MSS Prenatal Risk Factor Clarification Table

MSS Targeted Risk Factor Criteria	Clarification
Some additional background information for all risk factors	**1. Client risk criteria information can be obtained from:** • Client self-reports: please use probing questions to confirm • Medical care provider records • WIC agency reports • Chemical Dependency Treatment agencies • Mental Health providers • Other social services agencies **2. Risk determination-** some MSS targeted risk factors can be determined easily by any MSS team member (CHW or Clinician): • Client is diagnosed with gestational diabetes • Previous preterm birth • Late entry to prenatal care **While other risk factors require a clinician (CHN, BHS, RD) to determine the specific risk criteria (A,B,C):** • Pre-pregnancy BMI • Mental health • Developmental Disability • Substance Abuse or Addiction **3. Release of Information-** Please talk with your supervisor and/or legal counsel to determine when a release of information is needed. **4. Increased collaboration and marketing of MSS will be needed so women are referred back into services if their situation changes:** Prenatal medical care providers WIC Social workers within the hospitals, emergency rooms Drug treatment Mental health Child Protective Services Economic Services – TANF **5. Clients can self -refer** to a MSS agency initially or develop a targeted risk factor(s) later on in pregnancy.

Some additional background information for all risk factors cont'd	**6. Non MSS targeted risk factors-** Clients will have risk factors other than, or in addition too, the MSS targeted risk factors. MSS risk factors are the first priority but other risks that could impact the pregnancy should be noted. **7. Depression Screening-** All clients who answer positive to mental health screening questions or have symptoms of depression should be screened for depression using a standardized depression screening tool. Some agencies are already screening all clients for depression during the pregnancy cycle and others may want to consider this option.
Race • American Indian, Alaska Native, non-Spanish speaking indigenous women from the Americas (i.e. Mam in Guatemala and Mixteco from Oaxaca, Mexico) • Black or African American • Pacific Islander	**1. Racial determination**: To determine client race, have woman fill out demographics on the intake form or ask the woman "What do you consider your race or ethnic background to be?" Have the woman choose. The pregnant woman is the focus of this risk factor, not the baby or father of the baby. **2. Black or African American**: A person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as "Black, African Am., or Negro," or provide written entries such as African American, Afro American, Kenyan, Nigerian, or Haitian. (US census definition). **3. Non-Spanish speaking indigenous women from the Americas (original peoples)**: This risk factor does not include Spanish speaking Hispanic women for example, but it does include specific population of indigenous tribes from the Americas who speak only indigenous languages, i.e. Mam in Guatemala and Mixteco from Oaxaca, Mexico. **4. Pacific Islander**: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. (US census definition). **5. The decision to include these racial groups in the C level of service was based on**: • 2009 Washington State Legislature directive to increase services to these populations in an effort to reduce LBW/premature birth and other poor birth outcomes. (HB 1244) • Data analysis of poor pregnancy outcomes for these groups in Washington State. • Even though African American/black women are at the highest risk for LBW, preterm birth, and other poor birth outcomes, most of the women in this population do not screen in by standard risk criteria. (Washington data and literature both support this). • Maternal Child Health research literature on health disparity. • Policy decisions by other states' to target high risk racial population groups in an effort to reduce health disparities.

Prenatal Care • Greater than or equal to **(≥) 14** and less than **(<) 24 weeks** gestation **and no prenatal care** started. • Greater than or equal to **(≥) 24** weeks gestation before, or no, prenatal care started.	**1. Greater than or equal to (≥) 14 and less than (<) 24 weeks gestation and no prenatal care started:** • Woman is 3 ½ months pregnant or less than (<) 6 months pregnant and has not started prenatal medical care. • She may need help obtaining a medical services card, transportation, child care, finding a medical care provider, etc. • During these times of prenatal care access issues in Washington State, there may be several clients who meet this risk criteria. Prioritize your case load, with help from team members if needed, so the woman at most risk for poor birth outcomes is seen as soon as possible. For clients with less risk, the goal is to have the client seen within the month or sooner. **2. Greater than or equal to (≥) 24 weeks gestation before, or no, prenatal care started:** • Woman is at 6 months of pregnancy or further along and prenatal car**e was started** on or after the 6 month of pregnancy. • Woman is at 6 months of pregnancy or further along and **no** prenatal care has started. This woman needs help in accessing care as soon as possible. • In addition to possible access issues, these clients may not trust a health care provider or have underlying issues such as substance abuse, mental illness, or developmental disability.
Food Insecurity: Runs out of food before the end of the month or cuts down on the amount eaten to feed others.	**Food Insecurity:** • Anyone who answers positive to the food insecurity question will be marked as food insecure. • Most people who are food insecure may not disclose this information because there may be a level of embarrassment associated with this issue. • Regardless if a client is on WIC or accessing other services (food benefits, free meals, etc.), she can still be food insecure. Some reasons for continued food insecurity include homelessness, poor food storage, large family, and a lack of knowledge regarding budgeting, shopping, or cooking.

