CPSP

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Perinatal Services Coordinator
Santa Cruz County

CPSP Goal

- Improve the health of low-income pregnant women and give their babies a healthy start in life
There are over 1,500 approved CPSP providers

CPSP practitioners:
- MD’s
- CNM’s
- NP’s
- PA’s
- RN’s
- LVN’s
- RD’s
- Social Workers
- Psychologists
- HE
- MFCC
- CBE (LaMaze, ICEA, Bradley)
- CPHW

Characteristics of CPSP Care

CPSP services provided are
- Client-centered
- Multi-disciplinary
- Culturally competent
4 CPSP Service Areas

- Obstetrics
- Psychosocial
- Nutrition
- Health Education

CPSP
Scope of Services

CPSP Services
- Client Orientation
- Initial Assessments
- Individualized Care Plan (ICP)
- Interventions
- Reassessments
- Postpartum Assessment and Care Plan
Case Coordination

Means:
- Organizing the provision of comprehensive perinatal services
- Includes but is not limited to supervision of all aspects of patient care including
  - Antepartum
  - Intrapartum
  - Postpartum

Demystifying the Individual Care Plan (ICP)
Training Goals

- To promote a better understanding of the ICP
- To improve skill level in doing the ICP
- To provide better patient care

Individualized Care Plan

- A tool for coordinating perinatal care
- Covers all 4 components
  - OB, P/S, Nutrition, HE
- Identifies strengths
- Prioritize risk conditions/problems
Individualized Care Plan

- Goals for interventions and outcomes
- Referrals
- And identifies who is responsible for carrying out proposed interventions

The ICP should build on the client’s strengths, not simply identify her deficits
The ICP is made in consultation with the client
The whole purpose of conducting the assessment and creating the ICP
is to support her strengths and facilitate change
so she can improve her health
and that of her baby
Mandated referrals

- WIC
- Genetic Screening
- Dental Care
- Family Planning
- CHDP
Reassessments

- Reassessments in each of the discipline areas must be offered each trimester and postpartum.
- The ICP must be revised accordingly.

Most providers reassess at each visit (“what’s changed for you since your last visit”) and modify the ICP as needed.
Stages of Change

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance

Learning New Information (STT FS-19)

- People remember........
  - 10% of what they read
  - 20% of what they hear
  - 30% of what they see
  - 50% of what they see and hear
  - 70% of what they say or write, and
  - 90% of what they say as they do a thing
Cultural Considerations

Honor and Respect

- Behaviors
- Attitudes
- Values
- Beliefs
ICP

- When charting, the first initial, last name, title and date are required with every entry.

- Maybe used in conjunction with standardized prenatal/postpartum education or services checklist and may reference protocols.

- Address obstetrical, nutrition, psychosocial, and health education problems/needs/strengths.

ICP

- Both the Provider and Case Coordinator’s names must be on the ICP

- The Provider must also sign the ICP
ICP

- Patient Name: __________________________
- DOB: ________________________________
- Health Plan: __________________________
- I.D. # ________________________________

Practicum

Client -- Ana Flores
- Work together
- Review the Prenatal Combined Assessment Tool
- Using the ICP, identify strengths, problems/risks /concerns
- What health education do you want to provide? Referrals?
What are her strengths?

- Motivated to learn
- Motivated to change behavior
- Family support
- Still in school
<table>
<thead>
<tr>
<th>Date:</th>
<th>Identified Problem/ Risk/Concern</th>
<th>Teaching/ Counseling/ Referral</th>
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<tbody>
<tr>
<td>9/9/02</td>
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**Strengths Identified:**

- Motivated to learn
- Motivated to change behavior
- Family support
- Still in school

What are the problems/risks identified?

- She smokes a ½ pack of cigarettes/day
- Anemia – HCT 32.5%
- Drinks a 6 pack of beer on the weekend
- Potential domestic violence
Date: 9/9/02

Strengths Identified:

- Motivated to learn
- Motivated to change behavior
- Family support
- Still in school

Identified Problem/Risk/Concern:
Smokes ½ pack of cigarettes/day

Goal:
Client agrees to cut down to 3 cigarettes/day by next visit

Teaching/Counseling/Referral:

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What interventions would you do?

