OBCM Assessment Guide: Conducting a Patient-Centered Assessment

In the pregnancy care management model, the first step in developing a care plan is a thorough assessment of risk factors, conditions and needs associated with the pregnancy. The assessment also allows the care manager to understand the patient’s motivating factors and ability to manage those concerns. Assessment is a process that the care manager and patient engage in as part of the care management relationship; the Pregnancy Assessment tool in CMIS (referred to as the “Pregnancy Assessment” in this guide) is a document where assessment information is captured.

Documentation in the Pregnancy Assessment should reflect information that is relevant to the patient’s plan of care. The Pregnancy Assessment content is used by the Pregnancy Care Manager to guide care management activities and as a tool to provide services. The Pregnancy Assessment should contain enough information to assist the care manager in effectively working with the patient and achieving desired outcomes.

The Pregnancy Assessment is designed as an initial assessment, with the ability to be updated continuously. The Pregnancy Assessment should be 1) updated with new assessment findings on an ongoing basis, and 2) reviewed at least once every 90 days and during the postpartum period to document any changes or new concerns that are relevant to the patient’s care plan. Periodic review may not require significant updates if the patient’s needs and status of identified condition(s) have remained unchanged throughout the time period.

If care managers are unfamiliar with any condition in the Pregnancy Assessment, they should seek education to further their knowledge of the specific condition using available resources, including the care management supervisor(s), CCNC OB Nurse Coordinator, Division of Public Health Regional Social Work Consultant, educational materials available in Healthwise, and/or resources detailed in the Pregnancy Care Management pathways. The patient should always be redirected to her prenatal care provider to address any clinical questions about conditions, medications or the treatment plan.

Purpose of Assessment

A holistic, thorough assessment allows the care manager to explore any risk factors or conditions that might affect the pregnancy outcome, to understand the patient’s current needs and priorities, and to work with the patient to develop a care plan building on patient strengths and addressing identified concerns. A thorough assessment facilitates the care management process, improves coordination with the prenatal care provider’s clinical care plan, and allows the care manager to support the patient in meeting her goals.

Principles of Patient-Centered Assessment:

Patient-centered assessment is a process of collecting information from a patient through a conversation that conveys acceptance and understanding. The focus of the assessment should be on listening to the patient tell “her story” and gathering enough detailed information to understand her strengths, concerns and needs. By focusing on the patient’s strengths, rather than deficits, she is viewed as the “expert” in her own life, with knowledge and capabilities that can be built upon to address any concerns or needs that exist. Key principles for conducting assessments, based in motivational interviewing theory (Rollnick, Miller and Butler, 2008) are:

- **Convey Acceptance** – Do not pass judgment. Approach the patient with an attitude that anything she says or does is acceptable. (If the patient expresses an intention to harm herself or others, let her know that safety concerns mean that you will need to disclose that information; assist her to seek immediate assistance through crisis services or the emergency response system).

- **Know your assessment content** – As the conversation unfolds, make a mental note of which domains of the Pregnancy Assessment in CMIS are being covered and which are not.
• **Fit the assessment into the interview, not the interview into the assessment** – Allow the conversation to flow from the patient’s telling of her story, rather than forcing the discussion to follow the structure of the documentation tool.

• **Stay curious** – Do not hesitate to request more detail from the patient; this conveys to her that you are actively listening and working to understand what she is trying to say.

• **Resist the investigative impulse** – Overwhelming the patient with a long list of questions about problems can shut down the atmosphere of acceptance and curiosity.

• **Focus on both behavior and feelings** – As you conduct the assessment, pay attention to your observations of the patient’s behaviors (facial expressions, body posture, eye contact) and the emotions underlying the words (tone of voice, how loud or softly she talks, tearfulness or signs of anger).

Remember to keep the patient as the focus of the interview and let her do the majority of the talking. The patient will talk about what is most important to her if you maintain a comfortable, conversational style and relate to her in an empathetic, understanding and non-judgmental manner.

**Conducting the Assessment:**

The assessment process should involve a conversation with the patient where the care manager actively listens to the patient describe her current situation, her health concerns, her psychosocial needs, her feelings about the pregnancy, her future reproductive plans and family planning needs, and any other area that affects the patient’s ability to care for herself during and beyond the pregnancy. The care manager should use prompts throughout the conversation to ensure all key areas have been assessed thoroughly. The care manager should maintain a non-judgmental approach and use open-ended questions to elicit the patient’s needs and concerns and to establish trust between the patient and the care manager.

