OBCM Documentation Guide

https://cmis.n3cn.org – CMIS website for patient documentation
https://cmistraining.n3cn.org – CMIS training website for training and testing purposes

I.   Getting started with a new referral

Upon receiving a referral for pregnancy care management (OBCM), <u>search</u> for the patient in CMIS.
- Be certain you have the correct patient before documenting in a patient record.
- Search strategies:
    - Search by the patient's social security number if available.
    - Search by the first few letters of the first and last names; use the date of birth to narrow results if many are returned.
    - If the patient is not found this way, try again using only the first few letters of the first name and the date of birth (the patient may have a different last name or there may be spelling errors) or the date of birth only.
    - Do NOT search by the patient's current Medicaid ID number; it is possible that the patient has more than one Medicaid ID and will be in the system with a previous number.
    - Search across all networks by changing the Site on the search screen from a specific network to "Search All Sites" or by going to My Profile under the Administration tab at the top of the page in the User Workspace and changing the Default Search option to "Across All Networks".
- If the patient is not found in CMIS, follow local protocol for adding a new patient in CMIS.
    - To add a patient with multiple last names, enter the name as it appears on the patient's social security card, if available. If no social security card is available, enter as much of both last names as possible, with no spaces. This will allow the record to match any Medicaid records created by the Department of Social Services.

Assign the patient to Pregnancy Care Management under <u>Patient Programs</u> on the Demographics page.
- Select Pregnancy Care Management, then click Save.
- The patient may be assigned to multiple Patient Programs.

Complete the information in the Pregnancy Medical Home box on the Demographics page.
- If there is not an existing record for the current pregnancy, create a new pregnancy using the Manage Pregnancy Info icon in the grey Pregnancy Medical Home bar on the right side of the Demographics page.

- If there is an existing record for the current pregnancy, do not create a new pregnancy but update the other information (OBCM, Prenatal Care Provider and OB Case Status) as needed.
- Risk screening forms, pregnancy assessments and 17p assessments, as well as all information in the Pregnancy Medical Home box (case status, due date, pregnancy outcome, OB care manager, prenatal care provider) are all associated with a specific due date. It is extremely important to ensure this documentation is associated with the correct pregnancy.

Due Date:
- Assign a due date for the pregnancy.
- If the due date is not currently known, click the "Don't have due date yet" box, which will create a placeholder due date of 4/4/4000. It is important to go back and enter the due date when this information is obtained.
- If the patient is given a revised due date during the pregnancy, edit the current due date using the Manage Pregnancy Info icon in the grey Pregnancy Medical Home bar. (Do NOT add a new due date when the due date changes. This is the same as adding a new pregnancy.)
- It is important for the due date in CMIS to be kept as accurate as possible, as this information goes to Provider Portal for use by medical providers.
- If the patient already has a due date in the Pregnancy Medical Home section and this is a new pregnancy, create a new pregnancy by archiving the previous pregnancy and establishing a new due date before documenting risk screening, pregnancy assessment, or 17p assessment data or before entering any new information in the Pregnancy Medical Home box on the Demographics page. This information will then be associated with the correct pregnancy.

OB Care Manager:
- Assign the patient to the appropriate pregnancy care manager.
- Be sure to use the OB Care Manager box in the Manage Pregnancy Info screen; do NOT change the primary care manager assigned in the Patient Info section on the Demographics page.
- Assign a pregnancy care manager even if the Risk Screening Form has no priority risk factors.

Prenatal Care Provider:
- Assign the patient to a Prenatal Care Provider in the Manage Pregnancy Info box.
- If the patient's prenatal care provider does not appear in the drop-down menu, contact your CMIS champion or your OB Nurse Coordinator so that the practice can be added.

Case Status:
- Assign the patient an OB case status. If the patient has at least one priority risk factor, but has not yet been engaged by the care manager, the status should be set to Pending.

Once the care manager has interacted with the patient and determined her current level of need, the case status should be updated appropriately.

