PRENATAL PLUS
Provider Manual

Colorado Department of Public Health and Environment
Prevention Services Division - Women's Health Unit

Colorado Department of Health Care Policy and Financing
Health Benefits Division
- Acute Care Benefits Section

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SECTION 1:
PROGRAM OVERVIEW

HISTORY

In 1993 and 1994 the Colorado Department of Public Health and Environment used federal Maternal and Child Health Block Grant funds to conduct a pilot project called the *Helping Moms Program*. This demonstration project provided enhanced services to a group of low-income women. Services included care coordination, nutrition and mental health services.

Data from the two-year pilot project showed that women who received enhanced services had a better chance of delivering a healthy infant than women who did not receive the enhanced services. The data also showed that the program was most effective for the highest risk clients. The Prenatal Plus Program components were developed as the result of an extensive evaluation of the *Helping Moms Program*, including data analysis of health outcomes, focus groups with participants, and surveys of program staff.

In 1995, the Colorado Department of Health Care Policy and Financing approved expanding Medicaid benefits to include enhanced prenatal care coordination services through the Prenatal Plus Program. Local Prenatal Plus Program providers began delivering services to Medicaid-eligible women in 1996. Prenatal Plus services are provided at county health departments, county nursing services, community health centers and non-profit agencies. A list of Prenatal Plus providers is available on the Prenatal Plus website[1].

PROGRAM GOAL

Low infant birthweight is one of Colorado's most critical public health problems. A low-birthweight infant weighs less than 5 pounds, 8 ounces or 2500 grams. The health and quality of life for low-birthweight infants often is compromised for many years, including possible neurological deficits, sensory deficits, learning problems, central nervous system conditions and an increased risk for attention-deficit hyperactivity disorder. Other long-term health risks include an increased risk for obesity, diabetes, stroke and osteoporosis. This results in substantial cost to families and society in the form of increased medical care, increased educational needs and lower lifetime job achievement. The goal of the Prenatal Plus Program is to improve birth outcomes by reducing the prevalence of low-birthweight infants among Medicaid-eligible women in Colorado.

INTERVENTION

The Prenatal Plus Program is a Medicaid-funded program that provides care coordination, nutrition and mental health services to Medicaid-eligible pregnant women in Colorado who are at high risk for delivering low-birthweight infants. Prenatal Plus services complement medical prenatal care by addressing the behavioral, nutritional and psychosocial risks that contribute to low birthweight.

[1] http://www.cdphe.state.co.us/pp/womens/PrenatalPlus.html

Prenatal Plus team members empower women to make lifestyle changes that positively impact their pregnancies and result in healthy infants by using a client-centered counseling approach (See Section 4). The multidisciplinary team consists of a care coordinator, registered dietitian and mental health professional. Clients are seen in the office or at off-site visits throughout pregnancy and for two months following delivery. The Prenatal Plus team works with each client to:

- Improve her psychosocial and nutritional health status;
- Assist her in developing and maintaining healthy lifestyles during pregnancy and beyond, especially discontinuing the use of tobacco, alcohol, and illicit drugs;
- Increase her ability to appropriately use resources, including medical and social services.

Providing "model care" has shown the best birth outcomes. Model care consists of ten (10) total client contacts, in the office or at off-site visits. More specifics on the requirements for the service packages reimbursable through Medicaid are described in Section 9: Billing.

PROGRAM ELIGIBILITY

To qualify for the Prenatal Plus Program, a client must meet the following criteria:

- Currently receives regular Medicaid or is eligible for regular Medicaid and will initiate an application. Emergency Medicaid will **not** pay for Prenatal Plus services.

AND

- Is at high risk for delivering a low-birthweight infant using risk factors shown in research to be contributors to low birthweight. Refer to the *Intake Form* for the program's risk criteria and risk factor definitions.

PARTNERSHIP

The Prenatal Plus Program is a partnership between the Colorado Department of Public Health and Environment/Women's Health Unit and the Colorado Department of Health Care Policy and Financing/Acute Care Benefits Section. The Women's Health Unit oversees policymaking, administrative responsibilities, quality assurance activities, data collection and analysis, and training. The Department of Health Care Policy and Financing provides the funding for services through direct reimbursement to local providers, and also audits providers for compliance with Medicaid funding policies.

PROGRAM RESULTS

The Prenatal Plus Program has been effective in increasing the number of women who stop smoking, gain an adequate amount of weight and resolve psychosocial problems, and has decreased the number of infants who are born at low birthweight. Since 1996, the Prenatal Plus Program has consistently shown decreases in the low-birthweight rate for women who receive services, compared to Medicaid-eligible women who do not receive services. The annual report can be downloaded from the Prenatal Plus website and provides information on client outcome and risk resolution data.

A Prenatal Plus cost study completed in 2001 demonstrated the cost savings of providing Prenatal Plus services. The study concluded that for every $1 spent on Prenatal Plus services, $2.48 is saved in Medicaid costs annually. The short-term costs of delivering a low-birthweight infant are seen by increased length of stay in the hospital for newborns and the potential need for high-cost medical intervention. Long-term costs of delivering a low-birthweight infant are difficult to measure, but could include the need for on-going medical intervention and special programs for developmental or cognitive delays in childhood. Therefore, averting low-birthweight births among Medicaid clients through the Prenatal Plus Program results in cost savings to the state and taxpayers, and improved quality of life for the children of Colorado. A complete copy of the Cost Study Analysis is available on the Prenatal Plus website.

SECTION 2:
TEAM MEMBER ROLES

The Prenatal Plus Program uses a multidisciplinary team approach of a care coordinator, a registered dietitian and a mental health professional. The purpose is to provide a broad range of services that have been shown to improve birth outcomes. Sites are encouraged to hire staff members that reflect the cultural and ethnic background of the community in which they work.

PROGRAM COORDINATOR

The Prenatal Plus Program Coordinator is the primary contact person between the local agency and the Prenatal Plus Program Director at the Colorado Department of Public Health and Environment. This person is responsible for disseminating information such as e-mails, mailings, policies and procedures to the entire Prenatal Plus team. Effective communication skills are essential to keep all Prenatal Plus team members informed of program changes and updates. The Program Coordinator also reports any staffing or agency changes to the Prenatal Plus Program Director. In some agencies, the Program Coordinator also carries a caseload of clients and assumes the additional role of care coordinator, mental health professional or dietitian.

CARE COORDINATOR

The care coordinator is the hub of the multidisciplinary team and assesses the client's current strengths, needs and concerns. Care coordination is the central function of the Prenatal Plus service package. A supportive, encouraging, consistent relationship between the client and care coordinator is the vehicle for motivating positive behavior change. The care coordinator is the person responsible for interfacing with the client, the community and other team members. The care coordinator organizes resources and advocates for the client to assist her in accessing services to meet her individual needs. The care coordinator is the primary source for referrals to the registered dietitian and the mental health professional.

Care Coordinator Credentials

Professionally trained social workers, nurses, or other human service professionals are preferred as Prenatal Plus care coordinators. Other Prenatal Plus team members (registered dietitians or mental health professionals) may also serve as care coordinators. The expectation is that the professional holds a bachelor's degree in his/her field of expertise and, if applicable, has the ability to be registered or licensed in his/her profession. Registered nurses who hold a two or three-year degree or diploma may serve as care coordinators with adequate and relevant experience. Please contact the Prenatal Plus Program Director if there are questions about adequate and relevant experience.

Paraprofessionals (those without a bachelor's degree or nursing diploma, but holding at least a high school diploma or GED), with two years relevant work experience, may be considered for the position. All paraprofessionals must be under the direct supervision of a professional holding a minimum of a bachelor's degree and any applicable licenses.

Supervision of paraprofessionals must include, but is not limited to, bi-monthly face-to-face supervision sessions to review caseload size and consult about clinical and case management client issues. The supervisor must review and co-sign on all chart documentation within two weeks of any visit. In addition, the supervisor must conduct periodic in-depth chart reviews. Records documenting supervision must be maintained by the supervisor and made available upon request to the Prenatal Plus Program Director.

Care Coordinator Core Competencies

- Knowledge of basic information regarding the normal course of pregnancy, including physical and emotional changes, and the impact of abuse of tobacco, drugs and alcohol upon normal fetal development.

- A general understanding of basic nutrition, breastfeeding, postpartum depression and the risks associated with low birthweight and adverse birth outcomes.

- Strong verbal and non-verbal communication skills, the ability to convey empathy toward clients in a non-judgmental manner and strong, active listening skills.

- Ability to gather information and formulate an accurate assessment of client strengths and client needs.

- Commitment to the client-centered approach to working with clients and a belief in the empowerment model of client care.

- Sensitivity, respect and an appreciation for clients' diverse cultural backgrounds, including an understanding of the cultural environment of the larger community.

- Knowledge of community resources, expertise in resource referral and an understanding of the barriers to accessing care.

- Networking and teamwork skills, commitment to the model of multidisciplinary intervention and willingness to refer when appropriate.

- An ability to provide appropriate, accurate and timely documentation.

Care Coordinator Responsibilities

The care coordinator is the catalyst for entry into the Prenatal Plus Program and is responsible for facilitating and monitoring the care received by the client. This includes:

- Explaining the Prenatal Plus Program to prospective and enrolled clients, including information as to the number and type of visits, referrals for mental health and nutrition counseling, and the role of each team member.

- Confirming whether clients are currently receiving Medicaid or seem eligible for Medicaid.

- Ensuring all required paperwork is completed to satisfy the client record requirements (see Section 3: Client Chart).

- Reviewing client charts at each visit to ensure that all services are documented on the *Encounter and Risk Resolution Log* and that a matching progress note is recorded.

- Assessing client needs and making necessary referrals (i.e. medical provider, mental health professional, registered dietitian, WIC, food banks, housing, etc.)

- Advocating for services, when needed.

- Scheduling and facilitating multidisciplinary case conferences and documenting the results in the client record.

- Organizing client data and coordinating submission of data to the Women's Health Unit (see Section 8: Data).

- Arranging and providing home or off-site visits, if client is agreeable.

- Referring clients for postpartum follow up as appropriate (i.e., six-week postpartum medical exam, initial well child visit, family planning services, postpartum depression screening, etc.).

- Ensuring overall quality assurance standards of the client record.

- Adhering to the guidelines set by the Prenatal Plus Program through continued communication with the Prenatal Plus Program Director.

MENTAL HEALTH PROFESSIONAL

The Prenatal Plus mental health professional is the specialist for mental health issues and receives referrals directly from the care coordinator, or through an indirect means such as chart review or case conferencing. The mental health professional provides assessment and crisis intervention, brief therapy, networking within the larger community, case management and resource referral, consultation and education, and teamwork.

Mental Health Professional Credentials

A professionally trained mental health counselor, or clinical social worker, is required for the position of mental health professional. The expectation is that the professional will hold a master's degree, with the ability to be licensed in his/her field of expertise. Persons providing counseling in Colorado must be licensed, registered, certified or listed as an unlicensed therapist through the Colorado Department of Regulatory Agencies (DORA). There are a few exceptions to this rule, please contact DORA (303-894-7766) for further information.

Bachelor's level personnel with relevant experience may be considered for the position. Colorado regulations may require supervision by a master's level person for those persons holding a bachelor's degree. If required, supervision must include regular (i.e. monthly or weekly) face-to-face contact to review clinical cases, documentation and client issues.

Mental Health Professional Core Competencies

- Knowledge of human development and psychological theory as it relates to human behavior, pregnancy and addiction. A basic understanding of the normal course of pregnancy, the impact of pregnancy on relationships, and the dynamics of addiction and its effects on psychological and physical functioning.

- Strong assessment skills, incorporating the emotional, cognitive, social, cultural and physical aspects impacting human functioning. Be able to develop appropriate treatment plans and goals with the client as well as the ability to assess emergency situations and provide crisis intervention.

- Ability to communicate with clients, co-workers and other professionals in the community. This includes presentation of clinical findings in oral and/or written form, and documentation of client progress through the use of progress notes.

- Demonstration of networking and teamwork skills, commitment to the model of multidisciplinary intervention and a willingness to refer when appropriate.

- Sensitivity, respect and appreciation for clients' diverse cultural backgrounds, including an understanding of the cultural environment of the larger community.

Mental Health Professional Responsibilities

The mental health professional is the outpatient therapist for the Prenatal Plus client, and is responsible for providing direct clinical care, mental health referral and consultation to the Prenatal Plus team. This includes, but is not limited to:

- Contacting referred clients in a timely manner, not to exceed 2 weeks from the time of referral. The mental health professional is expected to be available to the client within 24 hours if the referral is considered an emergency, and be able to provide resources for emergency services.

- Conducting a face-to-face assessment of the client's situation (both psychological and social), and determining whether the client needs immediate, brief psychotherapy, or whether referral to long-term treatment is appropriate. If long-term treatment is indicated, the mental health professional will ensure the referral proceeds smoothly and will advocate for the client in other systems in order to secure services.

- Developing treatment goals with the client, and conducting outpatient counseling related to the stated goals. It is the responsibility of the mental health professional to ensure communication with the Prenatal Plus team concerning goals and treatment progress. This includes appropriate termination with the client and writing a summary of the treatment provided for the Prenatal Plus client chart.

- Actively participating in the team process by attending case conferences, providing expertise on individual client service plans, and providing consultation and education to the staff regarding community resources, psychological and social issues, and addiction problems

- Performing internal quality assurance activities, such as chart audits, to assess compliance and accuracy of referral criteria related to mental health issues

REGISTERED DIETITIAN

The Prenatal Plus registered dietitian is considered the specialist for nutrition issues. The role of the registered dietitian in the program is to perform nutrition assessments and interventions with clients identified as having nutritional problems, as well as provide technical assistance to the Prenatal Plus team. Nutrition intervention includes an individualized nutrition assessment, one-on-one client counseling, referral to other professionals as needed, follow-up, and communication with the client's health care provider and the other Prenatal Plus team members.

Registered Dietitian Credentials
The minimum credentials and competencies of the registered dietitian must include current registration with the Commission on Dietetic Registration as Registered Dietitian.

Dietetic interns in an internship program accredited by the American Dietetic Association may conduct nutrition assessments and consultation. An intern must be supervised by a registered dietitian who has agreed to serve as a preceptor for the intern. Supervision must include regular (i.e. monthly or weekly) face-to-face contact to review clinical cases, documentation and client issues.

Registered Dietitian Core Competencies

- Experience working in prenatal nutrition, and clinical and community nutrition is recommended.

- The ability to communicate effectively with a wide-range of people, including clients and other professionals in the community including the presentation of clinical findings, both oral and written, and documentation of client progress through the use of progress notes.

- Demonstration of networking and teamwork skills, including a commitment to the model of multidisciplinary team intervention.

- Sensitivity, respect and appreciation for clients' diverse cultural backgrounds, including an understanding of the cultural environment of the larger community.

Registered Dietitian Responsibilities
As the nutrition professional for the Prenatal Plus team, the dietitian is responsible for performing the following services:

- Contacting referred clients in a timely manner, not to exceed 2 weeks from the time of referral (or 4 weeks if the dietitian works once per month).

- Conducting face-to-face, comprehensive nutrition assessments and setting client-centered nutrition goals with clients. Time spent with clients is usually 45 - 60 minutes for initial appointments, and 30 - 45 minutes for follow-up appointments. Each appointment should include the following:

    - Review of the client's chart (especially the *Initial Assessment Form*) for personal information that impacts nutritional status, such as socioeconomic issues, cultural food practices, alcohol or drug use and physical activity.
    - Assessment of current weight gain using the required *Prenatal Weight Gain Grid* and the Institute of Medicine recommendations for weight gain.