It is not necessary for the care manager to read each item on the Pregnancy Assessment to the patient, except for those items which include validated screening questions that have been incorporated into this document. Those have been noted below in italics as items that should be read verbatim to the patient.

**Initial Assessment:**

Initial assessment promotes the development of the care management relationship as the care manager demonstrates empathy and concern for the patient’s needs and listens to the patient to learn what is important to her. The initial assessment should allow the care manager to determine how quickly to follow up with or on behalf of the patient to address specific needs. A thorough assessment should include a review of all of the major domains that are relevant to delivering care management services to a pregnant woman. If the care manager is not able to review all domains in the first encounter with the patient, additional domains should be assessed within a short follow-up period.

1) Prior to engaging the patient, conduct a brief review of available information about the patient, such as information from the referral source, including the Pregnancy Medical Home (PMH) Risk Screening Form, existing documentation in CMIS, utilization and medications displayed in Provider Portal (accessed through CMIS), the medical record, etc.

2) When first engaging the patient, assess her immediate needs and current concerns through an open-ended, non-judgmental conversation with the patient. Utilize information from step 1, above. Assign OB Case Status accordingly.

3) In order to develop the care plan, the initial assessment process, which may be conducted over one or more interactions with the patient, should include a review of all of the major domains that are relevant to providing services to a pregnant woman. These are the domains included on the Pregnancy Assessment.
Ongoing Assessment:

Assessment is an ongoing process, from the point the care management relationship begins until it ends with the patient's deferral from services. The care manager is always assessing the patient, to evaluate the current situation, priorities and needs, and should document assessment findings accordingly.

The patient’s risk factors, conditions, needs, and priorities are likely to change over the course of the pregnancy. Assessment is a continuous process that allows the care plan to remain current and relevant to the patient’s current situation.

The care manager should assess certain items on a regular basis. For example, the care manager should be knowledgeable about the signs and symptoms of preterm labor and should regularly assess whether the patient is experiencing any of these symptoms. Similarly, the care manager should periodically assess whether the patient is experiencing any symptoms of a mood disorder, such as depression or anxiety, or other mental health concern. The care manager should review the patient’s reproductive life plan and her anticipated postpartum contraceptive needs at least once per trimester to make sure that she will not experience barriers in the postpartum period to implementing this plan and to determine if her plan has evolved over the pregnancy.

Documentation considerations:

1) Document all assessment findings in the Pregnancy Assessment. Note the source from which the information was obtained (patient, medical record, claims review, referral source).
2) Upon reviewing existing documentation on the patient prior to engaging the patient, the OBCM can document relevant information in the Pregnancy Assessment and note the information source (e.g., Provider Portal).
3) If the patient has a PMH Risk Screening Form in CMIS before the Pregnancy Assessment is initiated for the current pregnancy, that information will transfer to the Pregnancy Assessment the first time the Pregnancy Assessment is opened.
4) If the Pregnancy Assessment has already been started before the first PMH Risk Screening Form is entered in CMIS for the current pregnancy, the PMH Risk Screening Form information will not automatically populate the Pregnancy Assessment, in order to prevent overwriting of findings the care manager has already documented. The Pregnancy Assessment will need to be updated manually with new information from the PMH Risk Screening Form in this situation. This is also the case for any new information from subsequent PMH Risk Screening Forms completed during the pregnancy.
5) For items where there is a Yes/No response option on the Pregnancy Assessment, “Yes” means a condition or issue is present, and “No” means the item has been assessed and the condition or issue is not present.
6) Leave an item blank if the care manager has not yet assessed this condition or if information is not known or not applicable.
7) If a “Yes” response has been documented for any item on the assessment, additional documentation should be included to provide further description of the patient’s background and experience with this item, and current status and needs, if there are active needs related to this item.
8) Items not assessed initially should be reviewed in future follow-up with the patient to ensure that all conditions that might affect her pregnancy health and birth outcome have been identified and considered for inclusion as part of the patient’s care plan.
9) The Pregnancy Assessment needs to be current for any patient who is receiving pregnancy care management services.
10) When a patient comes to the attention of the pregnancy care manager AND the date of the assessment is over 90 days, the Pregnancy Assessment needs to be updated to ensure that the care plan reflects the patient’s current needs and priorities.

11) If a patient who has been deferred re-engages in care management, her current needs should be assessed at that time and the Pregnancy Assessment should be updated accordingly.

