

INDIVIDUALIZED CARE PLAN (ICP) INSTRUCTIONS & SAMPLE

What is the ICP?

An ICP is a tool for coordinating a client's total perinatal care, including obstetrical, nutritional, health education, and psychosocial issues. The ICP prioritizes the risk conditions/problems from the Initial Combined Assessment/Reassessments, documents the client's strengths, goals, and interventions, including teaching, counseling, and appropriate referrals.

How is the ICP developed?

The ICP is developed with the patient present. She will be more motivated and likely to follow the plan if she is included in developing the goals and interventions.

Client Information

Patient: Write in the client's first name, middle initial and last name.

Gravida: Write in the number of times the patient became pregnant including this one. All pregnancies should be counted regardless of whether they resulted in a live birth or not.

Para: Write in the number of previous deliveries resulting in infants weighing 500 grams or more or having a gestational age of 20 weeks or more, whether alive or dead at delivery. A multiple fetal pregnancy (twins, triplets, etc.) counts as only one delivery.

EDC: Estimated Date of Confinement (EDC), also called Estimated Date of Delivery (EDD), or the due date, is the calculated birthdate of the infant using the first day of the client's last menstrual period. Charts or "OB wheels" can be used for the calculation. Write in the month/day/year.

Provider Name: Write in the name of the physician or certified nurse midwife in charge of the client's overall OB care.

Case Coordinator: Write the name and title of the Case Coordinator, for example:
Sarah Smart, CPHW

Provider Signature: It is recommended that the physician sign the Individualized Care Plan to comply with CPSP regulations that all services are provided by or under the personal supervision of a physician. (Title 22, CCR, Section 51179)

Date: Write in the date that the physician reviewed the Individualized Care Plan.

Column 1

Date: Write in the date when the problem is identified; whether at the initial assessment, reassessment, or a follow-up visit.

Strengths Identified: Write in the client's strengths that can help change the particular problem or issue identified. Each strength needs to be matched to its specific problem or risk. For example, if the problem is "low education," a possible strength is that the client is "motivated to go back to school". These are some examples of possible strengths:

- Ability to comprehend and make decisions
- Ability to cope with _____
- Adequate food
- Adequate shelter/ clothing
- Adequate transportation
- Emotionally stable
- Employed
- Experience/knowledge of delivery
- Experience/knowledge of parenting
- Experience/knowledge of pregnancy
- Financially stable
- Positive compliance
- Positive self-esteem
- High School Education
- Willing to participate in individual or group education
- Motivated to _____
- Refrigerator/stove
- Support system can assist with _____
- Wanted/accepted/planned pregnancy

Column 2

Identified Problem/Risk/Concern: Write in all problems, risks, and concerns related to obstetrical, health education, nutrition, and psychosocial issues. Problems/risks are the shaded items that are found on the Prenatal Combined Assessment/Reassessment Tool. Number the problems using the question number from the prenatal combined assessment. This column should also include concerns that the client wants to address at this visit as well as issues identified by the healthcare team. **Do not** include issues that have been adequately addressed with interventions noted in the Prenatal Combined Assessment & Reassessment Tool itself. Use all the space you need to adequately document the problem/risk/concern.

Goal: Each identified problem on the ICP needs to have a goal. This is the status or outcome to be achieved by the plan of action (intervention) for addressing the problem/need/risk.

Column 3

Teaching/Counseling/Referral(s)/Timeframe: In the clinic's CPSP protocols, look up the assessment question number where the risk is identified. Write down the specific actions being performed to resolve the problem/risk/concern(s), and the timeframe in which these actions will be completed. This can include teaching and counseling from Steps to Take (STT). When referencing STT, document the section name (HE, Nut., or Psy.) and title of the handout or information discussed. For example: "Reviewed & discussed STT Nut. 'Get the Iron You Need'." The referrals to other professionals (RD, dentist, etc.) or services (smoking cessation program, adult school, etc.) should be based on the clinic's protocols or provider recommendation. Document the name of the referral and a phone number if available. Use short sentences and do not rewrite the problem. Make sure the client agrees with proposed interventions. If client is not willing or interested in following recommended interventions for a particular problem, document your efforts.

Column 4 & 5

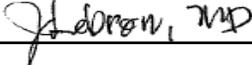
Follow-up/Reassessment Date - Outcome/Plan: Write in the date at the top of the box. At the follow-up prenatal visit/reassessment, record client's progress towards resolving the problem. Check the previous plan and comment on results obtained. If goals were not achieved, modify the plan and record new interventions and timeframes. If the problem continues past column 5, rewrite it on an additional care plan sheet. If problem/risk/concern(s) has been resolved, write a short note and then "resolved."