- Completion of a diet recall to assess nutrient intake and availability of nutritious foods. Documenting client's actual diet history is optional. A summary of the findings is to be included in the nutritional assessment.
- Establishment of a client-centered nutrition goal, if appropriate, and if the client is receptive.

- Providing appropriate documentation of all patient contacts. Required documentation includes:

  - Recording all client contacts on the *Encounter and Risk Resolution Log*
  - Charting all client contacts using the *Dietitian Care Plan,* S.O.A.P. format (Subjective, Objective, Assessment, Plan) or another approved charting format
  - Recording client-centered nutrition goal(s) in the progress notes or on the optional *Service Plan*

- Actively participating in the team process by attending case conferences and providing nutrition input on client service plans.

- Providing consultation to the Prenatal Plus team on nutrition-related issues.

- Facilitating and promoting the sharing of information and services with WIC staff (if client's release of information allows) in a positive manner.

- Performing internal quality assurance activities, such as chart audits, to assess compliance and accuracy of referral criteria and use of the *Prenatal Weight Gain Grid.*

Collaboration with the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

All Prenatal Plus and WIC sites located in the same service area are encouraged to discuss ways to decrease duplication of services and to promote delivery of consistent nutrition messages to common clients. Information that can be shared (if the client's release of information allows) includes: weight gain grids, hematocrit values, diet assessment (24-hour food recall or food frequency), nutrition goals, and care plans.

Prenatal Plus nutrition consultation is an enhancement to standard prenatal care, including any high-risk services provided by WIC. Resource limitations in WIC dictate that dietitian encounters are brief and may result in referrals beyond WIC for many high-risk conditions, including referrals to the Prenatal Plus dietitian. The Prenatal Plus dietitian may see a high-risk client as often as needed throughout the pregnancy, and each encounter generally takes 30 to 60 minutes. Therefore, the Prenatal Plus dietitian services are more comprehensive than WIC high-risk counseling, both in time and content.

Because Prenatal Plus dietitian encounters are more extensive than WIC high-risk encounters, WIC encounters may not count towards the Prenatal Plus total encounters and do not meet the Prenatal Plus Program requirements for nutrition referrals.

At some sites the WIC dietitian and the Prenatal Plus dietitian are the same person. If the dietitian notices a client has a WIC high-risk appointment scheduled and realizes the client will be seen for Prenatal Plus dietitian services as well, the client should be moved off the WIC dietitian schedule and onto the Prenatal Plus dietitian schedule. Those agencies that share dietitian time between the Prenatal Plus and WIC programs must designate specific FTE to each program.

STAFF CHANGES

Notification of Staff Changes

When a member of the Prenatal Plus team leaves the program, the Prenatal Plus Program Director must be notified of the change as soon as it is known. It is the responsibility of the local Prenatal Plus Program Coordinator to provide this information either through a phone call, written correspondence or email.

Vacancies

If a specific discipline (care coordinator, registered dietitian or mental health professional) remains vacant for 30 days, the Prenatal Plus Program Coordinator must submit to the Prenatal Plus Program Director a written plan of action outlining how clients will have their needs met until a new staff member is hired. If a position remains vacant for 60 days, the Prenatal Plus Program Coordinator must provide a written statement of progress made in the hiring process and summary of how the action plan is working to provide for client needs while the position remains vacant. If a Prenatal Plus team position is still vacant at 90 days, and a complete multidisciplinary team is not available, then no new clients can be enrolled. The Prenatal Plus Program Coordinator will need to continue to submit monthly updates on the hiring progress as well as how the existing clients needs are being met until a new staff member is hired.

Training New Prenatal Plus Staff

It is the responsibility of each Prenatal Plus Program to provide program orientation and training for new staff members, including mental health professionals and registered dietitians working in the program. They are also required to receive training on HIPAA protocols through your agency. The Prenatal Plus Program Director must be contacted when a new staff member starts working in the program so that program orientation and technical assistance can be provided. In addition, all new employees in the Prenatal Plus Program must complete the *New Employee Information Sheet*, found on the Prenatal Plus website, indicating that they have read the Prenatal Plus Manual.

Sample Interview Questions for Prenatal Plus Team Positions

Optional Interview Questions for the Care Coordinator

- The program consists of a counselor, dietitian, and the care coordinators who all work together to provide non-medical care for women during their pregnancy. What experiences have you had working with an inter-disciplinary team to provide client services? What did you find difficult and what did you like about it?

- Can you describe a "client-centered" approach to services?

- Please tell about your experiences in public health.

- What experience do you have working with pregnant women at high risk for poor birth outcomes? What types of issues do you think you might be dealing with?

- Have you worked with Medicaid clients in the past? If so, in what capacity? What type of challenges do you foresee in working with women in this population?

- Describe how you would ensure effective communication among team members.

- Please talk about your personal philosophy as it relates to women who make questionable lifestyle choices while pregnant such as using drugs, alcohol or tobacco.

- Can you give an example of how you maintain boundaries with clients?

- How would you work with a patient who says she does not want to parent and is not happy about the pregnancy, however she plans to keep the baby?

- You just finished assessing a very high-risk client with multiple psychosocial issues. You feel she could benefit from counseling so you inform the client about services available to her. She declines these services and says she just wants to meet with you. How do you work with the client?

- Situation: A patient calls you at 4:30pm on a Friday afternoon stating that she was just evicted and is now homeless. What would you do?

- Describe a time when you were successful in reaching out into the community to find resources or attract clients to your clinic.

Optional Interview Questions for the Mental Health Professional

- The program consists of a counselor, dietitian, and the care coordinators who all work together to provide non-medical care for women during their pregnancy. What experiences have you had working with an inter-disciplinary team to provide client services? What did you find difficult and what did you like about it?

- Can you describe a "client-centered" approach to services?

- Can you describe your experience working with the Medicaid population? What type of challenges do you foresee in working with women in this population?

- How would you separate your role as a counselor from that of the care coordinator?

- Can you give an example of a time when a client responded positively to your counseling advice and an example when it was difficult to establish a relationship with a client?

- Can you give an example of how you maintain boundaries with clients?

- You have just met with a very high-risk client with multiple psychosocial issues that would likely benefit from long term counseling, however when you recommend it the client is very resistant and prefers to just meet with you. How do you work with the client?

- You are meeting with a client who has just told you she is feeling depressed with suicidal ideations. What would you do?

Optional Interview Questions for the Registered Dietitian

- The program consists of a counselor, dietitian, and the care coordinators who all work together to provide non-medical care for women during their pregnancy. What experiences have you had working with an inter-disciplinary team to provide client services? What did you find difficult and what did you like about it?

- Can you describe a "client-centered" approach to services?

- Can you describe your experience doing one-on-one nutrition counseling with patients? What do you enjoy about one-on-one counseling sessions, what do you find difficult?

- What experience do you have with maternal nutrition? What interests you about working with pregnant women?

- Can you describe your experience working with the Medicaid population? What type of challenges do you foresee in working with women in this population?

- Can you describe a time when you felt you were innovative in providing nutrition care to a patient?

- The typical weight gain during pregnancy for a woman of normal weight prior to pregnancy is 25-35#. How do you think you would counsel someone who, when told this, states she only plans to gain as much weight as the baby will weigh (usually ~7#)?

- How would you approach a woman who tells you she hates most fruits and vegetables, can't drink milk, and the smell of meat "grosses her out" during pregnancy?

- How would you approach a woman who says that she is nervous about gaining weight and "has had a hard time with food" for the last few years, she also tells you that family members have been worried about her eating behaviors?

- Sometimes patients disclose other struggles in their life including homelessness, depression, domestic violence situations, parenting difficulties, and unresolved feelings about the pregnancy. How do you feel about discussing these topics and what would your approach be with the client who begins to talk about these issues?

- Some of the women in the program may be using drugs during their pregnancy. How would you respond to a woman who tells you she is using marijuana every day and that it is the only thing that gives her an appetite so she can eat?

- You meet with a very quiet 15-year-old in her 4th month of pregnancy. She has gained only two pounds during this pregnancy, does not know how to cook, and does not have a permanent residence. She also smokes two packs of cigarettes per day. What would you do?

SECTION 3:
CLIENT CHART

DOCUMENTATION STANDARDS

The client's chart is a legal document, and must follow medical and legal standards. The client's chart is also used to determine whether services billed to Medicaid were in fact provided to the client. The following standards are to be used when documenting information in the Prenatal Plus client record:

- All entries must be dated and signed with the provider's first initial, last name, title and degrees or licenses held.

- Do not leave any blanks. If the question doesn't apply, write, "N/A", meaning "not applicable".

- If an error is made, a single line with black ink must be drawn through each line of the incorrect information, leaving the original writing legible, marked "error" and initialed and dated at the end of the crossed out section by the person who made the original entry. The correct information must then be written. Do not change another person's note under any circumstances.

- Be sure that every page contains sufficient information to identify the client.

- Write in black ink for copying purposes.

- Write legibly or type notes.

- Document all contacts with client, including phone calls.

- Chart immediately to ensure that important information is not forgotten.

- Ensure that each entry describes:
  - Type of contact (telephone call, office, home/off-site)
  - Information given or discussed
  - Outcome of contact
  - Plan for follow-up, next contact

- Use only clinic approved abbreviations and symbols.

- Draw a line through any empty space at the end of an entry.

- Do not use white out or pencil; do not scribble over, or in any other manner obliterate any entry.

- Do not use names without describing their function in relation to the client (e.g. do not write "referred to Sally Smith").

- Do not try to squeeze in extra words on a line and/or write between the lines.

- Do not use client names, or names of family members, in the notes. Refer to the client as "client" or use initials to abbreviate a name.

CLIENT CONFIDENTIALITY

Prenatal Plus client records contain highly sensitive information. It is required that the agency providing Prenatal Plus services have Health Insurance Portability and Accountability Act (HIPAA) compliant policies and procedures regarding the protection of client records, including both the standards of confidentiality, as well as the exceptions to confidentiality (i.e., child abuse regulations). These policies must include the circumstances under which a release of information is required. As a Medicaid provider, Prenatal Plus agencies are required to use a HIPAA-compliant authorization to release information (see p. 9-10 of this section for more information). This form is to be used for disclosures of client information except for: treatment, payment and operations, disclosures to the client herself, and for other permitted disclosures (public health reporting, abuse, etc.). In addition, under certain circumstances the release of client information is further regulated. See the information below for more details on these circumstances.

Psychotherapy Notes

The mental health professional may choose to keep documentation of client encounters separate from the main Prenatal Plus client chart. It is always up to the discretion of the mental health professional whether psychotherapy notes will be released, even to the client herself. If the mental health professional chooses to release psychotherapy notes, then a HIPAA-compliant authorization that specifically indicates these notes are to be released must be used. An authorization for release of psychotherapy notes may not be combined with a standard authorization. Refer to the Department of Regulatory Agencies (DORA) and the Colorado Revised Statutes for further information about regulations regarding mental health counseling.

Drug and Alcohol Information

Drug and alcohol information is regulated under **Federal Statute 42 C.F.R. Part 2**, and must be specifically identified in order to include this information when information is released. The Federal statute is entitled "Confidentiality of Alcohol and Drug Abuse Patient Records" and these regulations cover any information (including information on referral and intake) about alcohol and drug abuse patients obtained by a program. The program is **required** to give notice to patients of the Federal confidentiality requirements. A sample *Notice for Clients* is included at the end of this section and may be copied and used by Prenatal Plus Programs. Please contact the Prenatal Plus Program Director if you would like a copy of the Federal statute or if you have questions.

Medicaid Eligibility Information
HIPAA allows a covered entity, such as the Prenatal Plus Program, to disclose the minimum necessary PHI (45CFR164.502(b)) for purposes of payment (45CFR164.506(c)(3)). The only information a provider would need for its payment activities is whether or not a Medicaid client was eligible on a particular date. Providers who are assisting Medicaid applicants in resolving application issues are acting as client representatives for purposes that go beyond payment. Seeking information beyond eligibility for the purpose of helping applicants understand why they were denied and how to remedy the problem through appropriate documentation does not fall under the definition of payment. A provider acting in this representative capacity must obtain an authorization for release of information from the client.

REQUIRED FORMS

The Prenatal Plus Program has required forms that must be used for documentation by all agencies. These include:

Intake Form
Initial Assessment Form
Prenatal Weight Gain Grid
Encounter and Risk Resolution Log

Intake Form
The Prenatal Plus Program enrolls women at risk for delivering low-birthweight infants by using risk factors for low birthweight to determine program eligibility. The *Intake Form* is the first step in identifying these risks and enrolling a client in the Prenatal Plus Program. This form is a brief assessment of a client's risk factors for poor birth outcomes. Factors that risk the client into the program may be identified during the first visit, and then as the provider forms a relationship with the client, additional concerns may become apparent and can be added to the risk criteria.

The *Intake Form* lists the absolute and conditional risk criteria for enrollment into the program. Absolute criteria, the category in which the client needs only one risk factor to enroll into Prenatal Plus, are listed at the top of the form. Conditional criteria, the category in which the client must have a minimum of three factors to enroll into the program, are listed at the bottom of the form. If the client is enrolled due to meeting one of the absolute criteria, then she is eligible for a Full Plus package of services. Refer to the *Intake Form* for a full list of risk factors and their definitions.

The *Intake Form* can be filled out by one of the Prenatal Plus Program staff or may be completed off site by referral sources to the Prenatal Plus Program such as, obstetric office staff, Department of Human Service caseworkers, WIC staff and school personnel. When completing the *Intake Form*, the staff person must complete all sections of the form and sign the form. A completed copy of the *Intake Form* must be included in the client record at enrollment.

Initial Assessment Form

The purpose of the *Initial Assessment Form* is to provide the Prenatal Plus team a complete, in-depth picture of the client's functioning, both past and present, in the areas of physical health, nutrition, housing and income, mental health, support systems, family structure and substance use (i.e. drugs, alcohol, and smoking). The *Initial Assessment Form* provides an assessment of priority areas, referrals, and the client's strengths and issues. The *Initial Assessment Form* is a working document that can be used to engage the client in discussions of client-centered goals, to identify referrals to the Prenatal Plus registered dietitian or mental health professional and to follow-up on issues that need to be addressed with the client. Refer to the *Initial Assessment Form* for a list of all questions.

After it has been determined that the client meets the risk criteria for enrollment (see *Intake Form*) and the client has agreed to participate in Prenatal Plus (signed a consent for Prenatal Plus services), the *Initial Assessment Form* must be completed. The care coordinator may choose to complete the form with the client during the initial interview, or have the client complete the form independently and review it with the care coordinator at a later date. The *Initial Assessment Form* must be completed and reviewed with the client within the first month of enrollment.

The care coordinator is typically the person on the team responsible for reviewing the form with the client. However, any member of the Prenatal Plus team may review the form with the client and sign off as the Prenatal Plus staff member. When reviewing the form with the client, it is important to document follow-up on responses. Documentation can be done on the *Initial Assessment Form* or in the progress notes section of the client's chart. The follow-up documentation must include additional information from the client, information or education provided to the client, and referrals both internally to the Prenatal Plus dietitian or mental health professional, and externally to other resources the client needs. The last page of the *Initial Assessment Form* pinpoints the areas of education and resources the client requests.

If the client does not want to answer a question, make a brief note on the form, such as "client declines". It is the expectation that all members of the Prenatal Plus team have access to the completed form in order to develop a consistent and on-going picture of the client's functioning and to plan accordingly.

It is important that the client signs and dates the bottom of the form for two reasons: first, this reinforces the client's acknowledgment of her participation in the Prenatal Plus Program; second, the *Initial Assessment Form* must be completed for billing purposes (see Section 9: Billing).