12) Tasks vs. Pregnancy Assessment documentation: The Pregnancy Assessment is a tool to document what you have learned about the patient, while tasks are the actions you take to manage the care plan of the patient. (e.g., if a patient identifies that she smokes, this should be documented in the Pregnancy Assessment. A pending task would reflect the specific action the care manager is planning to take to address the patient’s tobacco use, if addressing tobacco use is part of the care plan).

**Pregnancy Assessment Domains:**

The sections below outline each component of the Pregnancy Assessment, which includes all of the major domains that should be included in a thorough assessment in order to develop a patient-centered care plan. Each domain includes a sample script for how to initiate a conversation on this topic and suggested questions to use to ensure the patient’s needs related to each domain have been thoroughly reviewed. Finally, documentation pointers are included for each domain of the Pregnancy Assessment.

**I. Family / Support System**

**Setting the Stage:** It is important for the care manager to learn about what types of support a patient has. A patient may receive support during pregnancy from a variety of sources: family, friends, partner/significant other, coworkers, members of the faith community, other patients in a group prenatal care setting, or other community resources. Understanding a patient’s support system can help determine how best to address and meet patient needs and guide care management activities. Documenting contact information for members of the patient's social support network provides opportunities to reach out to the patient if she becomes lost to follow-up, provided the patient has given permission for the care manager to contact these people directly.

**Conversation starter:** “Women get emotional, financial or social support from many sources during pregnancy. I would like to ask you a few questions about what your support system looks like right now and what kind of support you think you need during the pregnancy and after the baby is born.”

**Recommended Questions:**
1) Who do you consider to be your support system? This could be friends, neighbors, family members, your significant other or anyone else who offers you any kind of support.
2) Who else is in your family? What are your relationships like with those people?
3) What is your relationship with the father of your baby?
4) Have you told the father that you are pregnant? What was his reaction? In what ways does he help or support you now? To what extent will he support you after you have your baby? (This question can be deleted or modified if the patient plans to place baby for adoption or terminate.)

**Documentation Cues:** Document all relevant information shared by the patient regarding her sources of social support, including the relationship with the father of the baby, family members, and others, in the Pregnancy Assessment, including the name, age, relationship, phone number (if the patient is comfortable with the care manager contacting the person directly) of each person and whether they live with the patient.

**II. Pregnancy Conditions/Current Pregnancy**
Setting the stage: It is important to understand any complications of the patient’s current pregnancy, including chronic health conditions, as they may impact the pregnancy outcome and the patient’s long-term health. The care manager should be specific when asking questions under Pregnancy Conditions and should address each item for its relevance to the patient’s care plan.

If the patient reports that she has any pregnancy complications, including chronic health conditions, ensure the patient has shared this information with her current provider or discuss how the prenatal care provider will be updated. The care manager should seek guidance from the patient’s provider regarding her treatment plan when developing the care management care plan with the patient.

Conversation starter: “I want to learn more about how your pregnancy is going so far and about your overall health. I’m going to review a list of conditions with you. Please let me know if I ask about anything that is not familiar to you or if you are not sure what I mean.”

Recommended Questions:
1) Have you experienced any complications during this pregnancy? (If yes), can you describe what you have experienced?
2) Can you tell me more about that condition? To what extent is it under control at this time (e.g., blood sugars within normal limits, current asthma control, frequency of depression or anxiety symptoms)?
3) Are you under a doctor’s care for [this condition]? When were you last seen? When is your next appointment?
4) Is your prenatal care provider aware of [these conditions/medications]?
5) What is your understanding of how this condition may affect your pregnancy?

Documentation Cues: If the patient answers “YES” to any of these questions, details should be documented (e.g., duration of the condition, how it is currently being treated, specific providers, how this may affect current pregnancy). Document information about any current medications in the medications section of the Pregnancy Assessment. If a specific condition is not asked about, leave the question blank.

III. Obstetric History (history of previous pregnancies) – skip this section if it is the patient’s first pregnancy, but include this section even if she has not given birth in the past but has been pregnant in the past.

Setting the Stage: It is important to understand the patient’s obstetric history as complications of prior pregnancies may have a significant impact on the outcome of the current pregnancy and the treatment plan. The Obstetric History section addresses ALL previous pregnancies, including spontaneous abortions (miscarriages), therapeutic/elective terminations of pregnancy, fetal demises, and live births. Make sure patient has shared this information with her current prenatal care provider.

