1. **PURPOSE**

The purpose of this document is to define the policies and procedures for providing services to patients in the Centering Pregnancy Clinic.

1. **DEFINITIONS & ABBREVIATIONS**

ACOG = American College of Obstetricians and Gynecology

ARNP = Advanced Registered Nurse Practitioner

ASCCP = American Society for Colposcopy and Cervical Pathology

ATU = Antenatal Testing Unit

CDC = Centers for Disease Control

CNM = Certified Nurse-Midwife

DCHD = Dade County Health Department

HIV = Human Immunodeficiency Virus

HLS = HIV Linkage Specialist

JHS = Jackson Health System

LD = Labor and Delivery OB= Obstetrics

PAC = Professional Arts Center

PCP = Primary Care Provider

PP = Post-partum

RN = Registered Nurse

SI = Special Immunology

STIs = Sexually Transmitted Infections

TOPWA = Targeted Outreach for Pregnant Women Act

US= Ultrasound

CW = Care ware - OB/Gyn SI Data base

1. **RESPONSIBILITY**
	1. The Medical Director of the Clinic has the final authority on policies and procedures involving the operation of the Centering Clinic.
	2. CNM / ARNPs are responsible for the enrollment of patients in Centering Pregnancy and for the clinical management in coordination with the Medical Director.
2. **PROCEDURE**
	1. **Requesting an Initial Appointment**
		1. Patient, referring doctor, etc., calls 305-243-5832 (main line) or 243-5645 to make an appointment.
		2. HIV Linkage Specialist (HLS) answers the line. If she is unavailable, the phone number is transferred to the Quality Control Management (QCM) Director.
		3. HLS starts a file on the patient before they are seen. She requires proof of pregnancy, proof of HIV status, recent results (if any), referral (if needed by referring doctor or PCP) and prior authorization if required, copy of ID, name and information on the insurance carrier.
		4. HLS submits the file to the CNMs.
		5. The CNMs review the file and any additional records in Cerner, UChart or CAREWare (CW) to determine if the patient is a candidate for Centering.
		6. If the patient is not a candidate for Centering Clinic based on the initial review of records (i.e., advanced gestational age, active substance use, insurance), she is referred back to HLS for scheduling in PRIM OB clinic.
		7. If the patient is a possible candidate for Centering Clinic, CNMs will call the patient to set up a brief interview at CRB to complete the medical history, describe Centering Pregnancy model and determine if the patient is interested.
		8. If the patient is interested in Centering Clinic, she will be asked to register at UHealth by calling 305-243-4551 and once she does this, CNMs will request a new OB visit at the OB/GYN UHealth office.
		9. HLS asks the patient if transportation is needed. If so, they are given the TOPWA phone number and HLS fills out a TOPWA referral for pick up.
		10. HLS contacts the Perinatal HIV Coordinator at the DCHD to report all new HIV diagnoses.
		11. New OB visit will be schedule and will take place in PAC with CNMs.
	2. **Pre-Clinic Meetings and Activities**
		1. Fridays: CNMs get a hard copy of the next week’s schedule for all clinics.
		2. Mondays at 1pm: CNM / ARNPs meet with the Medical Director, Psychologist, Registered Nurse, Medical Case Worker and Research team, to go over every scheduled patient.
		3. Mondays at 3pm: CNM / ARNPs, Part D Director, Part C QCM Director, Medical Case Manager(Sr. HIM Technician), RN, Patient Navigator, and Medical Case Worker (Eligibility Specialist) meet to go over the week’s schedule and address any issues.
		4. Medical Case Manager (Eligibility Specialist) calls the patient 2 days prior to the appointment as a reminder.
		5. Centering Clinic will be held on Mondays 9:00am – 5pm in group sessions of 2 hours at the Batchelor Institute – 2nd floor Resource Room.
	3. **Consent for treatment, Outreach and HIPAA**
