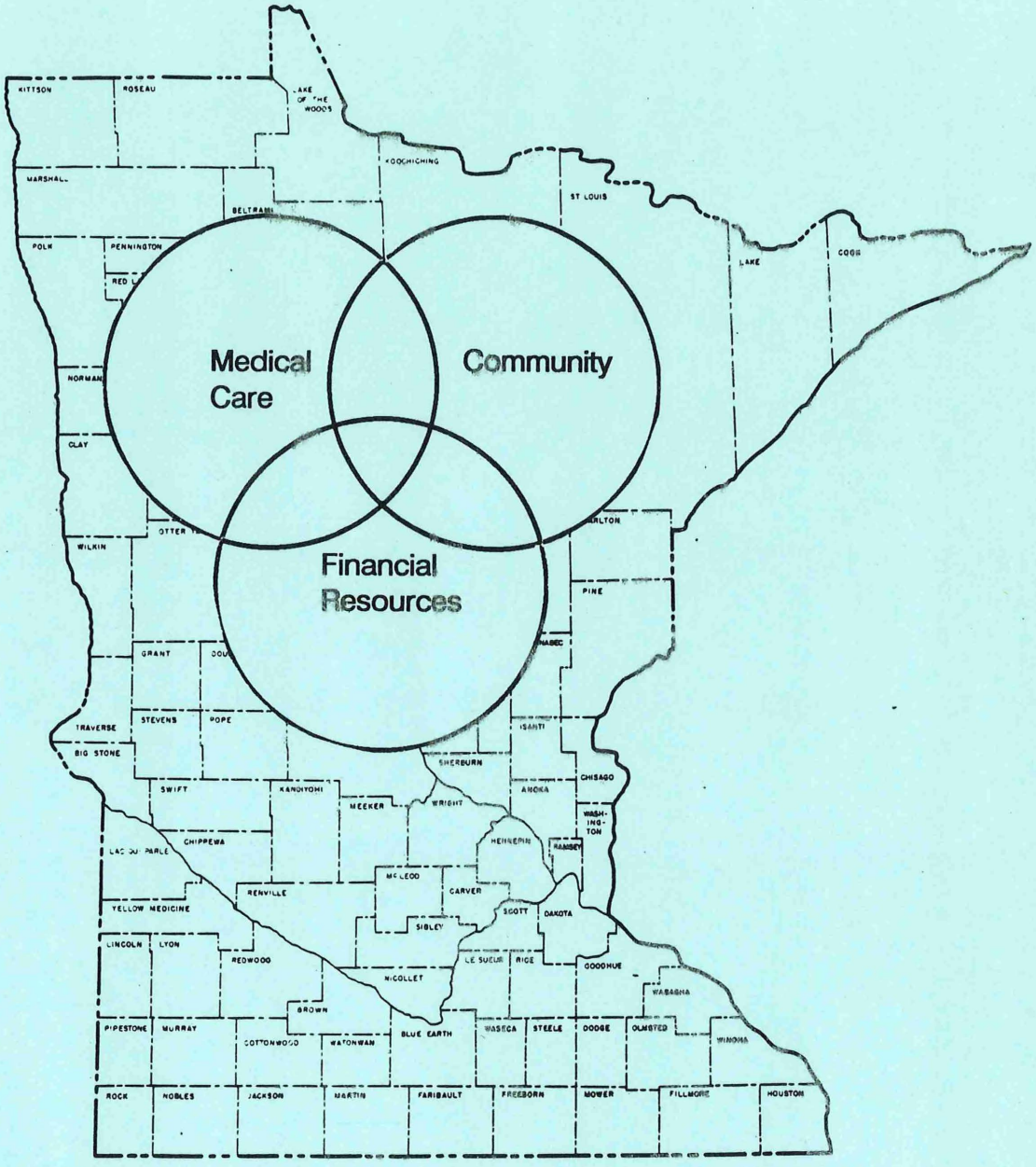
Healthy Moms and Healthy Babies: Your Role in the Prenatal Care Initiative



"Partners in Prenatal Care for Minnesota Moms"

Minnesota Prenatal Care Coordination Project
Minnesota Department of Health
Minnesota Department of Human Services
July 1990

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PRENATAL CARE INITIATIVE ENHANCED SERVICES

Included in this section are descriptions of each of the six enhanced services that may be provided for a pregnant woman determined to be high risk. The services are:

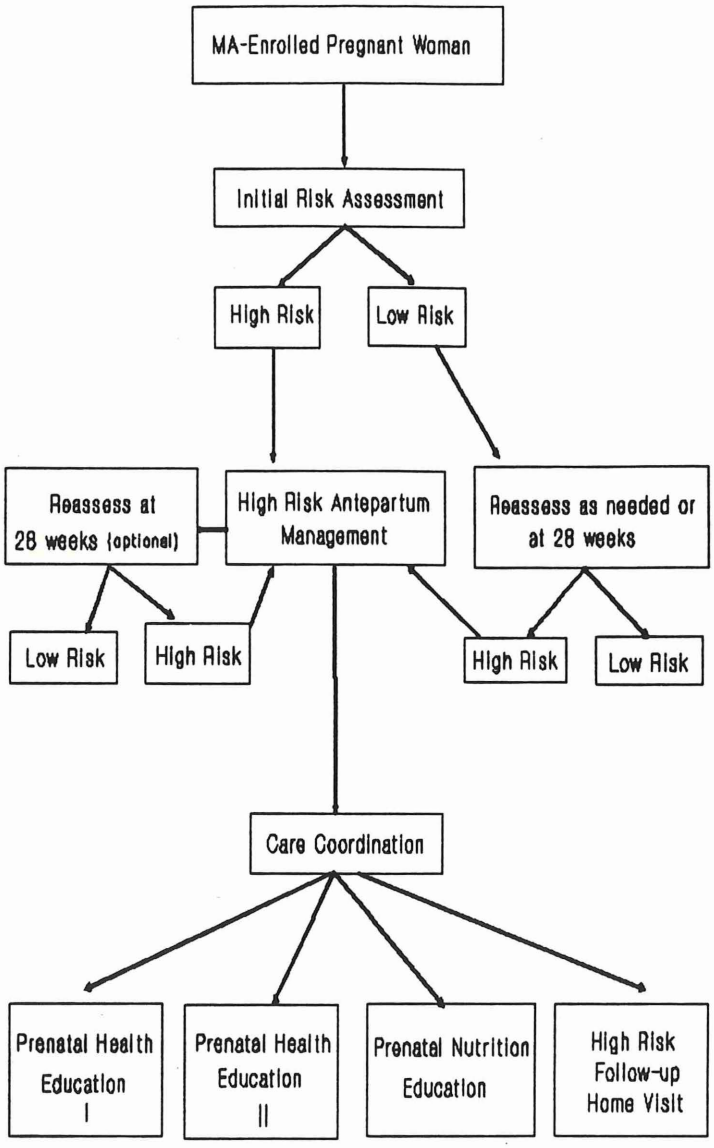
1. High Risk Antepartum Management
2. Care Coordination
3. Prenatal Health Education I
4. Prenatal Health Education II
5. Prenatal Nutrition Education
6. High Risk Follow-up Home Visit

The educational services (#'s 3-5) may be provided individually or in a group setting. Additional guidelines have been developed by the Minnesota Department of Health to provide assistance to those delivering perinatal services in Minnesota. The publication, Perinatal Health Care Services in Minnesota, Technical Guidelines for Community Health Agencies and Their Subcontractors, is available from the Minnesota Department of Health, Maternal and Child Health Technical Services.

Documentation guidelines are discussed separately, in the section which follows. Reimbursement rates are given in Appendix J.

On the following page is a flow chart outlining the risk assessment process and the enhanced services available to pregnant women.

FLOW CHART OF PRENATAL CARE INITIATIVE PROTOCOL



HIGH RISK ANTEPARTUM MANAGEMENT

Description: The medical care provider is eligible for reimbursement of a flat fee for the extra time and expertise needed to manage a high risk pregnancy.

High Risk Antepartum Management services include:

1) Determination of which of the enhanced services will benefit the pregnant woman

2) Indicating which services will be provided and by whom in the space provided on the Risk Assessment form (lower left hand corner)

3) Medical care as determined by the woman's needs

Eligible Providers: Physician, Certified Nurse Midwife, or Nurse Practitioner.

CARE COORDINATION

Description: Care Coordination is the development, implementation, and ongoing evaluation of a plan of care for the high risk pregnant woman. The care coordinator provides continuity, makes referrals to resources that will support a healthy pregnancy, monitors client progress, and advocates for the client to assure access to services.

Care Coordination services include:

1) Determining the woman's needs and risks in consultation with the primary medical care provider

2) Development, ongoing evaluation and revision of an individual plan of care with the pregnant woman that addresses her specific needs related to the pregnancy. Ongoing evaluation and revision, if appropriate, of the plan of care

3) Coordination of services and referrals to appropriate community providers

4) Assistance to the woman in identifying, obtaining, and using services specified in the plan of care

5) Monitoring, coordinating, and managing nutrition and education services to assure that these are provided in the most economical, efficient, and cost effective manner

Eligible Providers: Physician, Certified Nurse Midwife, or Registered Nurse.

PRENATAL HEALTH EDUCATION I

Description: Prenatal Health Education I teaches general information on pregnancy and prenatal care. It also covers high risk medical conditions and behaviors that can be alleviated or improved through education.

Prenatal Health Education I services include:

1) Importance of regular prenatal care

2) Normal changes of pregnancy (specific to trimester)
   a) Maternal anatomy and physiology
   b) Fetal development
   c) Emotional/psychosexual concerns

3) Comfort measures and self-care during pregnancy

4) Danger/warning signs during pregnancy

5) High risk medical conditions
   a) Diagnosis and significance during pregnancy
   b) Treatment: medications, activity level, options, and rationale
   c) Appropriate referrals

6) Labor and delivery (when client is in late 2nd or early 3rd trimester)
   a) Anatomy and physiology of labor and delivery
   b) Coping skills
   c) Medical management
   d) Hospital procedures
   e) Danger signs
   f) Communication with health care providers

7) Preterm labor
   a) Signs and symptoms
   b) Self-detection techniques
   c) Treatment of preterm labor
   d) Preventive measures

Eligible Providers: Physician, Certified Nurse Midwife, Registered Nurse or Health Educator with a baccalaureate degree in health education or higher and/or SOPHE (Society for Public Health Education) certification.

PRENATAL HEALTH EDUCATION II: LIFESTYLE AND PARENTING SUPPORT

Description: Prenatal Education II supplements Prenatal Health Education I. It is provided for clients who require more time and specialized education to make changes in high risk behaviors and lifestyles related to drug, alcohol and tobacco use, stress management, and parenting. Changes resulting from this early and consistent education may also have a long-term impact on the health of the mother, baby, and subsequent pregnancies.

Prenatal Health Education II services include:

1) Smoking
   a) Effects on mother and on fetal development
   b) Referral to smoking cessation programs if desired
   c) Encouragement to reduce smoking if unable to quit

2) Alcohol
   a) Effects on fetal development
   b) Emphasis on importance of complete abstinence from alcohol during pregnancy
   c) Referral to support program if needed

3) Street drugs
   a) Effects on fetal development
   b) Emphasis on no safe limit during pregnancy
   c) Referral to support program if needed

4) Over the counter/prescription drugs
   a) Emphasis on the need to consult with primary provider before using any type of medication during pregnancy

5) Environmental/occupational hazards (eg lead, petroleum products)
   a) Effects on fetal development
   b) Identification of potential exposure to hazards in woman's environment
   c) Efforts to minimize exposure
   d) Referrals for follow-up if needed

6) Stress management
   a) Identification of potential stressors (job, school, personal problems, etc)
   b) Self-identification of signs of stress
   c) Relaxation techniques
   d) Referral to support services if needed (financial, social)
   e) Coping skills

7) Communication skills and resources
   a) Family support systems
   b) Health care providers

8) Building self-esteem

9) Parenting skills to meet the physical, emotional and intellectual needs of the infant
   a) Identification and affirmation of positive prenatal parenting behaviors
   b) Infant needs/care/feeding
   c) Nurturing
   d) Referral to community resources if needed.

10) Planning for continuous, comprehensive pediatric care following delivery.

Eligible Providers: Physician, Certified Nurse Midwife, Registered Nurse, Health Educator with a baccalaureate degree in health education or higher and/or SOPHE (Society for Public Health Education) certification, or Social Worker (baccalaureate or masters prepared).

TABLE OF CONTENTS

THE MINNESOTA PRENATAL CARE INITIATIVE: PURPOSE AND IMPLEMENTATION STRATEGIES

Low birthweight and preterm birth are two of the major health problems infants face in the United States today. In 1985, 16% of the infants born to Minnesota women who were recipients of Medical Assistance were low birthweight, compared to 4.8% of all Minnesota babies. Studies cited in the 1985 Institute of Medicine report, Preventing Low Birthweight, indicate that low birthweight (LBW) infants account for 2/3 of the deaths during the first 28 days after birth and are five times more likely to die later in the first year of life than are normal weight infants. The incidence of death increases with decreasing birth weight and gestational age. Higher rates of low birthweight babies in certain subpopulations reflect disparities in socioeconomic and educational status, access to prenatal care, and prenatal nutrition (Child Health Outcomes Project, 1984). Low birthweight and preterm infants who survive face an increased risk of illness and handicapping conditions. Studies conducted in Georgia indicate that 8% of all LBW infants discharged from neonatal intensive care units experience significant handicaps preventing normal function (Alliance for Human Development, 1984).

Prenatal care is an important factor in improving pregnancy outcomes and reducing long-term disability, illness, and the accompanying social and medical costs. Women who have inadequate prenatal care are three times more likely to have a LBW infant than are women who have early and continuous prenatal care (Greenberg, 1983). Such care, however, is not consistently available to all women in Minnesota. In 1988, only 72% of all pregnant women in Minnesota started prenatal care in the first trimester of pregnan-

cy, and 4.1% obtained only third trimester or no prenatal care (Minnesota Department of Health, 1990). In the same year, pregnant women in Minnesota received an average of 11.4 prenatal visits, substantially less than the 14 prenatal visits recommended for uncomplicated pregnancies by the American College of Obstetricians and Gynecologists.

Two task forces in Minnesota have examined the delivery of prenatal care in the State (the Maternal and Child Health Advisory Task Forced formed in 1982 by the Minnesota Department of Health and the Prenatal Care Initiative Task Force formed in 1986 by the Minnesota Department of Human Services). They determined that low income women in Minnesota may not have access to prenatal care and also do not consistently receive comprehensive, risk appropriate care. In addition, the Health Plan for the Mothers and Children of Minnesota identified several problems in prenatal health care in Minnesota: fragmentation of perinatal health services, inadequate linkages among providers of care, and inconsistency across the state in ways that care is delivered, levels of care, technical knowledge and skills of professionals, and the availability of multidisciplinary teams.

Beginning in 1985, federal legislation amending Medicaid statutes has permitted states to offer enhanced prenatal services to women whose care is paid for by Medical Assistance. This legislation enabled the Prenatal Care Initiative to be developed in Minnesota to address the problem of inadequate access to prenatal care and to encourage comprehensive, risk appropriate care.

One assumption of the Prenatal Care Initiative (PCI) is that providers of medical care (largely through the private sector) and public health providers of preventive services such as community education, outreach, counseling, health education, and nutrition supplements can develop linkages at the community level. The public and private sector can work together so that women who refuse

prenatal care or who are hard to reach can be found and encouraged to obtain the full range of services needed to enhance birth outcomes.

Financial incentives are provided by the Minnesota Department of Human Services (DHS) to promote the objectives of the PCI. These incentives operate at both the client and the provider level. The Medical Assistance income guidelines for non-pregnant women in Minnesota are generally less than 90% of federal poverty level, with a test of assets required. In order to increase coverage for pregnant women and their infants up to age one, the Minnesota Legislature expanded eligibility for MA to those with net available incomes less than or equal to 185% of the federal poverty level. There is no assets test required and the application process is simplified. The Prenatal Care Initiative (PCI) reimburses prenatal care providers additional amounts of money for enhanced prenatal services to high risk pregnant women (See Appendix A, Minnesota MCH Programs). All MA-enrolled pregnant women are to be assessed for medical and psychosocial risks by their medical care provider, using a tool supplied by the Department of Human Services. This risk assessment serves as the basis for planning comprehensive care for those women determined to be at risk. The enhanced services available to high risk women include care coordination, prenatal health education, prenatal nutrition education, and a post partum home visit.

In 1988, the Minnesota Department of Health, in collaboration with the Department of Human Services, the Minnesota Medical Association, and the University of Minnesota School of Public Health, received federal SPRANS (Special Projects of Regional and National Significance) funding for the Minnesota Prenatal Care Coordination Project (MPCCP). The goal of this three year project is to provide technical support to promote coordinated efforts in communities by public and private providers to help prevent low birthweight babies. To accomplish this, the MPCCP provides education to health

care professionals about the PCI risk assessment tool, enhanced prenatal care services, and collaborative use of community resources.