Conversation Starter: “I would like to ask you a few questions about your previous pregnancies, as complications in earlier pregnancies can affect your current pregnancy and your treatment plan. I’m going to review a list of complications that you may have experienced with past pregnancies. Please let me know if I ask about anything that is not familiar to you or if you are not sure what I mean.

Recommended Questions:
1) What complications have you had with previous pregnancies?
2) Have you given birth to a baby born before 37 weeks, or more than 3 weeks before the due date?
3) How far along were you in each pregnancy when you gave birth in the past? How many days before or after your due date did you give birth?
4) Have you ever given birth to a baby that weighed less than 5.5 pounds? [If yes] How much did that baby (those babies) weigh at birth?
5) Have you had any pregnancy losses, such as a miscarriage or stillbirth? [If yes] Can you tell me more about what happened? How far along were you when you lost the pregnancy/baby?
6) Have you experienced depression after any deliveries? [If yes] Can you describe what that was like? What kind of treatment or support did you receive at the time?
7) Have you ever been told you have cervical insufficiency, a short cervix or an incompetent cervix, or did you have a cerclage with any of your previous pregnancies? [If yes] What kind of treatment did you receive? What is your provider recommending during this pregnancy?
8) Did you have any problems with your blood sugar, like gestational diabetes, or with your blood pressure with any previous pregnancies? [If yes] What kind of treatment did you receive? What is your provider recommending during this pregnancy?

**Documentation Cues:** It is important to be specific when asking questions under Obstetric History and to address each question. If the patient answers “YES” to any of these questions, details should be documented in the comments section of the question (e.g. duration, medications, specific providers, how this may affect current pregnancy). If a specific condition is not asked about, leave the question blank.

**IV. PSYCHOSOCIAL ISSUES, TOBACCO/ALCOHOL/SUBSTANCE USE, VIOLENCE/SEXUAL ABUSE, MENTAL HEALTH**

**Setting the Stage:** Sometimes the psychosocial components of the assessment may be difficult to assess given the sensitive and personal nature of the content. The care manager should assess the patient in a non-judgmental and empathetic manner. It is also important for the care manager to set aside any of his or her personal biases when assessing the patient’s psychosocial issues.

*With regard to tobacco use, follow the 5 A’s recommendations in the assessment, reading the questions as they are written. With regard to substance use, use the questions available on the assessment. If there is a positive response to any of the six substance abuse questions, then assess the patient’s frequency and quantity of use.*

**Conversation starter:** “We’ve talked about your physical health and pregnancy complications, but it is also important to understand your everyday life and your health behaviors, as they can affect your health and the health of the pregnancy. Stressors in everyday life can play a significant role in your pregnancy. Let’s talk further about where you are currently in terms of the pregnancy and your health behaviors.”

**Recommended Questions - Psychosocial Issues:**
1) What concerns do you have about your pregnancy?
2) *Reading the options from the Pregnancy Assessment, ask the patient to choose the option from the pregnancy intendedness item that best describes how she feels about becoming pregnant.*
3) How are you feeling about being pregnant at this point in your life? [For patients who report uncertainty about whether they want to be pregnant at this time] What options are you aware of for the pregnancy? Do you have any questions about your options? Tell me a little more about your plans. Would you like additional information about your options?
Recommended Questions - Tobacco/Alcohol/Substance Use:
1) Ask the patient the first “A” from the 5 A's to assess her tobacco use (see the Pregnancy Care Management Tobacco Cessation pathway for more information): reading the options from the Pregnancy Assessment item, ask the patient to choose the option that best describes her smoking status.
2) To what extent are you exposed to secondhand smoke at home or at work?
3) Ask the substance use screening questions as written. For patients who report any alcohol or drug use during the pregnancy, ask, “What are your thoughts about stopping your use of [alcohol and/or the name of the drug(s) she reports using]? Have you tried to stop in the past? What has your experience been with stopping your use of drugs or alcohol? Have you ever received any treatment for drug or alcohol use? How important is it to you at this time to discontinue your use of (drugs and/or alcohol she reports using)? How confident are you that you could stop using (drugs and/or alcohol she reports using)? In what ways could I help you address your drug or alcohol use at this time?