Prenatal Weight Gain Grid

Weight gain during pregnancy is an important predictor of birth outcome. Inadequate weight gain during pregnancy may result in intrauterine growth retardation, low birthweight and premature delivery. Excessive weight gain during pregnancy may be related to preeclampsia or postpartum weight retention. Therefore, tracking and assessment of weight gain, and referral to the Prenatal Plus dietitian if needed, are requirements of the Prenatal Plus Program. Use the *Prenatal Weight Gain Grid* to monitor this. This grid must be completed for all Prenatal Plus clients.

The *Prenatal Weight Gain Grid* shows the recommended weight gain range for a pregnant woman. The recommended range depends on a ratio of the woman's height and pregravid weight, otherwise known as body mass index (BMI). The *Prenatal Weight Gain Grid* lists the total recommended weight gain, according to BMI category. The rate of weight gain is shown as an upward sloping line on the grid, and is a different sloped line for each BMI category.

Determining BMI

After obtaining the height and known or estimated pregravid weight of the woman, use a BMI Chart or BMI Wheel made for pregnancy to determine if the woman is underweight, normal weight, overweight or obese. BMI is a better indicator of nutritional status than weight alone.

Example: A 5'4" (64") woman with a pre-pregnancy weight of 160 pounds has an estimated BMI of about 27.5, and therefore has a high BMI (overweight).

When pregravid weight is unknown, the agency should use the most current weight and height, determine a BMI category, and begin plotting on the appropriate BMI category line. Most women will not change an entire BMI category during their pregnancy. Selecting the BMI category line that most closely represents their BMI category (low, normal, high, or obese) will allow you to better assess weight gain trends and appropriate rate of weight gain for their pregnancy. This policy is consistent with the Women, Infants and Children (WIC) protocols for plotting on the weight gain grid when pregravid weight is unknown.

The National Academy of Sciences Subcommittee on Nutritional Status and Weight Gain during Pregnancy established the following BMI categories as the standard for determining the recommended weight gain for pregnant women. The cutoff points correspond in general to the standards used in past years, 90, 110, 120, and 135 percent of the 1959 Metropolitan Life Insurance Company's weight for height standards.

Low:	BMI <19.8
Normal:	BMI 19.8-26.0
High:	BMI 26.1-29.0
Obese:	BMI >29.0

Completing the Prenatal Weight Gain Grid

- Record all information in the upper left section, including the client's BMI.

- At the bottom of the grid, record the client's weight, the date the weight was taken and the change in weight from the last visit below the appropriate week of gestation. Plot the weight for each visit, according to the week of gestation on the grid.

- Record and plot weight as often as available, at least once per trimester. For each weight plotted, assess whether the client's weight gain is appropriate. To assess adequacy of weight gain, use the criteria for referral to the dietitian (see Section 5: Referrals). If the client's weight status requires a referral to the dietitian, make the referral and document it in the client's chart.

Recommended Weight Gain During Pregnancy

All pregnant women, regardless of age or race, must be advised to follow the weight gain recommendations listed below. Note the separate weight gain range for multiple gestations.

Prepregnancy BMI	**Target weight gain range**
Low <19.8	28-40 pounds
Normal 19.8-26.0	25-35 pounds
High 26.1-29.0	15-25 pounds
Obese >29.0	15 pounds
Twins (regardless of BMI)	35-45 pounds

Encounter and Risk Resolution Log

All client contacts must be recorded on the *Encounter and Risk Resolution Log* with the date of contact, provider, type of encounter, place of encounter and the provider's initials. No-show appointments and cancellations must also be documented on the *Encounter and Risk Resolution Log*. All contacts written on the *Encounter and Risk Resolution Log* must have matching progress notes that correspond to the date noted on the form. Types and places of encounter are defined below.

Types of Encounters

Case Management

The care coordinator (CC) must use the "C" code for all contacts with a client.

Nutrition Counseling

The registered dietitian (RD) must use the "N" code for nutritional counseling. It is understood that some nutrition discussion will occur in the course of care coordination, yet this coding is specific to the enhanced counseling provided by the nutrition specialist.

Psychosocial Counseling
The mental health professional (MH) must use the "P" code for psychosocial counseling. Again, the care coordinator may need to have some conversations related to psychosocial issues, yet the primary responsibility for counseling rests with the mental health professional as the specialist for this area.

Group Visit
Group contacts must be therapeutic in nature, with an emphasis on facilitating the group dynamic to further the discussion. Group visits are usually conducted in a circular arrangement with the professional as the facilitator among the participants. Educational classes, where the communication is primarily one-way, are more likely to be set-up classroom style with the professional as the instructor, and do not qualify as group visit encounters.

Group visits for Prenatal Plus clients meet the definition of an encounter under the following conditions:

- The group discussion must have the appropriate emphasis. For example, mental health groups might address issues of violence, effective coping skills, or dealing with depression. Nutrition groups might address prenatal weight gain, gestational diabetes, or concerns about breastfeeding.

- The facilitator of the group must be a mental health professional or registered dietitian, as appropriate. The groups may be co-facilitated by the care coordinator, but the primary responsibility for leading the group remains with the mental health professional or registered dietitian.

- Group sessions must be at least 45 minutes in length.

Places of Encounters
Office visit
An office visit occurs when there is direct face-to-face contact with the client at the site of the Prenatal Plus agency.

Telephone contact
One telephone contact during the course of Prenatal Plus services may substitute for one face-to-face contact. The telephone contact must be accompanied by corresponding documentation in the form of a progress note addressing issues discussed with the client. Calls to reschedule an appointment or to make an appointment with a client may **not** be considered a contact.

Home/Off-Site Visit
A home or off-site visit provides Prenatal Plus team members the opportunity to develop a relationship with the client in a space that is away from the traditional office setting. Clients may be more relaxed and forthcoming. Visiting the client's home provides an opportunity to observe the client's current living situation. As a result, certain factors may

be identified that could facilitate or impede her progress with risk reduction and/or risk resolution. To best assess client needs and impact risk resolution and birth outcomes, it is recommended that home or off-site visits occur as early in the pregnancy as possible. Any member of the Prenatal Plus team may do home/off-site visits. However, a postpartum nursing assessment cannot count as a Prenatal Plus home/off-site visit, as Prenatal Plus is a non-medical program.

If a client does not want a home visit, she may be willing to meet at some other off-site location. In addition, as of January 1, 2008 the home or off-site visit is no longer a requirement for providing model care. See Section 9: Billing for new requirements.

Risk Resolution

Clients' initial risks and risk resolution must be recorded on the *Encounter and Risk Resolution Lo*g. If a client is initially not at risk in a specific category, the care coordinator must indicate this on the form. However, if at some point it becomes clear the client is at risk, the care coordinator must change the initial risk to reflect the most current assessment (e.g., client has weight loss in the 2nd trimester or drug use is identified in later discussion).

REQUIRED DOCUMENTATION

There are some areas of care that must be documented in the client chart; however, the form or method of documentation is up to the discretion of the agency. These areas of documentation include:

Prenatal Plus Program Consent
Authorization to Release Information Form
Referrals
Case Conference
Service Plan
Progress Notes and Follow-up
Dietitian Care Plan, if seen by registered dietitian

Prenatal Plus Program Consent

The Prenatal Plus Program is a voluntary case management program. It is important to document the client's agreement to participate in the program through the use of a program consent form. From a legal standpoint, a signed consent form provides documentation of an agreement to services. It also encourages empowerment on the part of the client by agreeing to service and informs the client of what to expect during the course of the program.

It is best to use a separate consent form specific to the Prenatal Plus Program to avoid any confusion with other services provided by the agency. The advantage to this is that the client is aware of the specific program in which she is enrolling. If agencies choose to use a consent form for participation in all of their programs, it must include a statement specific to the services provided by the Prenatal Plus team. Refer to the *Prenatal Plus Consent Form* for an example.

All program consents must include:

- Name of the agency
- Name of the specific program in which the client is enrolling, with some description of the services provided, i.e., care coordination, number of visits, types of visits, i.e. office visits, home visits, off-site visits
- A statement describing HIPAA confidentiality requirements, except in the case of mandatory reporting
- A statement explaining that data is collected for program evaluation purposes
- A statement that services are voluntary and the client can choose to withdraw at anytime with notice to a Prenatal Plus team member
- Provider's signature, title and/or licensure, or degree
- Client's signature and date signed

Authorization to Release Information
Agencies may use their own authorization form for Prenatal Plus clients, or they may use the *Authorization to Release Information Form* provided on the Prenatal Plus website. A separate form must be signed for each individual release of information. A "blanket" release listing multiple agencies without any specifics, which is signed at the start of the woman's enrollment in the program, is **not** HIPAA-compliant.

Information that must be included on the *Authorization to Release Information* Form:

- Name and address of agency and program releasing information
- Name and address of **specific** agency, or program to which the information is being provided or released
- Client's name
- Birth date (optional)
- **Specific information to be released**, i.e., name, pregnancy status, weight gain information, psychosocial history*, drug abuse information**, etc.
- **Purpose for release**, i.e., coordination of care, communication regarding housing, etc.

* See information on page 2 of this section for more details on releasing this type of information.

- Statement that authorization may be revoked by the client
- Statement that authorization is not a condition of receiving services from your agency
- Date, event or condition upon which authorization will expire
- Client signature and date signed

The original signed *Authorization to Release Information* form must be included in the client's chart, a copy provided to the client and a copy sent to the agency or person with whom the information is to be shared.

Information may be shared with staff members working in the Prenatal Plus Program without a signed release. The *Prenatal Plus Consent Form* states the client agrees to treatment, and as the team members are part of providing treatment, they are exempt from HIPAA.

Referral Documentation

A key component and unique aspect of the Prenatal Plus Program is the use of a multidisciplinary team. The registered dietitian and mental health professional are pivotal to helping improve outcomes for high-risk women and their infants. The program has specific requirements regarding referral to these specialists (see Section 5: Referrals). All referral information must be documented in the client's record. Agencies may choose to develop a referral form specific to the needs of their particular agency, or may use the *Referral Form* provided. Place a copy of the form in the chart and provide a copy to the recipient of the referral. Agencies may also document a referral in the client's progress notes or on the *Initial Assessment Form*. The following information must be included when documenting a referral:

- Name of the agency/person referring the client, including contact information
- Name of agency/person to whom the client is being referred, including contact information
- Reason for the referral
- Outcome of the referral, including client's acceptance or refusal and follow-up

If the client is being referred outside the Prenatal Plus team, the agency must have a signed *Authorization to Release Information*.

Case Conference
The purpose of the case conference is to identify the client's needs for the course of the Prenatal Plus services using the expertise of all members of the multidisciplinary team. The case conference helps to ensure that the client is receiving the most comprehensive services and thereby increases the likelihood of a positive outcome.

Case conferences are *required* for clients who receive model care. For these clients, only one case conference is mandated, preferably as early in the pregnancy as possible. Those team members involved with a client are required to attend the case conference for that client, with the requirement that at least one care coordinator, mental health professional and dietitian are present. Team members may participate in case conferences by speaker phone.

The case conference must be documented. Agencies may use the C*ase Conference Form* on the Prenatal Plus website or create an agency-specific form, or document the conference in a progress note. The following information must be included:

- Date of conference
- Name of client
- Members of the Prenatal Plus team present, including those participating by phone
- Client's goal, strengths and barriers
- Other issues discussed and recommendations
- Any referrals made and follow-up
- Intervention plans and person(s) responsible

The *Case Conference Form* may be forwarded to other personnel providing care to the client, to ensure communication and promote collaboration. If the case conference form is sent outside the agency, a release of information form must be included.

Service Plan
A *Service Plan* provides the framework for the client and the care coordinator to work together to create client-centered goals. The care coordinator helps the client identify issues and concerns from the *Initial Assessment Form* or through conversation. The client's goals, identified using the client-centered counseling approach, must be documented in the chart. Agencies may use the *Service Plan* developed by the Prenatal Plus Program or may document goals in a progress note following the guidelines listed below.

Developing a service plan allows the client and the care coordinator to define issues and work together to create positive change in the client's life. A completed service plan must be in the client record no later than the 3rd visit following client enrollment into Prenatal Plus, this is estimated to be within 6-8 wks. Updates must be documented at each appointment.

Helping the client set goals promotes behavioral change that can accomplish risk resolution, thereby increasing the opportunity for a healthy outcome. Any Prenatal Plus team member can set goals with the client. More often than not, a client's most pressing issue is something different than what the team member might identify. People are far more motivated to change behaviors that they identify they want to change.

In working with clients, developing a service plan helps them prioritize their needs, identify strengths and barriers to meeting those needs, and break down the steps of problem solving into small, measurable goals. Below are tips for using a service plan with clients to set client-centered goals.

- **Address immediate needs first**. This will show the client you are concerned about her well being, will help establish rapport with the client and develop a trusting relationship.

- **Complete the service plan with the client.** Ask the client questions to elicit necessary information. Do this during a separate visit from the *Initial Assessment Form*, as it can be overwhelming for clients to complete them at the same time.

- **Ask the client to identify a behavior she wants to change**. You may identify several areas in the client's life that need improvement. Use the service plan to help the client prioritize and work on the one thing she identifies she would like to change first.

- **Work on just one goal**. For clients who have trouble identifying problems to work on, use the *Initial Assessment Form* as a starting point for discussing potential focus areas with the client.

- **Assess the client's stage of change** for the problem she chooses to work on. Use the stage of change assessment to help determine the intervention. Refer to Section 4 for more information on the stages of change.

- **Support the client's efforts to change**. Provide information and choices that will be helpful during the decision making process.

- **Help her identify her strengths** and document them in the progress notes or on the *Service Plan*.

- **Help the client identify one small, measurable step she can accomplish before her next appointment** that will move her in the direction of achieving her larger goal.

- **Revise the goal if needed.** Sometimes the client is not able to continue to work on the goal she identified Work with the client to identify what barriers prevented her from achieving her first goal, and help her to create a new goal.

Progress Notes
Progress notes include a description of the issues discussed, the client's affective state and any resolution regarding the concerns. Follow up on the status of nutrition, psychosocial and behavioral risks at each encounter. Review, update or change the client's service plan and goals as appropriate. Document follow-up on referrals made to other resources, including that the client is receiving medical care. Document missed appointments with care coordinators, registered dietitians and mental health professionals and follow-up. Sign all progress notes. If a paraprofessional is providing the services, the supervisor must co-sign within 2 weeks of the encounter.

The mental health professional may choose to keep documentation of client encounters separate from the main Prenatal Plus client chart. If the mental health professional keeps client psychotherapy notes separate from the client chart, then he/she must also document a brief note in the Prenatal Plus chart to demonstrate that an encounter occurred and any plans for follow-up.

Dietitian Care Plan
If the client chooses to see the registered dietitian, there must be documentation of an initial nutrition assessment. The Prenatal Plus dietitian may use the optional *Dietitian Care Plan* for documentation, or may use another form or progress notes that follow the SOAP format. A copy of the *Dietitian Care Plan* may be sent to the WIC Program, with a signed release of information.

WITHDRAWAL FROM THE PROGRAM

Clients who are withdrawn due to missed appointments must have at least three attempted contacts documented before withdrawal. It is recommended that a certified letter, return receipt requested, be the third and final step in this process. Notify client that she will no longer be enrolled in the program if there is no contact from her by a specific date. Place the return receipt from the certified letter in the client's chart.

Notice for Clients
Confidentiality of Alcohol and Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless:

(1) The patient consents in writing;

(2) The disclosure is allowed by a court order; or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.)