- Utilize protocols
- STT
- Refer to stop smoking hot line?
- Other?
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<thead>
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<td>R. Dixon, CPHW</td>
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<td>~ As above</td>
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<td><strong>Identified Problem/Risk/Concern</strong></td>
<td>Anemia – Hct 32.5%</td>
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<tr>
<td><strong>Goal:</strong></td>
<td>Client agrees - to increase iron rich foods in her diet.</td>
</tr>
<tr>
<td><strong>Teaching/Counseling/Referral</strong></td>
<td>Intervention per STT –N 33,37</td>
</tr>
<tr>
<td></td>
<td>Iron rich food list given STT - N  61</td>
</tr>
<tr>
<td></td>
<td>Ref to WIC</td>
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<tr>
<td></td>
<td>R. Dixon, CPHW</td>
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Would you refer her to the RD?

- Discussion (Ana also has pre-pregnant weight of 101 lb and has nausea/vomiting)

- Depends on providers resources and protocols

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<td>9/9/02</td>
<td>Drinks 6 Pack of beer each weekend</td>
<td>Intervention per STT Disc w provider</td>
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<td>Goal: Client agrees - to reduce amount of beer each weekend so that by next visit she will not be drinking beer or any other alcohol</td>
<td>R. Dixon, CPHW</td>
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**Strengths Identified:**
- As above

**Identified Problem/Risk/Concern**

**Teaching/Counseling/Referral**

**Reassessments**

- What are issues and successes on Ana’s next assessment regarding her goal of reducing her smoking?

- Let’s see what this would look like on the ICP
<table>
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<th>Follow-up Reassessment Date: 10/11/02 Outcome/Plan</th>
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<tr>
<td></td>
<td>Smokes ½ pack of Cigarettes/day</td>
<td>Intervention per STT.</td>
<td>Cut down to 4 cigarettes/day</td>
<td>Intervention per protocol &amp; monitor</td>
</tr>
<tr>
<td></td>
<td>Goal: Client agree to cut down to 3 cigarettes/day by next visit</td>
<td>Referred to 1-800-45-NO FUME R. Dixon, CPHW</td>
<td></td>
<td>Keep smoking log/diary</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Goal: Reduce to 2 cigarettes by next visit</td>
<td>S. Reyes, RN</td>
</tr>
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<td></td>
<td>Strengths Identified:</td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td>Anemia – Hct 32.5%</td>
<td>Intervention per STT.</td>
<td>HCT 33%</td>
<td>Enrolled at WIC</td>
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<td>Goal: Client agrees - to increase iron rich foods in her diet.</td>
<td>Iron rich food list given Ref to WIC R. Dixon, CPHW</td>
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<td>Iron rich foods per protocols</td>
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<td>Strengths Identified:</td>
<td></td>
<td>Goal: Con’t with Inc. Fe rich foods. Monitor</td>
<td>S. Reyes, RN</td>
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Would you refer her to the RD?

- Discussion  (Ana also has a gain of 1 lb since last visit and still has nausea/vomiting)

- Yes

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<td>10/11/02</td>
<td>Inadequate weight gain</td>
<td>Intervention per STT N 33, 37</td>
</tr>
<tr>
<td></td>
<td>Goal: Client agrees to try ideas in handout &amp; to see RD</td>
<td>Being seen at WIC</td>
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<td>Ref to RD</td>
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### Potential for Domestic Violence

**Goal:** Client agrees to be aware of boyfriend's anger and call 911 if needed

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<td>Potential for domestic violence</td>
<td>Intervention per STT. R. Dixon, CPHW</td>
<td>Con't to monitor situation</td>
<td>DV video &amp; class S. Reyes, RN</td>
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**Follow-up Reassessment Date:** 10/11/02

**Outcome/Plan:**
- Con't to monitor situation
- DV video & class
- S. Reyes, RN

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### Drinks 6 Pack of Beer Each Weekend

**Goal:** Client agrees to reduce amount of beer each weekend so that by next visit she will not be drinking beer or any other alcohol

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<td>Drinks 6 Pack of beer each weekend</td>
<td>Intervention per STT. R. Dixon, CPHW</td>
<td>Per protocol Disc w provider</td>
<td>Video #3</td>
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**Follow-up Reassessment Date:** 10/11/02

**Outcome/Plan:**
- Per protocol Disc w provider
- Video #3

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**Goal:** Client agrees to reduce two beers each weekend. Monitor S. Reyes, RN
Your work does make a difference in the lives of the women and babies you serve
Thanks for all you do
The End