Recommended Questions - Violence/Sexual Abuse/Mental Health Needs:
1) Ask the three intimate partner violence questions as written: I want to ask about your experiences with violence or abuse. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? Are you in a relationship with a person who threatens or physically hurts you? Has anyone forced you to have sexual activities that made you feel uncomfortable? [If yes to any of the above] Can you tell me more about your experiences? Are you unsafe at home at this time? What community resources are you aware of to help you with these issues?
2) Do you have any concerns about any of your thoughts or emotions at this time? [If yes] What concerns do you have about the way you currently are feeling?
3) Are you currently in counseling or therapy or seeing a doctor or taking medications for depression, anxiety or another mental health condition? Document information about any current medications in the medications section of the Pregnancy Assessment.
4) Have you ever been to counseling or therapy?
5) Have you ever seen a doctor or taken medications for depression, anxiety or any mental health conditions? [If yes] Tell me a little more about that.
6) Ask the two depression screening questions (PHQ-2) as written. If the patient answers yes to either question, complete the PHQ-9 screening tool.

V. SOCIAL, HOUSING, AND NUTRITIONAL ISSUES

Setting the Stage: One of the important functions of a care manager is identifying needed resources and making referrals to meet these needs. Many of these resources relate to the patient’s environment, including social, housing and nutritional needs. A thorough assessment of this information will ensure the patient is residing in an overall safe, stable environment and will assist the care manager in making appropriate referrals. The patient should be reassured that questions about her home are intended to determine if she has safe and stable housing or if there is need for care management intervention, not to judge the appearance of her home.

Conversation Starter: “Would it be ok if we talked about your current housing situation? This includes talking about your housing and sources of financial support. I want to help link you to available resources if needed.”

Recommended Questions Social, Housing and Nutritional Issues:
1) Can you describe your current living environment? How safe is your current living situation? Do you have necessary utilities (water, refrigerator, electricity, heat)?
2) Are you currently employed? If so, where? What kind of work do you do? Full-time or part-time? If not, are you interested in seeking employment?

3) Can you describe your sources of income? This could include any assistance you receive (child support, food stamps, Work First, etc.). To what extent is this income adequate for you and your family’s needs?

4) Are there any family issues that you are concerned about at this time?

5) Tell me a little bit about your other children (if applicable). Do you have any children that are not living with you? If so, where are they? Do you have custody of these children?

6) What are your current childcare arrangements? What are your plans for childcare following this pregnancy?

7) How do you get to appointments or run errands, such as grocery shopping? Do you need assistance with transportation to appointments?

8) Have you been hungry at any time in the past 12 months because you could not afford enough food?

9) What legal concerns do you have at this time? These could include child support, establishing paternity, an order of protection, a DUI or other legal or criminal justice matter.

10) What is the highest level of education you completed? Are you interested in pursuing further education at this time?

**Documentation Cues:** If the patient answers “YES” to any of these questions, details should be documented in the comments section of the question. The care manager should observe patient’s behavior patterns during the assessment and document the information in the appropriate box.

If the patient indicates she needs a specific resource, the care manager should document the needed resource and make the referral, documenting a pending task for any planned referrals or a completed task for any referrals that were made. The care manager should follow up with patient to make sure she received needed services from the referral resource.

**VI. Medications, Healthcare, and Utilization**

**A. Medications**

**Setting the Stage:** It is important to be aware of any medications the patient is taking during her pregnancy, including vitamins and supplements, as well as any problems she is experiencing with access to needed medications. Some medications may not be safe to take during the pregnancy, while some medications are crucial to the patient’s well being and the pregnancy outcome. The care manager should review the medications tab in Provider Portal and should ask the patient about those medications as well as any other medications that any of her providers has prescribed for her, as well as medications she is taking without a prescription.

**Conversation starter:** “It is important to make sure that your care team is aware of any medications and supplements you are taking, as well as any difficulties you may be experiencing getting access to medications. Let’s go over your current medications.”
Recommended Questions:
1) Are you on any medication? What medications do you take? How much do you take each time? How often do you take them? How long have you been taking each medication?
2) Can you tell me why you are taking each medication?
3) Are there other medications that have been prescribed for you but that you are not taking at this time? [If yes], why aren’t you taking that medication right now?
4) Are you having any trouble getting any of the medications that you are supposed to be taking?
5) Have you ever had an allergic reaction to any medications? Which medications and what type(s) of reaction have you had?
6) Do you take any medications for which you don’t have a prescription? [If yes, ask the same questions as above for prescribed medications.]

Documentation Cues: The care manager should document all medications and allergies reported by the patient, including supplements and any medications the patient is taking for which she does not have a prescription. Also document any issues with the current regimen, including difficulty obtaining prescribed medications.