Patient: Patty A. Preggers

Gravida: 1 Para: 0 EDC: August 15, 2013

Provider Name: Dr. Le Bron

Case Coordinator: Sarah Smart, CPHW

Provider Signature: 

Date: 1/24/2013

Date: 1/21/13	Identified Problem /Risk/ Concern	Teaching/Counseling/ Referral	Follow-up Reassessment Date- 4/08/13 Outcome/Plan	Follow-up Reassessment Date- 5/26/13 Outcome/Plan
<p>Strengths Identified:</p> <ul style="list-style-type: none"> - Motivated to see dentist 	<p>#30. Has not been to dentist within past year because of lack of insurance</p> <p><u>Goal:</u> Will go to dentist for cleaning and check-up</p>	<ul style="list-style-type: none"> - CPHW reviewed /discussed STT HE pg. 47 "Oral health during Pregnancy". - Reviewed and gave H/O STT HE "Prevent Gum Problems When You Are Pregnant" and "See a Dentist When You Are Pregnant" - CPHW referred pt to dentist (Denti-Cal provider) Happy Dental (323) 222-1111. Pt will call dentist w/in 2 wks. 	<ul style="list-style-type: none"> - Pt did not make dental appt because she states that she didn't feel well. Pt will call dentist by next prenatal appt. 	<ul style="list-style-type: none"> - Pt went to dentist appt 4/12/13 for cleaning and has no cavities. - Reviewed/gave H/O STT HE "Keep Your Teeth and Mouth Healthy! Protect Your Baby, Too."
<p>Date: 1/21/13</p> <p>Strengths Identified:</p> <ul style="list-style-type: none"> - Willing to discuss problems in relationship - Good family support 	<p>#102 Feels threatened by boyfriend</p> <p><u>Goal:</u> Pt. will have safe environment for herself & baby</p>	<ul style="list-style-type: none"> - Informed pt. of limits of confidentiality - Reviewed/ discussed STT Psy. "Spouse/Partner abuse" - Referred to SW, Wilma Ward, (323) 867-5309 scheduled apt. 1/24/13 - Notified MD - Referred to Women's shelter (323) 445-5694 - Referred to domestic violence hotline (800) 456-1111 	<ul style="list-style-type: none"> - Pt. met with SW on 1/24/13. See SW notes - Pt states broke up with boyfriend last month/feeling okay & safe. - Pt. states no contact w/ bf since break up 	<ul style="list-style-type: none"> - Pt. states she no longer has contact with boyfriend - Pt. continues weekly appt. w/ SW.

Date: 1/21/13	Identified Problem /Risk/ Concern	Teaching/Counseling/ Referral	Follow-up Reassessment Date- 4/08/13	Follow-up Reassessment Date- 5/26/13
<p><u>Strengths Identified:</u></p> <ul style="list-style-type: none"> - Willing to receive treatment - Concerned about health & baby's health 	<p>Lab test positive for Chlamydia</p> <p><u>Goal:</u> Pt free of STD's throughout pregnancy</p>	<ul style="list-style-type: none"> - Dr LeBron treated pt Azithromycin 1gm PO - Advised to tell boyfriend to come to clinic for treatment - Discussed STT HE pg. 23-25 "STDs" - Gave & discussed H/O STT H/E "What You Should Know About STDs" and "You Can Protect Yourself and Your Baby from STDs" - MD advised to refrain from sex for 2 weeks. 	<p><u>Outcome/Plan</u></p> <ul style="list-style-type: none"> - T.O.C. negative - Per pt: left messages for boyfriend to call back but no response. - Per MD orders advised to practice safer sex w/ condoms. 	<p><u>Outcome/Plan</u></p> <ul style="list-style-type: none"> - Pt states no complaints
<p>Date: 1/21/13</p> <p><u>Strengths Identified:</u></p> <ul style="list-style-type: none"> - Encouraged to learn about breastfeeding - Willing to try breastfeeding 	<p>#89 Plan to breast feed & formula feed because will return to work in 6 weeks</p> <p><u>Goal:</u> To exclusively BF for at least 4 weeks to establish milk supply</p>	<ul style="list-style-type: none"> - Reviewed & discussed STT Nut. "Tips for Addressing BF Concerns" - Reviewed/discussed STT Nutrition "What to Expect While BF: Birth to Six Weeks" - Reviewed and answered pt questions related to return to work (i.e. breast pumps) <p><i>Sarah Smart, CPHW</i></p>	<ul style="list-style-type: none"> - Pt considering exclusively BF but is worried about milk supply - Gave referral to attend BF classes and support group at WIC: (323) 312-4444 <p><i>Sarah Smart, CPHW</i></p>	<ul style="list-style-type: none"> - Pt agrees to exclusively BF for at least 4 weeks. - Encouraged pt to continue attending WIC for BF support/classes. - Will schedule return to clinic appt. 4 days after d/c from hospital to evaluate BF; pt. to call sooner if having problems. <p><i>Sarah Smart, CPHW</i></p>