - 2. Human milk provides babies with their mother's immunity to disease and helps guard against chronic disease.
 - 3. Human milk reduces colic, diarrhea and gastrointestinal infections.
 - 4. Breastfeeding helps the uterus return to shape faster and helps with weight loss after pregnancy.
 - 5. Mothers are more successful and continue nursing for longer periods of time when they have the support of the baby's father, family, friends, health care providers and community.

II. Prenatal Counseling

- A. Counseling should include the risks of formula feeding which include:
 - 1. Formula-fed infants have a greater number and severity of ear infections. The severity of these infections makes them three times more likely to need hospitalization for treatment of their ear infections.
 - 2. Infants who are formula-fed have a higher risk of obesity and diabetes.
 - 3. Women who do not breastfeed have a higher risk of breast cancer.
 - 4. Breastfed infants have higher IQs.
- B. Discuss client concerns about breastfeeding at each prenatal visit using open-ended questions such as, "Since our last visit, what have you been thinking about feeding your baby?" Clarify the client's concerns and any underlying misperceptions. Address those issues directly and factually **first**. Myths such as the impact of breast size on milk supply should be addressed factually and in a nonjudgmental manner. Be aware of information overload, particularly with irrelevant and/or too much information. Ensure that client has names and phone numbers of local breastfeeding support groups and the La Leche League's 24-hour hotline.
- C. Clients with possible risk factors for breastfeeding challenges should be referred to a health care provider or an International Board Certified Lactation Consultant (IBCLC). Risk factors include, but are not limited to: history of breast surgery or

infertility, previous difficulty breastfeeding, multiple pregnancy, or infant congenital anomalies.

- D. Information on pumping and storage of milk should be provided to all mothers during prenatal visits. Discussion of breastfeeding after return to work or school should be included in prenatal counseling sessions.

III. Postpartum Assessment and Counseling

- A. Assess progress of breastfeeding and discuss problems or concerns raised by the client. Signs of good breastfeeding include:
 - 1. Newborns waking to nurse 8-12 times per 24 hours.
 - 2. Mothers hearing their infants swallowing during feedings.
 - 3. Infants who are satisfied after feeds.
 - 4. Infants who have at least six to eight wet diapers daily.
 - 5. Infants who have at least three large, seedy yellow stools daily after five days.
 - 6. Mothers who are aware of breast fullness before feedings and softer breasts after feedings.
 - 7. Mothers should not have pain between feedings, cracked nipples or extreme engorgement. Breast engorgement after feedings or nipple trauma is not normal and may indicate problems with latching on or positioning. Referral to International Board Certified Lactation Consultant (IBCLC) or breastfeeding consultant is appropriate.
- B. Mothers who complain of **mild** nipple soreness with initial latch and breast fullness prior to a feed should be reassured that these can be normal signs of breastfeeding, but persistent discomfort should be evaluated.
- C. Resources
 - 1. Breastfeeding Coordinator or the WIC Breastfeeding Task Force Coordinator at (405) 271-4676
 - 2. The Lactation Center at OU Medical Center, 271-MILK

COMMON DISCOMFORTS

Anticipatory guidance and strategies to alleviate discomforts of pregnancy should be provided at each prenatal visit. Discomforts are listed by trimester to assist in organizing teaching activities.

I. First Trimester

A. Breast Tenderness

1. Education: Increased levels of estrogen and progesterone. These hormones stimulate the formation of ducts and glandular system in preparation for breastfeeding.
2. Counseling:
 - a. Wear a supportive cotton bra without underwire or seams that put pressure on the breasts. The straps and back should be wide so that the tension is even.
 - b. Encourage communication between client and partner regarding increased sensitivity. Adjustments in sexual foreplay may be necessary until tenderness is relieved.
 - c. If pain is persistent, or severe, call health care provider.

B. Fatigue

1. Education: Increased basal metabolism rate and increased demands on the cardiovascular and renal systems. Nocturnal urinary frequency, stress, anxiety and depression relating to the pregnancy and/or life stressors can decrease sleep.
2. Counseling:
 - a. Discuss stress management
 - b. Include exercise in daily routine to provide stress management
 - c. Discuss meditation and relaxation exercises to promote sleep
 - d. Discuss relaxing activities before bedtime
 - e. Get at least 8 hours of sleep a night

C. Bleeding Gums

1. Education: Estrogen causes increased blood vessel formation and increased blood flow to vascular areas of the body throughout pregnancy. Bleeding gums are an indication of this increased blood flow and vessel development as well as a sign of increased turnover of epithelial cells. Oral infections have been linked to preterm labor.
2. Counseling:
 - a. Counsel client to continue brushing and flossing teeth with a soft bristle brush two to three times a day.
 - b. Confirm that regular dental hygiene may stimulate bleeding and relate to physiologic changes in pregnancy.

- c. Continue routine dental cleanings during pregnancy.

D. Nasal Congestion

1. Education: Increased estrogen stimulates development of blood vessels and increased circulating volume leading to increased blood supply to normally vascular organs like the nose and gums.
2. Counseling:
 - a. Cool mist humidifier at night to keep mucous membranes moist. Saline drops can be purchased at a drug store or made at home by mixing $\frac{1}{4}$ tsp of salt with one cup of water and $\frac{1}{4}$ tsp baking soda. Solution is good for one week.
 - b. Instruct clients **NOT** to use any of the nasal sprays that contain epinephrine or any over-the-counter cold products. Do not use products like Afrin or Neo-Synephrine. Instruct clients to call clinic for recommendations of safe over-the-counter medications for cold symptoms.
 - c. For clients who have trouble with snoring at night, nasal strips that help keep the nasal passages open can alleviate snoring and increase airflow.

E. Nausea and Vomiting

1. Education: Increased levels of human chorionic gonadotrophin (hCG).
2. Counseling: Instruct client to try one or two strategies for one week before changing to a different strategy. Response to nausea and vomiting varies greatly between individual clients. If vomiting persists for 24 hours or more, call health care provider. Any one or combination of the following strategies may be used:
 - a. Dry toast or crackers before getting out of bed
 - b. Get up slowly and avoid sudden movements
 - c. Small frequent snacks throughout the day or sips of ginger ale or colas
 - d. Avoid long periods without eating (being “empty” can trigger nausea)
 - e. Easy to prepare meals/snacks for the time of day nausea most often occurs (low fat sandwiches, cottage cheese/fruit, low fat cheese/crackers, fruits)
 - f. Drink fluids between meals and snacks instead of with meals
 - g. Avoid or limit greasy, high fat and fried foods (margarine, butter, mayonnaise, bacon, sausage, high fat lunch meats, gravies, pie crusts, pastries, sopapillas, chips, French fries and onion rings), and spicy foods (chili powder, pepper, garlic)
 - h. Citrus fruits, pickles or strong mints like Altoids for sour taste
 - i. Avoid odors that trigger nausea or vomiting
 - j. Fresh air in sleeping area
 - k. Anise or fennel seed tea upon awakening

- l. A glass of water with one-teaspoon of apple cider vinegar or raspberry leaf tea for nausea
- m. Peppermint, spearmint **or** chamomile tea to relieve nausea
- n. Ginger for nausea and motion sickness
- o. Lemonade and potato chips prevent nausea and replace electrolytes lost during vomiting

F. Ptyalism

1. Education: Increased salivation, ptyalism, can contribute to nausea during pregnancy. Ptyalism may be influenced by culture.
2. Counseling:
 - a. Strategies for alleviating ptyalism are limited and frequently do not work. Validation of client concerns and problem solving to alleviate discomfort and embarrassment may be of more assistance than actual strategies.
 - b. Chewing gum or sour candy may help alleviate taste.
 - c. Counsel client to brush teeth frequently and rinse mouth as needed.
 - d. Do not eat non-food items such as cornstarch, clay or ice.
 - e. Drink at least eight large glasses of fluids daily.

II. Second and Third Trimester

A. Backache

1. Education: Combination of the effects of progesterone and relaxin hormones that induce softening of joints with changing center of gravity as abdomen enlarges. Upper backache is attributed to increased weight of breasts and postural factors.
2. Counseling:
 - a. Teach pelvic strengthening exercises such as pelvic rock, bridges and stretching.
 - b. Correction of lordosis
 - c. Counsel clients to wear low-heeled comfortable shoes.
 - d. Warm baths or showers
 - e. Use of pillows between legs and for abdomen support during sleep may lessen strain on back muscles as pregnancy progresses.
 - f. Counsel client to roll to side and use arms to lift upper torso when changing position from supine to upright.
 - g. Massage: Lavender and chamomile oils can be used **after** the first trimester.
 - h. Use of an abdominal binder or girdle may be indicated if lax abdominal muscles are contributing to back pain.
 - i. Upper back pain can be alleviated by the use of a good supportive bra and postural changes.

B. Constipation

1. Education: Increased levels of progesterone lead to smooth muscle relaxation, including intestinal muscles, delaying motility. Increased levels of aldosterone and angiotensin stimulate increased water absorption from intestinal contents leading to harder stools. In addition, the increasing weight of the uterus and fetus, decreasing activity as pregnancy progresses, and changes in diet contribute to constipation that may worsen in the third trimester.
2. Counseling:
 - a. Counsel client to drink six to eight eight-ounce glasses of fluids per day.
 - b. Increase dietary fiber by increasing fruits and vegetables.
 - c. Clients may try prunes, prune juice and/or hot drinks to stimulate peristalsis.
 - d. Identify behavior that can inhibit bowel functioning.
 - e. Instruct client to use clockwise abdominal massage to stimulate peristalsis.
 - f. Docusate sodium 100 mg at bedtime can be used for short-term relief of constipation after dietary changes have been tried. See *Advanced Practice Approved Orders: Constipation*.

C. Fainting/Lightheadedness

1. Education: Postural hypotension with rapid position changes. Supine positioning during the third trimester. Hypoglycemia can also cause lightheadedness and fainting during pregnancy. Weight of uterus and fetus markedly decreases venous return to the heart leading to dizziness, and/or fainting when in the supine position.
2. Counseling:
 - a. Instruct client to change positions slowly.
 - b. Avoid the supine position after the first trimester. Use of a pillow, blanket or wedge to provide lateral displacement of uterus is strongly encouraged if supine position cannot be avoided.
 - c. Encourage small frequent snacks throughout the day to maintain glucose levels.

D. Numbness or Tingling of Fingers

1. Education: There are several causes of numbness and tingling of fingers in the second and third trimesters of pregnancy. Fluid retention and swelling of the carpal tunnel can cause compression of the median nerve. De Quervain tenosynovitis is caused from compression and inflammation of the tendons in the wrists. Poor posture and exaggerated lordosis cause compression of the median nerve and ulnar nerves of the arm.
2. Counseling: Reassurance of normalcy and self-limiting nature.