		1. Patient will sign a consent for treatment, HIPAA authorization form and consent for outreach if they fall out of treatment. Consents are signed or scanned in Uchart.
	4. **Initial Visit**
		1. OB initial visit is individual. During this visit, the CNM takes a comprehensive health history, performs a complete head to toe physical exam, orders or reviews labs and diagnostic tests, makes assessment, estimates EDC, explores patient’s feelings toward pregnancy and discusses available options, evaluates maternal and fetal well- being, identifies risk factors, develops a plan of care including review of the Centering Pregnancy Model, pharmacologic and non-pharmacologic measures, patient education, follow-up, consults and referrals as needed (i.e., Nutritionist).
			1. Comprehensive health history includes but is not limited to: medical, obstetrical, genetic, gynecologic, contraceptive, nutritional, lifestyles, surgical, family, social including screening for substance use, domestic violence and human trafficking. HIV related history: past and current use of antiretroviral medications, resistance testing, mutations, compliance, hospitalizations or diseases related to the HIV infection, and co-morbidities.
			2. Complete physical exam includes but is not limited to general exam, obstetric and pelvic exam (fundal height, fetal heart tones, cervical pap smear, STIs screening, drug use screening, presence or absence of HIV related pathology).
		2. **Labs and Diagnostic Tests**
			1. If the patient comes in with no confirmed HIV diagnosis, appropriate HIV tests are ordered to confirm diagnosis.
			2. Initial prenatal labs are requested or reviewed and include but are not limited to: CBC, CMP, syphilis IgG, ABO, antibody screen, rubella IgG, Hepatitis B surface antigen, Hepatitis C Virus antibody, sickle cell screening, urinalysis, urine culture, antenatal maternal testing, T-cells, HIV viral load, HIV genotype, HLA-B\*5701, Quantiferon TB, Drug Abuse screening in urine, and other pertinent lab tests depending on each case.
			3. OB US or other diagnostic testing as per protocol or as needed
		3. **Assessment and Plan**
			1. Medical Director is available to discuss assessment and management with CNM.
	5. **Prescriptions, Ultrasounds, Referrals**
		1. Prescriptions are sent electronically to the pharmacy or printed out and given to the patient.
		2. Ultrasound orders are entered into UChart and scheduled for the same day of the visit or for a day that is more convenient for the patient.
		3. If referrals or consults are needed, CNMs enter request in UChart, make sure that appointment has been made and follow-up patient’s compliance with consult or referral.
		4. Patients are referred to Nutritionist, Dental, Ophthalmology, Fetal Surveillance (ATU) and other medical specialties as needed.
	6. **Provide Patient Education**
		1. The group facilitators discuss with participants perinatal and postnatal information and provide educational materials during the Centering sessions.
	7. **Psychological Evaluation**
		1. Psychological evaluation and psychotherapy are available for all patients at the medical campus. The psychological evaluation is usually done at the second visit except when after initial assessment an acute or uncontrolled chronic psychological problem is identified, in these cases the evaluation happens at the first visit, immediately after patient is seen by clinical provider. If there are no immediate concerns, an appointment with the psychologist is scheduled for the next visit. Psychiatric services are also available if needed.
	8. **Obtaining Lab Results and / or other Diagnostic Tests**
		1. Safety / monitoring labs are requested as per guidelines and clinical evaluation.
		2. CNM / ARNP will review lab results and will discuss with Medical Director as needed.
		3. Patients are notified about results at the following visit or by phone or letter if needed and depending of each case.