<u>Pre-pregnancy BMI</u>: IOM= Institute of Medicine

- Pre-pregnancy BMI less than **(<) 18.5** and **weight gain within** IOM guidelines.
- Pre-pregnancy BMI less than **(<) 18.5** and **weight gain outside** of IOM guidelines.
- Pre-pregnancy BMI **25.0 to 29.9**
- Pre-pregnancy BMI greater than or equal to **(≥) 30** and **weight gain within** IOM guidelines.
- Pre-pregnancy BMI greater than or equal to **(≥) 30** and **weight gain outside** of the Institute of Medicine guidelines

Pre-Pregnancy BMI and Pregnancy Weight Gain:

Please note weight is one way to screen for risk. Clients are sensitive about weight in most circumstances so being cautious of the words you use and providing positive messages will be important. More information on this will be provided in a guide later, but please use you a dietitian who is the expert in this area if you have questions.

1. Pre-pregnancy weight, current weight, and height can all be obtained from the following:

a. Medical record, if available.
b. WIC certification report, etc., if available.
c. Agency measurement and determination:
   - Have the women remove her shoes and heavy outer clothing before weighing or measuring.
   - Zero the scale out prior to weighing.
   - Have the woman step onto the center of the scale.
d. Client self-report:
   - Some populations are not use to having their height and/or weight checked so they will not be able to self-report.
   - If a client is not able to self-report and it is early in the pregnancy (1st trimester) you can weigh the client and then ask probing questions like "How have your clothes been fitting?"
   - When weight is self-reported, note that some women tend to under report their pre-pregnancy weight. Making a statement like "based on what you have shared, it looks like you have gained ~ x pounds so far for this pregnancy" "Does that sound about right"? If the weight gain does not sound right the client will usually tell you.

2. Calculating Pre-pregnancy BMI - BMI chart provided by First Steps and the following link provides CDC Online Calculator

www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

3. Determine if the weight gain is within the guidelines- Clinicians will need to determine if the pregnancy weight gain is within the guidelines (See risk factor matrix). Please note you are only determining if the client is within the guidelines, not what that determination means for that client.

Medical: **Inter-pregnancy interval:** Current pregnancy conception less than (<) 9 months from the end of last pregnancy **Diabetes:** • History gestational diabetes with last pregnancy • Pre-existing Diabetes- type 1 or 2 • Current gestational diabetes **Multiples:** Currently pregnant with multiples (2 or more babies) **Hypertension/Gestational Hypertension:** • Gestational Hypertension in prior pregnancies • Chronic Hypertension: Hypertension diagnosed prior to pregnancy or before 20 weeks gestation (5 months of pregnancy) • Current pregnancy induced hypertension (gestational hypertension) starting greater than (>) 20 weeks gestation (5 months of pregnancy) **Low Birth Weight (LBW) or Preterm birth/labor, Fetal Death:** • Prior LBW infant (less than (<) 5 lb 8 oz) **and/or** premature infant (less than (<) 37 weeks) and/or fetal death • Current preterm labor	**Medical Risk Factors**- this can be self-reported, but you must probe to ensure it was diagnosed by health care provider and not just client diagnosed. **Inter-pregnancy interval-** last pregnancy includes fetal loss and termination **Multiples:** • Extremely high risk for preterm/ LBW infants • Fetal birth defects • Placenta Previa, Abruptio Placenta • Preeclampsia – Gestational Hypertension • Greater occurrence in African American women • Greater occurrence in women over 35, with or without assisted reproductive technology • Possible postpartum mood and anxiety symptoms **Hypertension:** Hypertension can be determined through self-report, review of current medications, medical records, and Blood Pressure (BP) screening. BP screening is one way to assess for hypertension. BP screening by MSS providers will require an agency protocol for training staff and process for sharing BP screening information with medical care providers. Hypertension diagnosis cannot be determined through BP screening alone. **Gestational Hypertension:** This typically develops later in the third trimester of pregnancy and gestational hypertension can develop into preeclampsia. This condition occurs most often in young women with a first pregnancy. It is more common in twin pregnancies, women over the age of 35, women with chronic hypertension and/or preexisting diabetes, African-American women, and women who had hypertension in a previous pregnancy. **LBW/Preterm birth/labor/ fetal death:** Fetal death is defined at 20 weeks or more gestation (sometimes called stillbirth). If a woman has had more than one preterm birth and/or fetal death, she is at further increased risk of poor birth outcomes. If a woman is diagnosed at any time during the pregnancy with preterm labor, she is at high risk and needs support to prevent and recognize labor. Also, if a woman is placed on bed rest for a condition that can result in preterm delivery, she falls under this risk category. If a woman with a singleton gestation has had at least one spontaneous preterm labor and/or rupture of the membranes, she may qualify for 17P treatment. Refer the client to ask her OB provider about 17P.