- E. Excess Flatulence
1. Education: Relaxation of the smooth muscle due to progesterone influences leading to increased occurrence of pockets of gas.
 2. Counseling:
 - a. Avoid foods that stimulate formation of gas such as onions, beans and lentils, collard greens, cauliflower, brussels sprouts, cabbage and turnips.
 - b. Counsel clients to eat yogurt or drink buttermilk to maintain normal intestinal flora.
- F. Groin/Lower Abdominal Pain
1. Education: Rapid enlargement of the uterus between 14–20 weeks leads to stretching and tension on the round ligaments. Rapid movement or position changes can increase the tension on the round ligament causing pain.
 2. Counseling:
 - a. Reassurance of normalcy and self-limiting nature of pain
 - b. Instruct client to change positions slowly to reduce tension on round ligament.
 - c. Instruct client to use pillows to support abdomen.
- G. Heartburn
1. Education: Increased levels of progesterone and estrogen cause relaxation of the hiatal sphincter and delayed gastric emptying. Increasing upward pressure on the stomach from the enlarging uterus leads to regurgitation of acidic stomach contents into lower esophagus. Heartburn is a very common complaint in the late second and third trimesters.
 2. Counseling:
 - a. Counsel clients to eat small, frequent meals throughout the day and eat slowly without overeating.
 - b. Clients should be counseled to avoid spicy foods such as chili powder, pepper, garlic, caffeine sources, also limit high fat and fried foods.
 - c. Standing or sitting after eating can provide postural relief.
 - d. Fresh papaya or papaya tablets after meals and at bedtime may also help alleviate heartburn.
 - e. Anise or fennel seed tea after meals may relieve heartburn.
 - f. If heartburn occurs while lying down, advise clients to keep head and shoulders elevated. May use several pillows or wedge to raise head and shoulders.
 - g. Moderate to severe gastric reflux: clients may purchase Maalox Liquid, Amphojel, Mylanta, Riopan or Gelusil. See *Advanced Practice Approved Orders: Indigestion/Heartburn*. For clients in the third trimester Pepcid AC, Zantac 75 or Tagamet HB at bedtime may be recommended.

- h. Clients should be instructed to **avoid** antacids containing sodium bicarbonate (Alka-Seltzer) and baking soda. These products can interfere with the absorption of B-complex vitamins and may increase edema.
- i. Clients should be instructed to avoid antacids containing calcium carbonate (Tums). Calcium carbonate may cause rebound gastric secretions and may lead to the development of hypercalcemia and reduced renal function, particularly with overuse.

H. Hemorrhoids

- 1. Education: A combination of increased progesterone levels that stimulate relaxation of the smooth muscles plus increasing pressure from the uterus and constipation lead to the dilatation of blood vessels in the perianal area and hemorrhoids.
- 2. Counseling:
 - a. Clients should receive information on the normal changes associated with pregnancy.
 - b. Sitz baths and witch hazel compresses may provide relief.
 - c. Preparation H may be recommended for purchase. See *Advanced Practice Approved Orders: Hemorrhoids*.
 - d. Comfrey ointment, yellow dock root, plantain and yarrow ointments can be recommended for clients who prefer homeopathic remedies.

I. Leg Cramps

- 1. Education: May be attributed to an imbalance in the calcium/phosphorus ratios, magnesium deficiency, or build-up of lactic acid.
- 2. Counseling:
 - a. Counsel clients to avoid soft drinks and processed snack foods that may contain large amounts of phosphorus and low amounts of calcium.
 - b. Daily exercise such as walking or swimming
 - c. Once cramping has occurred instruct client to flex foot with leg straight.

J. Nosebleeds (Epistaxis)

- 1. Education: Increased levels of estrogen increase blood volume and promote formation of blood vessels.
- 2. Counseling:
 - a. Cool mist humidifier to increase humidity and decrease nasal irritation
 - b. Normal saline nose drops. See the *Health Promotion* section, *Common Discomforts, First Trimester*, Item D, *Nasal Congestion*.

- K. Increased Perspirations
1. Education: Endocrine glands increase secretions during pregnancy. Rationale for increased secretions is not clear at this time.
 2. Counseling:
 - a. Counsel client to wear loose fitting clothes that absorb perspiration.
 - b. Inform client that more frequent baths/showers may be needed.
 - c. Reassure client that increased perspiration is normal during pregnancy.
- L. Rash of Pregnancy
1. Education: The cause is generally unknown. The most common theory is increased levels of estrogen and progesterone that stimulate increased formation of blood vessels. There are three identified rashes.
 - a. Papular dermatitis. Discrete erythematous papules that do not appear in groups and may occur anywhere on the body. Lesions usually heal within 10 days.
 - b. Prurigo gestationis. Small excoriated pruritic papules located on the abdomen, trunk or extensor surfaces of the extremities. Lesions may be evident for several months following delivery.
 - c. Pruritic urticarial papules and plaques of pregnancy syndrome (PUPPS). Discrete erythematous papules and urticarial plaques found on the abdomen, thighs, buttocks, legs and arms. PUPPS is usually seen in the third trimester and may continue for several weeks after delivery.
 2. Counseling:
 - a. Acknowledge client concern and educate client regarding common discomforts associated with pregnancy.
 - b. Oatmeal baths, calamine lotion and loose-fitting clothing can be suggested to alleviate itching and discomfort.
 - c. Client may need pharmacological assistance or prescriptions for topical corticosteroids and/or antihistamine if itching is severe.
- M. Pruritis
1. Education: Intrahepatic cholestasis. Client will complain of itching that is worse at night on soles of feet, palms and abdomen without a rash. Symptoms may improve within seven to ten days following delivery. Complete resolution of itching may take six to eight weeks. Laboratory tests will indicate elevated levels of serum bile acids, serum transaminase, and possible hyperbilirubinemia. Clients with pruritis gravidarum are at a higher risk for stillbirths, fetal distress in labor, and preterm labor. Recurrence in subsequent pregnancies has been reported to be 40-60 percent.
 2. Counseling:
 - a. Use nonpharmacologic strategies listed above.

- b. See *Rash of Pregnancy*, Item L above. Treatment may not be effective in alleviating symptoms.

N. Shortness of Breath

1. Education: Increased maternal metabolic rate, fetal oxygen demands, the effects of progesterone on the respiratory system and increasing pressure on the diaphragm from the enlarging uterus will cause shortness of breath and a need to take deep purposeful breaths (sigh of pregnancy).
2. Counseling:
 - a. Educate client about the changes in the respiratory system with pregnancy such as increased metabolic rate, fetal oxygen needs and increased chest expansion.
 - b. Encourage client to stretch arms over the head and swing arms in a circular motion during inspiration to alleviate symptoms. Some clients may believe that reaching over their head will strangle fetus, so include reassurance that these maneuvers will not lead to fetal death.
 - c. Clients who have worsening symptoms, elevated respirations or chest pain should notify provider.

O. Skin Changes

1. Education: Increased estrogen levels stimulate production of melanin leading to increased pigmentation.
2. Counseling:
 - a. Keep abdomen moist with hand lotion, aloe, or vitamin E based lotions.
 - b. Clients should be informed that there is no effective prevention of stretch marks. Special lotions are not effective in prevention or removal of chloasma, linea nigra, or stretch marks.

P. Swelling in Lower Extremities

1. Education: Increased venous pressure from enlarging uterus. Edema in hands may be caused by poor posture.
2. Counseling:
 - a. Elevation of legs throughout day may decrease edema.
 - b. Increase exercise.
 - c. Clients must be educated that edema is not water from too much fluid intake. Fluids should **NOT** be restricted.
 - d. Support hose worn without elastic bands around thighs may improve circulation.
 - e. Teach danger signs of preeclampsia: visual disturbances, headaches, right upper quadrant pain, and epigastric pain.

- Q. Vaginal Discharge
1. Education: Increased cervical mucous production combined with increased vascularity of cervix and vagina. Normal discharge is clear, whitish in color without odor, itching, or burning.
 2. Counseling:
 - a. Educate clients regarding normalcy with pregnancy. Discharge may increase as pregnancy progresses.
 - b. Educate clients on signs and symptoms of infections to report including Candida and bacterial vaginosis.
 - c. Educate clients on signs and symptoms of ruptured membranes.
 - d. Encourage clients to wear cotton underpants and encourage good hygiene.
 - e. Alert clients to possible impact of discharge on sexual practices.
- R. Varicose Veins
1. Education: Increased levels of progesterone causing relaxation of vessel walls, combined with increased pressure from enlarging uterus may lead to the development of varicose veins or worsening of existing veins. Varicose veins may occur in legs or vulva.
 2. Counseling:
 - a. Client education on causes of varicose veins should be done when client verbalizes concerns.
 - b. Elevation of legs, particularly in a side lying position, and wearing support panty hose can minimize formation of varicose veins in the lower extremities.
 - c. Encourage client to eat foods rich in vitamins A, B, C and E. Vitamin E supplements up to 600 IU per day are safe.
 - d. Educate clients on signs and symptoms of deep vein thrombosis.
- S. Warmth/Feeling Hot
1. Education: Increased levels of progesterone cause vasodilatation and increased skin temperature. During the third trimester, increased maternal fatty stores in preparation for labor and breastfeeding may also contribute to feeling uncomfortably hot.
 2. Counseling:
 - a. Reassurance and education of normalcy associated with pregnancy.
 - b. Educate clients to take temperature and report elevations immediately.
 - c. Encourage clients to wear lightweight layered clothing.

EXERCISE

The American College of Obstetricians and Gynecologists recommend that women engage in regular moderate intensity physical activity throughout their pregnancy. Research has shown that women who engage in exercise have shorter labors, experience fewer discomforts associated with pregnancy and have healthier infants.

I. Education

Activities to avoid are any activity with a high potential for falling and trauma to the abdomen such as gymnastics, horseback riding, downhill skiing, vigorous racquet sports, sports that may result in trauma to the abdomen and scuba diving due to increased risks to the fetus of decompression sickness.