		4. If cervical Pap smear is abnormal, patient will be scheduled for colposcopy.
		5. If STI screening is positive, patient will receive counseling and treatment as per CDC guidelines and the DCHD will be notified as needed.
		6. The CNM / ARNPs enter the following data into CW: Pap smear, syphilis test, gonorrhea and chlamydia culture, current medications, information of pregnancy, each prenatal and post-partum visit, and delivery of the baby.
	9. **Centering Pregnancy Model**
		1. Centering Group is composed of 5-8 participants, facilitator (CNM) and co-facilitator.
		2. Participants will have similar gestational age.
		3. Initial OB visit will be individual.
		4. Once new OB visit is completed, patient will be scheduled in a Centering group.
		5. Participants will know ahead of time, the visit dates for all group sessions.
		6. Participants will sign a confidentiality agreement during the first visit.
		7. Women will attend ten Centering Pregnancy group sessions.
		8. Each group session meets for 90-120 minutes.
		9. At each session, women will actively take part in their own health care assisted by the facilitators and group.
		10. The session topics include but are not limited to: nutrition, fetal development, common discomforts of pregnancy and their remedies, exercise, relaxation, labor and delivery procedures, parenting and relationship issues, contraception and infant care.
		11. Essential elements of the Centering Pregnancy® model include: risk assessment and self-care activities.
		12. The Centering Pregnancy® curriculum has been adapted to fit the needs of HIV-positive pregnant women.
		13. A facilitative leadership style is used and there will be stability of group leadership.
		14. Each session has an overall plan; attention is given to the core content; emphasis may vary.
		15. Group conduct honors the contribution of each member; the group is conducted in a circle; the composition of the group is stable but not rigid; involvement of family support people is optional; opportunity for socialization within the group is provided.
		16. If OB or Special Immunology practice protocols require specific exams at particular points in care, or if a woman’s situation requires, the participant can have additional appointments for one-on-one examinations.
		17. If complications arise, additional visits are scheduled within the traditional setting, although the woman can continue to attend the Centering Pregnancy® groups.
		18. Plan for return visits is based on individual needs, risk assessment and Centering Pregnancy Model. If it is an uncomplicated pregnancy the follow-up Centering visits are schedule every 4 weeks until 24 weeks, every 2 weeks from 25 – 36 weeks and every week after 36 weeks until delivery.
		19. Option to transfer from Centering Model to Individual model is always available based on patient’s preference and / or medical / psychological condition.
		20. Labs and Ultrasounds will be ordered at UMH or other labs / facilities depending on insurance.
		21. Visits will be documented in UChart.
		22. Medical Director will be available for consultation as needed.
		23. CNMs enter the order in UChart for the next group session. UM staff schedule the next appointment for the group session or if needed, can also schedule an individual visit.
		24. Medical Case Worker (Eligibility Specialist) conducts a reminder phone call 2-3 days prior to the next Centering visit.
		25. If the patient can’t be contacted and misses two appointments to Centering, a home visit is requested to the HLS. Two persons from the staff visit the patient. If still the patient can’t be contacted, DCHD is notified.
		26. Medical management is provided following the updated version of the HIV perinatal guidelines, ACOG, CDC and ASCCP guidelines.
		27. Visit to OB triage, admissions and delivery will be at JHS.
		28. There is ongoing evaluation of outcomes.
	10. **Schedule of Prenatal Visits**

