Perinatal Case Management: Self Assessment Tool

PERINATAL CASE MANAGEMENT

Self Assessment Tool

BPHC

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U.S. Department of Health and Human Services
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PERINATAL CASE MANAGEMENT

Self Assessment Tool

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Introduction

Community and Migrant Health Centers (C/MHCs) play a vital role in the U.S. perinatal care system. Health centers serve many women at high risk of poor pregnancy outcomes including the poor and minority populations. Many of the women served by C/MHCs require a comprehensive array of services, but may lack the financial resources or awareness to obtain those services. Effective case management assists pregnant women who have complex needs navigate a complex, often fragmented, system of care.

The Case Management Self-Assessment Tool is a checklist-style instrument designed to enable programs to rate their existing system of case management based on five function areas:

- Risk Assessment
- Coordination & Referral
- Follow Up & Tracking
- Crisis Intervention
- Communication

A description of an "optimal" effort for each case management function follows.

A. Risk Assessment

A thorough risk assessment includes a medical risk assessment, a psychosocial risk assessment, and a nutritional risk assessment. An optimal risk assessment effort would include separate tools for conducting each assessment (commonly used obstetrical flow sheets only assess psychosocial and nutritional needs in a perfunctory manner). A team approach would be used with appropriately trained staff conducting the medical, psychosocial, and nutritional assessments. Information from the assessments results in a care plan (developed in conjunction with the patient), which guides the care team in the provision of risk-appropriate care. Assessments and care plans are updated throughout the perinatal period.

B. Coordination and Referral

An optimal effort under coordination and referral means that a network of referrals exists for other services offered by the health center and for services in the community. Patients are provided with appropriate referrals and the assistance necessary to follow through on the referral (for example, help with documentaion, transportation, and child care). If necessary, a member of the care team is available to act as a patient advocate with referral sources.

C. Follow-Up and Tracking

Optimal follow-up and tracking systems document prenatal appointments, patient referrals (both medical and other), whether patient followed through on referrals, post-partum appointments, and newborn appointments. Action is taken to determine why patient missed appointment or did not follow through on a referral, with assistance provided as necessary to help the patient to follow through on her care plan.

D. Crisis Intervention

Crisis intervention refers to the practice whereby a member of the care team makes an effort to develop a rapport with the patient. This care team member takes an active role in providing opportunities (usually through frequent face-to-face contact) for the patient to disclose any problems she may be having.

E. Communication

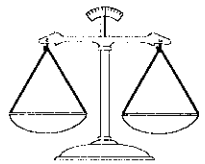
The communication function refers to the sharing of information among the care team. An optimal effort means that there is a formal system for sharing information; for example, having all care team members document to the medical chart. An optimal effort includes regularly scheduled case conferences for at least higher-risk patients, which all care team members attend.

The self-assessment tool can be used to "score" each functional area according to the point values assigned to each response. The range of points are translated into minimal, moderate, and optimal performance levels according to the following guidelines:

FUNCTION	MINIMUM	MODERATE	OPTIMAL
Risk Assessment	< 74	74 - 113	> 113
Coordination & Referral	< 31	31 - 90	> 90
Follow Up & Tracking	< 16	16 - 47	> 47
Crisis Intervention	< 21	21 - 50	> 50
Communication	< 16	16 - 85	> 85

While an optimal effort in each function area is ideal, the level of effort directed toward each function will depend on the particular requirements and available resources of each C/MHC. For example, a moderate effort for a particular case management function may be appropriate in light of program experience, patient load, patient needs, or available resources. The tool is intended to identify areas where health centers might improve their perinatal case management.

RISK ASSESSMENT



Scale to Measure Case Management Performance Level		
Minimal **<74**	**Moderate** **74-113**	**Optimal** **>113**
The extent of the risk assessment is limited to questions from the POPRAS/Hollister form. The primary medical provider is the only person involved in risk assessment.	A team approach is used to assess risk, with nutritional and psychosocial risk assessment more in-depth than simply the questions on the POPRAS/Hollister form. The risk assessment feeds into the development of a care plan for the patient.	Moderate Plus: The risk assessment is continually updated with the results discussed with the patient. A care team representative (may be case manager), develops with the patient a mutually agreed upon plan, which is also continually updated. The care plan is used by the care team to guide the provision of risk-appropriate care.

Case Management Self Assessment Tool

RISK ASSESSMENT

1. Are standard obstetric flow sheets used (e.g., POPRAS, Hollister, forms developed by center)?

   ☐ Yes (10)
   ☐ No (0)

2. Are formal tools, other than the standard obstetric flow sheet, used in the psychosocial risk assessment process (e.g., forms, checklists)?