II. Counseling

A. General Advice

1. All women should be advised to:
 - a. Increase fluid intake before and after exercise.
 - b. Wear clothing that is loose fitting and allows evaporation of perspiration from the body.
 - c. Perform five minutes of warm-up and cool-down stretching to lessen risks of injury to joints.
 - d. Do **not** perform exercises or engage in any activities that require the recumbent position after the first trimester. Increasing weight of the uterus and baby impairs venous return, increasing cardiac workload and contributing to supine hypotension.
 - e. Select exercises that do not require balance, or physical contact that would lead to abdominal injury or trauma.
 - f. Increase caloric intake by 300 calories per day to ensure adequate nutrition.
2. Women who are currently exercising: Counsel women who are currently exercising to continue exercising within the above parameters.
3. For women who are not currently involved in an exercise program:
 - a. Advise starting exercise program with 10-15 minutes of light activity daily.
 - b. Gradually increase both the duration and exertion of exercise over several months to 20-30 minutes daily.
 - c. Walking, swimming, and weight training are convenient ways to implement an exercise program.
4. All women should be aware that exercise tolerance may decrease in the first trimester. The body is increasing cardiac output by 50 percent, with a resultant lag in increasing blood volume. This may lead to shortness of

breath and increased fatigue. Instruct women to stop exercising when experiencing lightheadedness, fatigue and/or shortness of breath. Endurance may increase in the second trimester and then decrease again in the third trimester due to decreased lung capacity, decreased stability of joints, balance and increased fetal demands.

5. Exercise should be stopped if the client has or develops the following conditions:
 - a. Hemodynamically significant heart disease
 - b. Restrictive lung disease
 - c. Incompetent cervix/cerclage
 - d. Multiple gestation at risk for premature labor
 - e. Persistent second or third trimester bleeding
 - f. Placenta previa after 26 weeks of gestation
 - g. Premature labor during the current pregnancy
 - h. Ruptured membranes
 - i. Preeclampsia/pregnancy-induced hypertension
6. Exercise caution when recommending exercise for clients with the following conditions:
 - a. Severe anemia
 - b. Unevaluated maternal cardiac arrhythmia
 - c. Chronic bronchitis
 - d. Poorly controlled type-1 diabetes
 - e. Extreme morbid obesity
 - f. Extreme underweight (BMI <12)
 - g. History of extremely sedentary lifestyle
 - h. Intrauterine growth restriction in current pregnancy
 - i. Poorly controlled hypertension
 - j. Orthopedic limitations
 - k. Poorly controlled seizure disorder
 - l. Poorly controlled hyperthyroidism
 - m. Heavy smoker

FISH AND MERCURY CONTAMINATION

I. Education

- A. The Food and Drug Administration has advised pregnant and breastfeeding women not to eat shark, swordfish, king mackerel and tilefish. These fish accumulate methylmercury that is absorbed by the pregnant or breastfeeding woman and passed onto the fetus or child. Methylmercury has been shown to harm the nervous system of developing fetuses and infants. Shark, swordfish, king mackerel and tilefish have relatively long life spans and consume other fish, accumulating high levels of mercury.
- B. Shrimp, canned light tuna, smaller ocean fish, salmon or farm-raised fish are safe to eat if quantities are limited to 12 ounces per week. Do not eat the same type of fish and shellfish more than once per week.

II. Counseling

- A. Check local advisories about the safety of fish caught in local rivers and streams. If no advice is available, pregnant and breastfeeding mothers can safely eat up to six ounces (one meal) per week of either fish from local waters or albacore (white) tuna. Do not eat any other fish during the week.
- B. For more information check the following website:

FDA, 2005 – <http://www.cfsan.fda.gov/~pregnant/befmethy.html>

LISTERIOSIS

Listeria Monocytogenes is a gram-positive rod shaped bacterium found in a variety of contaminated raw foods such as uncooked meats, vegetables, soft cheeses and cold cuts. Hot dogs and deli meats are usually contaminated after cooking, but before packaging. Raw milk, or food made from raw milk, may also contain the bacterium.

I. Education

- A. Pregnant women who become infected with *Listeria Monocytogenes* are at increased risk for miscarriage, stillbirths, premature delivery and infection of the newborn. Newborns may exhibit bacteremia and meningitis. Pregnant women are 20 times more likely than other healthy adults to get listeriosis.
- B. Client may complain of mild flu-like symptoms, fever or stiff neck. Prompt referral for a blood culture to confirm listeriosis is indicated and antibiotics if confirmed.

II. Counseling

- A. Prevention is the best management. Pregnant women should be instructed to thoroughly cook all raw food from animal sources such as beef, pork or poultry. Vegetables should be washed thoroughly. Uncooked meats should be stored separately from cooked and ready to eat foods. Pregnant women should be instructed to avoid raw or unpasteurized milk.
- B. Client should not eat hot dogs, luncheon meats, or deli meats unless reheated to steaming hot. Pregnant women should be taught to wash all food preparation surfaces, foods and utensils especially if they have been contaminated with fluids from hot dogs or luncheon meats.
- C. If consuming cheeses, package labeling should clearly indicate that the cheese has been pasteurized. Soft cheeses such as feta, Brie, Camembert, blue-veined cheeses or Mexican style cheeses such as queso blanco, queso fesco and Panela are particularly prone to contamination and must be pasteurized.
- D. Pregnant women should not eat refrigerated pâtés, meat spreads or smoked sea food unless cooked. Canned or shelf-stable smoked seafood may be eaten.

ORAL HEALTH

I. Education

- A. Oral health is integral to general health. Oral health is more than just healthy teeth. It is being free of chronic oral-facial pain conditions, oral and pharyngeal cancers, as well as oral soft tissue infections and lesions. During pregnancy, women should be especially mindful of oral hygiene practices, eating habits, and professional dental care needs which form the foundation for good oral health. Good oral health habits and proper nutrition can help prevent problems during pregnancy and help determine the general and dental health of the unborn child. The tooth decay process begins with plaque, an invisible sticky layer of harmful bacteria that constantly forms on teeth. Unremoved plaque on teeth can irritate the gums, making them red, tender, and likely to bleed easily. This condition is called gingivitis. Gingivitis can lead to more serious periodontal diseases affecting the gums and bones that anchor teeth in place. During pregnancy, gingivitis may occur more frequently due to a rise in the body's hormone levels. Research has demonstrated that periodontal disease is associated with an increased incidence of preterm labor. Clients who received scaling and root planing decreased their risk of preterm labor by 84 percent.
- B. Estrogen causes increased blood vessel formation and increased blood flow to vascular areas of the body throughout pregnancy. Bleeding gums are an indication of this increased blood flow and vessel development as well as a sign of increased turnover of epithelial cells.
- C. Periodontal disease may contribute to adverse outcomes of pregnancy as a consequence of a chronic oral inflammatory bacterial infection. Toxins or other products generated by periodontal bacteria in the mother may reach the general circulation, cross the placenta, and harm the fetus. In addition, the response of the maternal immune system to the infection elicits the continued release of inflammatory mediators, growth factors, and other potent cytokines, which may directly or indirectly interfere with fetal growth and delivery.

II. Counseling

- A. Encourage daily brushing with soft bristled toothbrush and regular flossing.
- B. Encourage regular check-ups with dental provider.
- C. Emphasize importance of calcium intake through diet and supplements.

PREECLAMPSIA

I. Education

- A. The National High Blood Pressure Education Program Working Group identified four classifications of hypertension during pregnancy. These classifications include the traditional categories of preeclampsia, eclampsia, superimposed preeclampsia, and a new classification, gestational hypertension. Hypertension during pregnancy **without** proteinuria is classified as gestational hypertension (GH), replacing the term pregnancy induced hypertension. Hypertension during pregnancy **with** proteinuria is known as preeclampsia and may be associated with other symptoms such as edema, visual disturbances, headache, and epigastric pain. Eclampsia is a potentially life threatening disease process characterized by new onset grand mal seizures. Preeclampsia ranges from mild with slightly elevated blood pressure and pedal edema, to severe and life threatening with kidney damage and coagulation disorders. At this time, there are no effective methods of prevention, screening or treatment.
- B. Preeclampsia is defined as blood pressure elevation over 140/90 or a rise of 30 mmHg systolic or 15 mmHg diastolic over baseline after 20 weeks of pregnancy and proteinuria of 0.3 grams or higher in a 24-hour specimen.
- C. Preeclampsia is defined as severe if one or more of the following criteria is present: blood pressure elevation over 160 mmHg systolic or higher or 110 mmHg diastolic or higher on two occasions at least six hours apart while the client is on bed rest, during pregnancy with proteinuria, oliguria of less than 500 ml in 24 hours, pulmonary edema or cyanosis, epigastric or right upper-quadrant pain, impaired liver function, thrombocytopenia, fetal growth restriction or cerebral or visual disturbances. Hemolysis, Elevated Liver enzymes and Low Platelet count (HELLP) syndrome may be associated with severe preeclampsia.
- D. The diagnosis of superimposed preeclampsia is based on one or more of the following findings:
1. Chronic hypertension prior to 20 weeks
 2. Development of new-onset proteinuria after 20 weeks
 3. Severe exacerbation of hypertension (development of symptoms)
 4. Thrombocytopenia & abnormal liver enzymes
- E. Gestational hypertension is defined as the development of an elevated blood pressure without proteinuria during pregnancy or within the first 24 hours postpartum in a previously normotensive woman.

- F. The cause of preeclampsia is not known although several risk factors are associated with the development of preeclampsia. Women with trophoblastic disease, multiple pregnancy, chronic hypertension, vascular disease, chronic renal disease, diabetes mellitus, fetal hydrops, maternal age greater than 35, primigravidas, family history of preeclampsia, and women with a previous history of preeclampsia are more at risk for developing preeclampsia.

II. Counseling

- A. Client may experience unremitting headaches, blurring of vision, spots before eyes and/or dizziness, blood pressure elevation as described above after 20 weeks gestation, sudden excessive weight gain, ankle, pretibial, hand, face or abdominal edema, hyperreflexia, epigastric pain and/or proteinuria.
- B. Preeclampsia is a very serious condition requiring immediate physician consultation and referral. Clinical signs are not always valid indicators of the progression of the disease or the extent of harm to both mother and fetus.
- C. Eclampsia is a medical emergency. Clients who experience symptoms of seizures or impending seizures should call 911 immediately.

SEXUALITY IN PREGNANCY

I. Education

Women who are experiencing a normal pregnancy may continue to engage in sexual relations, including intercourse throughout the pregnancy. There are many myths and misconceptions surrounding sexual relations during pregnancy that will need to be addressed. Both partners may experience a decrease in overall interest in sexual relations during pregnancy. In addition, cultural practices and taboos on sex during pregnancy should be acknowledged and validated. Discussion and education of the woman and her partner may encourage open communication, understanding and increased support throughout the pregnancy.