- If the patient has no priority risk factors, assign a Case Status of OB Deferred – Does Not Meet Screening Criteria.
- Once the patient has been contacted and engaged by the pregnancy care manager and her current needs have been assessed, assign an active case status (OB Heavy, OB Medium, OB Light) that reflects the planned frequency of follow-up at the current time.
- Active case status is dynamic and should change over the course of pregnancy/postpartum, as the patient's needs change. (Example: Heavy for first four weeks until sufficient contacts are completed to fully complete her Pregnancy Assessment and address her immediate needs, then Medium for the next two months, until all referrals are in place and completed, then Light for remainder of pregnancy, then Heavy for postpartum period to ensure that her postpartum care, family planning, and primary care linkage needs are met.)
    - See Pregnancy Care Management Standardized Plan (found on CMIS Home Page under Resources > How to Guide > Standardized Plans) for definitions of case status levels.

Pregnancy End Date:
- When the pregnancy is over, document the date the pregnancy ended. This information should be as accurate as possible, as this information is shared with medical providers through Provider Portal.

Pregnancy Outcome:
- When the pregnancy is over, document the outcome of the pregnancy.

Update the patient's information in the Patient Info section on the Demographics page.
- Do NOT change the primary case status.
- Pay special attention to entering the correct county for the patient.
- The current contact information may not match the address listed in the Enrollment Info section; this information comes directly from the Medicaid eligibility file. In order to correct information in the Enrollment Info section, the patient needs to provide current information to her local DSS caseworker.

Document the referral.
- If a Risk Screening Form was entered with priority risk factors present, edit the system-generated pending task to reflect a completed task with the Intervention - Referral Received and Task Type – Case Review/Chart Audit.
- If a patient is referred for Pregnancy Care Management by any means other than a Risk Screening Form, create a completed task with the Intervention - Referral Received.
- Create a pending task reflecting planned follow-up activity for the patient. All patients receiving Pregnancy Care Management must have a patient-centered pending task.

II. **Risk Screening Forms**

Enter the Risk Screening Form (if applicable) in the Most Recent Screenings box.
- Enter all risk screening forms, even if there are no priority risk factors present.
- Ensure that the risk screening form is being entered under the correct (current) due date.
- Date of Screening is the date the form was completed at the PMH practice, not the date it was received or is being entered into CMIS.
- If the name of the person completing the form is not legible, enter the name of the prenatal care practice.
- To make error corrections to the Initial Risk Screening Form, go to Tools on the menu bar at the top of the page; select Screening Tools, then Pregnancy Risk Screening. Edit the form by clicking on the notepad icon on the left. This function should only be used to correct data entry errors.
- CMIS will auto-generate a completed task documenting the user who entered the Risk Screening Form into CMIS.
- If the patient has one or more priority risk factors, CMIS will auto-generate a pending task ("Other") that will go onto the user's pending tasks list as a reminder that this patient needs to be assessed (see above in "Document the referral" for instructions on editing this task to document the referral received by risk screening).
- If the patient will not be managed by the user who entered the Risk Screening Form, the auto-generated pending task must be assigned to the appropriate care manager.
- If additional risk screening forms are received, enter them by using the Add Screening icon to the left of Pregnancy Risk Screening in the Most Recent Screenings section on the Demographics page. Verify who the current prenatal care provider is and update the Pregnancy Medical Home box on the Demographics page accordingly.
- Create a completed task Referral Received and make a note of the additional risk screening form in this task.

III. **Pregnancy Assessment**

Enter assessment findings on the Pregnancy Assessment
- The Pregnancy Assessment should serve as a current snapshot of whatever information the pregnancy care manager has collected about the patient.
- If assessment information was gathered during initial or any subsequent contact with the patient, it should be documented in the Pregnancy Assessment.
- The Pregnancy Assessment should be updated whenever there are new assessment findings and must be updated at a minimum of every 90 days for every patient on an active OB Case Status (OB Heavy, OB Medium, OB Light).