This manual has been developed by the MPCCP to assist health care professionals who work with the Prenatal Care Initiative. It provides information on determination of client eligibility for Medical Assistance and the PCI, prenatal risk assessment, and information about billing for services provided. It also includes descriptions of the content of the PCI Enhanced Services and models for working with high risk pregnant women. Questions regarding this manual and other aspects of the Prenatal Care Coordination Project may be directed to any of the Minnesota Prenatal Care Coordination staff:

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Bemidji, Mn. 55744

Southern Minnesota.....Darlene Lind.....507/389-2501
Minnesota Department of Health
South Central District
Nichols Office Center
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Mankato, Mn. 56001

Metro & SE Minnesota.....Deborah Sodt.....612/623-5714
Minnesota Department of Health
Maternal and Child Health
717 Delaware SE, Box 9441
Minneapolis, Mn. 55440

Project Coordinator.....Sara Mullett.....612/623-5678
Maternal Infant Nurse Consultant
Minnesota Department of Health
Maternal and Child Health
717 Delaware SE, Box 9441
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DETERMINATION OF CLIENT ELIGIBILITY FOR MEDICAL ASSISTANCE AND THE PRENATAL CARE INITIATIVE ENHANCED SERVICES

Definitions

For the purposes of this manual, the following definitions apply. They will be discussed in more detail below:

Department of Human Services (DHS)- State agency which reimburses health care providers for care given to Medical Assistance eligible clients.

Medical Assistance (MA)- A program established under Title XIX of the Social Security Act and Minnesota Statutes, and administered by DHS. MA reimburses health care providers for services delivered to eligible clients. Eligibility is determined on the basis of financial need. If a woman is pregnant, there is expanded eligibility if her net income is <185% of poverty, without regard to assets. A woman who is pregnant can request a one page application at the time of her interview. She is entitled to an expedited review if she informs the county that she is pregnant. According to state law, her interview must be held within five (5) working days and a final determination made within ten (10) working days following the interview.

Prenatal Care Initiative (PCI)- A reimbursement mechanism administered by MA that offers financial incentives at the provider level for the provision of risk-appropriate, comprehensive prenatal care to MA clients. Women not eligible for MA are not eligible for the PCI.

Application For Medical Assistance

In Minnesota, if a pregnant woman's net available income is ≤185% of the federal poverty level she is eligible for coverage under the Medical Assistance (MA) program. MA will pay for her medical care until sixty (60) days postpartum. To obtain MA coverage, a woman should contact her county social service agency after having

her pregnancy confirmed, and make an appointment to determine eligibility (for a directory of county social service agencies, see Appendix B). There is an expedited processing system for pregnant women, including a shortened application form and a waiver of the test of assets normally required for MA (see Appendix C, Medical Assistance Application for Pregnant Women). When scheduling the appointment, she should identify herself as pregnant, as pregnant applicants are to be given appointments with a financial worker within five (5) working days of the request. She will need to bring written verification of a positive pregnancy test from a physician, certified nurse midwife, or registered nurse with information regarding her financial status (monthly income) to that appointment. Current income guidelines for the MA program for pregnant women are $15,577/year for a family of 2, and a pregnant woman equals 2 people (For income guidelines, see Appendix D). A decision regarding her eligibility is to be made within ten (10) working days of the date of her personal interview at the social service office. Although the mother's MA coverage ends at sixty days post partum, the baby is eligible for MA coverage until age one year, if the family's income remains at or below 185% of poverty. This requires a redetermination of eligibility, as the baby is not automatically covered by the mother's eligibility. If at this time the mother's income remains low, she may be eligible for Medical Assistance (MA) coverage, subject to the same guidelines applied to any other (non-pregnant) member of the general population.

(Note: A woman who becomes pregnant while under the coverage of the General Assistance Medical Care (GAMC) program of the Department of Human Services should contact her county social service office and be transferred to the MA program).

Assessment of Risk at Medical Clinic

At the first prenatal visit, the medical care provider should fill out the Medical Assistance Prenatal Risk Assessment form (DHS form #2867-see Appendix E). When a woman scores ≥10 points she is considered high risk and is eligible for enhanced prenatal services to meet her special health needs. There may also be situations in which a provider concludes that a woman is high risk, but the Risk Assessment (RA) score is under 10. For such cases, the Department of Human Services will accept the clinician's professional judgment and will reimburse for enhanced services. The provider must indicate a brief rationale for the high risk status on the RA form, along with the provider's signature. (Revised RA forms will reflect this change; until they are available providers may make the notation on the old forms. For program evaluation purposes, providers are encouraged to continue to score for risk. This will enable DHS to obtain a more accurate picture of the women's health status.)

Indicate on the lower left hand corner of the Risk Assessment form which of the enhanced services will be provided, as well as who will provide them. EXAMPLE:

X	Care Coordination	Dr. Jones
X	Prenatal Health Education I	Public Health Department
X	Prenatal Nutrition Education	Hospital Dietitian

DO NOT FORGET TO MAKE THE APPROPRIATE REFERRALS. (For an example of a recommended referral form developed for this purpose, see Appendix F).

Keep one copy of the Prenatal Risk Assessment form for your records, and send the white copy to DHS for reimbursement. With the client's signed release of information, make copies and send to any providers who will be providing enhanced services to your client.

Providers are encouraged to send all Risk Assessment forms to DHS, regardless of risk score. DHS needs to receive both high and low risk forms, to obtain an accurate understanding of the health status of the MA population being served. For information about reimbursement for Risk Assessment forms, see the billing section of this manual. PLEASE NOTE A MAJOR CHANGE: **Prior authorization by DHS is no longer needed for providers of PCI enhanced services** (effective 10/1/89).

A requisition to order more Risk Assessment forms is found in Appendix G.

The Risk Assessment form is to be filled out again at the 28-week prenatal visit (or earlier if the woman's status changes). For a woman already determined to be high risk at the initial screening, the 28 week risk assessment is optional, as she is not likely to convert to low risk. The 28 week reassessment is crucial for the low risk woman, however, as she may change to high risk status and become eligible for enhanced services at that time.

NOTE: The Minnesota Medical Association 1989 Standards and the American College of Obstetricians and Gynecologists both recommend that ALL pregnant women be assessed for risk factors, not only women on Medical Assistance.

Provision of Enhanced Services for the Individual Pregnant Woman

Most high risk women are eligible for ALL of the enhanced services. The completed Risk Assessment form serves as a guide as to which services will be provided. For example, if the woman smokes and/or drinks alcohol, Prenatal Health Education II should be provided.

High risk pregnant women require innovative and individualized approaches to meet their educational needs. The primary care provider may choose to provide services in the clinic setting, but there may be situations in which some or all of the individual woman's need for enhanced services can more adequately be met in non-office settings. Examples include women with transportation or child care problems that inhibit their ability to come to the office, women with language or cultural barriers who may feel more comfortable in a different environment, women with slow comprehension or low level literacy skills who need extra time to learn, women who work during regular office hours, and women who refuse or fail office appointments. Such women may be referred to a variety of community agencies for services, including Public Health Nursing (See Appendix F- Prenatal Care Initiatives Health Professional Referral Form and Appendix H- Directory of Public Health Nursing Agencies). The Community Health Service Agencies provide community needs assessments, outreach to pregnant women in need of services, and health promotion and education to high risk families.

If the primary provider refers a client to another enrolled MA provider for PCI enhanced services, that provider bills MA directly. If the primary provider refers to a provider <u>not</u> enrolled in the MA program, the primary provider bills MA and reimburses the provider performing the service. For further discussion of hard-to-reach women, see "Models" section later in this manual.

PRENATAL NUTRITION EDUCATION

Description: Prenatal Nutrition Education addresses nutritional problems the pregnant woman may have or be at risk of developing. It provides information and support to help the pregnant woman make informed nutritional choices that will support a healthy pregnancy and baby.

Prenatal Nutrition Education services include:

1) An initial assessment of nutritional risk based on height, current and pre-pregnancy weight, laboratory data, clinical data, and self-reported dietary information

2) On-going assessment of the pregnant woman's nutritional status (at least once every trimester) based upon dietary information, adequacy of weight gain, measures to assess uterine/fetal growth, laboratory data, and clinical data

3) Development of an individualized nutrition care plan which addresses the client's nutritional deficits, prioritizes her nutritional needs, and lists interventions

4) Referral to food assistance programs if indicated, (WIC, food stamps. etc.)

5) Nutritional needs in pregnancy
   a) Requirements for fetal growth and development
   b) Recommended Dietary Allowances for normal pregnancy
   c) Appropriate weight gain
   d) Vitamin and iron supplements
   e) Infant nutritional needs and feeding practices, including breastfeeding

6) Prenatal and postnatal exercise and activity

Eligible Providers: Physician, Certified Nurse Midwife, Registered Nurse, Dietitian or Nutritionist.

HIGH RISK FOLLOW-UP HOME VISIT

Description: The high risk follow-up home visit is in addition to and separate from the mother's six week postpartum visit to her primary care provider. It is to be made within the first two weeks of the mother's hospital discharge. This visit gives special support to high-risk mothers and infants by following up on pre-identified high-risk behaviors or medical conditions, and addressing the stress involved in caring for a new baby. It is an opportunity to provide reinforcement and support for positive behavior changes, family planning counseling, anticipatory guidance for healthy parenting, and education about infant care. The home visit assesses any needs of the family that will require additional home visits or referrals to appropriate health and social service providers.

The High Risk Follow-up Home Visit services include:

1) Assessment of mother's health
   a) Follow-up on any high risk behaviors or medical conditions
   b) Support for any positive changes made to date

2) Physical/emotional changes postpartum
   a) Anticipatory guidance regarding relationship with partner
   b) Sexuality
   c) Potential stress with family
   d) Nutritional needs
   e) Physical activity/exercise

3) Family planning

4) Parenting skills and support
   a) Adapting to parenthood
   b) Parent/child relationship
   c) Child care arrangements and support

5) Grief support if unexpected outcome

6) Parenting sick/preterm infant if indicated
   a) Follow-up on high risk conditions

7) Assessment of infant's health
   a) Weight/growth
   b) Development, newborn behaviors

8) Infant care
   a) Feeding and nutritional needs
   b) Recognizing signs of illness in the newborn
   c) Injury prevention
   d) Immunizations and pediatric care

9) Referral to community health resources, if needed

Eligible Providers: Physician, Certified Nurse Midwife or Registered Nurse. Must be able to anticipate the woman's need for guidance and arrange referrals to providers appropriate for those needs.

7) Assessment of infant's health
   a) Weight/growth
   b) Development, newborn behaviors

8) Infant care
   a) Feeding and nutritional needs
   b) Recognizing signs of illness in the newborn
   c) Injury prevention
   d) Immunizations and pediatric care

9) Referral to community health resources, if needed

Eligible Providers: Physician, Certified Nurse Midwife or Registered Nurse. Must be able to anticipate the woman's need for guidance and arrange referrals to providers appropriate for those needs.

DOCUMENTATION GUIDELINES

It is important that those who deliver the PCI enhanced services provide adequate documentation of those services. DHS will be auditing providers for completeness of documentation. Documentation is to include:

1. The initial physician's order.
2. The date and nature of the service provided.
3. The name of the person providing the service.
4. For services referred to another agency, that agency must obtain approval for continuation of the service, at least every 60 days, by the ordering physician (MA/GAMC Provider Manual).

This section outlines documentation needed for each of the PCI enhanced services. Included are examples of records that could be used to document the educational and home visit services. Each clinic or agency may choose to use its own forms for documentation purposes.

HIGH RISK ANTEPARTUM MANAGEMENT

Documentation of High Risk Antepartum Management is to include:

1) Completion of the Prenatal Risk Assessment form supplied by the Department of Human Services (See Appendix E).

2) Documentation in medical chart of medical care provided.

CARE COORDINATION

Documentation of Care Coordination is to include:

1) A written, individualized plan of care that addresses the woman's specific needs related to the pregnancy, including any revisions of that plan. Documentation should also include evidence of any referrals made, and of follow through with those referrals (See Appendix F- PCI Health Professional Referral form).

2) Evidence of the following: monitoring, coordinating, and managing nutrition and prenatal education services to assure that these are provided in the most economical, efficient, and cost effective manner (Minnesota Rules, part 9505.0353).

(Adapted from the MA/GAMC Provider Manual)

MINNESOTA MEDICAL ASSISTANCE
PRENATAL CARE INITIATIVES
HEALTH PROFESSIONAL CARE PLAN

PRENATAL EDUCATION I

Client Name _____

MA # _____

Date Initiated _____

Topic	Date and initials of provider			Comments (include materials/ A-V's used, reactions to teaching, review at next visit)
1st Trimester 1. Importance of regular prenatal care				
2. Normal changes due to pregnancy				
Conception				
Maternal anatomy and physiology				
Fetal development				
Emotional changes (i.e. mood swings, feelings and reactions to being pregnant)				
3. Self-care/hygiene during pregnancy				
Skin and breast changes				
4. Discomforts of pregnancy (i.e. morning sickness, frequency, vaginal discharge)				
5. Pregnancy danger/warning signs				
6. Identification of high risk medical condition(s)				
Diagnosis and significance during pregnancy				
Specific treatments and/or medications				
Activity level, options, and rationale				
2nd/3rd Trimester 7. Fetal growth and development				
8. Normal changes due to pregnancy (changes in posture due to growing fetus, body mechanics, balance, etc.)				
9. Sexual changes during pregnancy				

Topic	Date and initials of provider			Comments (include materials/ A-V's used, reactions to teaching, review at next visit)
10. Discomforts of pregnancy (fetal movement, constipation, heartburn, hemorrhoids)				
11. Danger Signs/Pre-term labor prevention				
Symptoms of pre-term labor				
Self-detection				
Treatment				
Preventive measures				
12. Anatomy and physiology of labor and delivery				
Coping skills and relaxation				
Medical management				
Hospital procedures (analgesia, anesthesia, birthing alternatives)				
13. Genetic counseling				
14. Postpartum expectations				
Physical changes (lochia, cramps, signs/symptoms of infection)				
Fatigue/Exercise/Activity				
Emotional changes				
Sexual Activity				
Contraception				
15. Investigate need for additional information and contract with community services for child birth education classes (specify name of program/provider)				

Additional Comments/Information:

Health Provider's Signature(s)

MINNESOTA MEDICAL ASSISTANCE
PRENATAL CARE INITIATIVES
HEALTH PROFESSIONAL CARE PLAN

PRENATAL EDUCATION II

Client Name _____

MA # _____

Date Initiated _____

Topic	Date and initials of provider			Comments (include materials/ A-V's used, reactions to teaching, review at next visit)
1st Trimester 1. Smoking assessment (how many/day)				
Effects of smoking on mother and fetal development.				
Alternatives to stop or decrease smoking				
Investigate need for further assistance to quit smoking or contract with community programs designed for this purpose (specify program/provider)				
2. Assessment of alcohol use (what, how much, how often)				
Effects of alcohol on fetal development				
Alternatives to stop or decrease alcohol use				
Refer to county for alcohol treatment program (specify program)				
3. Assessment of illicit or street drug use (what kinds, how much, how often)				
Effects of drugs on fetal development				
Emphasize no safe limit during pregnancy				
Refer to county for drug treatment program				
4. Safe use of OTC/prescription drugs				
5. Use of caffeine in pregnancy				
6. Identify environmental/occupational hazards related to pregnancy				
7. Stress Management				
Job/employment/school problems				
Coping skills/ support systems				
Assess need for further support or contract with community support services (specify services)				

Topic	Date and initials of provider			Comments (include materials/ A-V's used, reactions to teaching, review at next visit)
8. Communication with health care providers				
9. Building self esteem				
2nd/3rd Trimester 10. Effect of pregnancy on the family (change in roles, relationships, communication, patterns, life-styles)				
11. Identify and affirm prenatal parenting behaviors				
Name, clothing, equipment/supplies needed				
Methods of infant feeding				
Newborn appearance				
Newborn behaviors (sleep/awake cycles, crying)				
Reflexes/motor activity				
Sensory responses				
12. Expectations of parenting				
Adjustments in relationships				
Father participation				
Sibling preparation				
Anticipated childrearing practices				
Assess need for further parenting instruction or contract with community resources for parenting classes (specify provider/class)				
13. Importance of routine pediatric care and referral				

Additional Comments/Information:

Health Provider's Signature(s)

MINNESOTA MEDICAL ASSISTANCE
PRENATAL CARE INITIATIVES
HEALTH PROFESSIONAL CARE PLAN

PRENATAL NUTRITION EDUCATION

Client Name _____

MA # _____

Date Initiated _____

Topic	Date and initials of provider			Comments (include materials/ A-V's used, reactions to teaching, review at next visit)
1st Trimester 1. Identification and interpretation of nutritional risks relating to pregnancy				
2. 1st trimester nutritional assessment (dietary information, weight gain/loss, lab data, fetal growth, and other clinical data) (specify abnormalities)				
3. Nutritional requirements of pregnancy linked to fetal growth and development				
4. Recommended dietary allowance for pregnancy				
5. Weight gain				
6. Vitamin/iron supplements				
7. Prenatal exercise/physical activity program				
8. Development of nutrition care plan				
Nutritional deficiencies (specify)				
Prioritization of nutritional needs				
Incorporation of food likes/dislikes and cultural influences on diet				
9. Refer to food assistance programs				
10. Assess need for additional individual/group nutrition education or contract with community providers for additional nutrition education				

Topic	Date and initials of provider			Comments (include materials/ A-V's used, reactions to teaching, review at next visit)
11. 2nd trimester nutritional assessment (specify abnormalities)				
12. 3rd trimester nutritional assessment (specify abnormalities)				
13. Infant nutritional needs and feeding practices				
14. Postnatal exercise/physical activity program				

Additional Comments/Information:

Health Provider's Signature(s)

MINNESOTA MEDICAL ASSISTANCE
PRENATAL CARE INITIATIVE$
HEALTH PROFESSIONAL CARE PLAN

HIGH RISK FOLLOW-UP HOME VISIT

Client Name _____

MA # _____

Date Initiated _____

Topic	Date and initials of provider			Comments (include materials/ A-V's used, reactions to teaching, review at next visit)
1. Assessment of mother's health; follow-up of "high risk" behavior(s) and/or medical conditions (please specify)				
Support of positive changes made to date				
2. Physical/emotional changes postpartum:				
Relationship and role changes				
Emotional changes				
Activity and fatigue				
Exercise/weight loss				
Lochia/cramps				
Signs and symptoms of infection				
3. Contraceptive methods				
Interconceptional care				
Referral for genetic counseling (please specify)				
4. Grief support if unexpected birth outcome				
Assess need for additional grief support or contract with community health professional(s) and/or support group (specify services)				
5. Newborn care (bathing, cord care, circumcision, elimination, etc.)				
Feeding and infant nutritional needs				

Topic	Date and initials of provider			Comments (include materials/ A-V's used, reactions to teaching, review at next visit)
Growth and development				
Recognition of illness in the newborn				
Safety and accident prevention				
Immunizations and pediatric care				
6. Parenting and sick/preterm infant				
Follow-up "high risk" conditions (please specify)				
Infant weight and growth				
Infant behavior, physical development and capabilities				
7. Assist client to identify other community resources/services available to the family (specify)				
8. Refer to Public Health for additional home visits				

Additional Comments/Information:

Health Provider's Signature(s)

BILLING INFORMATION

This section contains information about billing the Department of Human Services (DHS) for services covered under Medical Assistance (MA), including the Prenatal Care Initiative (PCI). The Practitioner Invoice (See Appendices K and L) is used to bill DHS for services provided under these programs. Each service is assigned a procedure code for billing purposes. For procedure codes not listed here, consult the appropriate chapter of the MA/GAMC Provider Manual.