II. Counseling

- A. Clients and their partners may be embarrassed or reluctant to discuss fears for the baby's safety during intercourse, concerns that the baby is able to hear and/or feel sexual activities, concerns that the baby will be marked during intercourse or other concerns associated with pregnancy. Provide opportunities for clients to ask questions about sexual relations during pregnancy. Provide factual nonjudgmental information and assess fit with cultural practices.
- B. Some misconceptions are based on cultural practices that may be difficult to determine. Be accepting of cultural practices and assist client to incorporate factual information with traditional beliefs.
- C. Sexuality in the First Trimester: Nausea, vomiting, increased fatigue, breast tenderness and anxiety about the pregnancy can decrease a woman's desire and functioning. Communication about physical changes and feelings during this time should be encouraged.
- D. Sexuality in the Second Trimester: Women may experience a return of interest, or an increased desire, as they begin to feel better and experience fewer discomforts. Negative body image, sexual taboos and male disinterest due to a variety of issues may need to be addressed.
- E. Sexuality in the Third Trimester: Increasing fatigue, physical discomfort and increased abdominal size may decrease the woman's desire during the third trimester. Counseling may include trying different positions such as side-lying, sitting and woman on top positions. Use of other expressions of tenderness and love that do not include sexual intercourse may also be encouraged.

- F. Physiological changes that will occur during pregnancy:
1. Increased vascularity of the genital region begins at the end of the first trimester and continues throughout pregnancy. Increased vascularity may increase sexual tension, increase speed and amount of vaginal lubrication and may increase the ease of experiencing an orgasm.
 2. Women may experience more tonic uterine contractions with an orgasm in the third trimester.

SUBSTANCE ABUSE

I. Education

- A. Substance abuse includes the abuse of alcohol, tobacco, prescription medications, cocaine, methamphetamines, heroin, marijuana, and the use of other illegal or "street" drugs. Tobacco use is covered in *Standards of Care, Tobacco Use*.
- B. Substance abuse during pregnancy poses several dangers to both the mother and her fetus. In addition to the direct effects of drugs on the fetus, many women who use substances have late or inadequate prenatal care, poor nutrition and inadequate rest. They may be involved in violent or unstable relationships and are more likely to suffer from depression. Substance abuse treatment facilities for pregnant women are difficult to find and may not provide care for the pregnant woman and her children. Illicit drug use is estimated at 3.7 percent in pregnant women aged 15–44 years. Illicit drug use in pregnant adolescents aged 15–17 years is much higher at 15.1 percent. All illicit drugs cross the placenta. Illicit drug use frequently occurs in combination with alcohol abuse, making it difficult to separate the effects of alcohol from the effects of illicit drug use.
- C. Common Substances
 - 1. Alcohol
 - a. Alcohol is the most frequently abused drug occurring in 12.9 percent of pregnant women aged 15–44 years. Binge alcohol use, the consumption of five or more drinks on the same occasion, occurs in 3.3 percent of pregnant women. Heavy alcohol use, the consumption of five or more drinks on the same occasion on each of five or more days in the past 30 days, is reported by 0.2 percent of pregnant women.
 - b. Alcohol crosses the placenta and can cause alcohol related birth defects (ARBD), the most severe of which is fetal alcohol syndrome (FAS). Infants born to mothers who abuse alcohol are small for gestational age, and may exhibit difficulties eating, sleeping, seeing and hearing. As the child grows, problems with following directions, attention deficits, controlling behavior and social interactions are seen. Research has not demonstrated a safe level of alcohol use during pregnancy.
 - 2. Cocaine: Cocaine is a central nervous system depressant. It can be inhaled through the nostrils (snorted), smoked or injected. There is clear evidence that the use of cocaine during pregnancy may increase the chances of preterm birth, placental abruption, and fetal and maternal death.

3. Heroin
 - a. Heroin may be injected or smoked. It is a central nervous system depressant, giving users a sense of euphoria followed by a heroin "nod". Women will frequently trade sex for heroin increasing their risks for sexually transmitted infections including HIV, AIDS, Hepatitis B and C from sharing of needles, or drug works.
 - b. Heroin use during pregnancy crosses the placenta and has been shown to cause preterm birth, fetal death, addiction in the fetus and stunted fetal growth. Children of heroine users have trouble thinking clearly and have been shown to have behavioral problems.
4. Marijuana
 - a. Marijuana may be smoked or ingested. It is a central nervous system depressant. In addition to its euphoric effects, marijuana is frequently used by men and women with psychiatric disorders as a form of self-treatment.
 - b. Marijuana has been linked to low birth weight.
5. Methamphetamine
 - a. Methamphetamine use has been increasing in Oklahoma, particularly in the rural areas. Methamphetamine is a central nervous system stimulant, exhibiting rapid onset and short duration. The drug can be taken by snorting, injection or orally. While high on methamphetamine, users do not sleep for days, eat very little, and engage in a variety of risk-taking behaviors, including exchanging sex for additional drugs.
 - b. Manufacture of methamphetamines is a highly toxic process and can be conducted in an apartment or van. Women and children exposed to methamphetamines through the manufacturing process can become very ill.

D. Signs and Symptoms

1. Alcohol Abuse
 - a. Alcohol use may be detected by an odor on breath or skin. Other symptoms include mild flushing, talkativeness, impairment of memory and coordination, slurred speech and dizziness. Clients may complain of headaches, difficulty arousing, nausea and gastrointestinal upset.
 - b. Chronic use may lead to heart and liver damage, pancreatitis, peptic ulcers, malnutrition and neurological disorders.
2. Cocaine Use
 - a. Cocaine use causes physical and physiological dependence.
 - b. Clients who have just taken a hit may have dilated pupils, elevated blood pressure, increased heart rate, elevated body temperature, sleeplessness and restlessness. Cocaine may cause irritation of the mucous membranes causing a runny or stuffy nose with frequent nosebleeds.

- c. Symptoms present in the latter stages of abuse are irritability, unpredictability, paranoia, delusion or violent behavior.
 - d. Cocaine is also available as crack or freebase rock that is smoked or injected. Crack is highly addictive and is manifested by erratic mood swings, dilated pupils, increased pulse rate, elevated blood pressure, insomnia, loss of appetite, hoarseness, and parched lips, tongue and throat.
3. Marijuana Use
- a. Marijuana is most commonly smoked causing increased heart rate, blood-shot eyes, dry mouth and throat, and hunger.
 - b. Client may exhibit impaired short-term memory and comprehension, altered sense of time and reduced ability to perform tasks requiring concentration and coordination.
4. Methamphetamine Use: Clients abusing methamphetamines can display a number of psychotic features including paranoia, auditory hallucinations, mood disturbances and delusions, hyperthermia, increased attention and decreased fatigue.

E. Screening

- 1. All women entering prenatal care will receive information about potential effects of substance use to the pregnant woman, developing fetus and growing child.
- 2. Assess all clients for the use of alcohol and abuse of prescribed or illicit substances using CAGE. Suspect chemical dependency if client answers yes to two of the following questions.
 - a. **C - Cut Down:** "Do you feel a need to cut down?"
 - b. **A - Annoyed:** "Do you feel annoyed with people bothering you about your drinking/drug use?"
 - c. **G - Guilty:** "Do you ever feel guilty about your drinking/drug use?"
 - d. **E - Eye Opener:** "Do you need a drink/to use in the morning?"
- 3. Clients may not disclose alcohol or substance abuse during the initial prenatal visits. Assess for alcohol and substance use at each prenatal visit.
- 4. Advise all clients to abstain from alcohol, tobacco and other drug use during pregnancy and document in maternity record.

F. Tips for Interviewing

- 1. Assume a woman has tried alcohol and other drugs at least once. This allows a woman to admit to experimentation, which may be the first step towards her telling you more.
- 2. Inquire about both alcohol and other drugs. Present the questions as a part of their care.
- 3. Go from general questions to specific, from least sensitive to sensitive.
- 4. Ask open-ended questions.

5. Be sure your wording suits your style. Clients are more comfortable with comfortable caregivers. Practice with a colleague.
 6. Teach about maternal and fetal risks. Avoid guilt-inducing comments that could backfire and prompt a woman to increase her alcohol and other drug use.
 7. Compliment abstinence and attempts at abstinence. Be positive. Her efforts are increasing the chance of a healthy baby.
- G. Sample Questions: Ask the following questions to assess client's use of prescribed, or illicit substances.
1. "Do you ever drink wine, beer or mixed drinks?" "How much wine, beer or mixed drinks do you drink now?" (Suggest a range and start high. Also inquire about wine coolers and straight shots.)
 2. "Do you smoke cigarettes, drink coffee or use over-the-counter medications?" (Begin with legal substances.)
 3. "Have you ever used drugs such as...?" (Mention each drug in your area.)
 4. "How much of the drugs are you using now such as...?" "How often do you drink/use?"
 5. "Do you snort, smoke it or use needles?" (Inquire on method of use.)
 6. "When do you usually drink/use?" (Determine use patterns and triggers.)

II. Current Substance Use (Referred)

- A. Facilitate follow-up/consultation with backup or delivering physician in order to assure appropriate medical management of any related risks to the pregnant woman or fetus.
- B. Refer client to a Licensed Clinical Social Worker (LCSW) for further assessment and social services. In the absence of a social worker contact the Regional Social Work Supervisor or Public Health Social Work Coordinator at the Central Office for consultation and local resources.
- C. Facilitate referrals to community resources for counseling and support. Clients may benefit from a variety of group counseling, inpatient treatment, and/or outpatient treatment options.
- D. Assure follow-up on clients suspected of substance use.

III. Laboratory Testing

Clients who are abusing drugs may be at a higher risk for sexually transmitted infections, Hepatitis B, Hepatitis C, and HIV/AIDS. Conduct screening for sexually transmitted infections and HIV/AIDS at intervals noted in the *Laboratory* section.

IV. Counseling

- A. Inform the client of possible side effects of drugs on the fetus and maternal health. Ensure that counseling and education are conducted in a nonjudgmental manner.
- B. Be positive and provide verbal encouragement for all efforts targeted at quitting or cessation.
- C. Relapse is common when terminating any substance that is addictive. Provide support and encouragement to continue efforts at "kicking habits."

TOBACCO USE

I. Education

- A. Prenatal tobacco use is defined as the use of any tobacco product at any time during the prenatal period. Tobacco products include cigarettes, cigars, smokeless or chewing tobacco and pipes.
- B. In Oklahoma, 17 percent of pregnant women smoke during their pregnancy. Women who smoke during pregnancy are 1.5 – 3.5 times more likely to have a low birth weight baby. Other health consequences of smoking include increased risk of spontaneous abortion, infant health problems and increased risk of ectopic pregnancy. Infants of mothers who smoke are two to three times more likely to die from Sudden Infant Death Syndrome (SIDS). Women who quit smoking in the first trimester have been shown to have infants with weight and body measurements comparable to infants of nonsmokers.