(Approved by the Office of Management and Budget under control number 0930-0099)

SECTION 4:
CLIENT-CENTERED COUNSELING

Client-centered counseling is an approach to working with clients that allows both the provider and the client to focus and prioritize on small goals during each session. Counseling in this context does not mean ongoing therapy. It is the totality of communication, both verbal and non-verbal, made in the context of feelings. Counseling, as used here, is the work of supporting someone in the process of making positive decisions. The client-centered model has been called a "feelings first" approach that allows the partners, the client, and the provider, to work together to achieve positive results. In client-centered counseling, the focus is on the client's concerns and interests.

Client-centered counseling has many benefits in terms of client risk reduction, behavior change, client satisfaction and counselor effectiveness. Unlike the medical model of patient education, in this model the provider, or care coordinator, listens rather than speaks, offers options rather than directs, and provides support rather than advises. The counselor brings to the client-centered interaction a set of skills that can enable the client to reach a better understanding of the problem, deal with the attendant feelings and concerns, and assume responsibility for evaluating alternatives and making choices.

Effective client-centered counseling in Prenatal Plus can:

- Help clients prioritize their needs
- Negotiate a workable plan
- Support behavior changes
- Empower clients to continue to make decisions that are good for them and their infants

Try these tips to keep your work with clients interactive and productive:

- Solicit information from clients
- Reinforce knowledge, confirm accuracy
- Provide a brief, easily understood response to client's information needs
- Check to confirm understanding and solicit questions

CLIENT-CENTERED GOAL SETTING

A key element in client-centered counseling is goal setting. The process of goal setting helps clients define specifically what behavior they want to change, and to develop a plan for change. Each client contact should be unique and tailored to the specifics of what is happening at that time to the client. To be effective in working on behavior changes with a client:

- Ask the client to identify a behavior she wants to change
- Ask the client for possible solutions
- Praise her willingness to make change
- Deal with just one change at a time, if there is more than one change, ask which is most important
- Help the client weigh the pros and cons of each possible solution
- Break the behavior change down to small, achievable, measurable steps
- Avoid scare tactics because they are usually not effective for a behavior that is done repeatedly (such as smoking)
- Allow the client to select solutions and implement a plan
- Make a contract with the client to encourage her to agree to the changes she will make (this is the Service Plan)

THE STAGES OF CHANGE MODEL

Prochaska JO, DiClemente CC, Norcross JC. In search of how people change. Am Psychol 1992; 47:1102-4.

Assessment and Appropriate Intervention In Behavior Change Counseling

Before setting a goal with the client, the care coordinator should assess the client's readiness to change. The purpose of assessing the client's readiness to change is to ensure the greatest possibility for success. This is a period of exploration for the client, which can serve an educational purpose. Even if the client determines not to change certain risky behaviors, the contemplation process begins to promote a new way of thinking about old behaviors. Thus, information introduced during the assessment stage can help foster insight, which may lead to change later. The stages of change and the level of intervention the care coordinator may choose to impact the change are described below.

Precontemplation

Client's Role
The client is not yet or not currently considering the possibility of change, i.e., she is motivated *not* to change. Client may not be interested in talking about a change or may be defensive. The four reasons a client may be in precontemplation are the four "Rs":

- *Reluctance*- through lack of knowledge or through inertia does not want to consider change; not resistant, but reluctant

- *Rebellion*- has a heavy investment in the problem behavior and in making her own decisions, resistant to being told what to do, appears hostile and resistant

- *Resignation*- lack of energy and investment, has given up on possibility of change and seems overwhelmed by the problem

- *Rationalization*- has all the answers, it feels like a debate when talking

Care Coordinator's Role
In general, give information to raise her awareness of the problem and the possibility of change. Have her explore the drawbacks of staying the same and the benefits of changing. Validate her reasons for not wanting to change. Specifically address the appropriate "R":

- Provide information in a sensitive, empathetic manner.

- Provide choices.

- Instill hope, explore barriers.

- Listen empathetically and reflectively, acknowledge what she says and add to it the other sides of the issues.

- Be respectful and considerate, it will probably take time for her to work her way out of precontemplation.

- Plant a seed and leave the door open.

Contemplation

Client's Role
This period is characterized by ambivalence; the client both considers change and rejects it. She has reasons for concern and justifications for unconcern. The client is willing to consider the problem and the possibility of change. This offers hope. However, ambivalence can make contemplation a chronic condition. Contemplation is not commitment. Ambivalence is the archenemy of commitment and a prime reason for chronic contemplation.

Care Coordinator's Role
- Help her work toward resolving her ambivalence, have her explore issues and examine consequences.

- Have her compare the pros and cons of staying the same to the pros and cons of making a change.

- Further help her resolve her ambivalence by using information about past change attempts to increase self-efficacy, get her to see "some success" instead of "failure," help her develop an attitude of "want to" instead of "have to."

Determination/Preparation

Client's Role
The client's statements reflect a good deal of what might be judged to be "motivation." This stage represents preparation as much as it does further developing determination. She may be making some changes already. Commitment to change does not necessarily mean that change is automatic, that change methods used will be efficient, or that the attempt will be successful in the long term. All ambivalence is not necessarily resolved. The decision-making process continues. This stage offers a window of opportunity. If the client enters into action, the change process continues; if not, the client slips back into contemplation.

Care Coordinator's Role
- Assess her strength and level of commitment; continue to help her resolve her ambivalence.

- Help her to determine the best course of action to take in seeking change.

- The task is not one of motivating so much as matching and helping her find a change strategy that is acceptable, accessible, appropriate, and effective.

- Help her to explore the plan and focus on details, anticipating problems and pitfalls.

- Help her prepare mentally, emotionally and practically to do what will be required.

Action

Client's Role
Client engages in particular actions intended to bring about change. The client often uses the meeting with the care coordinator to:

- Make a public commitment to change.
- Get some external confirmation of the plan.
- Seek support.
- Gain greater self-efficacy.
- Create artificial external monitors of her activity.

Change requires building a new pattern of behavior. It takes time to establish this new pattern. This stage typically takes 3-6 months. Relapse is always possible.

Care Coordinator's Role
These efforts may or may not be assisted by formal counseling. If the care coordinator is involved in counseling the task is to:

- Help her take steps toward change.
- Help her increase her self-efficacy.
- Reaffirm her decisions.
- Focus on successful activity.

Help her identify and use strategies to prevent relapse. Specifically counsel her to anticipate and to prepare to survive any relapse crisis situations (situations that will challenge her new position and tempt her to go back to old behavior).

Maintenance

Client's Role
Client attempts to sustain the change accomplished by previous action, and to prevent relapse. May be maintaining strict changes or may occasionally be slipping. Slips are common, but can lead to full-scale relapse if not addressed. Relapse is always possible.

As time goes on, if relapse does not occur, the change requires less effort and vigilance and becomes routine. If maintenance continues, the changes ultimately become habits and the client's identity evolves to incorporate the changes.

Care Coordinator's Role

- Teach the difference between just "maintaining" the status quo versus working through a "trial and error learning period."

- Help her know what to expect, feedback concerning the length of time it takes to accomplish sustained change and the fact that some situations or cues can bring back a flood of memories associated with the problem behavior.

- Help her identify and use strategies to prevent relapse, have her periodically review her reasons for making the change and identify the benefits that have resulted from the change.

Relapse/Recycle

Client's Role

- Full-scale return to previous behavior with no pretense of continuing the changes, client surrenders, relapse begins and progresses for many reasons.

- The client may experience a particularly strong, unexpected urge or temptation and fail to cope with it successfully.

- Sometimes relaxing her guard or testing herself begins the slide back.

- Often the costs of the change are not realized until later, and the commitment or self-efficacy erodes.

- Most often relapse does not occur automatically, but takes place gradually after an initial slip occurs.

Care Coordinator's Role

The client's task is to go back and start again through the stages, beginning with contemplation, rather than getting stuck in relapse or returning to precontemplation. The care coordinator's task is to help the client:

- Avoid discouragement and demoralization.

- Continue contemplating change.

- Renew determination and preparation.

- Resume action and maintenance efforts.

SECTION 5:
REFERRALS

The multidisciplinary team is a unique component of the Prenatal Plus Program that allows access to a variety of professionals to meet client needs and resolve risk factors. It is important to have the registered dietitian and the mental health professional available for enhanced nutrition and supportive counseling services. If services beyond those provided by these team members are needed, clients should be referred to providers outside of Prenatal Plus. If the client is being referred outside the Prenatal Plus team, the agency must have a signed *Authorization to Release Information*.

REFERRALS TO THE REGISTERED DIETITIAN OR MENTAL HEALTH PROFESSIONAL

When To Refer

Most clients will have either nutrition or psychosocial risk factors that qualify for a referral to the dietitian and/or mental health professional. The need for a referral can be identified using the *Intake Form*, the *Initial Assessment Form*, or through client request and personal interview. While the *Intake Form* briefly lists the criteria for entry into the program, the *Initial Assessment Form* takes an in-depth look at the issues facing a client. There are specific sections that identify both nutrition and psychosocial risks. In addition, on the last page of the *Initial Assessment Form* the client can identify specific education and resource needs. This information can be used as a starting point for making appropriate referrals.

The purpose of a referral to the mental health professional in the Prenatal Plus Program is for brief psychotherapy. If the client needs long-term treatment, the client should be referred to an agency designated to provide for these needs. The purpose of the referral to the dietitian is for brief enhanced nutrition counseling.

The mental health professional or dietitian should see the client within two weeks of a referral. However, some Prenatal Plus sites use contract dietitians who see clients once per month. In this case, the dietitian should be scheduled to see the client within four weeks. The outcome of this referral, and all client contacts, must be documented in the client's chart.

How To Refer

It is the responsibility of the care coordinator to identify clients with nutrition and/or psychosocial risks and refer these clients to the Prenatal Plus dietitian or mental health professional. However, any member of the Prenatal Plus team may make a referral. The mental health professional or dietitian may recommend a referral during a case conference discussion. In addition, the client may request a referral.

The *Referral Form* can be used to refer clients. This form is optional, but provides a complete list of the minimum referral criteria for the team members. The criteria listed in this section indicate when a referral is required; clients may also be referred for other issues not listed. Keep the original copy of the *Referral Form* in the client chart as documentation that the referral was made and send a copy to the person accepting the referral. Regardless of whether the agency chooses to use the *Referral Form*, documentation that risk criteria have been identified, and a referral has been offered to the client, is required in the client chart. This documentation may be on the *Initial Assessment Form* or in the progress notes, if the *Referral Form* is not used.

In the event the client declines the referral, this must also be documented in the client's chart. If a client refuses a referral to either the dietitian or mental health professional, it is recommended that the care coordinator discuss the risk factor(s) with the appropriate professional on the team and determine how the client's needs can be met through the care coordinator or another professional or agency.

Mental Health Referral Criteria

The following are the **minimum** criteria that require a referral to the mental health professional. Referrals are not limited to these criteria, so if in doubt, refer.

- History of or current psychiatric diagnosis, including schizophrenia, personality disorder, suicidal ideation, affective disorder, depression, bi-polar disorder, history of psychiatric hospitalization, history of postpartum depression, and adjustment disorders.

- Significant emotional distress or crises, including: recent divorce or separation from partner, recent death of partner or child, AIDS/HIV, homelessness, extensive medical problems, recent job loss or other trauma.

- History of or current domestic violence or abuse, including: verbal, emotional, physical, or sexual abuse of client or others in the household; feeling unsafe with current partner or other household member; or severe family dysfunction.

- Suspected or confirmed current problems with alcohol or drug abuse, or history of substance abuse with high probability of relapse, or presence of drug or alcohol abuse in the household.

- Negative attitudes or feelings about the current pregnancy, including clients who are considering relinquishing the infant for adoption.

- Recent legal involvement including incarceration, current parole or probation, or other criminal justice supervision.

- Inadequate emotional or social support systems, including family estrangement or social isolation.

- Evidence of previous difficulties in child rearing or parenting, including having a child in protective custody.

- Suspected or confirmed eating disorder. These clients must also be referred to the dietitian.

Registered Dietitian Referral Criteria
The following are the minimum criteria that require a referral to the registered dietitian. Referrals are not limited to these criteria, so if in doubt, refer.

Medical Factors with Nutrition Implications

- Medical conditions, which require a special diet or affects nutrition, e.g., pre-existing diabetes, gestational diabetes, lactose intolerance, AIDS, pregnancy-induced hypertension, preeclampsia, cancer, eating disorders, or depression

- Current use of alcohol, tobacco, or drugs

- Severe anemia

- Suspected or confirmed eating disorder. These clients must also be referred to the mental health professional.

- Multiple gestations

- Adolescent, 15 years of age or younger

Factors Related to Weight

- Underweight, defined as pregravid BMI less than 19.8 kg/m^2

- Obese, defined as pregravid BMI greater than 29 kg/m^2

- Inadequate weight gain, defined as:

    - Weight loss below the appropriate BMI line
    - Weight loss below pregravid weight in the 1^{st} trimester
    - Weight loss of 2 pounds or more in the 2^{nd} or 3^{rd} trimester
    - Weight gain of less than 2 pounds per month during the 2^{nd} or 3^{rd} trimester
    - Weight gain which falls below the expected rate of weight gain

- Excessive weight gain, defined as:
    - Weight gain of 7 or more pounds per month in any trimester

Dietary Factors

- Excessive intake of nutritional supplements, such as vitamins, minerals, or herbs

- Client is considered by the care coordinator to require extra assistance with comprehending nutritional information, such as someone with a developmental disability

- Self-limiting diet that excludes foods from one or more food groups without replacing needed nutrients, i.e., a diet that excludes dairy products without the addition of a calcium source or a vegetarian diet that excludes meat but has no alternative protein source

- Pica: eating sufficient quantities of non-food items such as clay, starch, dirt, ice, etc.

Barriers to Referral

- Stigma or embarrassment regarding seeking counseling or other services

- Anxiety regarding counseling services or mental health agencies

- Waiting lists or lag time between referral and appointment

- Transportation, childcare or other issues related to the logistics of seeking services

- Client skill, language barriers and literacy level

The manner in which a referral is made often has an impact on whether or not it is accepted by the client. For each referral made, the care coordinator can encourage a positive outcome by:

- Acknowledging and working through some of the barriers to referral.

- Explaining the benefits of the referral and how it meets a need the client has identified.

- Describing the process of the referral (what has to happen before the client can receive the services).

- Giving positive feedback to the client for taking care of herself and the infant.

REFERRALS TO EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a special voluntary health care program within Medicaid for persons from birth to age 21. EPSDT is designed to detect and treat health problems early through regular medical, dental, vision and hearing screening, and to check for lead poisoning, immunizations and education. Prenatal Plus providers are required to refer all clients to the EPSDT caseworker in their county.

Agencies may use a referral form developed in conjunction with their county EPSDT program, or provide a list of client names and contact information to their county EPSDT caseworker on a regular basis. Referral must also be documented in the client's chart. Referral to this program does not require an Authorization to Release Information, as both programs are dealing with treatment aspects of a woman's prenatal care. For more information about the EPSDT program and a list of county contacts go to their website. http://www.chcpf.state.co.us/HCPF/EPSDT/EPSDT_Final_page2.asp

REFERRALS FOR SUBSTANCE ABUSING CLIENTS

Any client who is identified as substance abusing, (drugs and/or alcohol) should be referred to the nearest Special Connections provider or to a Drug and Alcohol Specialist. Clients can be enrolled in both Prenatal Plus and a drug and alcohol program, including Special Connections. Clients can be referred to the mental health professional designated to provide Prenatal Plus services if there is not a Special Connections provider or other drug and alcohol provider for the area served (See the list of *Special Connections Providers*). Referrals to Special Connections or other providers must be documented in the client's chart. All clients have the right to refuse referrals. If refused, it may be beneficial to offer it at another time, as the client may be more willing to accept the referral at a later date. If sharing information with Special Connections, a signed *Authorization to Release Information* is necessary

REFERRALS TO OTHER AGENCIES OUTSIDE OF PRENATAL PLUS

In some instances, it is necessary to refer clients to programs or agencies outside of Prenatal Plus. Whenever a referral is made outside the agency, a signed *Authorization to Release Information* is necessary. Care coordinators can facilitate the referral process by providing the exact address or directions, the hours of operation and any limitations of the agency to the client. If possible, refer directly to a person rather than a place. If your client has special needs, find out if the agency can accommodate these needs. If appropriate, offer to accompany the client on her visit.