The maximum allowable rates for the Prenatal Care Initiative Enhanced Service components are given in Appendix J. Agencies must bill their usual and customary charges, even if higher than the maximums allowed by DHS under Medical Assistance. DHS will use these charges when determining subsequent reimbursement rate allowances from the state legislature (these rates are often based on usual and customary averages). See the definition of "usual and customary charges" in the MA/GAMC Provider Manual.

Billing information for the medical care provider is discussed first, followed by information about billing for the public health or home care agency. For further information about billing, refer to the MA/GAMC Provider Manual.

Questions may also be directed to the following people at the Department of Human Services:

Prenatal Care Initiative .....(612)-296-6040
Obstetric Care Policy.....(612)-296-3386
Home Health Care Policy.....(612)-297-3583

Claims Processing:

Home Health Agencies.....(612)-296-1375

Ob (Physician) Services.....(612)-296-7471

Independent Nurse Midwives....(612)-296-7585 or 296-7471

Medical Clinic Billing for Medical Assistance (MA) Reimbursement for PCI Enhanced Services

The medical clinic bills for Prenatal Care Initiative (PCI) services following the same procedure as for other Medical Assistance billings and using the applicable codes listed below (See Appendix K, Practitioner Invoice-Clinic). Please note that prior authorization from DHS for PCI services is no longer needed.

"Enhanced Perinatal Services" refers to services delivered to high risk MA recipients that are reimbursed in addition to routine prenatal medical care. (MA/GAMC Provider Manual, 1990)

The following is a list of the PCI Risk Assessment and Enhanced Service components, along with applicable procedure codes.

Service	Code Used on DHS Practitioner Invoice
***Risk Assessment** (both high and low)	X5494
****Enhanced Service Components for High Risk Women:**	
High Risk Antepartum Management	X5495
Care Coordination	X5496
Prenatal Health Ed I	X5497
Prenatal Health Ed II	X5497-52
Prenatal Nutrition Ed	X5498
High Risk Follow-up Home Visit	X5499
Enhanced Services Package (consists of all of the above, if received from one provider)	X5493

*To receive reimbursement, bill for Risk Assessment (X5494) on the

MA Practitioner Invoice and mail to the address on the invoice (the usual DHS billing procedure). Send the completed original Risk Assessment form to the address at the top of that form. Keep pink copy in the client's chart. The Practitioner Invoice and the Risk Assessment forms should be sent separately because they are processed by different departments within DHS.

**To receive reimbursement for enhanced services, bill for the services provided, using the Practitioner Invoice and the appropriate code(s).

Reimbursement rates are listed in Appendix J.

Public Health and Home Health Agency Billing for Medical Assistance (MA) Reimbursement of Pregnancy Related Home Visits

Medical Assistance reimburses nursing agencies for various public health services provided in the client's home. These include both Home Health Services and Prenatal Care Initiative (PCI) Enhanced Services. The agency bills the Medical Assistance (MA) Program of the Department of Human Services (DHS) for PCI Enhanced Services through the same procedure as for other MA billing (See Appendix L, Practitioner Invoice- PHN Agency), using the applicable procedure codes. An agency providing a combination of PCI and Home Health Services to the same client uses both codes to bill MA: PCI procedure codes for home visits that provide PCI services and Home Health procedure codes for other home visits. Each PCI service may be billed <u>once</u> per client per pregnancy- there is a flat reimbursement for each service, with no limit on the length of time used to provide that service.

The content which follows was abstracted from the MA/GAMC Provider Manual. The MA/GAMC Provider Manual is updated on a quarterly basis. For further information or for the most current information regarding how to bill for these services, consult that manual. For PCI reimbursement rates, see Appendix J.

Home Health Services

Pregnancy related home visits that are not reimbursed as part of the PCI enhanced services but are ordered by a physician can be billed in the following ways:

1. Nurse Visit - code X5284 (see definition below).

OR

2. Health Assessment and Screening - code X5286.

OR

3. Health Promotion and Prevention Counseling - code X5287

If using # 2 or 3 above, additional billing may also be submitted for Interpretation of Findings (see definition below):

Length of time spent	Code #	
10-15 minutes	X5288}	one unit*
25-30 minutes	X5288}	is equal
40-45 minutes	X5288}	to 15
55-60 minutes	X5288}	minutes

Example:	Health Assessment and Screening (X5286)	$XX
	+ Interpretation of Findings (X5288)	$XX
	Total billing for this visit:	$xx

*Time spent for Interpretation of Findings is reimbursed in 15-minute increments (units). For example, for 30 minutes of time spent on Interpretation of Findings, bill for two units of code X5288. The amount of time spent for Interpretation of Findings should be documented. Physician's orders are needed only for the home visit and not for Interpretation of Findings. If billing for #1- "Nurse Visit" (X5284), no additional charge may be made for Interpretation of Findings.

Definitions:

Nurse Visit - Includes some type of client **treatment**, e.g. injection, dressing change, etc. In addition to the treatment a nurse visit should include education, health promotion, etc. when appropriate.

Interpretation of Findings - Time spent interpreting data, making phone calls and referrals, communicating with medical providers, etc. This is limited to one hour per day, must be done by a registered nurse, and may be used only in relationship to codes X5286 and X5287.

Note to Community Health Boards: The Medical Assistance Program requires that it be billed the actual usual and customary charge that is charged to other third party payers or private pay clients, if in fact the service is provided to clients who have other

coverage or are private pay. Persons without third party reimbursement sources may be served on a sliding fee schedule subsidized by funds such as the Formula MCH Grants, Community Health Services subsidies, and other revenues. Under such an arrangement, a client not eligible for MA may pay a minimum of $0 up to a maximum of the actual unit cost of service, based on ability to pay. Agencies typically establish their sliding fee schedules so that the maximum income eligibility level at which client payments are to be required exceeds the income level of the MCH Special Project (200% of poverty).

For example:

The unit cost of a PHN Health Promotion and Prevention Counseling home visit provided by a Community Health Board is $35.00. For Medical Assistance eligible persons with physician's orders who receive this type of prenatal service, the agency bills the Medical Assistance Program of DHS this amount and is reimbursed at the current DHS rate of $25.30. If MA reimbursement is less than the unit cost of service, as in this example, MCH or other agency funds cover the balance of $9.70. For persons who are eligible for Medical Assistance but do not have physician orders for the service, MCH grant or other agency funds pay for the full cost of the service, $35.00.

For persons who are above the Medical Assistance income guidelines and below 200% of the federal poverty level, the agency has decided that MCH or other agency funds will be used to pay for the full cost of the service. The agency thus starts its sliding fee schedule above 200% of poverty, but since it has no capacity to serve people with incomes above 200% of poverty, it refers all higher income persons elsewhere for service.

The agency is considering two alternative approaches by which it will serve persons more than 200% of poverty. Alternative one is a sliding fee schedule subsidized by local tax revenues up to 350% of poverty, at which level the person will be billed the full unit cost of service. If the agency is unable to obtain revenues for the sliding fee schedule it may instead adopt alternative two, which is to charge the full unit cost of service to all persons over 200% of poverty whom it serves.

Prenatal Care Initiative Enhanced Services

Except for High Risk Antepartum Management, which must be provided by the medical care provider, any or all of the PCI Enhanced Services may be referred to Public Health or Home Health nursing agencies and reimbursed as part of the Prenatal Care Initiative. Prior authorization from DHS is not needed. The services may be provided in the home or clinic setting (with the exception of the High Risk Follow-up Home Visit, which must be provided in the home). The services the nursing agency provides and bills to Medical Assistance must correspond with the physician's order (eg, "PHN to provide Health Education I and II, and High Risk Follow-up Home Visit", signed, Dr. Smith).

The following is a list of PCI services that may be provided by a Public Health or Home Health nursing agency, along with applicable billing codes:

Service	Code Used on DHS Practitioner Invoice
Care Coordination	X5496
Prenatal Health Ed I	X5497
Prenatal Health Ed II	X5497-52
Prenatal Nutrition Ed	X5498
High Risk Follow-up Home Visit	X5499

The following examples may be helpful in understanding which codes to use when billing for home visits:

Example 1:

The agency receives a referral from a physician for Prenatal Health Education I. It is determined that the woman needs only one visit to cover her educational needs. The agency provides the service and bills MA for Prenatal Health Ed I (X5497).

Example 2:

The agency receives a referral for Prenatal Health Ed I and II for a pregnant teen. At the initial assessment visit, the nurse determines that the teen has needs beyond the scope of the PCI services ordered, and that additional visits will be necessary to provide teaching and support. The agency should provide the PCI services ordered and obtain doctor's orders for additional visits. Bill as follows:

Bill for Prenatal Health Ed I (X5497) once.

Bill for Prenatal Health Ed II (X5497-52) once.

For the remaining visits, bill for Health Promotion and Prevention Counseling (X5287) and Interpretation of Findings (X5288), each visit. Document the need for the additional visits and what occurred at each visit.

NOTE: It might be desirable to obtain an order for "weekly visits prn" or "health education visits prn" as opposed to a certain number of visits. Orders must be renewed every 60 days.

Example 3:

The agency receives a referral from someone other than a physician to provide health promotion visits to a pregnant client who is on Medical Assistance. Obtain physician's orders to make home visits and bill MA for either Health Assessment and Screening (X5286) or Health Promotion and Prevention Counseling (X5287) along with Interpretation of Findings (X5288), as described under "Home Health Services" at the beginning of this section. If the physician later determines that the woman is high risk under the PCI and refers her for specific PCI services, the agency then bills for the PCI services it provides.

Example 4:

The agency receives a physician's order for "PHN home visits". Obtain clarified orders as to whether the woman is high risk and if so whether any PCI components are to be provided. Provide the needed services and bill accordingly. If the woman is not high risk, bill as described under "Home Health Services" at the beginning of this section.

Example 5:

The agency receives a referral to do daily blood pressure checks on a pre-eclamptic pregnant woman. During the first home visit, the nurse determines that the woman also needs extensive assessment and education. The agency should obtain a physician's order for these services and bill for either Health Assessment and Screening (X5286) or Health Promotion and Prevention Counseling (X5387) along with Interpretation of Findings (X5288). This allows for reimbursement more consistent with the care provided.

Example 6:

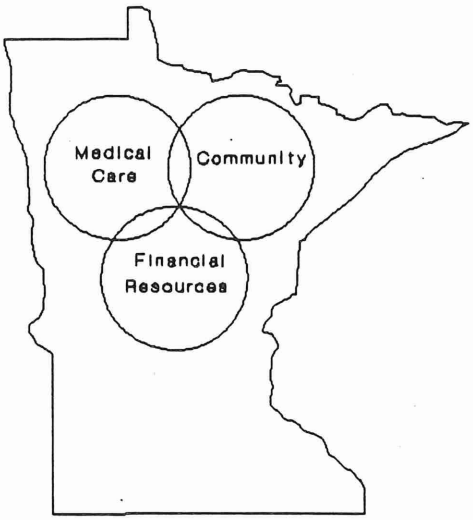
The agency receives referrals to provide the same PCI enhanced service to more than one client. The agency may choose to make home visits to each client OR it may be appropriate to have the clients come together at the agency for a class. If a class is provided, bill MA separately for the PCI service for each client attending the class.

Example 7:

The agency receives a referral to provide the Care Coordination component of the Prenatal Care Initiative to a high risk pregnant woman. This is a service the PHN can provide in addition to home visits. The agency should obtain physician's orders for home visits in addition to the Care Coordination. Bill MA for Home Health Services (Health Promotion and Prevention Counseling or Health Assessment and Screening) **in addition to** billing for Care Coordination under the PCI. If the agency provides additional PCI services (eg Prenatal Health Education or High Risk Follow-up Home Visit) as a result of this Care Coordination, obtain physician's orders and bill MA accordingly.

Billing for High Risk Follow-Up Home Visits (Post Partum):

Bill for the High Risk Follow-up Home Visit (X5499), as ordered by the primary care provider. If more visits are needed, obtain a physician's order and bill for MA home visits using the Home Health Services codes described at the beginning of this section.



"Partners In Prenatal Care for Minnesota Moms"

MODELS FOR ENHANCED PERINATAL SERVICES USING A PUBLIC-PRIVATE PARTNERSHIP

As the Prenatal Care Coordination Project logo depicts, there are three related resources that a pregnant woman needs in order to have a healthy pregnancy and baby: medical care, financial resources, and community support. Medical care is important to promote health and treat medical problems. Financial resources are necessary to pay for her care. In addition she needs support from a community that recognizes her special needs, such as education, promotion of a healthy lifestyle, and a positive environment. This support can be provided through family, friends, and professionals. Through a pooling of community resources and coordination of services available from private and public providers, more high risk pregnant women can be identified early in their pregnancies and provided with continuous prenatal care and supplemental health and social services.

This section describes two models for the provision of these three resources in an integrated manner. The first model describes the

provision of comprehensive, risk appropriate services to the motivated high risk pregnant woman, and the second discusses outreach and care for the hard-to-reach woman.

PRENATAL CARE FOR THE MOTIVATED HIGH RISK WOMAN

Some high risk women pregnant women on Medical Assistance are able to appropriately utilize all three of the resources needed to enhance their pregnancies: medical care, financial resources, and community support. They initiate prenatal care early in pregnancy and take an active part in that care. They are able to arrange for the financial resources needed to pay for the care, and they have adequate support from friends, family, and community. These women will most often be determined to be high risk due to the medical rather than psychosocial risk factors listed on the Medical Assistance Prenatal Risk Assessment form. Because of their motivation and support, they will require minimal if any community efforts to get into care and adhere to the care plan.

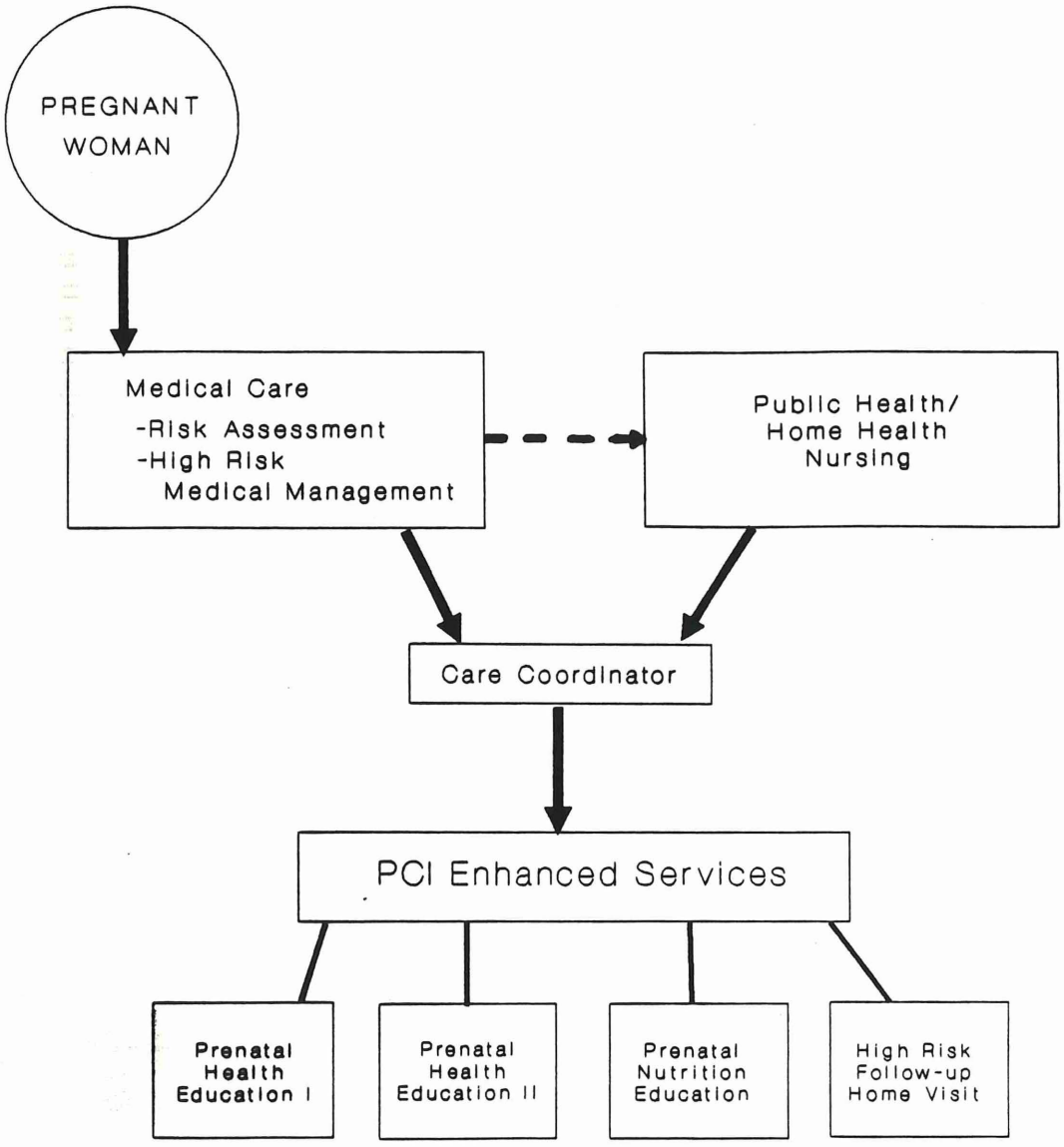
Enhanced prenatal care for the motivated high risk woman is outlined in the diagram which follows, "Prenatal Care for the Motivated High Risk Woman". The circle representing this woman is located at the top of the diagram because she initiates visits to her medical care provider, who does a risk assessment and provides the medical care appropriate to her needs. Since in this example the woman is on Medical Assistance and is at high risk for a poor pregnancy outcome, she is eligible for the enhanced services of the Prenatal Care Initiative (PCI). The Care Coordination services may be provided by the medical care provider (as shown by the solid arrow in the diagram), or referred out to a nursing agency (as shown by the broken arrows in the diagram). In either case, the educational and home visit services (Prenatal Health Education I and II, Prenatal Nutrition Education, and the High Risk Follow-up Home Visit) may be provided by either the medical care provider or the nursing agency. The flexibility of the PCI allows for services to be provided by a variety of professionals, depending on the

individual woman's needs, the resources available through her clinic (in terms of staff time and expertise), and the resources present in her community. Due to their motivation and the support available to these high risk women, only limited care coordination service is needed to assure the delivery of the enhanced services.