II. Counseling

- A. At the first prenatal visit, all clients should be assessed for smoking and exposure to passive smoke.
- B. Clients who indicate they have stopped smoking recently should receive positive reinforcement for their decision and encouragement to remain smoke free. Clients who are currently smoking should be given clear information about the impact of smoking on the mother and fetus.
 - 1. Assess client willingness to make an attempt to quit within the next 30 days. Suggest and encourage the use of problem-solving and skills cessation. Give clients the toll free number 1-866-748-2436 for cessation support. Provide social support as part of the treatment and pregnancy-specific, self-help smoking cessation materials.
 - 2. Pregnant women should NOT be prescribed or advised to use any of the nicotine reduction therapies including: nicotine gum, nicotine inhalers or the nicotine nasal spray. All products that contain nicotine, or nicotine substitutes, are classified by the Food and Drug Administration (FDA) as Pregnancy Category D. Nortriptyline has been shown to cause fetal limb reduction.
 - 3. Provide women who smoke with written materials, strong, clear advice to quit smoking and instruction and/or referral for smoking cessation, counseling and follow-up information.
 - 4. Document all counseling efforts and clients response in the progress notes.

WELL WATER

I. Education

Well water, which is used for infants or breastfeeding women, should be tested annually to measure **nitrates**. Water with nitrate levels greater than 10 mg/L should not be given to infants or breastfeeding women. Levels of nitrates greater than 10 mg/ml have been linked to a blood disorder named methemoglobinemia or "Blue Baby Disease."

II. Counseling

For infants less than six months of age, bottled water should be given and used in the preparation of formula. Unlike water contaminated with pathogens, boiling water with high levels of nitrates will not correct the problem, but may concentrate nitrate levels. If well water levels are in question, a Department of Environmental Quality environmental specialist should be consulted.

SCREENING

Research has shown that lifestyle changes can affect and improve the health and development of the fetus, as well as the health of the client and her family. The following topics present health promotion information as well as interventions to verify or eliminate risk factors for the client and the fetus. Recommendations are provided for consultation and referral if clients are identified as high risk for any of the following health/psychosocial conditions.

DEPRESSION

Maternal depression is a mood disturbance evidenced by inability to enjoy activities and relationships, feelings of worthlessness and hopelessness, problems eating and sleeping and thoughts of suicide. There is no single cause of maternal depression. Research indicates that the cause is most likely multi-factorial. Neurobiological and environmental factors along with genetic predisposition are all thought to be influential. Acute and chronic stress are also implicated in the development of maternal and postpartum depression.

The Diagnosis and Statistical Manual of Mental Disorders (DSM-IV) defines postpartum depression as the onset of symptoms within the first month of delivery with a period of at least two weeks of depressed mood or loss of interest in most activities and includes four of the following:

- Change in appetite
- Change in weight
- Change in sleep pattern
- Psychomotor agitation or depression
- Decreased energy
- Feelings of worthlessness or guilt
- Difficulty with concentration or suicidal ideation

Postpartum psychosis is on the severe end of the depression continuum, affecting 0.2 percent of women. Postpartum psychosis usually occurs within the first two months after delivery. Clients complain of delusions, hallucinations or both, suicidal ideation and homicidal thoughts may be present. This disorder requires emergency referral and medication.

I. Education

- A. Depression is the most common complication of the childbearing years with as many as 30 percent of pregnant and postpartum women experiencing some degree of depression. Maternal depression includes a range of mood disorders from mild mood alteration, and "baby blues" to maternal and postpartum psychosis.
- B. Postpartum blues or "baby blues" is common, occurring in 70-80 percent of women. This is a short-term self-limiting feeling of generalized anxiety and irritability characterized by mood swings and tearfulness. Symptoms usually start three to four days after delivery and are resolved by the tenth postpartum day.
- C. There are two leading theories to explain postpartum depression. The biological theory states that rapid hormone change brought on by the end of pregnancy triggers the depression. Estrogen has long been known to have anti-anxiety

properties. Prolactin, the hormone that stimulates the production of breast milk, has also been shown to have anti-anxiety properties.

- D. The Psychosocial Theory proposes that dissatisfaction with marital relations, stressful life events, feelings of inadequacy/self-esteem, weight gain, infant temperament, early discharge, and obstetric experience contribute to postpartum depression. Some research has implicated unplanned primary cesarean sections and perceived weight gain/loss as triggers.
- E. Infants of mothers suffering from depression during pregnancy and postpartum depression have been shown to experience delayed maternal responsiveness, inconsolability with excessive crying, attachment disorders and delayed behavioral and cognitive development.

II. Screening

- A. Signs and Symptoms of Antenatal Depression
 1. Onset of depression is often unrecognized as it is associated with high numbers of somatic symptoms. Symptoms closely resemble common discomforts of pregnancy.
 2. Client may exhibit depressed mood, feelings of worthlessness, guilt, loss of interest or pleasure in usual activities, poor maternal weight gain, insomnia or hypersomnia, psychomotor agitation, fatigue, difficulty concentrating, headache, nausea, stomach pain, shortness of breath, palpitations, dizziness, sexual dysfunction and thoughts of death or suicide. Increased incidence of substance abuse has also been associated with antenatal depression.
- B. Signs and Symptoms of Postpartum Depression
 1. Onset occurs within four weeks of birth. Symptoms are variable and last for longer than two weeks.
 2. Uncontrollable crying, persistent sadness, feelings of inadequacy or guilt, loss of appetite, insomnia (not due to baby's night time awakenings), irritability, moodiness, anxiety or panic attacks, difficulty concentrating, and/or lack of interest in the baby.
- C. Signs and Symptoms of Postpartum Psychosis
 1. Rarely occurs. Onset is usually within the first 2-3 weeks following birth.
 2. Client may have hallucinations, delusions (often about the baby, and often of a religious nature), severe insomnia, mania, or inability to stop activity, extreme anxiety and agitation, confusion, suicide or homicidal thoughts.
- D. Antenatal and postpartum psychosis is a mental health emergency. In severe cases, the life of the mother, her infant, and partner may be in danger. Immediate referral to an inpatient facility is needed.

- E. Assess all maternal clients at initial visit and as needed during subsequent visits. Assess postpartum clients at four to six week visits. Ask client how she is feeling, DO NOT ask her if she is depressed. Stigmatization around the issue of depression and mental health issues can lead to hiding of symptoms. Assess sleep patterns, ability to care for self and infant. Do not minimize client's feelings. Use of a Depression Screening Tool to evaluate client's status can be helpful. (See *Psychosocial Risk Factor*, ODH Form 305D.) Validation of feelings and acknowledgement of the difficult transition to pregnancy and the mothering role should be accomplished without patronization.

III. Counseling

- A. Clients who are experiencing mild symptoms of depression with onset in the antepartum or postpartum period should be reassured that most women experience a resolution of emotions and feelings in less than two weeks. Feelings of depression should resolve by, or around, the tenth postpartum day. Clients who continue to experience symptoms of depression should return to the clinic for referral.
- B. Clients who are exhibiting symptoms of depression should be referred to mental health resources. Support groups have also been shown to help women in overcoming the depression.
- C. Clients exhibiting signs and symptoms of psychosis should be referred immediately for psychiatric care.

HEPATITIS C

I. Education

- A. Hepatitis C (HCV) is a single-stranded RNA virus that infects the liver. The virus is spread by direct exposure to blood. The Centers for Disease Control and Prevention estimates a seroprevalence of 1.8 percent or 4 million infected Americans.
- B. The virus is primarily spread through contact with infected blood with increased prevalence seen in intravenous drug users, hemophiliacs, and recipients of blood transfusions. Transmission through sexual contact has been documented, but is less efficient than by direct percutaneous exposure.
- C. The incubation period is eight to nine weeks. Seventy-five to eighty-five percent of infected persons will develop chronic HCV infection that is discovered by elevated liver studies. Transmission of the virus continues to occur without symptoms of clinical illness.
- D. Vertical transmission of HCV to fetus occurs in three to six percent of infected women. Perinatal outcomes are not adversely affected by HCV.
- E. Signs and Symptoms
 - 1. Most women are asymptomatic when infected with HCV.
 - 2. Initial signs and symptoms are vague and include fatigue, malaise, anorexia, nausea, and right upper quadrant pain.
- F. There is no vaccine for Hepatitis C. Prophylaxis with Immune Globulin is not effective in preventing infection after exposure.

II. Counseling

HCV infected women may transmit the virus to their infants at the time of birth, but no treatment is available to prevent this transmission. Most infants infected with HCV from birth are asymptomatic and do well during childhood. Studies are continuing to determine more long-term effects. While breastfeeding is not known to spread HCV, HCV-positive women should consider ceasing breastfeeding if their nipples are cracked or bleeding.

III. Screening

Pregnant women who report that they are infected with HCV or have been exposed to an HCV infected person should be tested. The physician or the communicable disease nurse at a county health department may determine which tests are indicated.

HIV SCREENING (PRENATAL)

I. Education

- A. The risk of perinatal HIV transmission to the infant can be reduced approximately 2/3 by administering Zidovudine (ZDV also called AZT) to HIV-infected pregnant women and their newborns. An opportunity exists to improve health potential when HIV infection is diagnosed early in the course of the infection and before or early in pregnancy. Routine HIV education and testing is now recommended for **all** pregnant women in order that timely and effective interventions may be offered.
- B. All clients should receive testing for HIV infection and be advised that treatments are available which may decrease risk of transmission to infants. Maternity clinics will offer routine testing for every client. Strict confidentiality of testing and results must be maintained. Clients who are HIV positive will have care coordinated by a multidisciplinary team.
- C. The U.S. Public Health Service has recommended an algorithm for testing and preventing transmission during pregnancy. An initial screening with an enzyme immunoassay (EIA also called ELISA) with confirmatory testing of repeatedly reactive EIAs along with a supplemental test such as Western Blot (WB) or immunofluorescence assay. While each of these tests is highly sensitive and specific, the use of both the EIA and supplementary tests further increases the accuracy of the results.
- D. Blood specimens are submitted to Oklahoma State Department of Health (OSDH) Public Health Laboratory in a 7 ml serum separator tube utilizing *HIV-1 Antibody Test*, ODH Form 229.
- E. It is possible for rubella screening as well as HIV screening to occur with the same specimen providing that the appropriate identification is placed on the tube and the appropriate forms accompany.
- F. Clients should not be denied prenatal or other health care services, reported to child protective service agencies or discriminated against in any other way because of their HIV infection status or their desire not to be tested.

II. Counseling

- A. Women should be tested as early in pregnancy as possible because undetected HIV infection places the pregnant woman and infant at risk for poor health outcomes, opportunistic diseases, and possibly death. Although administration of zidovudine to HIV seropositive pregnant women and to newborns has been

shown to reduce the risk of perinatal transmission, clinical trials have not been conducted to predict long term consequences of ZDV on the fetus.