- Sources of information for the Pregnancy Assessment include the medical record, the referral source, claims review through Provider Portal, the prenatal care provider, and the patient herself. Information from these sources can be documented on the Pregnancy Assessment as soon as the referral has been received, including prior to contacting the patient.
- The Pregnancy Assessment should be thoroughly completed as soon as possible after engaging a patient. A complete assessment is required in order to develop a comprehensive plan of care and provide needed care management interventions to promote a healthy pregnancy outcome.
- Note the source of all assessment information. Sources for this information include the patient, prenatal care provider, claims data, comprehensive health assessment, previous pregnancy assessment, and patient's medical record.
- Documentation should be present on all items on the Pregnancy Assessment that are appropriate for the patient's current gestational age.
- Whenever the Pregnancy Assessment is updated, document the corresponding completed task that reflects the care management activity during which assessment findings were obtained (e.g., phone call, provider encounter, case review, etc.). The auto-generated completed task can be edited to reflect the care management activity that occurred.
- Every risk factor that is identified should have explanatory documentation in the box next to that item to provide information about the patient's experience, as evidence that the risk factor/need was thoroughly assessed.
- Every risk factor/need that is identified, including those pre-populated as positive or present from Risk Screening Form data, should be addressed and should have explanatory documentation as described above.
- Do not leave items on the assessment blank, if they have been assessed. If the item is not a need or concern, document "No" or "N/A". It is assumed that items left blank have not been addressed.
- The Pregnancy Assessment should be updated as new information is identified. Patient information that is not relevant to the pregnancy assessment should be documented in the task notes (i.e., patient leaving town to attend a funeral for a few days and unable to be contacted).

IV. Goals

- To document the creation or updating of goals, follow the Navigating the Case Management Functions – Managing Goals document posted in CMIS (Resources > How to Guide > Published Enhancements > June 2014 > Goals Tab).
- Adding and revising Goal(s) and building a Care Plan is a dynamic, ongoing process.

V. Tasks

Document all <u>tasks</u> performed with or on behalf of the patient.
- Document any tasks done to engage the patient.
- Document an attempted task if a message was left or a home visit or practice encounter was attempted, but the patient was not there.
- Document all conditions that were addressed and all interventions that took place (e.g., assessment, education, follow-up) as part of one task.
- Use "Task With" to document all participants involved with that task.
  - Only document that a task is "with patient" if the task was attempted or completed with the patient herself.
  - Only document that a task is "with care manager" if <u>another</u> care manager was involved in the task.
  - If the task is with the patient's record, the task is "with other" (e.g., Case Review/Chart Audit, document the following: Condition – Administration; Task Type – Case Review/Chart Audit; Intervention – Follow up/monitor; Task With – Other).
- Add "Comments" to a completed task to document notes about what was done; Comments are part of the permanent record. Task Comments should be clearly and succinctly documented, and appropriate for the patient's goals. New information that contributes to the assessment process should be documented in the Pregnancy Assessment and referenced, e.g., "See Pregnancy Assessment for further details." Information documented in the Pregnancy Assessment should only be duplicated in task notes when it is specifically related to task follow-up, i.e., upcoming appointments.
- Add "Instructions" to a pending task to document reminders for the care manager about what to do; Instructions are not part of the patient's permanent record and may be edited.
- Anyone reading a pending task should be able to clearly understand what needs to be done for the patient.
- Tasks are automatically assigned to the current user; to assign the task to another pregnancy care manager, choose that person's name from the drop-down menu.
- Definitions for tasks and interventions can be found under the Resources tab in CMIS.
- All care management activities should be documented as Tasks.

Ensure that all patients with an active case status (OB Heavy, OB Medium, OB Light) have at least one current patient-centered <u>pending task</u>, reflecting when the next care management activity with or on behalf of the patient is needed, based on thorough assessment of current patient needs.

VI.   17p Assessment

- Document 17p Assessments for patients receiving 17p treatment. For patients receiving intramuscular 17p treatment (any form, including compounded, Makena™, or through a study), document a weekly 17p Assessment for each week of gestation beginning the week that the patient initiates treatment.
- Enter any doses the patient received prior to referral to the care manager by working with the prenatal care provider who administered those doses.
- Document a 17p assessment for each week of gestation until the pregnancy is over, until the patient discontinues 17p treatment, or until the patient completes treatment at week 37 of pregnancy. If the patient misses a dose, document the missed dose and the reason for the missed dose.
- Only document receipt of 17p doses that were confirmed (along with the actual date of receipt) by the patient and/or prenatal care provider.
- If the patient discontinues 17p treatment, document the reason under "Manage 17p discontinuation". If the reason does not appear in the drop-down menu, select "Other" and describe the reason in the Comments box.

VII.   Deferral

A patient who is not actively receiving care management interventions should be deferred in accordance with the documentation process below.