Example of a Motivated High Risk Woman

> This is a 25 year old woman with a planned, well-spaced pregnancy. She began prenatal care early and has a good social support network, but smokes a pack of cigarettes per day and has had a previous preterm delivery. Her Prenatal Risk Assessment yields a score of 11 (1 for smoking, plus 10 for history of preterm delivery), which categorizes her as high risk and eligible for PCI enhanced services. She wishes to carry this pregnancy to term and has tried to quit smoking but is having difficulty doing so. Under the PCI guidelines, this woman is an appropriate candidate for Care Coordination and Prenatal Health Education II, which can be provided by her physician's office or a nursing agency. She may also be referred to a smoking cessation program. If she is able to stop smoking and carries the pregnancy to term, these may be all of the PCI enhanced services needed. If, however, she delivers a preterm baby with the current pregnancy, the High Risk Follow-up Home Visit would be indicated. At this home visit, the provider would focus on support of continued non-smoking and on the assessment and care of her preterm infant.

PRENATAL CARE FOR THE MOTIVATED HIGH RISK WOMAN



OUTREACH AND PRENATAL CARE FOR THE HARD-TO-REACH HIGH RISK WOMAN

In contrast to the motivated high risk pregnant woman who appropriately utilizes her resources, some women need extra support to obtain the medical care, financial resources, and community support needed for a healthy pregnancy. Such women may be referred to as hard-to-reach high risk women. While the hard-to-reach high risk pregnant woman may have medical risk factors, she most often will also be experiencing psychosocial risk factors. Personal problems, ambivalence about the pregnancy, dislike of physicians and medical institutions, language or cultural differences, child care problems, and lack of transportation can all be barriers for her in obtaining adequate prenatal care (Lia-Hoagberg, et al, 1990). In order to promote healthy pregnancies and babies, communities concerned about their future children need to identify and reach out to women not motivated or unable to get adequate prenatal care.

As outlined in the diagram which follows, "Outreach and Prenatal Care for the Hard-to-Reach High Risk Woman", the hard-to-reach woman does not initiate early and continuous prenatal care on her own. The circle representing her is located between the medical and community resources, because although she may be physically surrounded by a wide variety of resources, she is socially isolated from them and does not seek them out appropriately. Any of the resources listed (social worker, school, physician, nurse, employer, outreach worker, etc.) can be in the position of drawing this woman into prenatal care if they come into contact with her and are sufficiently alert to her special needs. As represented by the solid and broken arrows between the woman and the resources, she may reach out to any of these resources, but it is more likely that they will reach out to her. In either case, the resource drawing her into care has the role of referring her to a medical

care provider (solid arrows), who does the risk screening and provides the medical care appropriate for her needs.

A referral to public health nursing is appropriate for the hard-to-reach woman. This can be done by the medical care provider, or any other agencies involved with the woman. (For a list of PHN agencies in Minnesota, see Appendix H). Because of the barriers this woman faces in initiating prenatal care, she is likely to need the support of a Public Health Nurse (PHN) to continue with that care. By establishing a long-term supportive relationship with the pregnant woman through home visits, the PHN is in a unique position to provide a thorough assessment of the woman's social situation, encourage adequate medical care, provide education and social support, and make referrals to other appropriate services.

Care Coordination and the PCI educational services may by provided by the woman's medical care provider (broken arrow). However, the PHN can integrate these services into additional PHN services not covered under the PCI (solid arrows). These additional PHN services include more teaching and support, continued post partum home visits, and referrals to appropriate community resources (solid arrow). The two arrows forming a loop between the PHN and the medical care provider represent the ongoing communication between these two persons needed to provide optimal care to the woman.

Examples of Hard-to Reach High Risk Women

Example A:

This hard-to-reach high risk pregnant woman is a married Southeast Asian refugee woman new to the United States. She has had several closely-spaced pregnancies and her cultural beliefs do not encourage participation in this country's medical care system. She works on a farm and has come to the WIC clinic at 23 weeks gestation, seeking WIC for her other children. For this woman, the community resource that assists her in initiating prenatal care is the bilingual outreach worker employed by the local WIC and MCH programs. The worker schedules an appointment for her at a clinic in a nearby town

that has language interpreters on staff. This worker also refers her for an appointment with the county social service office to apply for Medical Assistance and accompanies her there to interpret and advocate for her.

At her initial visit with the physician, the woman's Prenatal Risk Assessment yields a score of 12 (2 for educational level, 2 for late prenatal care, 1 for close pregnancy spacing, 2 for having 3 young children at home, 2 for social situation (cultural barriers), plus 3 for heavy lifting at work. The physician or nurse-midwife provides medical care appropriate to her needs. This includes prescriptions for anemia and a urinary tract infection. In addition, under the PCI guidelines, this woman is a candidate for Prenatal Health Education I, Prenatal Nutrition Education, and the High Risk Follow-up Home Visit. The Prenatal Health Education I and Prenatal Nutrition Education services are provided by her clinic, which has bilingual workers and videos in her language.

When her infection continues despite repeated prescriptions and she begins to fail appointments, the clinic refers her for antepartum home visits by a PHN who is accompanied by a language interpreter. While at the home, the PHN discovers that the woman does not understand directions for taking her pills. She has shared some with her neighbor who doesn't feel well, and has decided to save the rest until after the baby is born. Medication compliance improves after the PHN reviews the purpose of the pills with the woman and her family and color codes the bottles so that she understands what time to take them. Home visits also allow the PHN to review and reinforce the teaching done by clinic staff, to do a thorough assessment of the home situation, to refer the woman to an English language class, a food shelf, and a refugee assistance agency. By establishing a long-term supportive relationship with this reserved woman and helping her with some of her concrete needs, the PHN gains her trust and encourages her to discuss her fears and concerns. Continuity of care is enhanced, as the PHN works with the family to arrange transportation for her prenatal appointments. After delivery, the same PHN provides the High Risk Follow-up Home Visit and as many additional post partum home visits as are needed to monitor the baby's health and encourage medical follow-up for mom and baby. Because this is this family's first birth in the United States, the PHN reviews with the parents how to do cord care, mix infant formula, and take the baby's temperature. She also teaches them to recognize signs and symptoms of illness in the infant, and how to obtain pediatric care. The PHN communicates closely with the medical care provider about the woman's social situation and her compliance with medical advice.

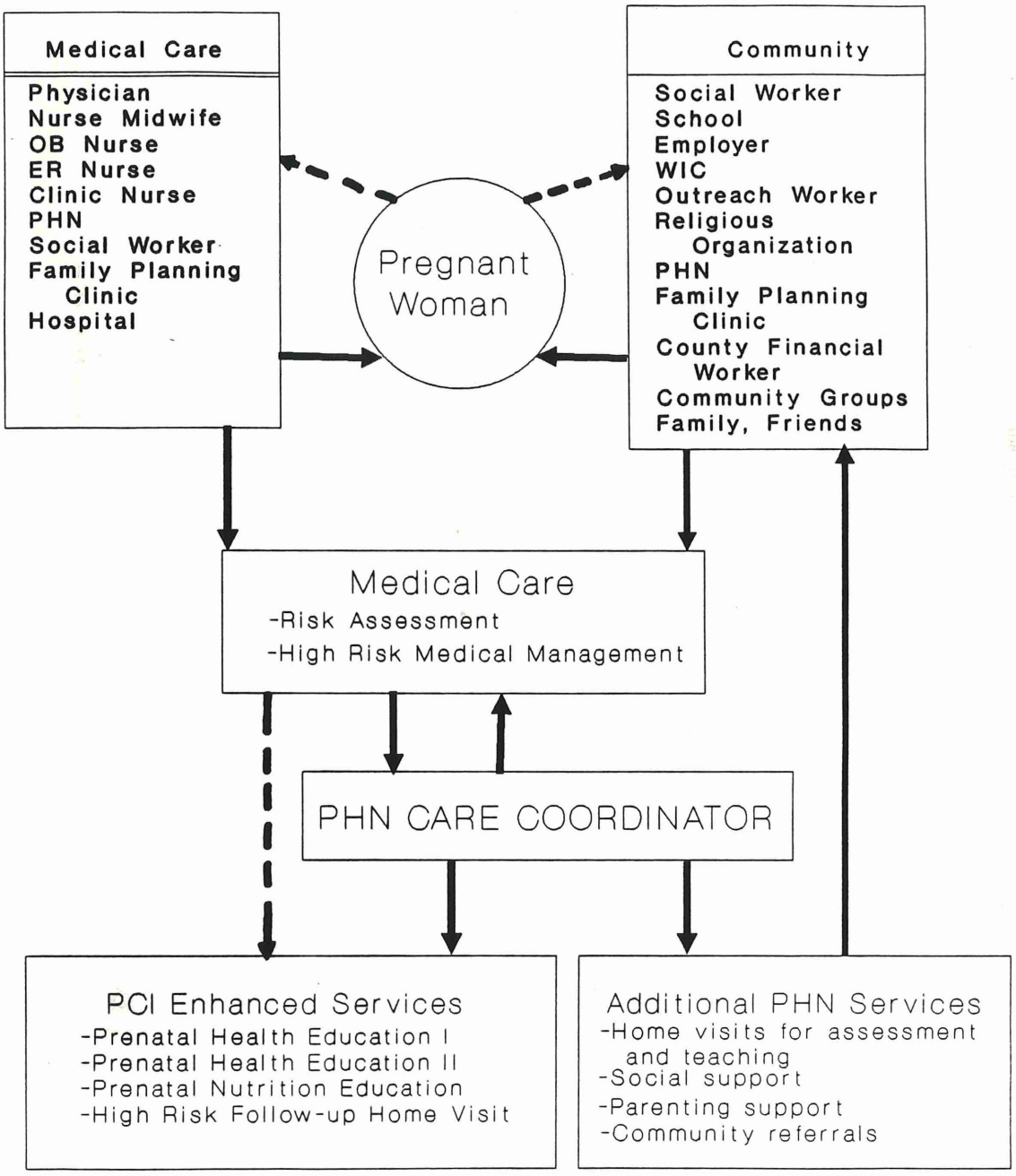
Example B:

This hard-to-reach high risk woman is an underweight pregnant teen who is a school dropout with a history of sexual abuse. She has been dieting to hide her suspected pregnancy from her family. She comes to the hospital emergency room at about 16 weeks gestation with a fever and flank pain, which is diagnosed as pyelonephritis and treated. Her pregnancy is also suspected and confirmed. For this woman, the resource for getting her into prenatal care is the social service and nursing staff at the hospital. They help her begin the MA application process and make a referral for prenatal care.

When the teen fails her first two prenatal appointments, a referral is also made to the public health nursing agency, which then follows up to help her work through the barriers to care that she is experiencing. At her initial clinic visit, this woman's Prenatal Risk Assessment yields a score of 19 (2 for age, 2 for education, 3 for pre-pregnancy weight, 2 for social situation, 2 for late prenatal care, 5 for current pyelonephritis, plus 3 for weight loss). This places her in the high risk category and makes her eligible for the PCI enhanced services. The provider of her medical care and High Risk Antepartum Management, her physician, determines that she would benefit from all of the enhanced services of the PCI. Since she is poorly motivated to attend clinic and appears to be developing a trusting relationship with the assigned PHN, the decision is made to refer all of these services to the PHN. The PHN is her Care Coordinator and does all of the health teaching on a one-to-one basis. The PHN follows up on a referral the hospital originally made to a county social worker who the teen has so far refused to see. The social worker is able to help the client set some short and long term goals. These include applying for Aid to Families with Dependent Children, working on communication with her family, re-enrolling in school, and obtaining baby clothes and supplies.

The PHN stays actively involved for the remainder of the pregnancy, reviewing the clinic's teaching, reinforcing compliance with medications, encouraging proper nutrition, avoidance of alcohol, tobacco and street drugs, referring her to Childbirth Education classes, and helping her gain confidence in her ability to be a parent. The PHN maintains communication with the physician and social worker to ensure that this client is able to utilize the medical care, financial resources, and community support she needs for the remainder of her pregnancy. The PHN provides the High Risk Follow-up Home Visit and continues to make additional post partum home visits to monitor and support healthy behaviors for mom and baby. She also intensively counsels the teen on family planning and responsible sexual behavior.

OUTREACH AND PRENATAL CARE FOR THE HARD-TO-REACH HIGH RISK WOMAN



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3. Alliance for Human Development. (1984). Consequences and costs of poor outcomes of pregnancy. Continuum. Atlanta.

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APPENDICES

A. Minnesota MCH Programs

B. Directory of County Social Service Agencies

C. Medical Assistance Application for Pregnant Women

D. Medical Assistance for Pregnant Women- Income Guidelines

E. Sample of a Completed Prenatal Risk Assessment Form

F. Prenatal Care Initiative's Health Professional Referral Form

G. Requisition for Department of Human Services Forms

H. Directory of Public Health Nursing Agencies

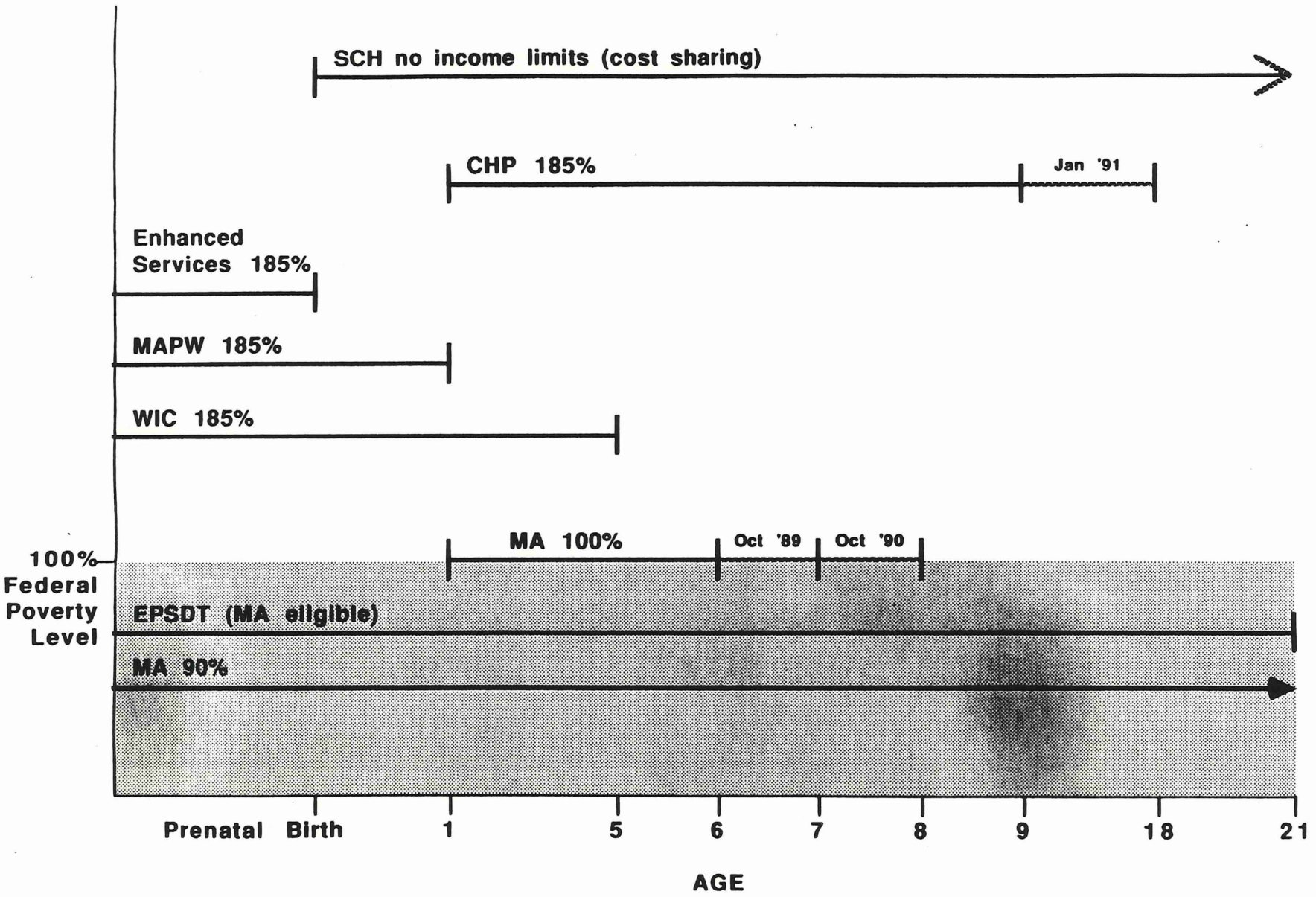
I. "Perinatal High Risk" MA Provider Manual, Chapter 57, Section 03 (October 1, 1990 revision)

J. Medical Assistance Reimbursement Rates for PCI Enhanced Services

K. Sample of a Completed Medical Assistance Practitioner Invoice (Clinic)

L. Sample of a Completed Medical Assistance Practitioner Invoice (Public Health Nursing Agency)

Minnesota MCH Programs



INFORMATIONAL BULLETIN #90-85B

July 23, 1990

TO: Chairperson, Board of County Commissioners
Attention: Director

Chairperson, Human Service Board
Attention: Director

Regional Centers/State Nursing Homes
Attention: Director

Private Agencies
Attention: Director

SUBJECT: Directory of County Human Service Agencies

Attached is a revised copy of the Directory of Minnesota County Welfare and Human Service Agencies, DHS-2090. The Minnesota Department of Human Services Management Services Division updates this directory every six months and mails one copy to each county agency director's office. Each county agency is responsible for photocopying additional sets.