- B. Uninfected pregnant women who continue to practice high-risk behaviors (e.g., injecting-drug use and unprotected sexual contact with an HIV-infected or high-risk partner) should be encouraged to receive prevention counseling, avoid further exposure, and to be retested in the third trimester of pregnancy.
- C. Clients should receive complete information regarding methods to decrease risk of HIV infection for themselves or others. They should be aware of local resources to aid with other possible services such as drug-treatment and social services.
- D. Family planning resources should be communicated to clients in order that future unintended pregnancies may be prevented.

III. Consultation/Referral

- A. HIV positive maternity clients must be referred to high-risk clinics for multidisciplinary care.
- B. Clients should be assisted in obtaining services as needed for social or psychological services. Information obtained during counseling sessions may reveal need for a variety of services.
- C. Documentation of referrals should include name of referral source, phone and address.

INTIMATE PARTNER VIOLENCE

A violent event is defined as being punched, shoved, hit, kicked or forced to engage in sexual relations against the woman's will. Domestic violence frequently includes verbal abuse, intimidation, progressive social isolation and deprivation of things such as food, money, transportation or access to health care.

I. Education

- A. Between four and eight percent of pregnant women in the United States experience domestic violence during pregnancy. In 2003, 5.23 percent of women in Oklahoma reported intimate partner violence by a husband or partner during the twelve months prior to pregnancy. Three percent reported intimate partner violence during pregnancy. Far from being protected from abuse during her pregnancy, violence against the expectant woman may escalate, and is often the starting point for violence in the relationship.
- B. Clients may trivialize and minimize the abuse, failing to recognize actual dangers to themselves and their children. Often there is a cycle of violence with tension building (blaming, anger, jealousy), followed by a battering, either verbal or physical, after which the abuser may deny the violence, make excuses, buy gifts and promise to never do it again. It is important for women to realize the serious and life-threatening nature of domestic violence.

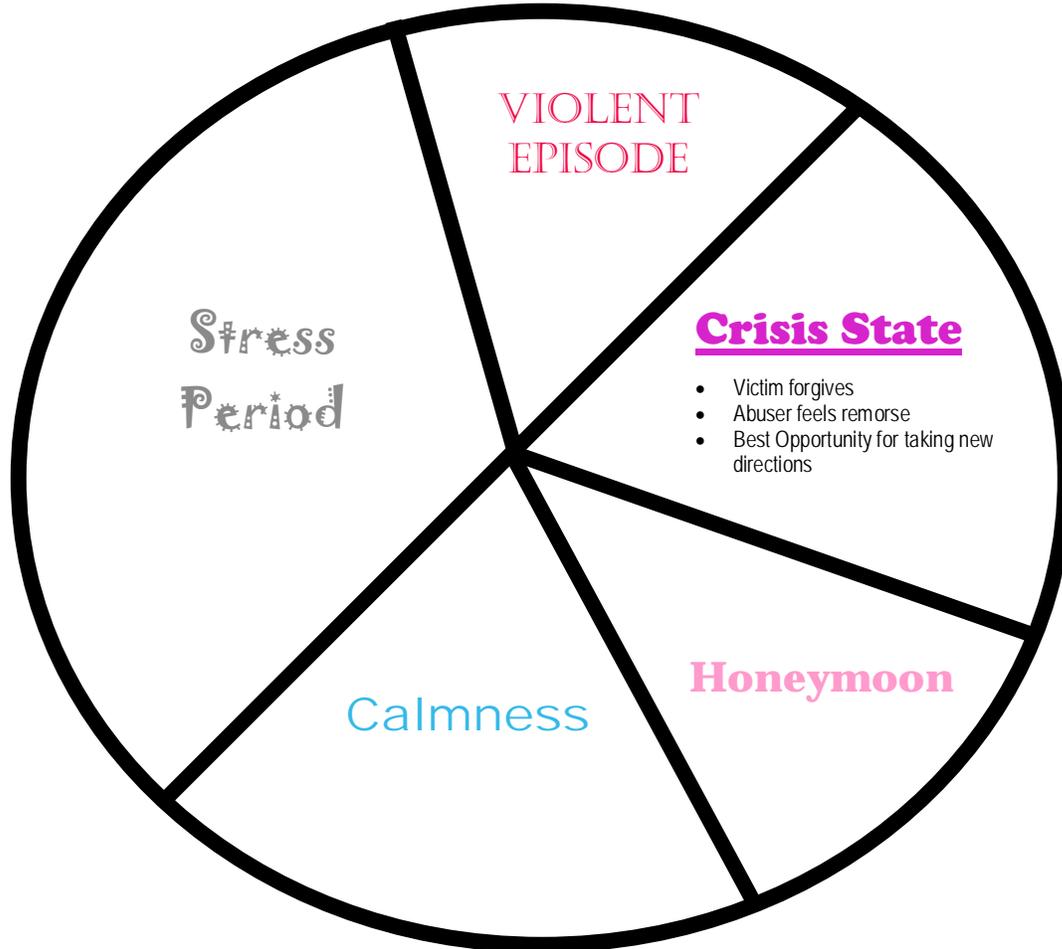
II. Counseling

- A. Making a decision to leave an abusive relationship can be very difficult. It may take time for the client to feel ready. Use community resources to assist the client in meeting his/her needs.
- B. If the client is ready to leave:
 - 1. Ensure client is aware of shelters.
 - 2. Suggest client pack a bag in advance and leave it at a neighbor's house. Include cash or credit cards, extra clothes and a favorite toy or plaything.
 - 3. Suggest client hide an extra set of car and house keys outside of the house in case she will have to leave quickly.
 - 4. Client will need to find and take important papers such as:
 - a. Birth certificates for client and children
 - b. Health insurance cards and medicine
 - c. Deed or lease to house or apartment
 - d. Pay stubs, checkbook and extra checks
 - e. Social security number or green card/work permit
 - f. Court papers or orders
 - g. Driver's license or photo identification

III. Screening

- A. All women, regardless of presenting symptoms, should be screened for intimate partner abuse and violence at her first prenatal visit. Assess for abuse in a totally confidential setting away from family members and friends.
- B. Questions about abuse should be open, direct, and asked in a variety of ways throughout the exam because women perceive violence in different ways and to different degrees. When possible, avoid simple yes/no questions. Instead, ask open-ended questions such as, “Tell me how your partner took the news that you are pregnant.” If it is not possible to ask the woman about abuse in a totally confidential setting, wait to assess for abuse until the next visit.
- C. If a woman has been identified as currently being in an abusive relationship, or is at risk for abuse through the screening tool, *Prenatal Risk Assessment and Care Plan*, ODH form 305D, she should be referred to the clinic social worker, or a staff member who has received training in domestic/family violence.
 - 1. Document all screening findings in as detailed way as possible, e.g., photos, drawings.
 - 2. Provide information regarding the periods of most danger in (and the best time to leave) an abusive relationship.
 - 3. Assist in the development of a plan for safety.
 - 4. Continue to follow and assess immediate danger throughout pregnancy.

Cycle of Violence



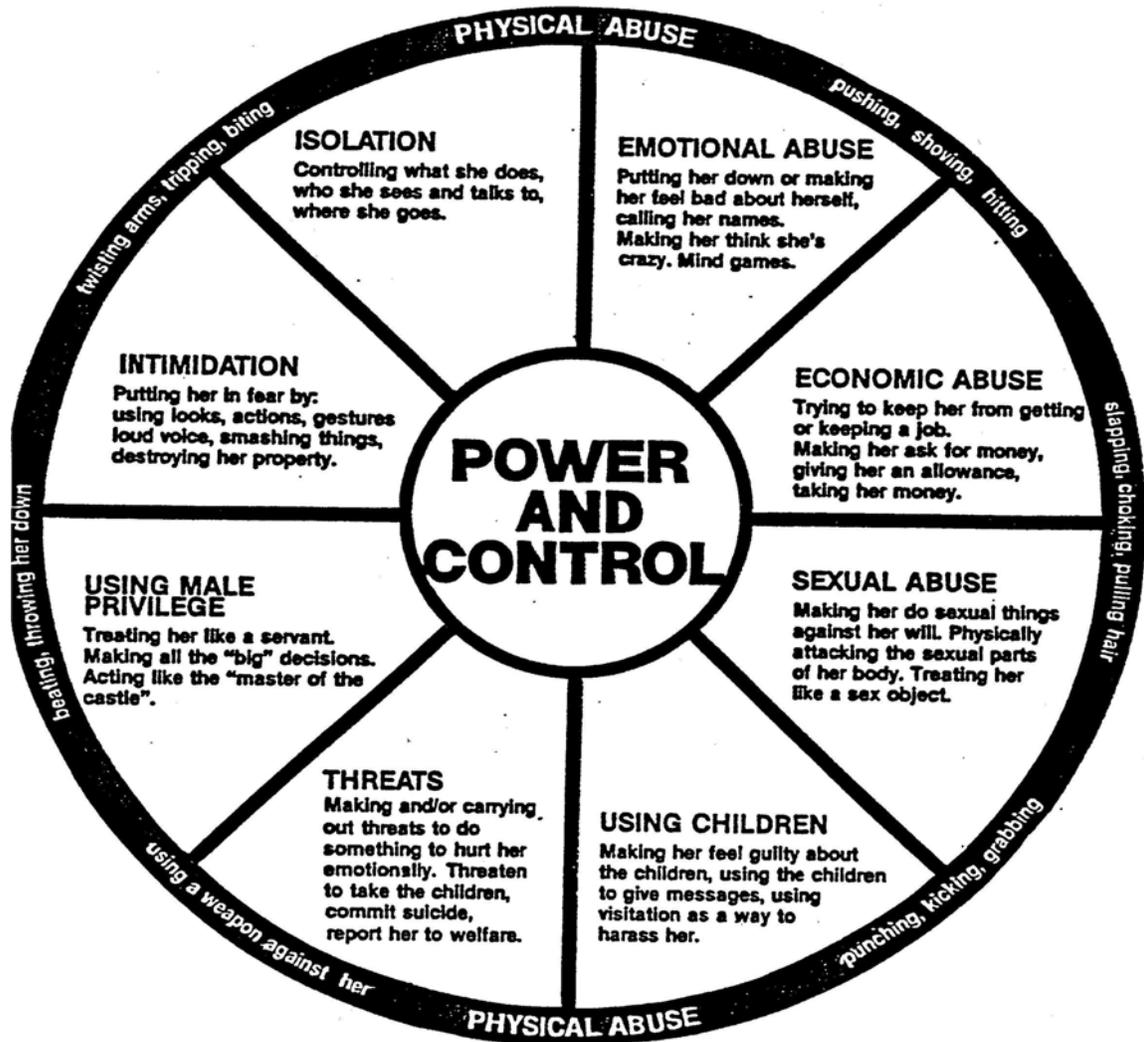
STRESS FACTORS

Isolation
Pregnancy
Economics
Alcohol/Drugs
Death
Role Change
Change in Family Structure
Sexual Dysfunction
Medical Problem

CHARACTERISTICS OF THE ABUSER

Possessive
Jealous
Low Impulse Control
Substance Abuse
Rigid Role Expectations
Controlling
Dictatorial

Distributed by:
Domestic Violence Intervention Services, Inc.
Tulsa, Oklahoma
(918) 585-3163



LEAD EXPOSURE

I. Education

Lead exposure may be from a variety of sources, i.e., lead based paint, soil, dust, work, hobbies, vinyl mini-blinds, water, food, air and alternative, home, or folk remedies. Lead is toxic to humans and has been linked to spontaneous abortion. Lead can also pass through the placenta to the fetus. Research has shown a U- shaped distribution of lead levels during pregnancy. Increased mobilization of lead from bone into the maternal circulation has been observed during the third trimester and in women older than 30 years.