Case Status
- Change the patient's Case Status to OB Deferred and select the appropriate deferral reason. Refer to the Pregnancy Care Management Standardized Plan for a list of acceptable deferral reasons and their respective definitions.
    - The deferral reason "Unable to contact" should be used at any point, including in the postpartum period, when the care manager cannot locate the patient according to the outreach expectations established in the OBCM Standardized Plan and the next planned care management intervention cannot be performed. The Case Status can be changed back to an active case status if the patient is subsequently located.

Goals
- When deferring a patient who has had an active Case Status, any goals created by the Pregnancy Care Manager should be closed as "Closed-met" or "Closed-deferred".

Conditions
- Leave conditions open if they are still present (e.g., diabetes); close conditions that have been resolved (e.g., pregnancy-related) by clicking the notepad icon under the name of the condition, choosing Edit Condition, then selecting Closed in the Status field. If a

condition that was identified by any previous care manager (OBCM, CC4C CM, PCM, etc.) has been resolved, close the condition.

- The condition of "Administration" can be left open.

Tasks
- Create a completed task describing the reason for deferral and patient's current situation.

Patient Programs
- Pregnancy Care Management can be left active in the Patient Programs list.

VIII.   Transfer

Transferring a patient from one pregnancy care manager to another pregnancy care manager in another county:
- Call the care manager (or lead pregnancy care management contact for that county) and document the call as a completed task with "Referral Sent" as the intervention.
- Use CMIS messaging as another communication option with that care manager.
- Describe the reason for the referral to the receiving care manager.
- Set a pending task for the new care manager "Referral received".
- Set a pending task for the current care manager "Follow-up/monitoring" in one week to make sure the receiving care manager has picked up the patient. If the new OBCM has not picked up the patient by that date, contact the OBCM's supervisor and/or OB Coordinator to alert them of the pending referral. Current goals should not be closed as they are specific to the patient not the care manager.
- The patient's case status should not be changed to Pending or Deferred. The receiving care manager should update the case status as needed following assessment of the patient's current needs.
- The receiving care manager should change the assigned OBCM on the demographics page, once the patient has been picked up.

Referring and/or Transferring a patient to a primary care manager (during pregnancy and/or at the end of the postpartum period):
- Call the primary care manager and document the call as a completed task with "Referral Sent" as the intervention.
- Use CMIS messaging as another communication option with that primary care manager.
- Describe the reason for the referral to the receiving primary care manager.
- Set a pending task for the primary care manager "Referral received".
- Set a pending task for the current pregnancy care manager "Follow-up/monitoring" in one week to make sure the receiving primary care manager has picked up the patient. If the primary care manager has not picked up the patient by that date, contact the primary care manager's supervisor and/or OB Coordinator to alert them of the pending

referral. Current goals should not be closed as they are specific to the patient not the care manager.

- The patient's pregnancy care management case status should only be changed to reflect any change in pregnancy care management case status. The receiving primary care manager will update the primary case status as needed following assessment of the patient's current needs.
- The receiving primary care manager should document the assigned primary care manager on the demographics page, once the patient has been picked up.
- Note:
  - o Only patients who are CCNC-enrolled can be referred to a primary care manager.
  - o Primary care management can be requested during the pregnancy, if needed, as well as at the end of the postpartum period.

IX.   General CMIS guidelines:

- Use the Resources tab in CMIS.
- Work with your local CMIS champion for further guidance.
- Contact CMIS support for technical assistance. Contact information is found at the top right corner of every CMIS screen.
- Report duplicate patients immediately when found.
- Contact your CCNC Network Privacy Officer and local agency Privacy Officer for guidance if you or your records are subpoenaed.
- Document all Pregnancy Care Management activity in CMIS; this is the patient's official care management record. "If it was not documented, it didn't happen."
- Use only CCNC-approved abbreviations, as posted in CMIS Resources. (Note: OBCM is the approved abbreviation for Pregnancy Care Manager; PCM is the approved abbreviation for Primary Care Manager.)
- Refer to other health care staff by full name and title in CMIS documentation, including any interpreters used.
- Document all communication with a patient's prenatal care provider(s) and other collateral contacts made with other agencies or individuals on the patient's behalf.