SECTION 6:
PROVIDER REQUIREMENTS

CLIENT CONFIDENTIALITY AND HIPAA REQUIREMENTS

All programs must ensure client confidentiality. Agencies must provide safeguards for clients against invasion of personal privacy as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Treat all personal information as privileged communication and divulge only upon the client's written consent, except when necessary to provide treatment to the client, seek reimbursement for services or in compliance with mandatory reporting regulations. Keep all written and verbal exchanges between clients and clinical or clerical staff private. Information may be disclosed in summary or statistical form that does not contain specific client identifiers. Since, contractual personnel are not agency employees, the contracts for these team members must spell out the person's confidentiality responsibilities under HIPAA guidelines. Contract personnel must be trained with HIPAA protocols as an employee of your agency because they are part of the Prenatal Plus team.

HIPAA provides for the rights of individuals to control and access their own medical records. HIPAA applies to the Medicaid program, and to all its providers who collect or receive Medicaid client Protected Health Information (PHI). As a Medicaid provider, Prenatal Plus providers are considered "covered entities" under HIPAA. Therefore, Prenatal Plus providers have obligations to clients to provide access to medical records, and to report any disclosures of information as defined by HIPAA guidelines. All Prenatal Plus providers must have policies and procedures in place that are HIPAA-compliant. Each agency likely has a HIPAA committee or representative who is responsible for ensuring the agency is HIPAA-compliant. Please check with the designated people within the agency to ensure Prenatal Plus is HIPAA-compliant. Please contact the Prenatal Plus Program Director with any questions about HIPAA. For more information on protecting the privacy of client's health information go to http://www.hhs.gov/news/facts/privacy.html or http://www.hhs.gov/ocr/hipaa.

CLIENT RIGHTS AND SERVICES

No person can be denied participation in the Prenatal Plus Program on the basis of religion, age, sex, race, color, creed, national origin, handicap, number of pregnancies, or marital status. Services are provided without a residency requirement.

Client must sign a consent form acknowledging desire to receive services through the Prenatal Plus Program. Client consent to participate in the Prenatal Plus Program must be voluntary, and individuals must not be subjected to coercion to receive services. Acceptance of services must not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participation in any other program.

CLIENTS WITH LIMITED ENGLISH PROFICIENCY

Providers are required under 45 C.F.R. Part 80 to ensure that persons with limited proficiency in English have a meaningful opportunity to apply for, receive or participate in, or benefit from the services offered. Providers of client education must have a mechanism to determine that information given has been understood. Clients should be encouraged to ask questions regarding the visit and all of

the information covered. Agency staff should assess client understanding by utilizing open-ended questions and asking the client to repeat, in her own words, instructions and/or follow-up recommendations.

Sites serving clients for whom English is a second language must provide educational materials and informed consent in a language understood by the patient. Pursuant to Title VI of the Civil Rights Act of 1964, it is the agency's responsibility to assure that persons with limited English proficiency (LEP) have equal access to federally assisted health programs, benefits, and services.

Current materials in the appropriate languages should be readily available to the client. Staff responsible for educational materials must ensure that all necessary forms and educational materials are available in Spanish, and other languages when needed.

Provisions for bilingual educators or interpreters must be made for non/limited English speaking clients. This should be determined when scheduling appointments. The client may choose to provide her own interpreter, however, the agency must inform the client that an interpreter will be provided to the client at no cost if the client requests.

It is always desirable to use a female staff member who is knowledgeable about prenatal care and sensitive to confidentiality. Husbands, children, and inappropriate agency staff should not be used unless there is no other alternative. In an instance where a sister or female friend has come for the express purpose of interpreting and no bilingual staff is available, she may be used, but it must be documented in the client record. Instruct the family member to repeat and interpret all discussions and counseling verbatim to increase the accuracy as much as possible.

When an interpreter is used to help the client understand the consent form(s), the interpreter must also sign the consent form(s) and write interpreter in parentheses.

If a clinic does not serve numbers great enough to warrant recruitment of bilingual staff they must have a listing of appropriate persons who can act as interpreters. Another option is to use a telephone interpreter service, such as the AT&T Language Line for unusual language needs (www.languageline.com).

For more information about the guidelines surrounding care provided to LEP clients go to: www.hhs.gov/ocr or www.lep.gov.

CLIENTS WITH SENSORY IMPAIRMENTS

Agencies must ensure that persons with disabilities, including those with impaired sensory or speaking skills, receive effective notice concerning benefits, services, or written material concerning waivers of rights or consent to treatment. Providers must provide communication aids and interpreters at no cost to the sensory impaired person.

For persons who are deaf or hearing impaired and who use sign language as their primary means of communication, a procedure must be developed and resources identified for obtaining the services of a qualified sign-language interpreter to communicate both verbal and written information. If your agency utilizes a Telecommunication Device for the Deaf (TDD), give a written explanation of where it is located, how to operate it, and the telephone number. If there is an arrangement for sharing a TDD,

give an explanation of the sharing arrangement, the telephone number and the procedures for borrowing the device. If you are using your State Relay Service, give a written explanation of how this is used.

For persons with visual impairments, staff must communicate the content of written materials concerning benefits, services, waivers of rights, and consent to treatment forms by reading them out loud. If other aids such as large print, taped, and Braille materials are used, client should be informed of what aids are available, where they are located, and how they are used.

For persons with speech impairments, writing materials, typewriters, TDD, and/or computers must be available to facilitate communication concerning program services and benefits, waivers of rights, and consent to treatment forms.

CLIENTS WITH DISABILITIES

An agency must be able to provide access to services for clients with disabilities as required by the Americans With Disabilities Act of 1990. The complete text of the federal statute can be found at http://www.usdoj.gov/crt/ada/statute.html.

COLORADO REVISED STATUTES AND OTHER LEGAL OBLIGATIONS

Refer to the Colorado Revised Statutes for complete text at http://www.leg.state.co.us/.

PARENTAL INVOLVEMENT AND CARE OF MINORS

Minors may consent for care in the following situations outlined in statute. The minor's consent must be obtained, and the provider must document the reason for treating without parental consent.

CRS 13-22-102 Minors – consent for medical care and treatment for addiction to or use of drugs.

- Notwithstanding any other provision of law, any physician licensed to practice in this state, upon consultation by a minor as a patient, with the consent of such minor patient, may examine, prescribe for, and treat such minor patient for addiction to or use of drugs without the consent of or notification to the parent, parents, or legal guardian of such minor patient, or to any other person having custody or decision-making responsibility with respect to the medical care of such minor patient. In any such case the physician or any person acting pursuant to the minor's direction shall incur no civil or criminal liability by reason of having made such examination or prescription or having rendered such treatment, but this immunity shall not apply to any negligent acts or omissions by the physician or any person acting pursuant to the physician's direction.

CRS 13-22-103 Minors – consent for medical, dental, and related care.

- Except as otherwise provided in sections 16-11-311 (4,5), 18-6-101, 25-4-402, and 12-34-103 (1), C.R.S., a minor eighteen years of age or older, or a minor fifteen years of age or older who is living separate and apart from his or her parent, parents, or legal guardian, with or without the consent of his or her parent, parents, or legal guardian, and is managing his or her own financial affairs, regardless of the source of his or her income, or any minor who has contracted

a lawful marriage may give consent to organ or tissue donation or the furnishing of hospital, medical, dental emergency health, and surgical care to himself or herself. Such consent shall not be subject to disaffirmance because of minority, and, when such consent is given, said minor shall have the same rights, powers, and obligations as if he or she had obtained majority. Consent to organ or tissue donation may be revoked pursuant to section 12-34-107, C.R.S.

CRS 13-22-103.5 Minors- consent for medical care- pregnancy.

- Notwithstanding any other provision of law, a pregnant minor may authorize prenatal, delivery, and post-delivery medical care for herself related to the intended live birth of a child.

CRS 13-22-105 Minors – birth control services rendered by physicians.

- Except as otherwise provided in part 1 of article 6 of title 18, C.R.S., birth control procedures, supplies, and information may be furnished by physicians licensed under article 36 of title 12, C.R.S., to any minor who is pregnant, or a parent, or married, or who has the consent of his parent or legal guardian, or who has been referred for such services by another physician, a clergyman, a family planning clinic, a school or institution of higher education, or any agency or instrumentality of this state or any subdivision thereof, or who requests and is in need of birth control procedures, supplies, or information.

CRS 13-22-106 Minors – consent – sexual assault.

- Any physician licensed to practice in this state, upon consultation by a minor as a patient who indicates that he or she was the victim of a sexual assault, with the consent of such minor patient, may perform customary and necessary examinations to obtain evidence of the sexual assault and may prescribe for and treat the patient for any immediate condition caused by the sexual assault.

    - Prior to examining or treating a minor pursuant to subsection (1) of this section, a physician shall make a reasonable effort to notify the parent, parents, legal guardian, or any other person having custody or decision-making responsibility with respect to the medical care of such minor of the sexual assault.

    - So long as the minor has consented, the physician may examine and treat the minor as provided for in subsection (1) of this section whether or not the physician has been able to make the notification provided for in paragraph (a) of this subsection (2) and whether or not those notified have given consent, but, if the person having custody or decision-making responsibility with respect to the minor's medical care objects to treatment, then the physician shall proceed under the provisions of part 3 of article 3 of title 19, C.R.S.

- Nothing in this section shall be deemed to relieve any person from the requirements of the provisions of part 3 of article 3 of title 19, C.R.S. concerning child abuse. (CRS 19-3-304 on page 8)

COLORADO PARENTAL NOTIFICATION ACT

12-37.5-104. Notification concerning abortion.

- (1) No abortion shall be performed upon an unemancipated minor until at least 48 hours after written notice of the pending abortion has been delivered… (see full statute text for accepted methods of notification).
- (2) (a) Notwithstanding the provisions of subsection (1) of this section, if the minor is residing with a relative of the minor and not a parent, the written notice of the pending abortion shall be provided to either the relative of the minor or a parent.

12-37.5-105. No notice required - when.

- (1) No notice shall be required pursuant to this article if:
  - The person or persons who may receive notice pursuant to section 12-37.5-104 (1) certify in writing that they have been notified; or
  - The person whom the minor elects to notify pursuant to section 12-37.5-104 (2) certifies in writing that he or she has been notified; or
  - The pregnant minor declares that she is a victim of child abuse or neglect by the acts or omissions of the person who would be entitled to notice, as such acts or omissions are defined in "The Child Protection Act of 1987", as set forth in title 19, article 3, of the Colorado Revised Statutes, and any amendments thereto, and the attending physician has reported such child abuse or neglect as required by the said act. When reporting such child abuse or neglect, the physician shall not reveal that he or she learned of the abuse or neglect as the result of the minor seeking an abortion.
  - The attending physician certifies in the pregnant minor's medical record that a medical emergency exists and there is insufficient time to provide notice pursuant to section 12-37.5-104; or
  - A valid court order is issued pursuant to section 12-37.5-107.

12-37.5-107. Judicial bypass.

- (2) (a) If any pregnant minor elects not to allow the notification required pursuant to section 12-37.5-104, any judge of a court of competent jurisdiction shall, upon petition filed by or on behalf of such minor, enter an order dispensing with the notice requirements of this article if the judge determines that the giving of such notice will not be in the best interest of the minor, or if the court finds, by clear and convincing evidence, that the minor is sufficiently mature to decide whether to have an abortion. Any such order shall include specific factual findings and legal conclusions in support thereof and a certified copy of such order shall be provided to the attending physician of said minor and the provisions of section 12-37.5-104 (1) and section 12-37.5-106 shall not apply to the physician with respect to such minor. (See full statute text and The Colorado Rules of Civil Procedure-Chapter 23.5 for more information on procedure and limitations.)

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

CRS 27-10-103 Voluntary applications for mental health services.

- Nothing in this article shall be construed in any way as limiting the right of any person to make voluntary application at any time to any public or private agency or professional person for mental health services, either by direct application in person or by referral from any other public or private agency or professional person. Subject to section 15-14-312 (1) (a), C.R.S. a ward, as defined in section 15-14-101 (4), C.R.S., may be admitted to hospital or institutional care and treatment for mental illness by consent of the guardian for so long as the ward agrees to such care and treatment. Within ten days of any such admission of the ward for such hospital or institutional care and treatment, the guardian shall notify in writing the court that appointed the guardian of the admission.

MANDATORY REPORTING REQUIREMENTS

Prenatal Plus agencies must be compliant with all applicable state laws regarding the mandatory reporting of child abuse, child molestation, sexual abuse, rape, incest, or domestic violence.

Requirements of the Prenatal Plus Program Staff

Program Coordinators must assure that all team members are familiar with Colorado law as summarized on the following pages. At the end of the following excerpts from the Colorado Revised Statutes there are summary tables outlining: who is required to report, to whom the report is made, and what the penalties are for failure to report.

It is an expectation that the Program Coordinator will solicit input from the various agencies and entities involved before writing up a procedure for how the agency will respond to any reportable or potentially reportable situation as outlined in this policy. All Prenatal Plus Program staff must be familiar with the policy and procedures outlined in this section.

CRS 18-3-402 Sexual assault

- Any actor who knowingly inflicts sexual intrusion or sexual penetration on a victim commits sexual assault if:
    - The actor causes submission of the victim by means of sufficient consequence reasonably calculated to cause submission against the victim's will; or
    - The actor knows that the victim is incapable of appraising the nature of the victim's conduct; or
    - The actor knows that the victim submits erroneously, believing the actor to be the victim's spouse; or
    - At the time of the commission of the act, the victim is less than fifteen years of age and the actor is at least four years older than the victim and is not the spouse of the victim; or

- At the time of the commission of the act, the victim is at least fifteen years of age but less than seventeen years of age and the actor is at least ten years older than the victim and is not the spouse of the victim… (see statute for complete text).

CRS 18-6-401 Child abuse

- A person commits child abuse if such person causes an injury to a child's life or health, or permits a child to be unreasonably placed in a situation that poses a threat of injury to the child's life or health, or engages in a continued pattern of conduct that results in malnourishment, lack of proper medical care, cruel punishment, mistreatment, or an accumulation of injuries that ultimately results in the death of a child or serious bodily injury to a child.

- Except as otherwise provided in subparagraph (III) of this paragraph (b), a person commits child abuse if such person excises or infibulates, in whole or in part, the labia majora, labia minora, vulva, or clitoris of a female child. A parent, guardian, or other person legally responsible for a female child or charged with the care or custody of a female child commits child abuse if he or she allows the excision or infibulation, in whole or in part, of such child's labia majora, labia minora, vulva, or clitoris.

- Belief that the conduct described in subparagraph (I) of this paragraph (b) is required as a matter of custom, ritual, or standard practice or consent to the conduct by the child on whom it is performed or by the child's parent or legal guardian shall not be an affirmative defense to a charge of child abuse under this paragraph (b).

CRS 19-1-103 Definition of child abuse or neglect

"Abuse" or "child abuse or neglect", as used in part 3 of article 3 of this title, means an act or omission in one of the following categories that threatens the health or welfare of a child:

- Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death and either: Such condition or death is not justifiably explained; the history given concerning such condition is at variance with the degree or type of such condition or death; or the circumstances indicate that such condition may not be the product of an accidental occurrence;

- Any case in which a child is subjected to unlawful sexual behavior as defined in section 16-22-102 (9), C.R.S.;

- Any case in which a child is a child in need of services because the child's parents, legal guardian, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take. The requirements of this subparagraph (III) shall be subject to the provisions of section 19-3-103.