II. Screening

- A. Routine serum lead screening of asymptomatic pregnant women is not recommended by the Centers for Disease Control and Prevention (CDC) or the American College of Obstetricians and Gynecologists (ACOG). Women who may be at risk for lead exposure should have a consultation with a physician and the Oklahoma State Department of Health (OSDH) Screening and Special Services. The prenatal period is an excellent time to educate women on the risks of lead exposure to the fetus, other children in the home, and themselves and assist them in identifying areas of lead exposure before the arrival of their infant. At the maternity intake visit, all clients should be screened for exposure to lead using the *Adult Lead Exposure Risk Assessment* tool found in the appendices.
- B. Clients who answer “yes” or “I don’t know” to any of the screening questions, should have blood drawn to check serum lead levels. If a client’s serum lead level is ≥ 25 $\mu\text{g}/\text{dl}$ initially, a follow-up serum test should be drawn at 36-38 weeks. An elevated serum lead level should be documented in the *Problems/Plans* section of the *ACOG Antepartum Record*, ODH Form 305B.

III. Counseling

- A. Women and their families should be taught strategies for minimizing lead exposure during pregnancy. The Childhood Lead Poisoning Prevention Program of Screening and Special Services has educational information. Additionally, more information may be obtained at the following web sites:
<http://www.epa.nsw.gov.au/leadsafe/index.htm>
<http://www.cdc.gov/nceh/lead/lead.htm>
- B. Clients identified as at-risk should receive counseling on key sources of lead exposure, how to reduce exposure to lead, and diets high in iron and calcium. Written lead education material should be provided.

- C. See *PHN Practice Guideline: Lead Screening* for more detailed information. Women exhibiting signs and symptoms of lead toxicity should be referred to a physician immediately.

NUTRITION

I. Education

- A. Weight gain during pregnancy is based on the recommendations from the Institute of Medicine and National Academy of Sciences. Women's Health Division adopted the following values as indicative of appropriate weight gain for underweight and normal weight women during pregnancy: two to five pound weight gain in the first trimester followed by a weight gain of one pound per week throughout the pregnancy.
- B. Quality nutritional intake is an important factor in promoting optimal fetal growth, brain development, and prevention of low birth weight (LBW) infants. Although weight gain does not ensure a quality nutritional intake, it is an indicator of fetal growth. Until recently, weight gain during the second and third trimesters was viewed as affecting birth weight and fetal development, with little to no emphasis placed on gain during the first trimester. Recent studies indicate that nutrition in the first trimester, which reflects maternal blood volume expansion and placental growth, is vital to fetal development. Assuring adequate maternal caloric and nutrient intake beginning in the preconception period and continuing throughout the pregnancy are factors that can prevent LBW births and optimal fetal brain and cellular development. Nutritional deprivation during the first trimester reduces birth weight, length, and head circumference resulting in proportionate growth retardation. Disproportionate growth retardation is caused by failure to achieve adequate nutritional intake later in pregnancy, reducing birth weight and length, but sparing the brain (head circumference).
- C. Prepregnancy weight for height determines the gestational weight gain requirements. Women entering pregnancy underweight require a larger gain than normal weight women. The Institute of Medicine and National Academy of Sciences has developed recommended weight gain ranges based on prepregnancy Body Mass Index (BMI). BMI, defined as $\text{weight}/\text{height}^2$, is a better indicator of maternal nutrition status than is weight alone. The table below identifies the Institute of Medicine's recommended weight gain ranges, first trimester gain and rate of gain by BMI. Women who are overweight, BMI > 26, or obese, BMI > 29, are at risk to deliver large for gestational (LGA) age babies and develop gestational diabetes. Neonatal mortality increases when birth weight exceeds 4,250 gms (9.35 lb).

Weight-for-Height Category	Recommended Total Gain in Pounds	1st Trimester Gain in Pounds	Rate of Gain lb/wk
Low (BMI < 19.8)	28 - 40	5	1.07
Normal (BMI 19.8-26)	25 - 35	3.5	0.97
High (BMI > 26.0 to 29.0)	15 - 25	2	0.67
Obese (BMI > 29.0)	at least 15	*	*

* No recommendation (may use Prenatal Weight Gain Grid's lowest dotted line as guide)

- D. The recommended weight gain for overweight women is approximately one half (.67) pound per week during the second and third trimester. Obese women have significantly heavier babies independent of weight gain. It is generally recommended that obese women gain a minimum equivalent to the products of conception (15 pounds), although lower weight gains are often compatible with optimum birth weight.
- E. Pregnant adolescent women have the dual challenge of meeting the nutritional needs of their own growth in addition to providing adequate nutrition for fetal growth and development. Poor nutritional habits, developmental issues, and the need to establish their own identity compounds nutritional deficits.
- F. The combined impact of inadequate weight gain and cigarette smoking on LBW must be taken into account when assessing clients for inadequate weight gain. It is well-known that cigarette smoking during pregnancy is strongly associated with LBW.

II. Screening

- A. Subjective Information:
 - 1. Client may not be certain of her prepregnancy weight.
 - 2. Client identifies nausea and/or vomiting occurring in the first trimester that resulted in weight loss or failure to gain weight.
 - 3. Review of client's eating habits through the WIC *Eating Habits Sheet*, ODH Form 383, or 24-hour recall to identify unfavorable dietary habits. Unfavorable dietary habits may include high fat, high calorie foods and/or caloric intake higher than needed.
 - 4. Client indicates that she smokes cigarettes.
 - 5. Client verbalizes concerns over becoming fat.
 - 6. Client reports current nausea and vomiting.
- B. Objective Information:
 - 1. Low prepregnancy BMI or normal prepregnancy BMI and failure to gain weight or a weight loss at any time before 13 weeks. Use *Prenatal Weight Gain Grid*, ODH Form 321 to determine prepregnancy BMI and follow weight gain pattern.
 - 2. A weight gain of three pounds or less by 16 weeks; six pounds or less by 20 weeks; nine pounds or less by 24 weeks; and 13 pounds or less by 30 weeks indicates inadequate weight gain. Use *Prenatal Weight Gain Grid*, ODH Form 321 to determine prepregnancy BMI and follow weight gain pattern.
 - 3. An illness or medical condition, such as vomiting, could lead to dehydration and failure to expand maternal blood volume, resulting in an elevated hematocrit or hemoglobin value. The following values **may** indicate dehydration:

Smoking Status	Hematocrit Value	Hemoglobin Value
Non-smoker	above 36 percent	above 12.0 g/dL
Smokes 1 pack/day	above 37 percent	above 12.3 g/dL
Smokes 2 packs/day	above 38 percent	above 12.7 g/dL

4. A 1+ or 2+ ketone value upon testing the urine indicates client is metabolizing body fat and weight loss is occurring (provided client is not diabetic).
5. Prepregnancy BMI is high and weight gain is average or higher than average.

III. Counseling

A. Complications

1. Clients who lose weight or fail to gain weight in the first trimester are at risk of delivering a LBW (5lb 8oz or less) infant and of having a preterm delivery (before 37 weeks gestation). Clients who fail to gain adequate weight after 20 weeks of pregnancy are at risk of delivering a LBW infant.
2. Overweight and obese clients who gain more than the recommended weight are at risk for gestational diabetes and macrosomic infants.
3. Women who smoke during pregnancy are at increased risk of giving birth to a LBW infant. Even when smokers gain the recommended amount of weight during pregnancy, their risk of delivering a LBW infant is great. Smokers who gain under the recommended amount of weight during pregnancy have the highest risk of delivering a LBW infant.

B. Counseling for Clients with Below Normal Weight Gain

1. Begin nutritional counseling and problem solving at first prenatal visit to ensure all clients have adequate nutritional intake.
2. Assess dietary intake through *Eating Habits Checklist*, or a 24-hour recall.
3. Identify poor eating pattern (skipping meals and/or omission of food groups resulting in inadequate caloric intake).
4. Counsel client regarding dietary intake and link to healthy infant at birth.
5. Assess client's smoking status and advise abstinence from cigarettes. Offer smoking cessation interventions or referrals.
6. Determine if client's inadequate weight gain is a result of nausea/vomiting.
7. Recommend improvements in prenatal diet to be implemented over the following week. Refer to nutritionist.
8. Schedule client to return in one week for weight and assessment of nutritional intake.
9. At return visit, if weight gain shows no improvement, recommend dietary changes to be implemented over the following week.
10. At second return visit, if client shows no improvement, refer to physician or obtain consultation with nutritionist and physician.

- C. Counseling for Clients with High Prepregnancy BMI.
1. Weight loss should never be promoted during pregnancy. Quality nutrition, including limiting high carbohydrate foods, beverages and fat can promote healthy development of the fetus.
 2. The following guidelines may be used to counsel overweight and obese clients:
 - a. Exercise by walking and performing upper arm resistance training.
 - b. Carbohydrates should be lowered to 40-45 percent of day's total calories per day.
 - c. Protein should consist of 20 percent of total calories.
 - d. Fat should comprise 30-35 percent of the day's total calories.
- D. Hyperemesis Gravidarum
1. Severe, persistent nausea and vomiting in early pregnancy is known as hyperemesis gravidarum and occurs in approximately one of every 200 pregnant women. The nausea and vomiting may be sufficiently severe to require parenteral hydration and medical therapy due to abnormal fluid balance, electrolytes and nutrition.
 2. Assess severity of nausea and vomiting at each prenatal visit.
 3. Persistent nausea and vomiting resulting in weight loss over two consecutive one week visits should be referred to the physician or be managed in collaboration with a physician. Referral to the physician and/or the tertiary center is warranted for management of this condition.
- E. Low Birth Weight
1. Clients should understand the connection between inadequate prenatal weight gain and delivering a LBW infant. Infants born at LBW:
 - a. Are forty times more likely to die in the first year of life.
 - b. Account for two-thirds of all neonatal deaths.
 - c. Are five times more likely to die if they survive the first month of life.
 - d. Are at higher risk to develop neurodevelopmental handicaps, including Cerebral Palsy and seizure disorders.
 - e. Are more susceptible to chronic respiratory problems
 2. Clients should receive information regarding the combined impact of cigarette smoking, prepregnancy BMI and LBW. Although weight gain alone is not an adequate intervention for pregnant women who smoke, those women who are unable to quit smoking during pregnancy should be encouraged to achieve at or above the recommended amount of weight in order to reduce the risk of LBW.
 3. Clients should understand the importance of proper nutrition during pregnancy.
 4. Clients should receive prenatal smoking cessation materials and individually tailored counseling regarding smoking cessation techniques.