   ☐ Yes (20)
   ☐ No (0)

3. Are formal tools, other than the standard obstetric flow sheet, used in the nutritional risk assessment process (e.g., 24-hour recall, dietary intakes)?

   ☐ Yes (20)
   ☐ No (0)

4. How often are the following topics specifically addressed as part of the initial risk assessment?

	Always/Almost Always	Sometimes	Rarely/Never
Past Obstetric History	(2)	(0)	(0)
Contraceptive History	(2)	(0)	(0)
Sexual History	(2)	(0)	(0)
Family/Genetic History	(2)	(0)	(0)
Nutrition	(2)	(0)	(0)
Smoking	(2)	(0)	(0)
Alcohol Use	(2)	(0)	(0)
Drug Use	(2)	(0)	(0)
Social Support	(2)	(1)	(0)
Family Violence	(2)	(1)	(0)
Stress	(2)	(1)	(0)
Pregnancy Readiness	(2)	(1)	(0)
Housing	(2)	(1)	(0)
Finances	(2)	(1)	(0)

5. Given the following list of providers, estimate the proportion of patients with whom the provider would be involved in conducting a psychosocial risk assessment.

	All/Almost Patients	Some Patients	Few/No Patients
Primary obstetric provider	(10)	(5)	(0)
Staff trained specifically in psychosocial risk assessment	(40)	(20)	(0)
Other staff	(20)	(10)	(0)

6. Given the following list of providers, estimate the proportion of patients with whom the provider would be involved in conducting a nutritional risk assessment.

	All/Almost Patients	Some Patients	Few/No Patients
Primary obstetric provider	(10)	(5)	(0)
Staff trained specifically in nutritional risk assessment	(40)	(20)	(0)
Other staff	(20)	(10)	(0)

7. Estimate the proportion of patients for which psychosocial risk assessments are updated at the following intervals.

	All/Almost Patients	Some Patients	Few/No Patients
At least once/trimester	(20)	(10)	(0)
Post partum	(20)	(10)	(0)

8. Estimate the proportion of patients for which nutritional risk assessments are updated at the following intervals.

	All/Almost Patients	Some Patients	Few/No Patients
At least once/trimester	(20)	(10)	(0)
Post partum	(20)	(10)	(0)

9. Is the risk assessment information used to develop a formal, documented patient care plan?

- ☐ Yes (20)
- ☐ No (0)

10. Does the risk assessment process encourage patient involvement in their own care plan development?

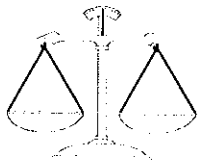
- ☐ Yes (20)
- ☐ No (0)

RISK ASSESSMENT

SCORING

	Subtotal		Total Points
Add Total Points for Questions 1, 2, 3, 9, & 10			
Add Total Points for Questions 4, 5, 6, 7, & 8		÷ 2	
		TOTAL RISK ASSESSMENT	

COORDINATION & REFERRAL



Scale to Measure Case Management Performance Level		
Minimal <31	Moderate 31-90	Optimal >90
Patient is told about referral sources and/or given a list of referral sources. Referrals made are limited to services provided on site, to the Medicaid eligibility office, and/or WIC.	Network of referrals exist with social service organizations in the community. Assistance is provided, if necessary, in arranging an appointment.	Moderate Plus: Patients are assisted to the extent necessary to follow through on the referral, including but not limited to assistance with transportation, assistance with child care, assistance with completion of any forms, assistance with translation, etc. Member of care team acts as patient advocate with referral sources.

COORDINATION AND REFERRAL

11. How are the following services accessed?

	On-Site	Off-Site by Formal Referral*	Off-Site by Informal Referral	Not Available
Medicaid Enrollment	(4)	(4)	(1)	(0)
WIC Services	(4)	(4)	(1)	(0)
Family Planning	(4)	(4)	(1)	(0)
HIV/AIDS Education/Testing	(2)	(2)	(1)	(0)
Smoking Cessation Counseling/Program	(2)	(2)	(1)	(0)
Nutrition Counseling	(2)	(2)	(1)	(0)
Alcohol & Drug Avoidance Education	(2)	(2)	(1)	(0)
Mental Health	(2)	(2)	(1)	(0)
Home Visiting	(2)	(2)	(1)	(0)
Childbirth/Parenting Education Classes	(2)	(2)	(1)	(0)
Safe Shelter for Domestic Violence	(2)	(2)	(1)	(0)

* Note: *Formal referral* implies that an agreement (verbal or written) has been established between the health center and the referral organization. The referral implies that the referral organization will provide services to health center users. The two organizations communicate about common users to the extent permitted by confidentiality considerations. The relationship between the two organizations is nurtured and maintained through regular contact.