If you wish to make changes or corrections to the directory for the next printing or would like information on Minnesota Department of Human Services programs, please contact the DHS Information Desk at the address below or by calling (612) 296-6117.

Many county agencies are purchasing FAX machines. We want to add these FAX numbers to the Directory of County Human Services Agencies.

If you want to have your agencys FAX number added to the next update of this directory, please contact the Department of Human Services Information Desk.

Minnesota Department of Human Services
Information Desk
444 Lafayette Road
St. Paul, MN 55155-3807
Telephone: (612) 296-6117
Telefax Phone Number: (612) 296-6244

Sincerely,

DAVID S. DOTH
Assistant Commissioner

Attachment

APPENDIX B Directory of County Social Service Agencies

DIRECTORY OF

MINNESOTA COUNTY WELFARE AND HUMAN SERVICES AGENCIES

DHS-2090
7/90

COUNTY	DIRECTOR		TELEPHONE	ADDRESS
1. Aitkin County Family Service Agency	Lester Kachinske	(Aids) (Social Services)	218/927-2141 218/927-3744	Courthouse Annex, Aitkin 56431
2. Anoka County Community Health & Social Services	George Steiner	(Health & Social Serv.) (Financial Services) (Anoka County Branch)	612/422-7000 612/422-7200 612/789-4326	325 East Main Street Courthouse, Anoka 55303 3980 Central Avenue Northeast Columbia Heights 55421
3. Becker County Human Services	Matt Casey	(Aids) (Social Services)	218/847-5628 218/847-5684	County Annex, 712 Minnesota Ave. P.O. Box 1637 Detroit Lakes 56501-1637
4. Beltrami County Social Service Center	Stephen Jackelen	 (Beltrami Co. Branch)	218/751-4310 218/679-3945	522 Beltrami Avenue, P.O. Box 6008 Bemidji 56601 Red Lake 56671
5. Benton County Social Service Agency	Donald J. Sykora		612/968-6254	Courthouse, Foley 56329
6. Big Stone County Family Service Center	Daniel Hanratty		612/839-2555	340 Northwest Second Street, Box 338 Ortonville 56278
7. Blue Earth County Human Services	Dennis McCoy	 TELEFAX PHONE NUMBER	507/625-3031 507/387-8379	Blue Earth County Government Center 410 South Fifth Street. P.O. Box 8608 Mankato 56001
8. Brown County Family Service Center (Also see Brown/Nicollet HSB)	Thomas Henderson		507/354-8246	114 North State Street, P.O. Box 788 New Ulm 56073
9. Carlton County Human Service Center	William Pinsonnault	 TELEFAX PHONE NUMBER*	218/879-4583 218/879-4583 X197*	1215 Avenue C Cloquet 55720
10. Carver County Community Social Services	Gary Bork	 TELEFAX PHONE NUMBER	612/448-3661 612/448-1206	Carver County Courthouse, Box 7 Chaska 55318
11. Cass County Department of Social Services	John Fjelstul		218/547-1340	Welfare Building, Box 519 Walker 56484

COUNTY	DIRECTOR		TELEPHONE	ADDRESS
12. Chippewa County Family Services	Kevin P. Coler		612/269-6401	Community Service Building
		TELEFAX PHONE NUMBER*	612/269-6405	7th & Washington, Montevideo 56265
13. Chisago County Human Services	Marina Vork	(Social Serv., Acct.)	612/257-1300	Courthouse Annex, Center City 55012
		(Inc. Maintenance)	612/257-1300	425 South Dana Street, P.O. Box 647
		(Metro Area)	612/462-2141	Rush City 55069
14. Clay County Social Service Center	Dennis Lien	(Social Services)	218/299-5200	1004 First Avenue North, Box 1177
		(IV-D)	218/299-5209	Moorhead 56560
		(Food Stamps)	218/299-5208	
	Social Service Annex		218/299-5180	123-1/2 21st St. S., Moorhead 56560
15. Clearwater Department of Human Services	Ordean A. Synstelien	(Aids)	218/694-6512	Courthouse, Box X, Bagley 56621
		(Social Services)	218/694-6164	
16. Cook County Social Services	Warren Anderson		218/387-2282	Courthouse, Grand Marais 55604 and NorShor Building, Grand Marais 55604
17. Cottonwood County Family Service Agency	Duane Ahlness		507/831-1891	Industrial Park Site, Box 9 Windom 56101
18. Crow Wing County Social Service Center	Dennis O. Johnson	(Social Services)	218/828-3966	County Service Building, Box 686
		(Income Maintenance)	218/828-3968	Brainerd 56401
		TELEFAX PHONE NUMBER	218/828-2927	
19. Dakota County Human Services	Dave Rooney, Human Services Director		612/450-2742	33 East Wentworth, Suite 315
	Sally Moran, Deputy Human Services Director		612/450-2742	West St. Paul 55118
	Jerry Krueger, Employment & Economic Asst.		612/450-2611	33 East Wentworth, Suite 66
	Sally Moran, Social Services Director		612/450-2742	West St. Paul 55118
		TELEFAX PHONE NUMBER	612/450-2948	33 East Wentworth, Suite 222 West St. Paul 55118
20. Dodge County Social Services	Brian D. Hartung	(Income Maint./Admin.) (Social Service)	507/635-6170	Box 278, Mantorville 55955
21. Douglas County Social Services	F. Michael Marxen		612/762-2302	Courthouse, 305 - 8th Avenue West
		TELEFAX PHONE NUMBER	612/762-2389	Alexandria 56308
22. Faribault County Human Services Center	(See HSB of Faribault/Martin/Watonwan Co.)		507/526-3265	Faribault County Office Building Box 446, Blue Earth 56013
23. Fillmore County Welfare Department	Thomas Boyd	(Aids)	507/765-2175	Courthouse, Preston 55965
		(Social Services)		

COUNTY	DIRECTOR		TELEPHONE	ADDRESS
24. Freeborn County Department of Human Services	Darryl Meyer		507/377-5400	203 West Clark Street
	General Info., Income Maintenance, Suppoprt & Collections			Post Office Box 649
				Albert Lea 56007
	Community Support, Mental Health Center		507/377-5440	
	Victim's Crisis Center		507/377-5460	
	Children & Adult Services		507/377-5480	
		TELEFAX PHONE NUMBER	**507/377-5160**	
25. Goodhue County Social Service Center	Greg Schoener		612/388-8261	Citizen's Building
				426 West Avenue, P.O. Box 31
				Red Wing 55066
26. Grant County Social Service Department	Joyce M. Pesch		218/685-4417	10 - 1st Street Northwest
				P.O. Box 1006, Elbow Lake 56531
27. Hennepin County Bureau of Social Services	Case Inquiries - All Programs		612/348-3000	
	Kevin Kenney, Bureau of Social Services		612/348-4806	A-2303 Government Center
		TELEFAX PHONE NUMBER	**612/348-7970**	A-1005 Government Center
	Michael Weber, Community Services			A-1005 Government Center
	John L. Sims, Director, Economic Assist.			300 So. 6th St., Minneapolis 55487
28. Houston County Social Services	Harold Thompson		507/724-5211	Courthouse, P.O. Box 310, Caledonia 55921
		TELEFAX PHONE NUMBER	507/724-5550	
29. Hubbard County Social Service Center	Daryl Bessler		218/732-1451	Courthouse, Park Rapids 56470
30. Isanti County Family Service & Welfare Dept.	Ronald Mooers		612/689-1711	1557 S. Highway 293, Cambridge 55008
31. Itasca County Social Services	Tom Papin	(Aids)	218/327-2941	Courthouse, Grand Rapids 55744
		(Sr. Comm. Services PAS/ACG)	218/327-2971	
		(MR Unit)	218/326-6601	
		(Social Services)	218/327-2981	
		TELEFAX PHONE NUMBER*	**218/327-2848***	
32. Jackson County Human Services	Norbert L. Bruegmann		507/847-4000	310 Sherman Street, P.O. Box 67
		TELEFAX PHONE NUMBER	**507/847-5616**	Jackson 56143
33. Kanabec County Family Service Department	Philip Peterson	(Aids)	612/679-3465	114 W. Maple, Mora 55051
		(Social Services)	612/679-4740	
34. Kandiyohi County Family Service Dept.	John Haines	(Aids)	612/231-6232	Courthouse, Box 757, Willmar 56201
				905 West Litchfield, Box 757
		(Social Services)	612/235-8317	Willmar 56201

COUNTY	DIRECTOR		TELEPHONE	ADDRESS
35. Kittson County Welfare Department	John R. Beau Lac		218/843-2689	Box 160, Hallock 56728
36. Koochiching Family Services	Teresa VanderEyk		218/283-8405	615 - 4th Street International Falls 56649
		(Northome Branch)	218/897-5266	Northome 56661
37. Lac qui Parle County Family Service Center	Joel Churness		612/598-7594	Courthouse, Box 7, Madison 56256
38. Lake County Social Service Department	William T. Green		218/834-8400	616 Third Avenue, Two Harbors 55616
39. Lake of the Woods Social Service Dept.	Robert Goudge		218/634-2642	Courthouse, Box G-200, Baudette 56623
40. LeSueur County Department of Human Services	Robert E. Podhradsky		612/357-2251 800/635-9786	P.O. Box 126, Highway 89 & Maple Ave. LeCenter 56057 Mailing Address: 88 S. Park Avenue LeCenter, 56057-1620
41. Lincoln County	(See Region VIII North Welfare)		507/694-1452	Courthouse, P.O. Box 44 Ivanhoe 56142-0044
42. Lyon County	(See Region VIII North Welfare)		507/537-6747	Courthouse, 607 West Main, Marshall 56258
43. McLeod County Social Service Center	Daniel Papin	VOICE/TDD TELEFAX PHONE NUMBER	612/864-3144 612/864-5265	County Office Building, P.O. Box 130 Glencoe 55336
44. Mahnomen County Human Services	Gordon Hagen		218/935-2568	Courthouse, Mahnomen 56557
45. Marshall County Social Services Dept.	Jennifer Anderson		218/745-5124	208 E. Colvin Ave., Warren 56762
46. Martin County Human Services Center	(See HSB of Faribault/Martin/Watonwan Co.)		507/238-4757	P.O. Box 938, 218 Lake Avenue Fairmont 56031
47. Meeker County Social Service Department	Clark Gustafson		612/693-2418	Courthouse, Litchfield 55355
48. Mille Lacs Co. Family Serv. & Welfare Depart.	William McQuillan		612/983-6161	Courthouse, Milaca 56353
49. Morrison County Social Services	Kenneth Ebel		612/632-2941	Human Serv. Bldg., Little Falls 56345
50. Mower County Social Services	James Huber	(Aids & Services) (Food Stamps) TELEFAX PHONE NUMBER	507/437-9483 507/437-9484 507/437-9485 507/437-9514 507/437-9471	Courthouse, 201 First Street N.E. Austin 55912

COUNTY	DIRECTOR		TELEPHONE	ADDRESS
51. Murray County	(See Region VIII North Welfare)		507/836-6144	Courts Building, Slayton 56172
52. Nicollet County Social Services	Clifford Nebel		507/931-6800	Courthouse, Box 300, St. Peter 56082
		TELEFAX PHONE NUMBER	**507/931-9220**	
		Branch Office	507/387-4556	360 Pierce Avenue, Box 2095 North Mankato, 56002-2095
53. Nobles County Family Service Agency	Lee McAllister		507/372-2157	901 Fourth Avenue, Box 189 Worthington 56187
54. Norman County Social Service Center	David N. Bertils		218/784-7136	County Office Building, Ada 56510
55. Olmsted County Dept. of Social Services	Patricia Carlson	(Administration)	507/285-8382	515 2nd St. SW, Rochester 55901
		(Aids & Social Serv.)	507/285-8416	
56. Otter Tail County Dept. of Social Serv.	Thomas M. Fawcett		218/739-4491	Government Services Building 505 South Court Street Fergus Falls 56537
57. Pennington County Department of Welfare & Human Services	Phyllis Schmidt		218/681-2880	Box 340, 318 N. Knight Avenue Thief River Falls 56701
58. Pine County Department of Human Services	Robert Walz		612/629-6781	Courthouse, Pine City 55063
			612/245-2268	City Hall, Sandstone 55072
59. Pipestone County Family Service Center	Dennis Roelfsema		507/825-3357	Post Office Box 157 Pipestone 56164
60. Polk County Social Service Center	Bill Kurpius-Brock	(Social Services, Acct., Financial Assistance)	218/281-3127	Courthouse, P.O. Box 608 Crookston 56716
		Child Support Unit	218/281-3423	223 E. 7th St., Box 608, Crookston 56716
		Migrant Social Serv.	218/281-7329	223 E. 7th St., Box 608, Crookston 56716
		TELEFAX PHONE NUMBER	**218/281-3926**	
	East Grand Forks Branch - Financial Asst.		218/773-2431	Professional Building, P.O. Box 433
		TELEFAX PHONE NUMBER	**218/773-3602**	East Grand Forks 56721
	Fosston Branch - Financial Assistance		218/435-1585	102 2nd Street NW
		TELEFAX PHONE NUMBER	**218/435-1552**	Fosston 56542
61. Pope County Family Service Department	John V. DeMorett		612/634-5301	Courthouse, Glenwood 56334

COUNTY	DIRECTOR		TELEPHONE	ADDRESS
62. Ramsey County Human Services Department	Thomas J. Fashingbauer		612/298-5351	160 East Kellogg Boulevard St. Paul, 55101
63. Red Lake County Social Service Center	Linda Molenaar		218/253-4131	Courthouse, Red Lake Falls 56750
64. Redwood County Human Services Department	Gordon Fritz		507/637-5741	301 South Jefferson, P.O. Box 27 Redwood Falls 56283
Region VIII North Welfare Department	Frank Moorse		507/537-6747	Courthouse, Marshall 56258
65. Renville County Human Service & Welfare Dept.	Gerald Brustuen		612/523-2202	300 South Seventh Street Olivia 56277
66. Rice County Social Services	Dale Szyszka		507/334-0031	1201 West Division Street, Box 718 Faribault 55021
67. Rock County Family Service Agency	Charles Olson		507/283-9507	2 Roundwind Road, Box 219 Luverne 56156
68. Roseau County Social Service Center	David Anderson		218/463-2411	300 - 6th Street Southwest
		TELEFAX PHONE NUMBER	218/463-1455	Roseau 56751
69. St. Louis County Social Service Department	Robert Zeleznikar		218/726-2000	Government Services Center 320 West 2nd Street, Duluth 55802
		(St. Louis Co. Branch)	218/262-6000	Graysher Shopping Center Hibbing 55746
		(St. Louis Co. Branch)	218/749-7100	Northland Office Center 307 South 1st Street, Virginia 55792
		(St. Louis Co. Branch)	218/365-6151	118 South 4th Avenue East, Ely 55731
70. Scott County Human Services	Eileen Moran		612/445-7751	Courthouse, Room 300 - 428 S. Holmes
		TELEFAX PHONE NUMBER	612/496-8257	Shakopee 55379-1375
71. Sherburne County Social Services	Donald Strei	(Metro)	612/441-1711	13880 Hwy. 10, P.O. Box 310 Elk River 55330
		(Sherburne Co. Branch)	612/261-4550	County Office Building,
		(Toll Free - St. Cloud)	612/253-2384	13122 1st Street, Becker 55308
		TELEFAX PHONE NUMBER*	612/441-1711 X597*	