B. Healthcare and Utilization

Setting the Stage: Many women do not receive all of the healthcare they need or are eligible for while they have Medicaid coverage. The care manager should review all of patient’s healthcare needs, not just her pregnancy needs. Receiving needed health services is important for the pregnancy outcome and the patient’s long-term health. Making the patient aware of what services are available to her to address unmet health needs is a key component of the care manager’s role.

Conversation Starter: “I’d like to learn more about your overall healthcare so we can make sure you have everything you need to stay healthy during and after your pregnancy.”

Recommended Questions:
1) When did you have your first prenatal visit for this pregnancy?
2) Do you have a primary care provider (PCP)? [If yes] Who is your PCP?
3) When was the last time you went to the dentist? Do you have a dentist?
4) Do you plan to have any more children at any time in your future? [If yes] How many more children would you like to have? How long would you like to wait before becoming pregnant again? What family planning method do you plan to use until you are ready to become pregnant again? How sure are you that you will be able to use this method without any problems? [If no] What family planning method will you use to avoid pregnancy? How sure are you that you will be able to use this method without any problems?
5) What types of birth control methods have you used in the past? What were your experiences like with those methods?
6) Tell me about any issues that prevent you from keeping prenatal appointments or getting to other healthcare providers?

Documentation Cues: Be sure to make comments on all items for which you learn information. If the patient answers “Has” to these questions, note any additional information shared, such as PCP name, eye doctor name, etc. If the patient answer “Needs” to these questions, write a brief explanation of what the patient states about her needs (e.g., “I don’t have a regular doctor but I use urgent care when I am sick”). Document the patient’s planned contraceptive method during the pregnancy so that arrangements can be made in advance to ensure she has access to it in a timely manner in the postpartum period.
VII. POSTPARTUM

Setting the Stage: The postpartum period is a time of physical and emotional adjustment and is an important time to promote a smooth transition into well woman care. The purpose of this section is to assess the needs of the woman after a birth or the loss of a pregnancy. Consider what resources are available in your community to know when a patient has delivered and how to obtain pertinent delivery information that will impact her postpartum period.

The patient’s unique conditions, delivery experience, family planning needs, and risk factors all contribute to what care she needs during the postpartum period and the timing of that care. All patients should receive a comprehensive postpartum visit 14-42 days following the delivery and may need to be seen earlier for follow up of specific conditions, such as a wound check or blood pressure measurement, and may need additional follow up after the postpartum visit, such as diabetes screening for patients who experienced gestational diabetes.

Contact with the patient should be made as soon as delivery outcome is known so that the care manager can assess current needs and adjust the care plan accordingly. (See the Postpartum section of the OBCM Common Pathway for detailed expectations related to care management service delivery during the postpartum period.) If the patient had a fetal demise (stillbirth) or miscarriage, the care manager should address the situation appropriately when making contact following the loss.

The care manager should also be aware of the signs and symptoms of postpartum depression and should be able to offer support to the patient. This includes providing a mental health referral and following up to ensure that the patient accessed this resource. The care manager should also refer a patient who is experiencing symptoms of depression back to her provider, and the care manager should contact the provider directly to discuss any concerns related to the patient’s mental health.

Conversation Starter: “Congratulations on the birth of your child. Tell me about your labor and delivery experience. How are things going for you at home right now? How is the baby doing?” or “I am sorry for your loss. I’d like to talk with you about what kind of support you need during this time.”

Recommended Questions:
1) When is your postpartum visit with your OB provider?
2) What concerns do you have about your health right now?
3) How are you feeling emotionally? Have you experienced any feelings of sadness or crying episodes that have gone on for several days or are troubling to you? Have you experienced any thoughts or worries that are troubling to you?
4) When is your appointment scheduled with WIC for you and your baby?
5) What are your plans about a birth control method? (Refer back to earlier assessment to follow up on the patient’s desired contraceptive option.)
6) Where do you plan on going for health care after your postpartum period ends?
7) What do you feel will be your biggest challenges in the next few weeks and/or months?

Documentation Cues: A pregnancy ending date should first be documented in the Pregnancy Medical Home section of the Patient Demographics page in CMIS by selecting the appropriate pregnancy outcome from the dropdown box. The pregnancy end date and pregnancy outcome will then auto-populate from Patient Demographics page into the postpartum section of the Pregnancy Assessment.

Date of postpartum clinic visit: Use this date to document the date of the actual postpartum visit. This is not a placeholder for the patient’s scheduled appointment; it should only be used to document when the comprehensive postpartum visit with the OB provider occurred.