	On-Site	Off-Site by Formal Referral	Off-Site by Informal Referral	Not Available
Housing Assistance	(2)	(2)	(1)	(0)
AFDC	(2)	(2)	(1)	(0)
Food Stamps	(2)	(2)	(1)	(0)
Child Care Services	(2)	(2)	(1)	(0)
Transportation Services	(2)	(2)	(1)	(0)
Translation Services	(2)	(2)	(1)	(0)
Legal Services	(2)	(2)	(1)	(0)

12. Is the center part of a formal referral network of health and human service agencies serving perinatal patients?

- ☐ Yes (20)
- ☐ No (0)

13. Are patients provided with referral recommendations as part of initial and on-going care plan development?

- ☐ Yes (10)
- ☐ No (0)

14. Are patients assisted with arranging appointments to referrals?

- ☐ Yes (20)
- ☐ No (0)

15. Are patients assisted in overcoming access barriers to referral services (e.g., transportation, child care, translation services, etc.)?

- ☐ Yes (20)
- ☐ No (0)

16. Are patients assisted in completing any paperwork necessary for enrollment in services?

- ☐ Yes (20)
- ☐ No (0)

17. Is a specific perinatal team member(s) identified and available to advocate for patients having difficulty accessing needed support services?

- ☐ Yes (20)
- ☐ No (0)

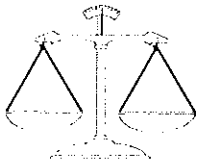
COORDINATION & REFERRAL

SCORING

	Subtotal		Total Points
Add Total Points for Questions 12 - 17			
Add Total Points for Question 11		÷ 2	

TOTAL COORDINATION & REFERRAL

FOLLOW-UP & TRACKING



Scale to Measure Case Management Performance Level		
Minimal **<16**	**Moderate** **16-47**	**Optimal** **>47**
Referral is documented. No shows for prenatal appointments are followed up by phone or by letter	Tracking system exists and is used by a member of the care team to determine of all components of the care plan are completed; i.e., patient followed through on all referrals, came to all appointments, received risk-appropriate health promotion and health education, and returned for post partum follow-up and well baby visit. Responsibility for maintaining the tracking system is clearly defined.	Moderate Plus: Action is taken to determine reason why patient missed appointment or did not follow through on referral. Assistance is provided to the extent necessary to get patient to follow through on care plan (transportation, child care, etc.).

FOLLOW UP AND TRACKING

18. Which of the following are systematically tracked? CHECK ALL THAT APPLY

- ☐ Prenatal appointment reminders (2)
- ☐ Medical referrals made (2)
- ☐ Other referrals made (4)
- ☐ Lab results (2)
- ☐ Post-partum visits (4)
- ☐ Reason for missed prenatal appointments (2)
- ☐ Medical referrals completed (2)
- ☐ Other referrals completed (4)
- ☐ Health education provided (4)
- ☐ Newborn visits (4)

19. How are missed prenatal visits followed up? CHECK ALL THAT APPLY

- ☐ Letter (2)
- ☐ Phone call (2)
- ☐ Discussion by provider at next visit (2)
- ☐ Home visits (4)

20. How are other missed visits followed up? CHECK ALL THAT APPLY

- ☐ Letter (2)
- ☐ Phone call (2)
- ☐ Discussion by provider at next visit (2)
- ☐ Home visits (4)

21. Responsibility for follow up and tracking for OB visits is: CHECK ONE BEST RESPONSE

- ☐ Not clearly defined (0)
- ☐ Assumed to be shared by all perinatal team members (5)
- ☐ Clearly assigned to one individual (10)

22. Responsibility for follow up and tracking for abnormal labs is: CHECK ONE BEST RESPONSE

- ☐ Not clearly defined (0)
- ☐ Assumed to be shared by all perinatal team members (5)
- ☐ Clearly assigned to one individual (10)

23. Responsibility for follow up and tracking for post partum and newborn visits is: CHECK ONE BEST RESPONSE

- ☐ Not clearly defined (0)
- ☐ Assumed to be shared by all perinatal team members (5)
- ☐ Clearly assigned to one individual (10)

24. Responsibility for follow up and tracking for non-clinical referrals is: CHECK ONE BEST RESPONSE

- ☐ Not clearly defined (0)
- ☐ Assumed to be shared by all perinatal team members (5)
- ☐ Clearly assigned to one individual (10)

25. Does follow up on missed appointments include an action plan to eliminate barriers to future appointments (e.g., transportation, child care)?