COUNTY	DIRECTOR		TELEPHONE	ADDRESS
72. Sibley County Human Services	Steven J. Schow (Interim)		612/237-2978	Box 237, 112 Fifth St., Gaylord 55334
73. Stearns County Social Service Center	Pasquale Serrano	(Social Services)	612/255-6000	700 Mall Germain, St. Cloud 56301
		(Financial Aids)	612/255-6078	711 1/2 Mall Germain, Box 1107
		TELEFAX PHONE NUMBER*	612/255-6253	St. Cloud 56301
		(Stearns Co. Branch)	612/352-6531	Sauk Centre 56378
		TELEFAX PHONE NUMBER*	612/352-2350	
74. Steele County Social Service Center	Stanley A. Groff		507/451-0414	590 Dunnell Drive, P.O. 890 Owatonna 55060
75. Stevens County Social Services Department	George French		612/589-1481	Courthouse, Box 530-HS, Morris 56267
76. Swift County Welfare & Family Service Agency	Ronald G. Laycock		612/843-3160	109 - 12th Street South, P.O. Box 208 Benson 56215
77. Todd County Social Services	Frank Sandelin		612/732-4500	Courthouse Annex, 212 - 2nd Avenue S. Long Prairie 56347
78. Traverse County Social Services Department	Christine Borsheim		612/563-8255	15 - 10th Street South, Wheaton 56296
79. Wabasha County Department of Social Services	Terry Smith	(Social Services Admin.)	612/565-3351	Courthouse, Wabasha 55981
		(Income Maint., Acctg.)	612/565-2613	
		(IV-D Child Support)	612/565-3356	
		TELEFAX PHONE NUMBER	612/565-2774	
80. Wadena County Social Service Department	Paul M. Sailer	(Social Services Div.)	218/631-4225	22 Southeast Dayton, Wadena 56482
		(Finan. Ser., Account., Child Support, Housing)	218/631-2832	124 Southeast 1st St., Wadena 56482
81. Waseca County Welfare & Social Service Dept.	Russell W. Lee		507/835-0560	123 - 3rd Avenue NW, Waseca 56093
		TELEFAX PHONE NUMBER*	507/835-0633	
82. Washington County Social Services	James R. Schug		612/439-6901	Washington County Government Center
		TELEFAX PHONE NUMBER	612/779-5498	14900 - 61st Street North P.O. Box 30, Stillwater 55082-0030

COUNTY	DIRECTOR		TELEPHONE	ADDRESS
83. Watonwan County Human Services Center	(See HSB of Faribault/Martin/Watonwan Co.)		507/375-3294	720 - 1st Avenue South, Box 31 St. James 56081
84. Wilkin County Family Service Agency	David L. Sayler		218/643-8561	Courthouse, Breckenridge 56520
85. Winona County Department of Social Services	Wm. Craig Brooks		507/457-6200	County Office Building 202 West 3rd Street, Winona 55987
86. Wright County Human Services	Don Mleziva		612/682-3900	Courthouse, 10 Northwest 2nd Street
		(Metro Area)	612/339-6881	Buffalo 55313
		TELEFAX PHONE NUMBER	**612/682-6178**	
87. Yellow Medicine County Family Service Center	Richard Wambeke		612/564-2211	Courthouse, Granite Falls 56241

* County TeleFax Phone Number

When calling, wait for the phone to be answered by the receptionist, announce FAX or ask for the extension, and then proceed to send material.

MULTI-COUNTY HUMAN SERVICE BOARDS AND WELFARE DEPARTMENTS

COUNTY	DIRECTOR	TELEPHONE	ADDRESS
Human Services Board of Faribault, Martin, Watonwan Counties	Duane Shimpach, Director	507/238-4757	218 Lake Avenue, P.O. Box 938 Fairmont 56031
	Thomas Hustvet, Income Maint./Child Support	507/526-3265	
	Carmen Reckard, Community Health Services	507/375-3294	
	Dorothy Kappes, Community Social Services	507/238-4757	
	David Rynders, Mental Health/Chemical Dependency	507/238-2521	
Region VIII North Welfare Department (Lincoln, Lyon, Murray Counties)	Frank Moorse	507/537-6747	Courthouse, 607 West Main Marshall 56258

For information on Minnesota Department of Human Services programs, please contact the DHS Information Desk at 612/296-6117.

Published by the Minnesota Department of Human Services, Management Services Division.

DHS-2873 (5-88)
PZ-02878-01

MEDICAL ASSISTANCE APPLICATION FOR PREGNANT WOMEN

This application is for medical assistance for pregnant women. A decision will be made within 10 working days from the date of your personal interview appointment. You must provide proof of pregnancy and income to be found eligible. **If you are under age 21, single (never married) and living with your mother and/or father, their income must be verified and considered for your medical assistance eligibility.**

1. PLEASE ANSWER ALL QUESTIONS.
2. **Print in ink.**
3. If a question does not apply write NONE.
4. Fill in **exact** dollars and cents amounts.
5. If you need help with this form, ask your financial worker.

1. Your name (Last) (First) (Middle Initial)			2. Birthdate (Mo/Day/Yr)	AGENCY USE ONLY
3. Your current home address (Street Address) (Apt.#)	City	State	ZIP Code	
4. Your mailing address (if different from address listed above)			5. Your telephone number	
6. Work phone if we may contact you there	7. Your marital status: ☐ Never married ☐ Married, living with husband ☐ Married, not living with husband ☐ Legally separated ☐ Divorced and not remarried ☐ Widowed and not remarried			
8. Your Social Security number				
9. Your Social Security claim number				
10. Are you or your husband a veteran? ☐ Yes ☐ No	11. Your VA claim number		12. Your Railroad Retirement Number	

21. Do you presently live in the state of Minnesota and plan to make this state your home? ☐ Yes ☐ No

22. Are you a United States citizen or legal resident? ☐ Yes ☐ No

23. Have you ever received assistance before? ☐ Yes ☐ No If "yes," complete below.

In which city and state?	From which county?
Under what name?	When? From _____ To _____

24. Has the pregnancy been verified by a medical doctor or nurse-midwife? ☐ Yes ☐ No

25. Medical assistance may help you pay for medical expenses which happened three months prior to the month of your application. Are you requesting medical assistance to help pay for medical expenses which happened prior to this application date? ☐ Yes ☐ No

26. Do you receive income from a job(s)? ☐ Yes ☐ No If "yes," complete below.
Where do you work? _____ What is your gross income per pay check? _____
How often are you paid: ☐ weekly ☐ every two weeks ☐ monthly ☐ other, please explain _____

27. Does your husband receive income from a job(s)? ☐ Yes ☐ No If "yes", complete below.
Where does your husband work? _____
What is your husband's **gross** income per pay check? _____
How often is your husband paid: ☐ weekly ☐ every two weeks ☐ monthly ☐ other, please explain _____

28. Do you or your husband get income from a farm, business, or self-employment? ☐ Yes ☐ No If yes, you must attach a sheet listing and explaining operating expenses and income. Receipts must be attached for all expenses claimed. You may also attach the most recent copy of your income tax return.

29. Do you or your husband receive income from any other source (such as alimony, Worker Compensation, Veterans benefits, Social Security and etc.)? ☐ Yes ☐ No If yes, who receives it? _____ How much is received? _____
How often it is received: ☐ weekly ☐ every two weeks ☐ monthly ☐ other, please explain _____

30. Do you or your husband have health insurance? ☐ Yes ☐ No or dental insurance? ☐ Yes ☐ No

The county provides other programs that could help you. Check those that you are interested in.

☐ Family planning ☐ Help with personal and/or family problems ☐ Food stamps
☐ Child support collections ☐ Medical Assistance for other family members

If you have any questions you want us to answer, or information that would help us understand your situation, or any comments about these forms, write them here, or on a separate sheet of paper. _____

GO TO BACK SIDE →

PLEASE READ THE FOLLOWING ABOUT YOUR RIGHTS AND RESPONSIBILITIES

The information we request is needed for one or more of these reasons: to determine your eligibility for financial assistance and the amount of your assistance; to enable us to collect federal or state funds for assistance you receive; and to meet federal or state statistical requirements. You may refuse to supply the requested information; however, such refusal could make you ineligible for financial assistance.

- The information we collect will be used by our staff and staff members of other agencies to refer you to other benefit programs. If you move to another state or county, certain information will be automatically transferred to that human service agency. When you are no longer a client of your agency, we will retain your file until federal, state and county retention requirements are met.
- You may review all of the public and private information we collect about you, except for information that is legally classified as "confidential" (such as certain psychological or medical evaluations, records which will be used to prosecute a crime, etc.). You also have the right to disagree with information which you think is incorrect. For more information about your data privacy rights, ask your financial worker.
- You have the right to apply or reapply for public assistance at any time. If you are denied you have the right to know the eligibility requirements for the program for which you apply and to receive an explanation of how your grant is figured.
- You have the right to receive an explanation if your application for medical assistance is not processed within 10 working days from your personal interview appointment.
- You have the right to choose where and with whom you wish to live and to choose your own doctor, hospital, etc. within certain limitations.
- You have the right to appeal any decision about your case. You may appeal within 30 days to the county agency, or write directly to the state appeals office at the Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155. If you show good cause for not appealing within the 30 day limit, the state agency can accept your appeal for up to 90 days from the date you receive the notice.
- If you appeal before the action occurs or within 10 days of finding out, your assistance may continue until the hearing.
- If you feel you are discriminated against in any manner in the handling of a public assistance application or payment because of race, color, national origin, marital status, religion, sex, age or because of physical, mental, or emotional disability, you may file a complaint with any of these agencies:

State Agency
Department of Human Services
Human Services Building
St. Paul, MN 55155-3848

Federal Agency
U.S. Department of Health
and Human Services
Washington, D.C. 20201

State Department of Human Rights
500 Bremer Tower
7th Place and Minnesota Streets
St. Paul, Minnesota 55101

- You are responsible for informing the county of any changes which may affect your assistance, such as starting or changing employment; change in number of persons in the household; marriage, divorce or separation; return of absent parent or spouse; change in absent parent's known address or change in visitation; change in student status; change in insurance coverage; starting to receive or change in income or support payments from any source. (Social Security or Veterans benefits, lump sum payments, tax refunds, inheritances, court settlements, etc.); address change, property changes, buying or selling a house. These changes must be reported within 10 days or by the 8th of the following month, whichever is earliest.
- If you knowingly provide false information on these forms, you will be subject to prosecution for fraud. Any of the information you provide may be verified by the county agency. Some information can be obtained only with your signed consent. However, failure to consent may make you ineligible for financial assistance.
- Your case may be randomly selected for review by the state agency's quality control. This means a state quality control staff person will review statements you have made on forms and will review whether or not the county agency correctly determined your eligibility for assistance. The reviewer may seek information from sources other than you. If information is sought from another source, you will be informed of the contact the reviewer intends to make and requested to give your signed permission to make the contact. Even if you object to the contact and refuse to give your signed permission, the reviewer may still make the contact after notifying you. FAILURE TO COOPERATE WITH THE QUALITY CONTROL REVIEW PROCESS WITHOUT GOOD CAUSE WILL RESULT IN TERMINATION OF YOUR ASSISTANCE.

I declare that this application has been examined by me and to the best of my knowledge and belief and is a true and correct statement.

I hereby assign to the Commissioner of Human Services any rights available to me under private health care or automobile coverage and any rights to payment for medical care from any third party for myself or my dependents. I agree to cooperate with the Department in any legal action commenced against a third party for payment of medical expenses or subsistence and to report any legal action initiated against a liable third party on my or my dependents' behalf.

If I am covered by Part B of Medicare, I give my permission for Medicare to make payments on my behalf directly to my physicians or other medical providers for services rendered while I am receiving public assistance.

In accordance with Minnesota Statutes 256B.27(3) and (4), I authorize access to all medical records developed while receiving medical assistance. I understand that any medical provider, in order to be paid, will be required to provide medical information necessary to justify that payment. Medical providers have my authorization to release that information.

Signature or mark of applicant (or legal guardian)	Date
Witness to mark (necessary only if person cannot sign full name)	Date
Signature of other person who helped you complete this form	Relationship to you
Address	Phone / Date

This form has important welfare information.

If you do not understand it, get help now.

ឯកសារនេះមានព័ត៌មានសំខាន់អំពីសុខុមាលភាព។
ចូរស្វែងរកជំនួយឥឡូវនេះ។

ຂໍ້ຄວາມສຳຄັນກ່ຽວກັບກິຈການຄົ້ນປະຊາຊົນ.
ພຍາຍາມຫາຄົນຊ່ວຍແລະແປໃຈ້ຫາບຢ່າງຮີບດ່ວນ.

Lus tseem ceeb txog kev pab (welfare).
Nriav neeg twm thiab txhais rau koj
kom sai kawg nkaus.

Tin tức quan trọng về chương trình an sinh
(welfare). Xin nhờ thông dịch tức khắc.

Información importante de welfare.

Hagala traducir inmediatamente.

Do you know...

...about MAPW ?

Medical Assistance for Pregnant Women (MAPW)

-Pregnant women with net incomes at or below 185% of federal poverty guidelines are eligible for Medical Assistance subsidized care.
Infants under one year are also eligible under these guidelines.

-The MA application form for pregnant women has been shortened to one page.

-MA application for pregnant women requires written verification of pregnancy by a health care provider.

-DHS requires an expedited application process for pregnant women:

1. Pregnant women must be seen by county staff for MA eligibility determination within 5 days of request.

2. Determination of eligibility must be completed within 10 days of the applicant's original appointment.

Income Guidelines for Minnesota Residents*

Family Size	Income Annually
2	$ 15,588
3	$ 19,536
4	$ 23,496
5	$ 27,456
6	$ 31,416
7	$ 35,376
8	$ 39,336

*Pregnant woman counts as 2 people

July, 1990

APPENDIX E Sample of a Completed Prenatal Risk Assessment Form

Minnesota Medical Assistance Prenatal Risk Assessment

Please return to:
Minnesota Department of Human Services,
Children's Health Section, P.O. Box 64202
St. Paul, MN 55164-0202
Call 1-800-652-9747 Ext. 6015 with questions
~~(For reimbursement you must send a prior authorization form with this risk assessment.)~~

Recipient Name: YOLANDA GRANT

Recipient MA #: 00 · 0 · 000 · 000 · 0000 · 000

Primary Provider Name: PAT YOUNG, MD

Primary Provider #: 2100000

Prior Authorization #: ———

Instructions: Write the score which applies to each risk factor (*for risk factors definitions — see back).

RISK FACTOR	VALUE	SCORE
Maternal Age	20-40 = 0 16-19 or > 40 = 2 ≤ 15 = 4	0
Education	≥ 9 = 0 ≤ 8 = 2	0
Marital Status	Married = 0 Single, div, sep = 2	0
Height	> 5 feet = 0 ≤ 5 feet = 3	0
Prepreg Weight	> 100 = 0 ≤ 100 = 3	0
AB 1st Trimester	< 3 = 0 ≥ 3 = 1	0
AB 2nd Trimester	none = 0 1 = 5 ≥ 2 = 10	5
Cone Biopsy	no = 0 yes = 5	0
Uterine anomaly	no = 0 yes = 5	0
DES exposure	no = 0 yes = 10	0
Hx preterm labor or preterm delivery	no = 0 yes = # x 10	20
Hx pyelonephritis	no = 0 yes = 3	0
Cigarette smoker	0-1½ pack = 1 ≥ 1½ packs = 4	0
Street drug use (this pregnancy)	no = 0 yes = 5	0
Alcohol use (this pregnancy)	no = 0 yes = 2	0
Initial prenatal visit	< 20 wks = 0 ≥ 20 wks = 2	0
Poor social situation	no = 0 yes = 2	0
Children ≤ 5 yrs at home	0 or 1 = 0 ≥ 2 = 2	0
Employment	none = 0 Outside work = 1 Heavy work = 3	0
Last birth within 1 year	no = 0 yes = 1	0
	Subtotal A1	25

RISK FACTOR* CURRENT PREGNANCY	VALUE	1st OB	28 WKS
Bacteriuria, Chlamydia, GC this pregnancy	no = 0 yes = 3	0	
Pyelonephritis	no = 0 yes = 5	0	
Fibroids	no = 0 yes = 5	0	
Presenting part engaged	no = 0 yes = 3	0	
Bleeding ≥ 12 wks	no = 0 yes = 4	0	
Cervical length < 1 cm	no = 0 yes = 4	0	
Dilation ≥ 1 cm	no = 0 yes = 4	0	
Uterine irritability ≤ 34 wks	no = 0 yes = 4	0	
Placenta previa at ≥ 26 wks	no = 0 yes = 4	0	
Oligohydramnios	no = 0 yes = 5	0	
Polyhydramnios	no = 0 yes = 5	0	
Multiple pregnancy	no = 0 yes = 10+	0	
Surgery (abdominal ≥ 18 wks or cerclage)	no = 0 yes = 10	0	
Febrile illness	no = 0 yes = 3	0	
Weight gain at 22 wks	≥ 7 lb = 0 < 7 lb = 2	0	
Weight loss	< 5 lb = 0 ≥ 5 lb = 3	0	
Urine protein	0/trace = 0 ≥1+ = 2	0	
Hypertension or HTN medications	no = 0 yes = 2	0	
	Subtotal B1 and B2	0	

Subtotal A1	25	Subtotal A1	———
Subtotal B1	+ 0	Subtotal B2	+ ———
Total 1st OB	25	Total 28 Wks Screen	

Total score of 10 points or more = High Risk for Preterm Delivery. Complete Enhanced Services Section below.

Enhanced Services: Check all that apply and indicate person(s)/ agencies that will be providing services.