- Any case in which a child is subjected to emotional abuse. As used in this subparagraph (IV), "emotional abuse" means an identifiable and substantial impairment of the child's intellectual or psychological functioning or development or a substantial risk of impairment of the child's intellectual or psychological functioning or development.

CRS 19-3-304 Persons required to report child abuse or neglect.

- Except as otherwise provided by section 19-3-307 and sections 25-1-122 (4) (d) and 25-4-1404 (1) (d), C.R.S., any person specified in subsection (2) of this section who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions which would reasonably result in abuse or neglect shall immediately upon receiving such information report or cause a report to be made of such fact to the county department or local law enforcement agency.
- Persons required to report such abuse or neglect or circumstances or conditions shall include any:

  (a) Physician or surgeon, including a physician in training;

  (b) Child health associate;

  (c) Medical examiner or coroner;

  (d) Dentist;

  (e) Osteopath;

  (f) Optometrist;

  (g) Chiropractor;

  (h) Chiropodist or podiatrist;

  (i) Registered nurse or licensed practical nurse;

  (j) Hospital personnel engaged in the admission, care, or treatment of patients;

  (k) Christian science practitioner;

  (l) Public or private school official or employee;

  (m) Social worker or worker in any facility or agency that is licensed or certified pursuant to part 1 of article 6 of title 26, C.R.S.;

  (n) Mental health professional;

  (o) Dental hygienist;

  (p) Psychologist;

  (q) Physical therapist;

(r) Veterinarian;

(s) Peace officer as described in section 16-2.5-101, C.R.S.;

(t) Pharmacist;

(u) Commercial film and photographic print processor as provided in subsection (2.5) of this section;

(v) Firefighter as defined in section 18-3-201 (1), C.R.S.;

(w) Victim's advocate, as defined in section 13-90-107 (1) (k) (II), C.R.S.;

(x) Licensed professional counselors;

(y) Licensed marriage and family therapists;

(z) Unlicensed psychotherapists;

(aa) (I) Clergy member.

(II) The provisions of this paragraph (aa) shall not apply to a person who acquires reasonable cause to know or suspect that a child has been subjected to abuse or neglect during a communication about which the person may not be examined as a witness pursuant to section 13-90-107 (1) (c), C.R.S., unless the person also acquires such reasonable cause from a source other than such a communication.

(III) For purposes of this paragraph

(aa), unless the context otherwise requires, "clergy member" means a priest, rabbi, duly ordained, commissioned, or licensed minister of a church, member of a religious order, or recognized leader of any religious body.

(bb) Registered dietitian who holds a certificate through the commission on dietetic registration and who is otherwise prohibited by 7 CFR 246.26 from making a report absent a state law requiring the release of this information;

(cc) Worker in the state department of human services.

- Any commercial film and photographic print processor who has knowledge of or observes, within the scope of his or her professional capacity or employment, any film, photograph, video tape, negative, or slide depicting a child engaged in an act of sexual conduct shall report such fact to a local law enforcement agency immediately or as soon as practically possible by telephone and shall prepare and send a written report of it with a copy of the film, photograph, video tape, negative, or slide attached within thirty-six hours of receiving the information concerning the incident.

- In addition to those persons specifically required by this section to report known or suspected child abuse or neglect and circumstances or conditions which might reasonably result in abuse or neglect, any other person may report known or suspected child abuse or neglect and circumstances or conditions which might reasonably result in child abuse or neglect to the local law enforcement agency or the county department.

- No person, including a person specified in subsection (1) of this section, shall knowingly make a false report of abuse or neglect to a county department or local law enforcement agency.

- Any person who willfully violates the provisions of subsection (1) of this section or who violates the provisions of subsection (3.5) of this section:

  (a) Commits a class 3 misdemeanor and shall be punished as provided in section 18-1.3-501, C.R.S.;

  (b) Shall be liable for damages proximately caused thereby.

CRS 19-3-307 Reporting procedures

- Reports of known or suspected child abuse or neglect made pursuant to this article shall be made immediately to the county department or the local law enforcement agency and shall be followed promptly by a written report prepared by those persons required to report. The county department shall submit a report of confirmed child abuse or neglect within sixty days of receipt of the report to the state department in a manner prescribed by the state department.

- Such reports, when possible, shall include the following information:

  (a) The name, address, age, sex, and race of the child;

  (b) The name and address of the person responsible for the suspected abuse or neglect;

  (b) The nature and extent of the child's injuries, including any evidence of previous cases of known or suspected abuse or neglect of the child or the child's siblings;

  (d) The names and addresses of the persons responsible for the suspected abuse or neglect, if known;

  (e) The family composition;

  (f) The source of the report and the name, address, and occupation of the person making the report;

  (g) Any action taken by the reporting source;

  (h) Any other information that the person making the report believes may be helpful in furthering the purposes of this part 3.

- Notwithstanding the requirements set forth in subsection (2) of this section, any officer or employee of a local department of health or state department of public health and environment who makes a report pursuant to section 25-1-122 (4) (d) or 25-4-1404 (1) (d), C.R.S., shall include only the information described in said sections.

- (a) A copy of the report of known or suspected child abuse or neglect shall be transmitted immediately by the county department to the district attorney's office and to the local law enforcement agency.

  (b) When the county department reasonably believes a criminal act of abuse or neglect of a child in foster care has occurred, the county department shall transmit immediately a copy of the written report prepared by the county department in accordance with subsection (1) of this section to the district attorney's office and to the local law enforcement agency.

- A written report from persons or officials required by this part 3 to report known or suspected child abuse or neglect shall be admissible as evidence in any proceeding relating to child abuse, subject to the limitations of section 19-1-307.

CRS 19-3-309 Immunity from liability- persons reporting

- Any person, other than the perpetrator, complicitor, coconspirator, or accessory, participating in good faith in the making of a report, in the facilitation of the investigation of such a report, or in a judicial proceeding held pursuant to this title, the taking of photographs or X rays, or the placing in temporary protective custody of a child pursuant to section 19-3-405 or otherwise performing his duties or acting pursuant to this part 3 shall be immune from any liability, civil or criminal, or termination of employment that otherwise might result by reason of such acts of participation, unless a court of competent jurisdiction determines that such person's behavior was willful, wanton, and malicious. For the purpose of any proceedings, civil or criminal, the good faith of any such person reporting child abuse, any such person taking photographs or X rays, and any such person who has legal authority to place a child in protective custody shall be presumed.

CRS 12-36-135 Injuries to be reported- penalty for failure to report

- It shall be the duty of every licensee who attends or treats a bullet wound, a gunshot wound, a powder burn, or any other injury arising from the discharge of a firearm, or an injury caused by a knife, an ice pick, or any other sharp or pointed instrument that the licensee believes to have been intentionally inflicted upon a person, or any other injury that the licensee has reason to believe involves a criminal act, including injuries resulting from domestic violence, to report such injury at once to the police of the city, town, or city and county or the sheriff of the county in which the licensee is located. Any licensee who fails to make a report as required by this section commits a class 2 petty offense, as defined by section 18-1.3-503, C.R.S., and, upon conviction thereof, shall be punished by a fine of not more than three hundred dollars, or by imprisonment in the county jail for not more than ninety days, or by both such fine and imprisonment.

- As used in subsection (1) of this section, unless the context otherwise requires:

  (a) "Domestic violence" means an act of violence upon a person with whom the actor is or has been involved in an intimate relationship. Domestic violence also includes any other crime against a person or any municipal ordinance violation against a person when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship.

  (b) "Intimate relationship" means a relationship between spouses, former spouses, past or present unmarried couples, or persons who are both the parents of the same child regardless of whether the persons have been married or have lived together at any time.

- Any licensee who, in good faith, makes a report pursuant to subsection (1) of this section shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed with respect to the making of such report, and shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

Any licensee who makes a report pursuant to subsection (1) of this section shall not be subject to the physician-patient relationship described in section 13-90-107 (1) (d), C.R.S., as to the medical examination and diagnosis. Such licensee may be examined as a witness, but not as to any statements made by the patient that are the subject matter of section 13-90-107 (1) (d), C.R.S.

REPORTING PRENATAL SUBSTANCE ABUSE

As noted above, Prenatal Plus providers are considered mandated reporters in the case of child abuse. Colorado defines a child as someone who has been born, and case law has upheld this determination. Therefore, maternal substance abuse does not fit the definition of child abuse, and there is no mandatory reporting requirement. In Colorado, Social Services agencies cannot act on a report of a pregnant woman using substances prenatally since it is not considered child abuse.

A referral may be made prenatally to the county Department of Health and Human Services or to Special Connections, although it is not required. A referral with client consent for a needs assessment is encouraged in order to help the woman get access to counseling and treatment services, but it is not mandated. Special Connections, a drug treatment and counseling program for pregnant women, is an approved entity for needs assessment in addition to the county Department of Health and Human Services.

Once the child is born, action may be taken if there is information of the infant being exposed to substances prenatally. This could be self-admission by the client, urinalysis results in a medical chart, or a test of the meconium at birth that shows the newborn is positive for substances. The health care provider may make a report to county Health and Human Services with any of the above information. It is recommended that a client that is using substances prenatally receive an explanation of this policy as part of the risk education done during her pregnancy.

26-4-508.2 Pregnant women - needs assessment - referral to treatment program.

- (1) The health care practitioner for each pregnant woman who is enrolled for services pursuant to section 26-4-508 or who would be eligible for aid to families with dependent children pursuant to rules in effect on July 16, 1996, shall be encouraged to identify as soon as possible after such woman is determined to be pregnant whether such woman is at risk of a poor birth outcome due to substance abuse during the prenatal period and in need of special assistance in order to reduce such risk. If the health care practitioner makes such a determination regarding any pregnant woman, the health care practitioner shall be encouraged to refer such woman to any entity approved and certified by the department of health for the performance of a needs assessment. Any pregnant woman who is eligible for services pursuant to section 26-4-508 or who would be eligible for aid to families with dependent children pursuant to rules in effect on July 16, 1996, may refer herself for such needs assessment.

- (2) For the purposes of this section, unless the context otherwise requires, a "needs assessment" means an assessment which is designed to make a determination of what services are needed by a pregnant woman to minimize the occurrence of a poor birth outcome due to substance abuse by such pregnant woman.

19-3-401 Taking children into custody.

- (3) (a) Notwithstanding the provisions of subsections (1) and (1.5) of this section and except as otherwise provided in paragraphs (b) and (c) of this subsection (3), a newborn child, as defined in section 19-1-103 (78.5), who is not in a hospital setting shall not be taken into temporary protective custody for a period of longer than twenty-four hours without an order of the court made pursuant to section 19-3-405 (1), which order includes findings that an emergency situation exists and that the newborn child is seriously endangered as described in paragraph (a) of subsection (1) of this section.

  (b) A newborn child, as defined in section19-1-103 (78.5), who is in a hospital setting shall not be taken into temporary protective custody without an order of the court made pursuant to section 19-3-405 (1), which order includes findings that an emergency situation exists and that the newborn child is seriously endangered as described in paragraph (a) of subsection (1) of this section. A newborn child may be detained in a hospital by a law enforcement officer upon the recommendation of a county department of social services, a physician, a registered nurse, a licensed practical nurse, or a physician's assistant while an order of the court pursuant to section 19-3-405 (1) is being pursued, but the newborn child must be released if a court order pursuant to section 19-3-405 (1) is denied.

  (c) The court orders required by paragraphs (a) and (b) of this subsection (3) shall not be required in the following circumstances:

    (I) When a newborn child is identified by a physician, registered nurse, licensed practical nurse, or physician's assistant engaged in the admission, care, or treatment of patients as being affected by substance abuse or demonstrating withdrawal symptoms resulting from prenatal drug exposure;

MANDATORY REPORTING
Child Abuse
Statute: C.R.S. 19-1-103, 19-3-304,-307,-309

Definition	Required Reporters	To Whom is Issue Reported	What is Reported	Penalties for Failure to Report
19-1-103 Definitions. (1) (a) "Abuse" or "child abuse or neglect", as used in part 3 of article 3 of this title, means an act or omission in one of the following categories that threatens the health or welfare of a child: (I) Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fractures of any bone, subdural hematoma, soft tissue swelling, or death and either: Such condition or death is not justifiably explained; the history given concerning such condition is at variance with the degree or type of such condition or death; or the circumstances indicate that such condition may not be the product of an accidental occurrence. (II) Any case in which a child is subjected to unlawful sexual behavior as defined in section 16-22-102 (9), C.R.S.; (III) A case in which a child is a child in need of services because the child's parents, legal guardian, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care or supervision that a prudent parent would take… **18-6-401**. A person commits child abuse if such person causes injury to a child's life or health, or permits a child to be unreasonably placed in a situation that poses a threat of injury to the child's life or health, or engages in a continued pattern of conduct that results in malnourishment, lack of proper medical care, cruel punishment, mistreatment, or an accumulation of injuries that ultimately results in the death of a child or serious bodily injury of a child.	**19-3-304** A physician or surgeon (includes in-training), child health associate; medical examiner or coroner; dentist; osteopath; optometrist; chiropractor; chiropodist or podiatrist; registered nurse or licensed practical nurse; hospital personnel engaged in the admission, care, or treatment of patients; Christian Science practitioner; public or private school official or employee; social worker or worker in a any facility or agency that is licensed or certified pursuant to part 1 of article 6 of title 26, C.R.S.; mental health professional; dental hygienist; psychologist; physical therapist; veterinarian; peace officer; pharmacist; commercial film and photographic print processor; firefighter; victim's advocate; licensed professional counselors; licensed marriage and family therapists; unlicensed psychotherapists; clergy; registered dietician; worker in the state department of human services.	**19-3-307** County department of Human services or local law enforcement agency. Report known or suspected child abuse or neglect immediately and follow with a written report **Third party abuse** (see definition bottom of page) is reported to law enforcement ***where the crime occurs***. **Intrafamilial** abuse is reported to the department of Human services ***where the victim lives*.**	**19-3-307** When possible include: Name, address, age, sex, and race of child; name and address of person responsible for suspected abuse or neglect; nature and extent of child's injuries, including previous cases of known or suspected abuse or neglect of the child or the child's siblings; names and addresses of the persons responsible for the suspected abuse or neglect, if known; the family composition, the source of the report and the name, address and occupation of the person making the report; any action taken by the reporting source; any other information the person making the report believes may be helpful.	19-3-309 grants immunity to those persons who have made a report of child abuse or neglect, thereby protecting the reporting person from civil and criminal liability as well as termination of employment... Failure to report constitutes a class 3 misdemeanor. Punishment is up to six months in prison and up to $750 fine. Additionally, the person shall be liable for damages proximately caused by failure to report.

GLOSSARY: Third Party Abuse is by any person who is not a parent, stepparent, guardian, legal custodian, spousal equivalent... or any person who is not included in the definition of Intrafamilial abuse. Intrafamilial Abuse occurs within a family context by a child's parent, stepparent, guardian, legal custodian, or relative, by a spousal equivalent..or by any other person who resides in the child's home or who is regularly in the child's home for the purpose of exercising authority over or care for the child...except if the person is paid for such care and is not related to the child.