**Traditional Care CenteringPregnancy® Care**

12 weeks (initial exam) 12 weeks (initial exam)

16 weeks 16 weeks (Session 1)

20 weeks 20 weeks (Session 2)

24 weeks 24 weeks (Session 3)

28 weeks 28 weeks (Session 4)

30 weeks 30 weeks (Session5) 32weeks 32weeks (Session 6)

34 weeks 34 weeks (Session 7)

36 weeks 36 weeks (Session 8)

37 weeks 38 weeks (Session 9)

38 weeks 40 weeks (Session 10)

39 weeks

40 weeks

1. Billing for session attendance is done through the standard reimbursement system because the program follows the schedule of prenatal visits recommended by the AAP and the ACOG (2002).
2. **Visits to OB triage and Admissions**
	1. If the patient is admitted to the hospital or if is in triage, the Medical Director and OB physician team are responsible for patient management.
	2. The CNM visit the patient during hospitalization and document as needed.
3. **Labor and Delivery**
	1. Prenatal records are available electronically in UChart
	2. If the patient is candidate for trial of labor, she will present to OB triage at JMH when she presents labor signs and symptoms; Medical Director is notified when the patient arrives.
	3. After evaluation, a decision is made if the patient will be admitted to LD floor or discharge home.
	4. If the patient needs induction of labor, she will come to LD floor and present for induction the day that has been scheduled.
	5. If the patient is scheduled for Cesarean section, she will come to LD floor on the date and time that has been scheduled.
	6. CNMs report the delivery to Pediatric Special Immunology and to the Manager of the Comprehensive AIDS Program sending a secure email.
	7. CNMs and/or RN visit the patient on the LD, recovery or post-partum floor.
	8. CNMs enter the information about delivery in CW and Antiretroviral Registry.
	9. Before the patient is discharged, she is counseled regarding continue treatment for her and the newborn, contraindication of breastfeeding, breast care, post-partum care and warning signs and symptoms, appointment at the Pediatric Screening Clinic for the newborn, postpartum appointment for her, family planning and other pertinent issues.
	10. Patient is discharged with reliable birth control method (if patient agrees) and with prescriptions for mother and newborn.
	11. Case manager, Social worker, Psychology, Psychiatric services are available during hospitalization and involved particularly in cases with history of abuse, mental health problems, substance use, among others.
	12. WIC office is in the same post-partum floor and patient can see them before discharge.
4. **Postpartum**
	* 1. Post-partum visit is individual.
		2. Patient is seen at 6 weeks postpartum but may be seen before, at 2-3 weeks postpartum if needed.
		3. Confirmation that patient is compliant with infant screening visits at Pediatric SI.
		4. Follow-up family planning. If patient still is not on a reliable birth control method, contraceptive counseling is given and patient is encouraged to initiate a birth control method.
		5. Follow-up particular post-partum issues, review post-partum labs / referrals or consults (ie. Anemia, hypertension or other co-morbidities) and medications.
		6. Labs as needed (ie. f/u pap smear if abnormal during pregnancy, CBC if significant anemia post-delivery)
		7. Patient is referred to primary care in our facilities or community clinics depending on prior provider, medical insurance and patient decision.
		8. Results, assessment, management, referrals discussed with Medical Director.
		9. Monitor that patient has appointment with HIV specialist.
		10. Case closure form completed and submitted to enter in CW.
5. **DOCUMENTATION**
	1. **Maintenance of SOPs**

The signed originals of this SOP will be scanned and stored in the J drive (shared drive for the Division of Research and Special Projects).

The SOP is maintained and continuously reviewed by the Steering Committee / Board to ensure that the described operating procedures are accurate and are clinically updated.

1. **REFERENCES**
	1. Rising, Sharin S. Centering Pregnancy: An Interdisciplinary Model of Empowerment. Journal of Nurse-Midwifery. Vol 43, No. 1. January/February 1998.
	2. Massey Z, Rising Sh, and Ickovics, J. 2006. Centering Parenting Group Prenatal Care: Promoting Relationship-Centered Care. Journal of Obstetrics, Gynecologic and Neonatal Nursing. March/April.
	3. Centering Pregnancy Facilitator’s Guide. 2014. Centering Health Care Institute.
	4. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. <http://aidsinfo.nih.gov/contentfiles/lvguidelines/PerinatalGL.pdf>

* 1. The American College of Obstetricians and Gynecology. <http://www.acog.org/Resources-And-Publications/>
	2. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2010. [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5912a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5912a1.htm%20)
	3. American Society for Colposcopy and Cervical Pathology. <http://www.ASCCP.org/Consensus2012>
1. **TEMPLATES**
2. **REVISION HISTORY**

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| --- | --- | --- | --- |
| Effective Date | Revision Date | Author | Description of Changes |
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**SIGNATURES**

Prepared by: JoNell Potter, PhD Date: \_\_\_\_\_\_\_\_\_\_\_\_

 Director, Division of Research and Special Projects

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 Signature

Approved by: Ira Karmin, MD Date: \_\_\_\_\_\_\_\_\_\_\_\_

 Chairman, Department of OB/GYN

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