- ☐ Yes (10)
- ☐ No (0)

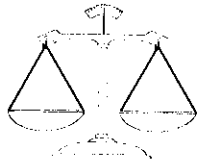
FOLLOW UP & TRACKING

SCORING

	Subtotal		Total Points
Add Total Points for Questions 24 & 25			
Add Total Points for Questions 18 - 23		÷ 2	

TOTAL FOLLOW UP & TRACKING

CRISIS INTERVENTION



Scale to Measure Case Management Performance Level		
Minimal <21	**Moderate 21-50**	**Optimal >50**
Patient has phone number of health center/hospital to call in case of a medical emergency.	Patient has specific contact at site to call in case of an emergency during health center hours. A relationship is established between this care person and the patient. However, patient generally must initiate communication with this care person. An after hours emergency number is also available.	Moderate Plus: A care person takes an active roll in providing opportunities for disclosure before troubles reach the point of crisis.

CRISIS INTERVENTION

26. Are patients provided a list of phone numbers for after-hour emergencies (e.g., health center, hospital)?

- ☐ Yes (10)
- ☐ No (0)

27. Does the center provide 24-hour call and medical back-up in case of emergency?

- ☐ Yes (10)
- ☐ No (0)

28. Does each patient have the name of a specific perinatal team member to call with questions, concerns, or emergencies during operating hours?

- ☐ Yes (10)
- ☐ No (0)

29. Is there an identified perinatal staff member(s) who attempts to build a rapport with the patient in order to increase comfort in discussing issues and concerns?

- ☐ Yes (10)
- ☐ No (0)

30. If yes on question 29 above, how frequently does this staff member have contact with the patient? CHECK ONE

- ☐ Every/almost every appointment (20)
- ☐ At least once per trimester (10)
- ☐ Less than once per trimester (0)

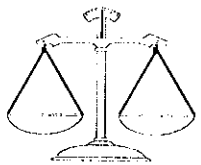
CRISIS INTERVENTION

SCORING

	Subtotal		Total Points
Add Total Points for Questions 26 - 29			
Add Total Points for Question 27		÷ 2	

TOTAL CRISIS INTERVENTION

COMMUNICATION



Scale to Measure Case Management Performance Level

Minimal <16	Moderate 16-85	Optimal >85
Communication of patient information among members of the care team is informal, usually by word of mouth and not on a routine basis. Psychosocial and nutritional risk assessments and care plans are not routinely shared with clinical providers and medical assessments and care plans are not routinely shared with non-clinical care givers.	Patient information is communicated through documentation of all care givers directly to the medical chart. If all care givers do not document directly to the medical chart, an alternative method of communication, such as case conferencing, is used on a routine basis.	Established procedures and protocols address the collection and flow of information among care givers. All care givers use specific tools for their area of expertise that are included in the medical charts. Documents are easy to read and present an overview of assessments completed and a care plan. If all care givers do not document directly to the medical chart, an alternative method of communication, such as case conferencing, is used on a routine basis. Case conferencing among the providers/team is utilized for complex cases. Individual care plans emerge from the case conference. Results of case conference are documented and all car givers have access to documentation.

COMMUNICATION

31. How often do maternal charts include notes from:

	Always/Almost Always	Sometimes	Rarely/Never
Medical Providers	(10)	(5)	(0)
Other Clinical Staff	(10)	(5)	(0)
Non-Medical Caregivers	(20)	(10)	(0)
Primary Obstetric Provider	(10)	(5)	(0)
Staff Trained Specifically in Psychosocial Risk Assessment	(40)	(20)	(0)
Other Staff	(20)	(10)	(0)

32. Is a formal care plan included directly in the maternal chart?

- ☐ Yes (20)
- ☐ No (0)

33. Are psychosocial risk assessments included in the chart?

- ☐ Yes (20)
- ☐ No (0)

34. Are nutritional risk assessments included in the chart?

- ☐ Yes (20)
- ☐ No (0)

35. Does the chart include notes on health promotion/health education topics provided?

- ☐ Yes (20)
- ☐ No (0)

36. How often are case conferences conducted?

- ☐ All/Almost Patients (20)
- ☐ Some Patients (10)
- ☐ Few/No Patients (0)

37. Are there established procedures and protocols specifying the collection and flow of patient information among caregivers?

- ☐ Yes (20)
- ☐ No (0)

COMMUNICATION

SCORING

	Subtotal		Total Points
Add Total Points for Questions 32 - 37			
Add Total Points for Question 28		÷ 2	
		TOTAL COMMUNICATION	