Maternal Age: • 16 years old at conception • Up through age 15 at conception. • **35** years of age or older at conception **and** this is not her first pregnancy **and** she did not use assisted reproductive technology (ART) for this pregnancy. • **35** years of age or older at conception **and** one of the following: (1) First pregnancy. (2) Current pregnancy via assisted reproductive technology (ART).	**Assisted Reproductive Technology (ART) -**Assisted reproductive technology (ART) is a general term referring to methods used to achieve pregnancy by artificial or partially artificial means. It is reproductive technology used primarily in infertility treatments.
Tobacco/Nicotine Use • Quit before pregnancy or upon diagnosis of pregnancy. • Smokes or uses tobacco or other nicotine products during pregnancy.	**Tobacco use:** • Any maternal tobacco/nicotine use including type and amount. • This does not include second hand smoke. • Relapse: If woman quits but returns to tobacco/nicotine use, she can be moved into the B category. Women who continue to use tobacco/nicotine throughout pregnancy may also have one of the other risk factors such as substance abuse or mental illness.
Alcohol and Substance Abuse/Addiction • **Stopped use** of alcohol (see clarification table), illicit substances, or non-prescriptive use of prescriptive drugs **following pregnancy diagnosis and** has not used for more than or equal to **(≥) 90 days** • Actively engaged in alcohol/drug treatment program and has not used for greater than or equal to (≥) 90 days. • **Stopped use** of alcohol (see clarification notes), illicit substances, or non- prescriptive use of prescriptive drugs **following pregnancy diagnosis and** has not used for less than **(<90)** • **Any use** of alcohol, illicit substances, or non-prescriptive use of prescriptive drugs once the client knows she is pregnant.	• **B risk criteria-** This risk criteria **does not apply** to the woman who drank an occasional alcoholic beverage before pregnancy but stopped all alcohol use either before planning pregnancy or at the time of pregnancy diagnosis. o A client who has stopped using or is actively involved/engaged in treatment and shows no signs of use may be at risk for relapse and need support. o A woman who has relapsed during her pregnancy can be moved to the C level and stay there for the duration of her pregnancy. o **Actively involved/engaged**- participating in CD treatment and/or attending regular AA/NA meetings. This includes methadone treatment. • **C risk criteria-** This risk level **does include** any level of alcohol (even "social" drinking) or drug use once the woman knows she is pregnant including those who relapse during pregnancy. • If a woman enters jail having used alcohol, illicit substances, or non-prescriptive use of prescriptive drugs, her jail time does not count as part of that abstinent time period.
Intimate Partner Violence • In the last year, the woman's intimate partner or father of baby (FOB) has committed or threatened physical/sexual violence against her.	**Intimate Partner Violence-** The risk is greatest if the person who inflicted the violence is the father of the baby or the current intimate partner.

Mental Health • No history of mental health diagnosis, but screens positive for "In the last month, have you felt down, depressed or hopeless?", or showing signs of depression and standardized depression screen indicates mild risk (Edinburgh less than (<) 10 or a comparable score on another standardized depression screening tool)**.** • History of mental health treatment **and/or** postpartum depression and Edinburgh score currently less than (<) 10 (or a comparable score on another standardized depression screening tool) **or** • Current mental health diagnosis and is actively participating in mental health treatment. • Mental health symptoms of depression are evidenced by Edinburgh depression score greater than (>) 10 (or a comparable score on another standardized tool that indicates possible depression) **or** • Client has a mental health diagnosis and active symptoms which are interfering with general functioning.	**Standardized depression screening**- Any standardized tool. Some tools can be self-administered by literate clients and others need to be done by a clinician. Some examples of a standardized tool include: • Edinburgh • CES-D • BECK's Depression Inventory • Postpartum Depression Screening Scale • PHQ 9 • GAD 7- needs to be done in combination with depression screening **Some symptoms of depression can be similar to some of the changes that naturally occur during pregnancy, and this is why a clinical determination is needed. Symptoms of depression may include:** • Flat affect • Complaining of tiredness • Over or under eating • Can't sleep or sleep too much • Can't control negative thoughts, no matter how much they try • Much more irritable and short-tempered than usual **Actively engaged** in treatment: Client is using prescriptions as prescribed, and/or involved with mental health treatment.
Developmental Disability • Severe developmental disability which could impact the woman's ability to take care of herself during the pregnancy or a child, but has an **adequate** support system and **follows through** with health care appointments/advice and self-care. • Severe developmental disability which impacts the woman's ability to take care for herself during the pregnancy or a child, and has an **inadequate** support system or **does not demonstrate** evidence of follow through with health care appointments/advice and self-care.	• **Defining Severe Developmental Disability-** This risk factor has been difficult to define and measure objectively. Providers will need to use their clinical assessment skills to determine the client's developmental disability related to her ability to care for herself during pregnancy and if she has limited safety nets. Document finding in the chart. • **Adequate support**- Safety Net (family, partner, or support system) that will help the client keep appointments, support the client with Activities of Daily Living (ADLs) during pregnancy, and with the infant postpartum. • **Demonstrated follow thru on medical care and self-care**- following through with medical appointments and medical advice for specific condition (gestational hypertension, diabetes, preterm labor, etc.). • Women with a severe developmental disability may have other issues (mental illness, interpersonal violence, substance abuse, and medical issues) that are difficult to assess due to client's cognitive disability.