- [X] Care Coordination — Dr. Young
- [X] Prenatal Education I — S. JONES, RN
- [X] Prenatal Education II — S. JONES, RN
- [X] High Risk Follow-up Home Visit — City Public Health Nurse
- [X] Prenatal Nutrition Education — Dr. Young

Refer to WIC [X] Yes [ ] No

1st OB Screen By: Sue Jones, RN

Signature of Primary Provider: Pat Young, MD

2nd OB Screen By: ———

Signature of Primary Provider: ———

Adopted from Lupo, VR and Leafblad, BA, 1986
Modification of Creasy Risk Scoring System

DHS-2867 (5-88)
PZ-02867-01

RISK FACTOR DEFINITION

AB 1st Trimester	– More than 3 spontaneous induced abortions at less than 13 weeks gestation. Does not include ectopics.
AB 2nd Trimester	– Spontaneous or induced abortion between 12-19 weeks gestation.
Uterine anomaly	– Bicornate, T-shaped Septate uterus, etc.
DES exposure	– Exposure to DES (Diethylstilbesterol) in utero Patient who has anomalies associated with DES receives points for this item and uterine anomaly.
Hx PTL	– Spontaneous preterm labor or preterm delivery during any previous pregnancies whether or not it results in preterm or term birth.
Hx pyelonephritis	– One or more episodes of pyelo in past medical history.
Street drug use	– Any street drug use during this pregnancy, e.g. speed, marijuana, cocaine, heroin (includes methadone).
Alcohol use	– Consumption of 6 or more glasses of beer or wine per week or 4 or more mixed drinks per week. Includes any binge drinking.
Late prenatal care	– First prenatal visit at or after 20 weeks gestation.
Poor social situation	– Personal or family history of abuse, incarceration, homelessness, psychiatric disorder, child custody loss, cultural barriers, low cognitive functioning, mental retardation, negative attitude toward pregnancy, exposure to hazardous/toxic agents, inadequate support system.
Employment	– Light work = part-time and/or sedentary work Heavy work = work involving strenuous physical effort standing or continuous nervous tension, i.e. nurses, sales staff, cleaning staff, babysitters, laborers.
Bacteriuria	– Any symptomatic or asymptomatic UTI, i.e. 100,000 colonies in urinalysis.
Pyelonephritis	– Diagnosed pyelo in current pregnancy. Points are given for pyelo only, not both pyelo and bacteriuria.
Bleeding after 12th week	– Vaginal bleeding or spotting after 12 weeks of gestation of any amount, duration or frequency which is not obviously due to cervical contact.
Dilatation (Internal os)	– Cervical dilatation of the internal os of 1 cm or more at 34 weeks gestation.
Uterine irritability	– Uterine contractions of 5 contractions in one hour perceived by patient or documented by provider without cervical change at less than 34 weeks.
Surgery	– Any abdominal surgery performed at 18 weeks or more of gestation or cervical cerclage at any time in this pregnancy.
Febrile illness	– Systematic illness with temperature of 10[illegible] or greater such as pyelonephritis, influenza determined by thermometer reading on [illegible] more occasions.

NUTRITIONAL RISK* FACTOR ASSESSMENT AND DEFINITIONS

Instructions: Check prenatal Nutrition Education if any of the below risk factors indicate nutritional risk. Criteria for Low Iron Level are listed. Food Group risk factor indicates nutritional risk if deficient in one or more groups.

Iron Level

Anemia — Hematocrit is ≤ 31 or Hemoglobin is ≤ 11.

Food Group*

Milk (includes milk, cheese, yogurt, cottage cheese, etc.)

Serving Size	Recommended minimum servings for pregnant adults/teens
cups (milk) or ounces equiv. (cheese)	4 Adult 6 Teen

Meat or Alternates (includes meats, fish, poultry, eggs, nuts, legumes, peanut butter, etc.)

Serving Size	Recommended minimum of 2-3 ounce servings for pregnant adults/teens
ounce	2-3 Adult 3 Teen

Breads and Cereals (includes bread, cereal, pasta, rice, etc.)

Serving Size	Recommended minimum of servings for pregnant adults/teens
ounce or slice equiv.	4 Adult 5 Teen

Fruits/Vegetables Vitamin C (includes citrus fruit and juices, other vitamin-C enriched vegetables including broccoli, tomatoes, cabbage, baked potato, etc.)

Serving Size	Recommended minimum of servings for pregnant adults/teens
cup	1 Adult 1 Teen

Vitamin A (includes green and yellow vegetables: carrots, squash, broccoli, sweet potatoes, spinach, etc.)

Serving Size	Recommended minimum of servings for pregnant adults/teens
cup	1/4 Adult 1/4 Teen

* Nutritional risk to be determined by diet history (foods typically eaten in a day)

MINNESOTA DEPARTMENT OF HUMAN SERVICES
PRENATAL CARE INITIATIVES
HEALTH PROFESSIONAL REFERRAL FORM

Client Name _____ County _____

MA # _____ Home Phone # _____

_____ Gestational Age _____

Marital Status S M W D Sep Delivery Date _____

Street Address _____ Is Client Aware of Referral? _____

City, State, Zip _____

Primary Physician/Nurse Midwife _____

Care Coordinator _____

High Risk Factors Identified: _____

_____

ENHANCED PERINATAL SERVICES	REFERRAL DATE	COMPLETED
Care Coordination		
Prenatal Health Education I		
Prenatal Health Education II		
Prenatal Nutrition Education		
High Risk Follow-up Home Visit		

WIC Referral Done: Yes ____
No ____

Referral Sent By: _____

Date _____

Physician's Signature _____

*SEE BACK FOR ENHANCED PERINATAL SERVICES DESCRIPTIONS AND ELIGIBLE PROVIDERS.

ENHANCED PERINATAL SERVICES	ELIGIBLE PROVIDERS
CARE COORDINATION The development, coordination, and ongoing evaluation of a plan of care for the "at risk" pregnant woman.	Primary physician, certified nurse midwife, licensed registered nurse.
PRENATAL HEALTH EDUCATION I Services will target high-risk medical conditions and health behaviors that can be alleviated or improved through education and include: self-care, high-risk medical factors with emphasis on the significance and management during pregnancy, pre-term labor, childbirth process.	Primary physician, certified nurse midwife, licensed registered nurse, health educator with BA level degree in health ed. or higher and/or SOPHE certification.
PRENATAL HEALTH EDUCATION II Services will include information and guidance to support a healthy pregnancy and will include: reduction or cessation of drug, alcohol, cigarette use, stress management, building self-esteem, anticipatory parenting behaviors.	Primary physician, certified nurse midwife, licensed registered nurse, health educator with the same qualifications as required in Health Ed I, or a BA or masters prepared social worker.
PRENATAL NUTRITION EDUCATION Services will include ongoing assessment of nutritional status and educational efforts to minimize problems hindering normal nutrition.	Primary physician, certified nurse midwife, licensed registered nurse, dietitian, or nutritionist.
HIGH-RISK FOLLOW-UP HOME VISIT A visit will be made within the first two weeks after the mother's discharge from the hospital. Services will include: support of positive lifestyle/behavior changes, follow-up on high-risk factors, contraception, infant care and parenting, and referrals to community family support resources.	Primary physician, certified nurse midwife, licensed registered nurse.

REQUISITION FOR DHS FORMS

APPENDIX G Requisition for DHS Forms

Mail this requisition to:

DEPT. OF HUMAN SERVICES FORMS SUPPLY UNIT
HUMAN SERVICES BLDG.
444 LAFAYETTE ROAD
ST. PAUL, MINNESOTA 55155-3804

★★ M.A. PROVIDER NUMBER IF APPLICABLE

ND FORMS ORDERED TO:

AGENCY OR NAME		
ADDRESS		
CITY	STATE	ZIP CODE

PLEASE SIGN REQUISITION HERE:

DATE	TELEPHONE NUMBER

Form Number	Form Title	Quantity	ACTION TAKEN DHS use only (see reverse)
DHS-			
DHS-			
DHS-			
DHS-			
DHS-			
DHS-			
HS-			
DHS-			
DHS-			
DHS-			
DHS-			
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DHS-			
DHS-			
DHS-			
DHS-			

Send WHITE, LABEL, AND BLUE copies with stub and carbon intact to DHS.
Retain PINK copy. Destroy last carbon. ★★ See back of pink copy.

DHS-121 (1-89)
PZ-00121-06

Rev. 05/09/90

PUBLIC HEALTH NURSING SERVICES IN MINNESOTA

COUNTY	AGENCY NAME & ADDRESS	PHN DIRECTOR/ TELEPHONE NUMBER
AITKIN	Aitkin County PHN Service Courthouse Aitkin, MN 56431	Lester Kachinske (218)927-2102
ANOKA	Public Health Nsg.Off., 325 E.Main ATTN: Jackson Street Office Anoka, MN 55303	Nancy V. Dagg (612)422-7030
BECKER	Multi County Nursing Service 928 Eighth Street S.E., PO Box 701 Detroit Lakes, MN 56502 (Includes Becker, Mahnomen & Norman Counties)	Nancy Bauer (218)847-9224
BELTRAMI	Beltrami County PHN Service 815 West 15th Street Bemidji, MN 56601	Mary Marchel (218)751-7300
BENTON	Benton County PHN Service 1139 Franklin Avenue, Box 661 St. Cloud, MN 56302	Pat Rudie (612)253-8440
BIG STONE	See COUNTRYSIDE NURSING SERVICE listed under SWIFT	
BLUE EARTH	Blue Earth County PHN Service 410 South Fifth Street Mankato, MN 56001	Nancy Meyer (507)625-3031
BROWN	Brown County PHN Service 1200 South Broadway New Ulm, MN 56073	Anita Hoffmann (507)354-4418
CARLTON	Carlton County PHN Service 2801 Dewey Avenue Cloquet, MN 55720	Karen Wunderlich (218)879-4511
CARVER	Carver Co. Community Health Serv. 540 East First Street Waconia, MN 55387	Georgianne Lowney 612/442-4493 local 612/448-1216 metro
CASS	Cass County PHN Service Box 179, Community Health Center Walker, MN 56484	Dorothy Opheim (218)547-3300
CHIPPEWA	See COUNTRYSIDE NURSING SERVICE listed under SWIFT	

PUBLIC HEALTH NURSING SERVICES IN MINNESOTA

COUNTY	AGENCY NAME & ADDRESS	PHN DIRECTOR/ TELEPHONE NUMBER
CHISAGO	Chisago County PHN Service Box 649 Lindstrom, MN 55045	Janet Strauss (612)257-1300
CLAY	Clay County PHN Service 914 8th Avenue North Moorhead, MN 56560	Shirley Stelter (218)299-5220
CLEARWATER	North Country CHS & Clearwater PHN Clearwater Co. Courthouse, Box 237 Bagley, MN 56621	Mary Tronerud (218)694-6581
COOK	Cook County PHN Service Courthouse Grand Marais, MN 55604	Rosemary A. Lamson (218)387-2282
COTTONWOOD	See COTTONWOOD-JACKSON PHN SERVICE listed under JACKSON	
CROW WING	Crow Wing County Health Services County Services Building Brainerd, MN 56401	Carol Carlson (218)828-3973
DAKOTA	Dakota County PHN Service Suite 345, 33 East Wentworth West St. Paul, MN 55118	Patricia Adams (612)450-2907
DODGE	Dodge County PHN Service P.O. Box 325 Mantorville, MN 55955	Peggy Espey (507)635-6150
DOUGLAS	Mid-State CHS, Douglas County PHN 1311 Hwy. 29 N., BOX 878 Alexandria, MN 56308	Shirley Faehnrich (612)763-5438
FARIBAULT	See FARIBAULT-MARTIN-WATONWAN HUMAN SERVICE BOARD listed under MARTIN	
FILLMORE	Fillmore County Public Health Nsg. Courthouse, P.O. Box 84 Preston, MN 55965	Sharon K. Serfling (507)765-3898
FREEBORN	Freeborn County CHS Courthouse, 411 South Broadway Albert Lea, MN 56007	Margene Gunderson (507)377-5100
GOODHUE	Goodhue-Wabasha Comm. Health Serv. 419 Bush Street Red Wing, MN 55066	Jane Dietzman (612)388-0433

PUBLIC HEALTH NURSING SERVICES IN MINNESOTA

COUNTY	AGENCY NAME & ADDRESS	PHN DIRECTOR/ TELEPHONE NUMBER
GRANT	Grant County PHN Service Tenth and First Street N.E. Elbow Lake, MN 56531	Betty Kirsch (218)685-5301
HENNEPIN	Metropolitan Visiting Nurse Assoc. 250 South Fourth Street Minneapolis, MN 55415	Karen Swanson (612)673-2734
HENNEPIN	Bloomington Division of Health 1900 West Old Shakopee Road Bloomington, MN 55431 (also provides service in Edina and Richfield)	Gayle Hallin (612)887-9603
HOUSTON	Houston County PHN Service Courthouse, 304 South Marshall Caledonia, MN 55921	Kathryn Lammers (507)724-5211
HUBBARD	Hubbard County PHN Service St. Joseph's Hospital Home Care Park Rapids, MN 56470	Kathy Kleen (218)732-3311
ISANTI	Isanti County PHN Service 1557 South Highway 293 Cambridge, MN 55008	Linda Halcon (612)689-4071
ITASCA	Itasca County Health Department Courthouse Grand Rapids, MN 55744	Ruth Schuder (218)327-2851
JACKSON	Cottonwood-Jackson CHS/PHN Service 503 Fourth Street Jackson, MN 56143 (Includes Jackson & Cottonwood Counties)	Pat Stewart (507)847-2366
KANABEC	Kanabec County PHN Service 18 North Vine Street Mora, MN 55051	Rhonda Kolberg (612)679-2282
KANDIYOHI	Kandiyohi County CHS/PHN Service 905 West Litchfield Avenue Willmar, MN 56201	Pat Berg (612)235-4785
KITTSON	Kittson County PHN Service Courthouse Hallock, MN 56728	Claudia Nyegaard (218)843-3662

PUBLIC HEALTH NURSING SERVICES IN MINNESOTA

COUNTY	AGENCY NAME & ADDRESS	PHN DIRECTOR/ TELEPHONE NUMBER
KOOCHICHING	Koochiching County PHN Service Courthouse International Falls, MN 56649	Susan Congrave (218)283-6240
LAC QUI PARLE	See COUNTRYSIDE NURSING SERVICE listed under SWIFT	
LAKE	Lake County Home Health Services 4th Street & 11th Avenue Two Harbors, MN 55616	Joyce Highmark (218)834-2171
LAKE OF THE WOODS	Lake of the Woods Co. PHN Service Trinity Hospital, Box H Baudette, MN 56623	Raella Gustafson (218)634-1795
LE SUEUR	Le Sueur County PHN Service Courthouse Le Center, MN 56057	Lucy Helfter (612)357-2251
LINCOLN	See LYON	
LYON	Lincoln Co./Community Nursing Serv. 1210 East College Drive Marshall, MN 56258	Michelle Malmquist (507)537-6713
MAHNOMEN	See MULTI-COUNTY NURSING SERVICE listed under BECKER	
MARSHALL	Marshall County PHN Service 109 South Minnesota Street Warren, MN 56762	Diana Kostrzewski (218)745-5154
MARTIN	FMW Human Services Board 218 Lake Avenue Fairmont, MN 56031	Carmen Reckard (507)238-4757
MC LEOD	McLeod County PHN Service 804 - 11th Street Glencoe, MN 55336	Brenda Birkholz (612)864-3185
MEEKER	Meeker County PHN Service 101 South Gorman Litchfield, MN 55355	Ann Bajari (612)693-2882
MILLE LACS	Mille Lacs County CHS/PHN Service 635 Second Street S.E., Courthouse Milaca, MN 56353	Linda Massey (612)983-2561
MORRISON	Morrison County PHN Service 808 S.E. Third Street Little Falls, MN 56345	Mary Ann Blade (612)632-6665

PUBLIC HEALTH NURSING SERVICES IN MINNESOTA

COUNTY	AGENCY NAME & ADDRESS	PHN DIRECTOR/ TELEPHONE NUMBER
MOWER	Mower County PHN Service Courthouse, 201 N.E. First Street Austin, MN 55912	Anna Agerbeck (507)437-9458
MURRAY	See LYON	
NICOLLET	Nicollet County PHN Service Courthouse, Box 179 St. Peter, MN 56082	Nita Aasen (507)931-6800
NOBLES	Nobles-Rock CHS/PHN Service P.O. Box 757, 315 10th Street Worthington, MN 56187	Bonnie Frederickson (507)372-8256
NORMAN	See MULTI-COUNTY NURSING SERVICE listed under BECKER	
OLMSTED	Olmsted Co. Health, Nursing Div. 1650 S.E. 4th Street Rochester, MN 55901	Mary Rippke (507)285-8354
OTTER TAIL	Otter Tail Co. Dept. of Pub. Health Courthouse Fergus Falls, MN 56537	Diane Thorson (218)739-2271x260
PENNINGTON	Inter-County PHN Courthouse, Box 616 Thief River Falls, MN 56701 (Includes Pennington & Red Lake Counties)	Susan Olson (218)681-5950
PINE	Pine County PHN Service Courthouse Pine City, MN 55063	Virginia Rootkie (612)629-6781x166
PIPESTONE	See LYON	
POLK	Polk County PHN Service 1500 University Avenue, Box 403 Crookston, MN 56716	Brenda L. Menier (218)281-3385
POPE	Pope County PHN Service Courthouse Glenwood, MN 56334	Sharon Braaten B(612)634-5301x39
RAMSEY	Ramsey County PHN Service 150 East Kellogg Boulevard St. Paul, MN 55101	Jane Norbin (612)298-4549