MANDATORY REPORTING
Domestic Violence
Statute: C.R.S. 12-36-135

Definition	Who Reports	To Whom is Issue Reported	What is Reported	Penalties for Failure to Report
12-36-135 Any injury arising from the discharge of a firearm, or an injury caused by a knife, an ice pick, or any other sharp or pointed instrument that the licensee has reason to believes to have been intentionally inflicted, or any other injury that the licensee has reason to believe involves a criminal act, including injuries resulting from domestic violence.	**12-36-135** Every licensee who attends or treats any injury that the licensee has reason to believe is the result of domestic violence. When setting your agency's policy, it is our recommendation that you consult with your county District Attorney regarding how broadly to interpret "licensee." It should include anyone licensed to practice such as RN, NP, PA, MD, DO, etc.	**12-36-135** Police of the city, town, or city and county or sheriff of the county in which the licensee is located.	**12-36-135** Name and address of the victim. Name and address of the perpetrator, if known. Where the crime occurred.	**12-36-135** grants immunity from any liability, civil or criminal to any licensee who, in good faith, makes a report... Failure to report constitutes a class 2 petty offense. (Defined in **18-1.3-503)** A fine of not more than three hundred dollars and/or imprisonment in the county jail for not more than ninety days.

Glossary: Domestic Violence means an act of violence upon a person with whom the actor is or has been involved in an intimate relationship. Domestic violence also includes any other crime against a person or any municipal ordinance violation against a person when used as a method of coercion, control, punishment, intimidation or revenge directed against a person with whom the actor is or has been involved in an intimate relationship.

Intimate relationship means a relationship between spouses, former spouses, past or present unmarried couples, or persons who are both the parents of the same child.

MANDATORY REPORTING
Sexual Assault and Sexual Assault on a Child
Statute: C.R.S. 18-3-402 & -405; C.R.S. 19-3-304,-307,-309

Definition	Who Reports	To Whom is Issue Reported	What is Reported	Penalties for Failure to Report
18-3-402 Sexual contact by someone not the spouse where "..the **victim is less than fifteen years** old and the **actor is at least four years older…"** (also contained in 18-3-405, Sexual Assault on a Child) or "…the **victim is at least fifteen years of age but less than seventeen years** of age and the **actor is at least ten years older** than the victim and is not the spouse of the victim…" (Bold added) This includes sexual contact, sexual intrusion, and sexual penetration as defined in C.R.S. 18-3-401 Definitions.	**19-3-304** A physician or surgeon (includes in-training), child health associate; medical examiner or coroner; dentist; osteopath; optometrist; chiropractor; chiropodist or podiatrist; registered nurse or licensed practical nurse; hospital personnel engaged in the admission, care, or treatment of patients; Christian Science practitioner; public or private school official or employee; social worker or worker in any facility or agency that is licensed or certified pursuant to part 1 of article 6 of title 26, C.R.S.; mental health professional; dental hygienist; psychologist; physical therapist; veterinarian; peace officer; pharmacist; commercial film and photographic print processor; firefighter; victim's advocate; licensed professional counselors; licensed marriage and family therapists; unlicensed psychotherapists; clergy; registered dietician; worker in the state department of human services.	**19-3-307** County department of social services or local law enforcement agency. Third party perpetrators (see definitions at bottom of page) are reported to law enforcement ***where the crime occurs.*** Intrafamilial cases are reported to the department of social services ***where the victim lives***.	**19-3-307** Name, address, age, sex, and race of child; name and address of person responsible for suspected abuse or neglect; nature and extent of child's injuries, including previous cases of known or suspected abuse or neglect of the child or the child's siblings; names and addresses of the persons responsible for the suspected abuse or negligence, if known; the family composition, the source of the report and the name, address and occupation of the person making the report; any action taken by the reporting source; any other information the person making the report believe may be helpful.	**19-3-309** Grants immunity to those persons who have made a report of child abuse or neglect, thereby protecting the reporting person from civil and criminal liability as well as termination of employment... Failure to report constitutes a class 3 misdemeanor. Punishment is up to six months in prison and up to $750 fine. Additionally, the person shall be liable for damages proximately caused by failure to report.

GLOSSARY: Third party abuse is by any person who is not a parent, stepparent, guardian, legal custodian, spousal equivalent...or any person who is included in the definition of intrafamilial abuse. Intrafamilial abuse occurs within a family context by a child's parent, stepparent, guardian, legal custodian, or relative, by a spousal equivalent...or by any other person who is regularly in the child's home for the purpose of exercising authority over or care for the child...except if the person is paid for such care and is not related to the child.

PHYSICIAN BACK-UP REQUIREMENT

Under the rules established for certified health agencies in the Medicaid regulations, local public health agencies that are certified by the Department of Public Health and Environment can bill for Medicaid services without having a physician on-site. However, they must have a physician back-up. A written agreement is required between the agency and the physician. The responsibilities of the physician who permits his or her Medicaid number to be used on the Colorado 1500 Medicaid billing form are as follows:

- The Prenatal Plus staff provides case management, nutrition and counseling services under the authority of their particular licenses, degrees, or employer. Liability for their actions or failure to act lies with the staff and the employing agency, and not with the physician. The physician is neither responsible for nor liable for the quality of these services.

- The physician does not delegate medical functions for the Prenatal Plus staff to carry out.

- The physician will be generally available for consultation as needed by the Prenatal Plus staff. However, it is understood that for the vast majority of situations in which Prenatal Plus staff may seek consultation with a physician, it will be with the client's primary care provider. In the case of emergencies, clients will be sent to a hospital emergency department if their primary care provider cannot immediately attend to these needs.

PROVIDER APPLICATION PROCEDURE

The Prenatal Plus Program is a collaborative effort between the Colorado Department of Public Health and Environment/Women's Health Unit and the Colorado Department of Health Care Policy and Financing/Acute Care Benefits Section. Agencies interested in providing Prenatal Plus services must submit an application to the Prenatal Plus Program at the Colorado Department of Public Health and Environment. See the *Prenatal Plus Provider Application*. If there are questions during the application review process, please contact the Prenatal Plus Program Director at 303-692-2495.

The review process begins upon receipt of an agency application. The Prenatal Plus Program Director will review the application and request additional information as needed. In reviewing applications, the Prenatal Plus Program Director will consider the applicant's ability to demonstrate how they will meet the Prenatal Plus Program requirements, including:

- Enrollment in Colorado Medicaid as a participating provider with a valid Medicaid provider number.

- Identifying pregnant Medicaid-eligible women in the area that will be eligible to receive Prenatal Plus services. The agency must have a minimum of 10 or more Medicaid births per year in the area for which Prenatal Plus services will be appropriate.

- Delivering Prenatal Plus services to Medicaid-eligible pregnant women through the use of a multidisciplinary team, consisting of a care coordinator, registered dietitian and mental health professional.

- Agreeing to comply with all requirements of the Prenatal Plus Program, as outlined in the Prenatal Plus Provider Manual, including the use of all required forms.

- Referring clients to other services as necessary and coordinate with other community agencies.

- Tracking, documenting, and reporting risk resolution and pregnancy outcome information. Agreeing to maintain client records as required by HIPAA, and submitting all the required data in a timely manner.

The Prenatal Plus Program Director will contact the applicant within four weeks of receipt of the application. If additional information is needed, the coordinator will request it at this time. The applicant will have thirty days to respond and will be notified of the status of the application within two weeks of receipt of this response. When the application is approved, a training plan will be developed with the Prenatal Plus Program Director.

If an agency has submitted an application to become a Prenatal Plus provider, and the application has been reviewed and denied, the agency may request reconsideration regarding the Prenatal Plus application. The agency should provide additional information that addresses the concerns/issues that led to the application being denied. This information must be submitted in writing to the Prenatal Plus Program Director within 60 days. The agency may also request a meeting with the Prenatal Plus Program Director and/or the Director of the Women's Health Unit to discuss the concerns and issues related to the application. A final written decision will be sent to the agency within 30 working days of receiving the request for reconsideration. Agencies that have been denied may submit a new application whenever there is new information available.

SECTION 7:
QUALITY ASSURANCE

Quality assurance is a planned, systematic, and ongoing process for monitoring, evaluating and improving the quality of care. Quality reflects the degree of adherence to generally recognized contemporary standards of good practice and achievement of anticipated outcomes for a particular service. Quality assurance is a part of the Prenatal Plus Program at both the state and local provider levels.

PRENATAL PLUS ADVISORY GROUP

The Prenatal Plus Advisory Group consists of the Prenatal Plus Program Director and representatives from local Prenatal Plus agencies. The Advisory Group provides guidance regarding changes in both policy and implementation of the Prenatal Plus Program. It is through the local agencies' experience and expertise that the Prenatal Plus Program is better able to serve the client population. The Advisory Group meets quarterly at the Department and the meetings are open to all Prenatal Plus agencies. Agencies may participate in person or via teleconference.

QUALITY ASSURANCE ACTIVITIES AND RESPONSIBILITIES

Prenatal Plus Provider

All Prenatal Plus providers must have an internal system in place for quality assurance and improvement to include the following activities:

New Employee Chart Audits

Agencies must perform a chart audit of new employees after three months of employment, using the chart audit criteria for Prenatal Plus (see the *Chart Audit Worksheet*). The Program Coordinator typically completes this audit.

Annual Program Self-Audits

Agencies must perform a self-audit process to monitor the agency's systems for delivering Prenatal Plus services, client record keeping, and data reporting. Agencies must do self-chart audits for each clinic site on at least an annual basis, as well as a quarterly audit of the data entered into IRIS.

Client Satisfaction Survey

Agencies must complete an annual client satisfaction survey. Staff must collect a written survey from a representative sample of Prenatal Plus clients, and summarize and review the findings with the team. At a minimum this sample should include 10 clients, this may be more depending on the size of the agency. Agencies may use the *Client Satisfaction Survey* or they may develop a survey specific to their site. At minimum, agencies must provide a summary of the survey results to the Prenatal Plus Program Director during site visits.

Minimum Caseload

In order to maintain an effective program and an intact team, it is important that Prenatal Plus Programs maintain a minimum caseload. The following describes the minimum caseload requirements and outcomes.

- Prenatal Plus agencies must enroll a minimum of 10 clients per year to remain a Prenatal Plus Program provider.

- If an agency does not enroll new clients into Prenatal Plus for a continuous three-month period, the agency must communicate this information to the Prenatal Plus Program Director and describe options for increasing program enrollment.

- If a Prenatal Plus agency has not enrolled new clients into the program for a six-month period of time, their status will be changed to inactive and Medicaid will be informed of the inactive status. If the agency is still interested in being a Prenatal Plus provider, they will be required to submit a detailed plan to the Prenatal Plus Program Director outlining how they will recruit more clients into the program, enroll more than 10 clients per year and maintain the required multidisciplinary team. Once the Prenatal Plus Program Director approves the plan, the agency may return to active status.

Prenatal Plus Program Director

Site Visits

Prenatal Plus agencies are required to participate in a site visit from the Prenatal Plus Program Director every three years. The site visit is an opportunity for the agency staff to meet with the Prenatal Plus Program Director to discuss any areas of concern and to highlight accomplishments. More frequent site visits may be scheduled as needed, e.g., there has been frequent staff turnover, or follow-up is needed on the provision of services. The process is as follows:

- The Prenatal Plus Program Director and the agency's Program Coordinator will agree upon a date and time for the site visit that allows for all Prenatal Plus team members to attend.

- The Prenatal Plus Program Director will send the Program Coordinator site visit forms to be completed three weeks prior to the site visit, including the *Pre-Site Visit Review Tool, Personnel Roster, IRIS Audit Sheet* and *Chart Audit Worksheet.*

- The Prenatal Plus Program Director may request complete copies of client records with identifiers removed, from clients who delivered, for review at least three weeks prior to the actual site visit OR the Prenatal Plus Program Director will ask that five to ten complete records of clients that have delivered be available for review on site at the time of the site visit.

- Charts will be reviewed based on the criteria included on the *Chart Audit Worksheet* and a review of the client record in IRIS.

- During the site visit, the *Pre-Site Visit Review Tool, IRIS Audit Sheet* and *Chart Audit Worksheet* results will be discussed with the Prenatal Plus team.

- A follow-up report from the site visit, listing an action plan to resolve any deficiencies, will be sent to the agency's Program Coordinator and supervisor following the site visit.

- The Prenatal Plus agency will be required to submit a written plan of action to the Prenatal Plus Program Director to correct any deficiencies within 90 days.

Chart Audits

The Prenatal Plus Program Director or designated person will review client charts on a two-year rotation. Occasionally, some agencies may have a site visit and a chart audit in the same year.

Agencies participating in the chart audit will be required to submit five to ten complete copies of charts, with identifiers removed, from clients who delivered. The *Chart Audit* and *IRIS Audit Worksheets* will be used to assess compliance in addition to review of general documentation practices. See Section 3 for chart requirements.

AGENCY NON-COMPLIANCE AND PROBATIONARY STATUS

When a Prenatal Plus agency is found to be out of compliance after a site visit or chart audit, then the following steps will be taken:

1. A corrective action plan containing the written findings and recommendations of the Prenatal Plus Program Director will be submitted to the Prenatal Plus agency within 4 weeks of the site visit or chart audit. The agency will have 90 calendar days from the date of the corrective action plan to correct any deficiencies. The agency must submit a written response to the Prenatal Plus Program Director describing how the deficiencies have been corrected, or the progress that has been made towards correcting the deficiencies within the 90-day period. The Prenatal Plus Program Director may request a follow-up chart audit or site visit.

2. During the 90-day corrective action period, the Prenatal Plus Program Director will provide necessary technical assistance, training and consultation to promote timely resolution of the deficiencies.

3. If the deficiencies are not corrected within 90 days, the agency may negotiate an extension to the corrective action plan and a new due date for the progress report with the Prenatal Plus Program Director.

4. If deficiencies are not corrected within the extended due date, the agency's Prenatal Plus Program will be placed on probationary status. The agency may not

enroll any new Prenatal Plus clients during this time frame. The agency will be notified of the probationary status for the next 60 calendar days via certified mail, return receipt requested.

5. A summary of the deficiencies and negotiations will be given to the agency's Program Coordinator, the Program Coordinator's supervisor, the agency's Director, the state Prenatal Plus Program Director, and the Women's Health Unit Director.

If the agency continues to be out of compliance after the probationary period, then written notice will be mailed to the agency advising them that the Women's Health Unit has de-certified their Prenatal Plus Program. Medicaid will be informed and the agency will be removed from the approved provider list.

INACTIVE STATUS

If an agency decides to temporarily discontinue Prenatal Plus services, a letter indicating this decision along with the agency's Medicaid billing number, must be sent to the Prenatal Plus Program Director within one month of the designated inactive date. The agency will be put on inactive status until the agency indicates that they would like to resume Prenatal Plus services again. The Prenatal Plus Program Director will notify Medicaid and the agency will be removed from the approved provider list during this time.

SECTION 8:
DATA COLLECTION AND SUBMISSION

The Women's Health Unit at the Colorado Department of Public Health and Environment collects data for all Prenatal Plus clients including client information, the number of Prenatal Plus visits, risk factors, behavioral risk resolution information and birth outcomes. This data is required to track trends over time and evaluate the effectiveness of the program in resolving maternal risks and reducing low birthweight.

A Prenatal Plus report is produced annually, which gives information on participant health outcomes. This report is distributed to Medicaid, the Executive Director and other senior management of the Colorado Department of Public Health and Environment, local agency administrators and nursing directors, and Prenatal Plus staff. The most recent report is available on the Prenatal Plus website.

Prenatal Plus providers must submit data on all Prenatal Plus clients according to the data submission requirements described below. Failure to submit client data as required is out of compliance with Medicaid guidelines, and may result in denial of Medicaid billing, a refund of money to Medicaid for claims paid, and de-certification of the agency as a Prenatal Plus provider. For questions regarding data submission please contact the Prenatal Plus Data Coordinator at 303-692-2496.