- F. Clients who experience nausea and vomiting utilize a variety of strategies to relieve nausea. Refer to the *Education and Counseling* section, *Common Discomforts in Pregnancy*, for a detailed description of strategies.

IV. Consultation/Referral

- A. Maternity staff may utilize the Public Health Nutritionist at the one week return visit to provide further nutrition assessment of the client. Referral to the psychosocial health professional is warranted to further assess psychosocial factors which may be having an impact on the client's inadequate weight gain or smoking status. In the absence of the psychosocial health professional, contact the Regional Technical Social Work Supervisor.
- B. If a client has a history of an eating disorder such as anorexia nervosa or bulimia and a mental health professional is unavailable, more frequent monitoring is recommended until adequate nutrition and appropriate weight gain is established. While eating disorders are manifested through manipulation of dietary intake, they are psychological illnesses and require more treatment than a nutrition consultation.

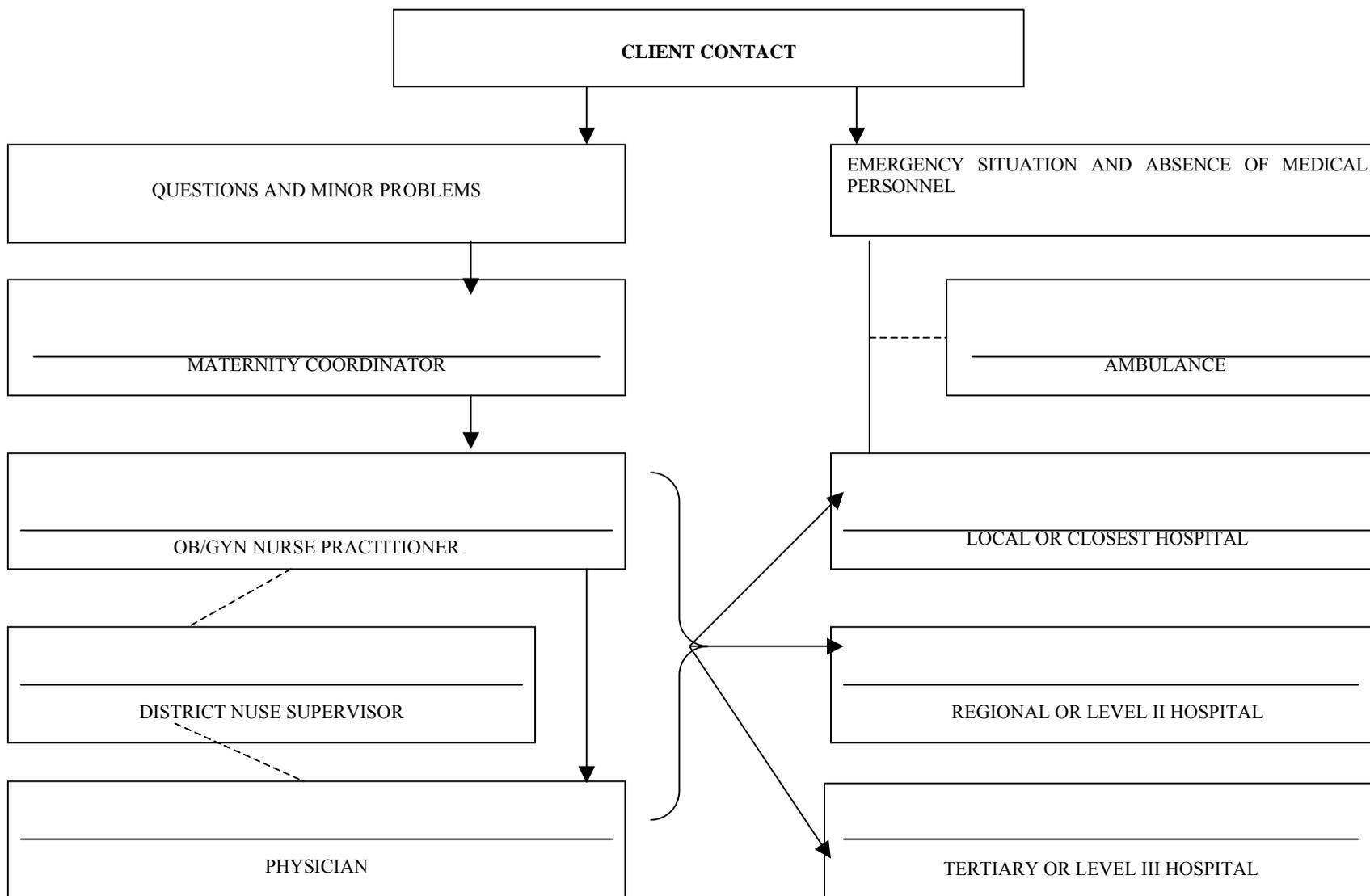
CHECKLIST
Opening or Re-Opening a Public Health Maternity Clinic
CLINIC LEVEL

- Identify and contact Women's Health Consultant for the area to provide consultation.
- Conduct community needs assessment regarding service needs and resources.
- Obtain medical back-up (physician) and facilitate the signing of the contract.
- Staff – designate a Maternity Coordinator, Nurse Practitioner, and other staff
- Obtain Maternity Manual and assure orientation to the program policy and procedures for all staff
- Obtain self-assessment questionnaire to be completed and returned to the Women's Health Division prior to the Title XIX Certification visit
- Identify and develop rapport with delivery resource
- Identify and contact Records Consultant for the area
- Develop a statement of non-discriminatory practices
- Request Title XIX Certification from Women's Health Division
- Order and stock supplies
- Order and stock medications
- Obtain Maternity Related Forms
- Obtain and utilize a uniform record system
- Complete Maternity Medical Referral algorithm (Maternity Manual Appendix)
- Establish a locked location or cabinet for maternity records and medications
- Assure hand-washing capability in each exam room
- Assure biohazard waste disposal in each exam room
- Assure handicap accessibility
- Establish routine for pre- and/or post- clinic conferences
- Establish routine for quality assurance and client satisfaction surveys
- Post hours for maternity clinic in a location that is visible when the clinic is closed.
- Post emergency evacuation maps on the walls
- Establish an oxygen source and emergency tray in accordance with PHN guidelines.

CHECKLIST
Closing a Public Health Maternity Clinic
CLINIC LEVEL

1. Inform the following people of plans to close the clinic:
 - Medical back-up (physician)
 - Chief, Maternal and Child Health Service
 - Director, Women's Health Division
 - Regional Social Work Supervisor
 - Pharmacy
 - Records Consultant for the area
 - Shipping and Receiving
 - Delivery resource
2. With consultation from any of the above resources, develop a listing of other pre-natal care and delivery resources for the public to use once the clinic is closed.
3. Post public notice at the clinic site 30 days in advance of the clinic closing.
4. Return the following items to the Central Office:
 - Unused supplies
 - Unused medications
 - Unused maternity related forms and brochures
5. Develop a plan for storage of maternity records and submit the plan to the Director, Women's Health Division for review and approval.

MATERNITY MEDICAL REFERRALS



Lead Exposure Risk Assessment Questionnaire
for Maternity Clients

1. Name _____

Date _____

Do you live in a home built before 1950, have peeling paint, and/or have plastic or vinyl miniblinds in your home?	YES	NO	I DON'T KNOW
Do you or does anyone in your household engage in the following activities: <ul style="list-style-type: none"> • Making stained glass windows • Making fishing weights • Firing and cleaning of rifles • Remodeling or refinishing furniture • Painting bridges • Demolition or renovation of buildings 	YES	NO	I DON'T KNOW
Do you use home/folk remedies? (Especially items imported from Greta, Azarcon, and Rudea) or eat candy from Mexico?	YES	NO	I DON'T KNOW
Do you cook and/or eat food prepared and served in pottery made outside the United States?	YES	NO	I DON'T KNOW
Do you live in an at-risk zip code area? (See ODH # 386 in PHN Orders and Guidelines)	YES	NO	I DON'T KNOW

Clients who answer “yes” or “I don’t know” to any of the screening questions should have blood drawn to check blood lead levels. Levels ≥ 25 are considered toxic levels for adults. Although there is no approved treatment of lead toxicity for pregnant women, dietary and environmental changes should be addressed with all clients at risk.

If client is identified as high risk, document date serum lead level drawn and result on ACOG form D, under Optional Labs (Other). If serum lead level is repeated, document under additional labs.

SERVICE PLAN						
Services may need to be adjusted based on when client enters care.						
Appointment Intervals: 4-28 weeks every 4 weeks; 28-36 weeks every 2 weeks; 36-42 weeks every week . Postpartum visit must be scheduled within 60 days.						
Service	Initial Visit	Subsequent Routine Visits	15-22 week visit	24-28 week visit	35-37 week visit	Postpartum Visit
Health and Obstetrical History	X					
Comprehensive Physical Assessment	X					X
Review of Systems	X	X	X	X	X	X
Laboratory						
Hct/Hgb	X			X		
Type & Antibody Screen	X					
Pap	◆					◆
Rubella	◆					
RPR	X			◆		
Urine Culture	X					
HbsAG	X					
HIV	X			◆		
Hgb Electrophoresis	If non-white					
Chlamydia	X			◆		
Gonorrhea	X			◆		
Wet prep			History of preterm labor			
MSAFP			X			
Diabetes Screen	◆			X		
3 Hour GTT		◆	◆	◆	◆	◆ (2 hr GTT)
Ultrasound	See Guidelines	See Guidelines				
Group B Strep					X	
Nutrition Assessment	X	◆				
Psychosocial Assessment	X	◆				X
Assessment of Oral Health	X	◆				
Assessment of Genetic Risk Factors	X					
Assessment of Environmental Risk Factors	X	◆				
Weight	X	X				
Blood Pressure	X	X				
Fetal Heart Tones	◆	X				
Fundal Height	◆	X				
Urine dipstick for protein and glucose	X	X				
Vaginal Exam					36 + weeks	
LEGEND: ◆ If Indicated X Routine						