PUBLIC HEALTH NURSING SERVICES IN MINNESOTA

COUNTY	AGENCY NAME & ADDRESS	PHN DIRECTOR/ TELEPHONE NUMBER
RED LAKE	See INTER-COUNTY NURSING SERVICE listed under PENNINGTON	
REDWOOD	Redwood County PHN Service 600 South Gould Street Redwood Falls, MN 56283	Genie R. Simon (507)637-2969
RENVILLE	Redwood-Renville CHS 2510 West Lincoln Avenue Olivia, MN 56277	Jill Bruns (612)523-2570
RICE	Rice County CHS/PHN Service 128 N.W. 3rd Street Faribault, MN 55021	Mary Ho (507)334-2281
ROCK	See NOBLES	
ROSEAU	Roseau County PHN Service Roseau Home Care Ag., 715 Delmore Roseau, MN 56751	Colleen Nelson (218)463-3211
SCOTT	Scott County Human Services Courthouse 300, Health Services Shakopee, MN 55379	Jo Billy (612)445-7751
SHERBURNE	Sherburne Co. Government Center Box 311 Elk River, MN 55330	Vonna Henry B(612)441-8665 H(612)757-0883
SIBLEY	Sibley County PHN Service 400 Court Ave., Courthouse Box 166 Gaylord, MN 55334	Theresa Pesch (612)237-2962
ST. LOUIS	St. Louis County PHN Services 1001 East 1st Street, 2nd Floor Duluth, MN 55805	Carol Fielders (218)727-8661
STEARNS	Stearns County CHS Box 153 St. Cloud, MN 56302	Roma Steil (612)255-6155
STEELE	Dodge-Steele CHS/PHN Service 590 Dunnell Drive, P.O. Box 890 Owatonna, MN 55060	Carol LeMaster (507)451-4400
STEVENS	Stevens-Traverse PHN Service Box 530 Morris, MN 56267	Sandy Tubbs (612)589-2294

PUBLIC HEALTH NURSING SERVICES IN MINNESOTA

COUNTY	AGENCY NAME & ADDRESS	PHN DIRECTOR/ TELEPHONE NUMBER
SWIFT	Countryside Public Health Service 1125 Kansas Avenue, Box 313 Benson, MN 56215 (Includes Big Stone, Swift, Chippewa, Lac Qui Parle & Yellow Medicine Counties)	Julie Jensen (612)843-4546
TODD	Todd County PHN Service 119 3rd Street S.E., Courthouse Anx Long Prairie, MN 56347	Julie Krause (612)732-4440
TRAVERSE	See STEVENS	
WABASHA	Goodhue-Wabasha Comm.Health Service 107 East 3rd Street Wabasha, MN 55981	Judy Barton (612)565-3335
WADENA	Wadena County Health Department 415 South Jefferson, Courthouse Wadena, MN 56482	Karen Nelson (218)631-1344
WASECA	Waseca County PHN Service 301 North State Street, Courthouse Waseca, MN 56093	Shirley Lundquist (507)835-0685
WASHINGTON	Washington County Public Health 14900 N. 61st St., P.O. Box 6 Stillwater, MN 55082	Mary Luth (612)779-5445
WATONWAN	See FARIBAULT-MARTIN-WATONWAN HUMAN SERVICE BOARD listed under MARTIN	
WILKIN	Wilkin County PHN Service Courthouse, Box 127843 Breckenridge, MN 56520	Shirley Larson (218)643-4722
WINONA	Winona County PHN Service Winona Co. Courthouse, 171 W. Third Winona, MN 55987	Sue Steiner (507)457-6420
WRIGHT	Wright County Human Services Agency Courthouse Buffalo, MN 55313	Carol Schefers (612)682-3900 or (612)339-6881
YELLOW MEDICINE	See COUNTRYSIDE NURSING SERVICE listed under SWIFT	

Public Health Nursing Section
Minnesota Department of Health

5703.01 Policy/Background

All pregnant women must be screened to determine risk status, using the Risk Assessment form #2867 provided by the Department. The MA Risk Assessment form measures the client's risk for pre-term delivery or a low birthweight baby. Pregnant women defined to be "high risk" (a score of ten points or more on the MA Risk Assessment form) are eligible for enhanced services as defined by Minnesota Statutes, section 256B.02, subdivision 8. Enhanced services will receive reimbursement in addition to the prenatal and delivery services described in the Delivery and Newborn chapter.

5703.02 Definitions

High risk: A pregnant women who requires additional prenatal care services because of medical or lifestyle factors that increase the probability of a preterm birth or the delivery of a low birthweight infant.

Low birth weight: Birth weight less than 2,500 grams. (5.5 pounds)

Preterm birth: Birth before the gestational age of 38 weeks; also termed premature birth.

Risk Assessment: Identification of the medical, genetic, lifestyle, and psychosocial factors that identify recipients at risk of a low birth weight or premature infant.

Enhanced services: Services delivered to recipients defined to be at risk of poor pregnancy outcome, that are reimbursed in addition to OB services as described in the Delivery and Newborn chapter. Enhanced services include: high risk antepartum management, prenatal health education I, prenatal health education II, prenatal nutrition education, high risk follow-up home visit, and the enhanced service package that combines all of the above.

5703.03 Risk Assessment

To be eligible for enhanced services payment, the physician or certified nurse midwife is required to complete a risk assessment for each pregnant recipient, at the recipient's first prenatal visit and on the form supplied by the Department. The form should be submitted to the address indicated on the top of the form. The Risk Assessment is reimbursed when billed on the Practitioner Invoice.

Enhanced services will be reimbursed only for "high risk" pregnant women: women who score ten or more points on the DHS Risk Assessment form. Enhanced services will not be reimbursed unless a Risk Assessment form, indicating the woman's high risk status, is received in the Department. The enhanced services are subject to post-payment review. A provider can decide to increase the Risk Assessment to high risk (10 points) to qualify the recipient for enhanced services by documenting the rationale (i.e., gestational diabetes, autoimmune disease, mental health impairment) on Risk Assessment form.

5703.04 Covered Services for High Risk Women

The following enhanced services are covered by MA:

A. High Risk Antepartum Management. The primary physician or certified nurse midwife will be eligible for reimbursement if the recipient is defined as "at risk" by the MA Prenatal Risk Assessment form.

B. Care Coordination Services, including the following components:

1. development of an individual plan of care that addresses the recipient's specific needs related to the pregnancy.

2. ongoing evaluation and, if appropriate, revision of the plan of care according to the recipient's needs related to pregnancy.

3. assistance to the recipient in identifying, obtaining, and using services specified in the recipient's plan of care.

4. monitoring, coordinating, and managing nutrition and prenatal education services, to assure that these are provided in the most economical, efficient, and cost effective manner (Minnesota Rules, part 9505.0353).

Care Coordination Services may be performed by the following qualified providers: primary physician, certified nurse midwife, or a licensed registered nurse.

C. Prenatal Health Education I, targeting high risk medical conditions and health behaviors that can be alleviated or improved through education. These services must begin with the initial prenatal visit and continue throughout the perinatal period. Prenatal Health Education I services must provide information to the recipient on the following: self-care, specific high risk medical conditions with emphasis on the significance and management during pregnancy, instruction on self-detection of preterm labor, warning signs and appropriate methods to delay labor, the childbirth process and contraception education.

Prenatal Health Education I services may be delivered by the following qualified providers: physician, certified nurse midwife, licensed registered nurse, or a health education professional with either a baccelaureate level degree in health education or higher and/or SOPHE (Society of Public Health Educators) certification.

D. Prenatal Health Education II, including information and techniques to support a healthy lifestyle during pregnancy, and providing information and guidance in the following areas: reduction or cessation of drug, alcohol, and cigarette use, stress management, self-esteem, communication skills and support resources, and anticipatory parenting behaviors. Services may be provided on a one-to-one basis or in small group or classroom settings.

Prenatal Health Education II services may be delivered by the following qualified providers: physician, certified nurse midwife, licensed registered nurse, a health educator with either a baccelaureate level degree in health education or higher and/or SOPHE certification, or a baccelaureate or masters prepared social worker.

E. Prenatal Nutrition Education Services, including ongoing assessments of the recipient's nutritional status, and efforts to minimize the problems hindering normal nutrition, in order to improve the recipient's nutritional status during pregnancy.

Prenatal Nutrition Education Services may be delivered by the following qualified providers: physician, certified nurse midwife, licensed registered nurse with specialized nutrition education, or a dietitian or nutritionist.

F. High Risk Follow-up Home Visit, in addition to and separate from the six week postpartum visit with the recipient's primary provider. It will be made within the first two weeks after the mother's discharge from the hospital. Services will include: reinforcement of positive behavior and lifestyle changes relating to the pregnancy, follow-up on high risk factors, contraception education, infant care and parenting skills, and identification and referral to community health and social service resources.

High Risk Follow-up Home Visit services may be delivered by the following qualified providers: physician, certified nurse midwife, or a licensed registered nurse.

**Reductions in reimbursement for physician-extenders do not apply to the enhanced services.

5703.05 Providers

To be eligible for reimbursement for enhanced services, the provider must be enrolled and have signed a provider agreement approved by the Department for the provision of health services to a recipient.

The following provider types are eligible for reimbursement for enhanced services:

A. Physician Directed Clinics

B. Community Health Clinics

C. Physician Services

D. Public Health Clinic Services

E. Nurse Midwife Services

F. Outpatient Hospital Services

G. Home Health Agency Services

5703.06 Billing Procedures

A. The following enhanced services and codes may be billed to MA by an enrolled provider.

ENHANCED SERVICES	BILLING PROCEDURE CODE RATE
Enhanced Service Package*	X5493
Risk Assessment**	X5494
High Risk Antepartum Management	X5495
Care Coordination	X5496
Prenatal Health Ed. I	X5497
Prenatal Health Ed. II	X5497-52
Prenatal Nutrition Ed.	X5498
High Risk Follow-up Home Visit	X5499

*Indicates high risk recipient received all enhanced services, X5495 - X5499 from that enrolled provider.

**Limited to four payments per recipient within a 12-month period. Physician-extender modifiers are not needed when billing for enhanced services X5493-X5499.

B. To bill MA for enhanced perinatal services, an enrolled eligible provider must:

1. Complete the Prenatal Risk Assessment form (DHS-2867) at the time of the first prenatal visit. If the recipient does not present a high risk at the first prenatal visit, but risks increase or develop later in the pregnancy, complete the Risk Assessment form again to document the change. Completing the form at 28 weeks gestation is optional, but will be reimbursed when done.

a. Mail one copy of the Risk Assessment form to the Department and retain the second copy for the recipient's record.

b. Include any or all enhanced services considered to be appropriate interventions for the high risk recipient, based on the risk factors identified by the MA Risk Assessment form, whether the service will be delivered by the primary provider or a referral agency/provider.

2. Bill MA your usual and customary charge using a Practitioner Invoice (DHS-1497) which will be provided by the Forms Supply Department at DHS. Although providers will be paid according to above reimburesement rates, DHS encourages billing to reflect actual service charges.

3. The primary provider may opt to contract or refer the enhanced services to other enrolled MA providers. In this case, the enrolled provider performing the service may bill MA directly using the Practitioner Invoice and the codes listed above.

4. The primary provider may opt to contract or refer the enhanced services to providers <u>not</u> enrolled in the MA program. In this case, the primary provider is responsible for billing the department in the manner described previously, and is also responsible for reimbursing the provider performing the service.

Legal References

Minnesota Statutes, section 256B.02, subdivision 12
Minnesota Rules, part 9505.0353
Public Law 99-272, section 9501(b)

MEDICAL ASSISTANCE REIMBURSEMENT RATES FOR PCI ENHANCED SERVICES (as of 07/01/90)

Service	Code	Reimbursement Rate
Risk Assessment	X5494	$6.32
High Risk Antepartum Management	X5495	$75.90
Care Coordination	X5496	$30.36
Prenatal Health Education I	X5497	$75.90
Prenatal Health Education II	X5497-52	$64.51
Prenatal Nutrition	X5498	$18.97
High Risk Follow-up Home Visit	X5499	$61.75
Enhanced Services Package (includes X5495-X5499)	X5493	$327.40

APPENDIX K Sample of a Completed MA Practitioner Invoice (Clinic)

SEND INVOICES TO: Minnesota Medical Assistance Program -- Department of Human Services, Box 64166, St. Paul 55164

PRACTITIONER INVOICE

Claims Processing Document Control Number

1

ELITE PICA — TYPEWRITER ALIGNMENT — USE CAPITAL LETTERS ONLY — ELITE PICA

PROVIDER INFORMATION

2 Provider's Name: MEDICAL CLINIC
3 Provider I.D. #: 2100000
4 Own Reference #: 344567
5 Billing Date: 04-10-89
6 Prior Auth. #:
7 Street Address: 12345 ANYBODY'S ROAD
8 Referring Practitioner's Name:
9 City / State / Zip Code: OUTBACK, MN 55123
10 Name and City of Hospital or Nursing Home:

RECIPIENT INFORMATION

11 Recipient's Name (Last, First, Initial): PATTERSON, MARY
12 Recipient's Medical Assistance Number: 27-2-000-000-3456-101
13 Sex: F
14 Birthdate: 01-11-50
15 Pre-admission Certification Phone and Certification Number:
16
17 Medical Insurance Company
18 Medical Insurance Policy Number
19 TPL: 1
20 Injury: 1
21 Primary Diagnosis: GYNECOLOGICAL EXAM
ICD Code: 22 V72.3
23 Secondary Diagnosis:
ICD Code: 24

STATEMENT OF SERVICES RENDERED

		Individual Group Member Number	If Applicable	Service Date	Procedure Code	Modifier	Units	Place	Charge	Delete
01	25	206745X	26	06-01-88	27 90050	28 WW	29	30 1	31 25.00	32
Procedure Name										
01A	33	OFFICE CALL - PHYSICIAN EXTENDER								
02	34	206745X	35	06-01-88	36 88150	37	38	39 1	40 11.00	41
Procedure Name										
02A	42	PAP SMEAR								
03	43		44		45	46	47	48	49	50
Procedure Name										
03A	51									
04	52		53		54	55	56	57	58	59
Procedure Name										
04A	60									
05	61		62		63	64	65	66	67	68
Procedure Name										
05A	69									
06	70		71		72	73	74	75	76	77
Procedure Name										
06A	78									

		Indv. Grp. Member #	From Date	Through Date	Procedure Code	Modifier	Units	Place	Charge	Delete
07	79		80	81	82	83	84	85	86	87
08	88		89	90	91	92	93	94	95	96

97

Total Number Of Lines Used: 98 2
Type Of Bill: 99
Total Units:

GROSS TOTAL CHARGES: 100 36.00
Amount Received From Other Sources: 101
Amount Received From Medicare: 103
NET BILLED TO MA: 105 36.00

PROVIDER CERTIFICATION

This is to certify that all information given on this form is true, accurate and complete and all medical services indicated have been rendered. I understand that payment and satisfaction of this claim will be from Federal, State and Local funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State Laws.

X YOUR SIGNATURE
Authorized Signature

MEDICARE

Deductible: 102
Co-Insurance: 104

PZ 01497 00
DHS 1497 (1-89)

PRACTITIONER INVOICE

APPENDIX L Sample of a Completed MA Practitioner Invoice (PHN Agency)

ELITE PICA — TYPEWRITER ALIGNMENT — USE CAPITAL LETTERS ONLY — ELITE PICA

OVIDER INFORMATION

Provider's Name	Provider I.D. #	Own Reference #	Billing Date	Prior Auth. #
YOUR PUBLIC HEALTH AGENCY	3 60XXXXX	4	5 08-27-90	6

7 Street Address: 1234 HOME STREET

8 Referring Practitioner's Name:

9 City / State / Zip Code: WELLNESS, MN 51234

10 Name and City of Hospital or Nursing Home:

RECIPIENT INFORMATION

11 Recipient's Name (Last, First, Initial): JONES, SUSAN

12 Recipient's Medical Assistance Number: 27-2-000-000-3456-101

13 Sex: F

14 Birthdate: 10-01-70

15 Pre-admission Certification Phys. Ind. / Certification Number: 16

17 Medical Insurance Company / 18 Policy Number

19 TPL: 1

20 Injury: 1

21 Primary Diagnosis: PREGNANCY WITH OTHER POOR OBSTETRIC HISTORY

ICD Code 22: V234

23 Secondary Diagnosis:

ICD Code 24:

STATEMENT OF SERVICES RENDERED

	Individual Group Member Number / If Applicable	Service Date	Procedure Code	Modifier	Units	Place	Charge	Delete
01	25	26 05-08-90	27 X5284	28	29 1	30 2	31 60.00	32
01A	Procedure Name 33 NURSE VISIT							
02	34	35 06-01-90	36 X5497	37	38 1	39 2	40 66.00	41
02A	Procedure Name 42 PRENATAL HEALTH EDUCATION I							
3	43	44 06-20-90	45 X5284	46	47 1	48 2	49 60.00	50
03A	Procedure Name 51 NURSE VISIT							
04	52	53 08-24-90	54 X5499	55	56 1	57 2	58 60.00	59
04A	Procedure Name 60 HIGH RISK FOLLOW-UP HOME VISIT							
05	61	62	63	64	65	66	67	68
05A	Procedure Name 69							
06	70	71	72	73	74	75	76	77
06A	Procedure Name 78							

	Indv. Grp. Member #	From Date	Through Date	Procedure Code	Modifier	Units	Place	Charge	Delete
07	79	80	81	82	83	84	85	86	87
08	88	89	90	91	92	93	94	95	96

97

4 Total Number Of Lines Used — 98 2 Type Of Bill — 99 4 Total Units

PROVIDER CERTIFICATION

This is to certify that all information given on this form is true, accurate and complete and all medical services indicated have been rendered. I understand that payment and satisfaction of this claim will be from Federal, State and Local funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State Laws.

X F. Nightingale
Authorized Signature

MEDICARE

Deductible 102

Co-Insurance 104

GROSS TOTAL CHARGES 100 246.00

Amount Received From Other Sources 101

Amount Received From Medicare 103

NET BILLED TO MA 105 246.00

PZ 01497 03
DHS-1497 (3-90)

PROVIDER'S FILE COPY