DATA SUBMISSION REQUIREMENTS

Providers must submit accurate and complete data for each Prenatal Plus client once the client has completed the program. Client participation in the Prenatal Plus Program ends either:

1) At the end of two months following the month in which a client delivered; or
2) Upon withdrawal from the program prior to delivery

Data must be submitted by the 15th of the month for all clients who completed the program in the previous month. The data collected include information on the *Client Record Form* and the *Intake Form*. Providers who do not send in data for a period of at least three months will be asked to submit a plan for enrolling Prenatal Plus clients into their agency and maintaining caseload levels (see Section 7).

TYPES OF DATA SUBMISSION

Electronic Data (IRIS)

Prenatal Plus providers enter data directly into the Prenatal Plus data collection system, IRIS (Integrated Registration Information System). Client information may be entered into IRIS upon enrollment, after each client contact or at the completion of client services. All Prenatal Plus staff members that have access to IRIS must receive training and sign a *Secure Web User ID Form and Data Security Use and Confidentiality Agreement Form* and submit a letter from their direct supervisor. The form and a template that can be edited for the supervisor letter can be downloaded from the CITRIX homepage at: https://cxf.dphe.state.co.us.

New Prenatal Plus providers are required to directly enter data into IRIS. There are two exceptions to direct entry into IRIS:

- Prenatal Plus providers who see fewer than 20 clients per year will be allowed to submit paper data forms to the Women's Health Unit. The data will be entered into IRIS by Women's Health staff.

- Previously approved Prenatal Plus providers who submit data on at least 100 clients per calendar year, and have their own electronic data collection programs, are allowed to submit data to the Women's Health Unit on all Prenatal Plus clients via a third party electronic file.

Paper Data
Providers approved by the Prenatal Plus Program Director to submit data using paper data forms must use the *Client Record Form* and the *Intake Form* provided by the program when submitting data to the Women's Health Unit.

Third Party Data
Agencies approved to submit Prenatal Plus data via a third party electronic file must have an ongoing caseload of at least 100 clients per year, meet all specifications for data submission and have client data accepted monthly. The Prenatal Plus Data Coordinator will upload the electronic file to IRIS on a monthly basis and report back any on any data that has been rejected. The third party site must have access to IRIS to routinely assess whether the data they submit is accurate in IRIS.

ACCURACY OF DATA ENTRY

It is the sole responsibility of each site to correct the data submitted if it is found to be inaccurate or incomplete in IRIS. Third party sites are required to resubmit valid data that was rejected. The agency is required to check client records in IRIS that were submitted via a third party system, direct entry or paper data. The purpose of this check is to determine if the client record is accurately entered in IRIS. If errors exist, it is up to the Prenatal Plus Program Director and the agency's Program Coordinator to decide what steps need to take place to fix these errors. Each agency is expected to conduct quarterly checks, in IRIS, of the data submitted to ensure all records are present and that the data is accurate. If the errors are not resolved in a timely manner, the agency may be required to enter client data directly into IRIS, or may be placed on inactive status and not allowed to bill Medicaid for Prenatal Plus services. A quarterly report will be sent to agencies for signature to verify that the quarterly data check has been completed and the data is accurate in the system.

CLIENTS WHO TRANSFER TO ANOTHER PRENATAL PLUS PROVIDER

If a Prenatal Plus provider has a client who withdraws from the program, and re-enrolls in Prenatal Plus at another agency within the same pregnancy, the following guidelines apply regarding data submission:

- The Prenatal Plus provider who originally enrolled the client must submit withdrawal information on the client. For IRIS users, this includes, completing the Withdrawn screen. Data must be submitted on all clients by the 15th day of the month following the withdrawal date. Medicaid may be billed a Partial or Partial Plus package, dependent on number of visits completed.

- The second Prenatal Plus provider should submit separate data on the client. For IRIS users, begin a "new" pregnancy record in IRIS for data entry. Be sure the information entered matches the data for the initial entry (i.e. same EDD), this helps clarify that the patient has transferred to a new provider during the same pregnancy rather than enrolling during a different pregnancy. Medicaid may be billed any of the four packages of service as long as all billing requirements are met.

- When entering a client into IRIS, if it appears that she has already been enrolled in Prenatal Plus through another agency, **do not** overwrite data in the fields already completed by the other agency. Call the site where the client was previously enrolled, verify that she is no longer being followed there, and notify them of her enrollment in the new agency. Encourage them to complete the Withdrawn screen for the client. If the client is found to be actively participating in both programs, inform the client and ask her from which agency she would prefer to receive services. In IRIS, start a "new" pregnancy record for this client with the information collected by the new agency.

CLIENTS WHO RE-ENROLL WITH THE SAME PRENATAL PLUS PROVIDER

If a Prenatal Plus provider has a client who withdraws from the program, and then re-enrolls with the same provider within the same pregnancy, the following guidelines apply regarding data submission:

- If the Prenatal Plus provider has not yet submitted data in IRIS on the client, or billed Medicaid, re-enroll the client and continue to collect data. Submit client data and bill Medicaid at the end of the second enrollment.

- If the Prenatal Plus provider has submitted data in IRIS on the client and completed the Withdrawn screen, then contact the Prenatal Plus Data Coordinator and ask to have the client re-activated. The old Withdrawal information will be deleted and the agency will submit new data at the end of the second enrollment.

- If the provider billed for a lesser package of services, and the requirements are met to bill a higher reimbursed package, the provider should request that the claim for the previous service package be backed out of the Medicaid system so that the current package can be billed.

GETTING STARTED ON IRIS

Internet Access

To connect to IRIS use a computer capable of connecting to the Internet either through an Internet Service Provider (ISP) or a direct DSL or T1 connection through the network. Internet Explorer (IE) is the recommended Internet software, but the program accommodates Netscape and other browsers. Browser software must be at the Cipher strength of 128-bit level to allow for encryption of the data transmission. To check Cipher strength open IE, select Help from the top main menu list and select About Internet Explorer. The program will open a screen showing the Cipher Strength value of 128-bit or it will provide a link to upgrade the software to that level.

Software Requirements

The IRIS System uses a web browser application called Citrix. Connect to the web address https://cxf.dphe.state.co.us, and find a link at the bottom of the page to download the latest version of Citrix. Download the software directly to the C: drive. After doing so, execute the application and complete installation by double clicking on the downloaded software. Contact the Citrix help desk number available on the website for printed installation instructions for first time users. The application is supported on Windows 2000, XP or Vista machines.

Network Connection Requirements

Networks usually lock out outside access to their network via a firewall to reduce problems with destructive viruses from the Internet. Your Network firewall may block access to the IRIS site. If this is the case and you need assistance, contact the helpdesk for instructions on how to enable access thru your network firewall. IRIS uses several security methods to protect users and clients, including the use of a Secure Socket Layer (SSL). Citrix also uses multi-level security roles and database recognition of the users only after each user has signed a security access form and is given access to the various programs. Supervisors for each user must submit a letter on their agency's letterhead requesting this access; see the next page for more information.

Sending Client Specific Information via the Internet

In order to comply with HIPAA regulations, the Department does not accept information via open email systems. When asking questions regarding client-specific information from contacts within the Department please use HyperSend.com. HyperSend is a proprietary product (www.HyperSend.com). It uses the Secure Socket Layer (SSL) technology to protect the files, the same protection used for on-line payments and other secure transactions. There is an extensive discussion of security features on the HyperSend site. HyperSend is free for a certain level of usage, up to 100 messages a month, and 10Mgb files can be sent for free. There are charges if usage exceeds this amount. Files are always free for the receiver.

NEW IRIS USERS

To have access to IRIS, the following steps must take place:

1. The local Prenatal Plus Program Coordinator will contact the Prenatal Plus Data Coordinator to request access to IRIS for the specific staff person(s).
2. The supervisor of the person seeking access must write a letter to request the access. See the *IRIS Supervisor Letter* for a template. The letter should be sent to the Prenatal Plus Data Coordinator.
3. The *Secure Web User ID Form and Data Security Use and Confidentiality Agreement Form* should accompany the letter. The supervisor and the requestor must both sign the form.
4. If the requesting agency is new, agency information should accompany the first staff person request. In addition, a list indicating IRIS user preferences (county, zip, printer, etc.) should be completed and submitted with the other forms.
5. The Data Coordinator, in consultation with the Prenatal Plus Program Director, will review the request. If accepted, the request will be tracked in the IRIS user setup database.
6. The Data Coordinator will keep the signed *Secure Web User ID Form* and will send a copy to the Department's IT staff to add the new user to the IRIS system.
7. Once the new IRIS user is established, the Data Coordinator will contact the new user at the Prenatal Plus agency by phone and convey the new ID and password.
8. The same process, and the same *Secure Web User ID Form*, should be used when there are name or other information changes.

IRIS USER TRAINING

All users of the IRIS system will be trained in how to use the system and in security measures for protecting the privacy of the clients and the confidentiality of the information. Each individual accessing the IRIS system must have his or her own User ID. Training can be either by the Prenatal Plus Data Coordinator or by the local Program Coordinator or other staff proficient in IRIS. Please notify the Data Coordinator, in writing, of training provided by local staff. The Data Coordinator will keep the documentation with the signed *Secure Web User ID Form* for all IRIS users.

EXISTING IRIS USERS

All staff granted access to IRIS will be required to renew security access annually. The Prenatal Plus Data Coordinator will coordinate the process of getting annual signatures from all IRIS users, and keep a copy of the signed forms. Anyone whose signature is not received at the time of the renewal request will lose access to IRIS.

If an IRIS user leaves the Prenatal Plus Program, the Program Coordinator must notify the Prenatal Plus Data Coordinator immediately in order to remove the user's access rights.

SECTION 9:
BILLING

The Prenatal Plus Program is a Medicaid-funded, collaborative effort between the Colorado Department of Public Health and Environment and the Colorado Department of Health Care Policy and Financing, also referred to as "Medicaid". The Department of Public Health and Environment provides administrative oversight of the program and Medicaid provides financial reimbursement. Local programs submit billing to Medicaid for direct reimbursement. There are four billing options, which are described below. Providers can only bill for services provided after the date that they receive the Prenatal Plus orientation training or approval from the Prenatal Plus Program Director to start to see clients.

PACKAGE TYPES

Partial Package Billing Information—Code H1005-TH 52

Reimbursement for a Partial package of services is **$150** and can be billed under the following conditions:

- Client enrolls at 28 or more weeks gestation and receives 1-4 contacts, at least one of which must be a face-to-face contact
  OR
- Client enrolls in the first or second trimester (prior to 28 weeks) and receives 1-4 contacts, at least one of which must be a face-to-face contact, but withdraws from the program before delivery OR does not meet the criteria for the other package categories.

- All required forms and required documentation are completed. See Section 3: Client Chart for details.

Partial Plus Package Billing Information – Code H1005-TH TF

Reimbursement for a Partial Plus package of services is **$400** and can be billed under the following conditions:

- Client enrolls at 28 or more weeks gestation and receives 5-9 contacts, at least one of which must be a face-to-face contact
  OR
- Client enrolls in the first or second trimester (prior to 28 weeks) and receives 5-9 contacts, but withdraws from the program before delivery OR does not meet the criteria for the Full package categories. With appropriate documentation, one telephone call can be counted as a contact. Calls to reschedule an appointment or to make an appointment with a client cannot be considered a contact.

- All required forms and required documentation are completed. See Section 3: Client Chart for details.

Full Package Billing Information—Code H1005-TH
Reimbursement for a Full package of services is **$750** and can be billed under the following conditions:

- Client enrolls at 27 or fewer weeks gestation.

- All required forms and required documentation are completed. See Section 3: Client Chart for details.

- A minimum of one case conference is held.

- Client receives a total of ten (10) contacts over the course of the pregnancy and through the end of the second month following the month in which the client delivered. With appropriate documentation, one telephone call can be counted as a contact. Calls to reschedule an appointment or to make an appointment with a client cannot be considered a contact.

Full Plus Package Billing Information– Code H1005-TH TG
Reimbursement for a Full Plus package of services is **$850** and can be billed under the following conditions:

- Client enrolls at 27 or fewer weeks gestation.

- All required forms and required documentation are completed. See Section 3: Client Chart for details.

- A minimum of one case conference is held.

- Client receives a minimum of eleven (11) contacts over the course of the pregnancy and through the end of the second month following the month in which the client delivered. With appropriate documentation, one telephone call can be counted as a contact. Calls to reschedule an appointment or to make an appointment with a client cannot be considered a contact.

- The client has one of the following absolute risk criteria listed on the *Intake Form*
  - History of previous low birth weight infant
  - Seventeen years or younger at time of delivery
  - Recent or current alcohol use
  - Recent or current illicit drug use
  - Recent or current smoker
  - Pre-pregnancy underweight (BMI < 19.8)

CLAIMS SUBMISSION AND TIMELY FILING

Prenatal Plus claims must be submitted directly to Medicaid within 120 days after the last date of service. The last date of service is either the delivery date or the last date of contact for those who withdraw from the program. Bill completed packages as soon as possible after the delivery date, even if the client may be seen for additional visits. Claims rejected by Medicaid for out of timely filing may be submitted to the Medicaid reconsideration committee with justification for the late filing.

OTHER INSURANCE COVERAGE

Occasionally, Prenatal Plus clients have primary insurance coverage in addition to being eligible for Medicaid coverage. In these instances, claims for Prenatal Plus services must first be submitted to the primary insurance company. Once the primary insurance company denies the claim, the claim can be submitted to Medicaid for reimbursement, along with a copy of the denial. If the client is covered by one of Medicaid's managed care organizations, a denial is not necessary before billing Medicaid for Prenatal Plus services.

BILLING MORE THAN ONCE IN A NINE-MONTH PERIOD

Medicaid's computer system allows for one billing per client in a nine-month period using Prenatal Plus billing codes. However, the following exceptions may be made:

- A client is seen for an initial pregnancy, subsequently has either a miscarriage or an abortion, and becomes pregnant again within a nine-month period. In this case, the provider may bill for the second pregnancy within the nine-month period.

- A client receives a Partial or Partial Plus package from one provider, then moves from the area and re-enrolls with a new provider. In this case, the first provider may bill a Partial or Partial Plus package, and the second provider may bill either a Partial, Partial Plus, Full or Full Plus package depending on the level of services provided (i.e., if all requirements for a Full package have been met, the provider can bill a Full package).

If a client leaves the program, and then re-enrolls with the **same** provider during the **same** pregnancy, the provider must request that the claim for the previously billed service package be backed out of the Medicaid system. Billing for the new service package can be done once criteria for the new package are met. An agency cannot bill Medicaid for two separate packages for the same client during the same pregnancy.

MEDICAID BILLING INSTRUCTIONS

- **Claim Form**: Colorado 1500 Form
- **Diagnosis Code**: Any ICD-9 diagnosis code between V22 and V24.2, including V23 (supervision of high-risk pregnancy)
- **Date of Service**: Delivery date, or if unknown due to client termination, date of last contact
- **Place of Service**: Use 11 or 12 (11 = office visit, 12 = home visit; since Prenatal Plus services can take place in both locations, either 11 or 12 is appropriate)
- **Procedure Code**: Use H1005-52 TH for a Partial package of services; H 1005-TF TH for a Partial Plus package of services; H1005-TH for a Full package of services; and H 1005-TG TH for a Full Plus package of services
- **Rendering Provider Number**: Use agency Medicaid provider number
- **Referring Provider Number**: Does not need to be completed
- **Diagnosis**: Use (1) in column P
- **Charges**: $150 for Partial package; $400 for Partial Plus package; $750 for Full package and $850 for Full Plus package of services
- **Days or Units:** Use (1) in column H
- **Billing Provider Number**: Must use agency Medicaid provider number, not individual number