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| Reviewer’s Name: | Date of Review: | Month Reviewed: |
| Pregnancy Care Manager’s Name: | Care Manager FTE: |

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| **OB USER CASE LOAD ACTIVITY REPORT - SUMMARY STATISTICS** |
| Unique Patients OB Heavy, Medium, Light |  |
|  | **OB Heavy** | **OB Medium** | **OB Light** | **OB Pending** |
| Case Load at Start of Reporting Period |  |  |  |  |
| Case Load at End of Reporting Period |  |  |  |  |
| Number of Patients Pending >30 days |  |

| **CMIS DOCUMENTATION REVIEW** |
| --- |
| Codes: √=Yes or Present, 0=No or Absent, NA=Not Applicable | **OB Heavy** **at End of Reporting Period** | **OB Medium at End of Reporting Period** | **OB Light at End of Reporting Period** | **Deferred-PP Period Ended** |
| **Patient Name** |  |  |  |  |
| **Patient Date of Birth** |  |  |  |  |
| **Patient MID** |  |  |  |  |
| **DEMOGRAPHICS**  |
| Patient county of residence entered. |  |  |  |  |
| Patient Program listed. |  |  |  |  |
| OB Practice entered. |  |  |  |  |
| **PREGNANCY RISK SCREENING** |
| Initial Pregnancy Risk Screening received within 7 business days of PMH completion. Note: See Tools>Screening Tools>Pregnancy Risk Screening.Also, view Risk Screening form for “Date Screening Completed” and “Date Screening Received.”[Follow-up Risk Screenings, if completed, should also be received within 7 business days of PMH completion.] | Date Completed: |  |  |  |
| Date Received: |  |  |  |
| # of Days  |  |  |  |
| List Patient’s priority risk factors. Note: Review Risk Screening form(s) and Pregnancy Assessment. Indicate if each risk factor was identified through Pregnancy Risk Screening as “RS” or identified through the Pregnancy Assessment as “PA”.List Patient’s priority risk factors. (Continued from above.)  |  |  |  |  |
| Initial Pregnancy Risk Screening and any Follow-Up Pregnancy Risk Screening (if received) entered within 7 calendar days of receipt.Note: Review documentation of tasks. |  |  |  |  |
| Evidence of attempts to engage the patient in a timely manner, based on her known risk factors and needs.Note: Review task notes. |  |  |  |  |
| **PREGNANCY ASSESSMENT** |
| Pregnancy Assessment initiated on a timely basis, based on patient need(s), and no later than 30 days after the Pregnancy Risk Screening (or other non-PMH referral) was completed.Note: Pregnancy Assessment should be fully completed, as soon as possible after engaging the patient, to completely assess patient status in all applicable domains. |  |  |  |  |
| Pregnancy Assessment updated at least every 90 days, and each time there are new assessment findings. |  |  |  |  |
| Comment sections in the Pregnancy Assessment effectively describe pertinent details of patient risks/needs for every positive finding, to effectively inform OBCM activities. |  |  |  |  |
| Ongoing assessment findings are documented in the Pregnancy Assessment rather than in task comments. |  |  |  |  |
| Postpartum section of the Pregnancy Assessment is complete. |  |  |  |  |
| **CARE PLAN & GOALS** |
| Conditions are appropriate for the patient. |  |  |  |  |
| Status of conditions (open/closed) is accurate for patient. |  |  |  |  |
| If case status is OB Heavy, OB Medium or OB Light, AT LEAST one goal is written. |  |  |  |  |
| Goal is updated AT MINIMUM every 30 days for OB Heavy or OB Medium; every 90 days for OB Light. Also, for active patients, goal tab is current (not red). |  |  |  |  |
| **Broad goal** chosen from the “Drop-Down” menu. |  |  |  |  |
| * Is assigned High, Medium or Low priority level
 |  |  |  |  |
| * Target date for broad goal/long term goal documented in *“By When”*
 |  |  |  |  |
| **Long Term Goal** (LTG) is written in the *“As Evidenced By”* text box  |  |  |  |  |
| * Correlates with the “Broad Goal”
 |  |  |  |  |
| **Short Term Goal** (STG) is written in the *“As Evidenced By”* text box |  |  |  |  |
| * Represents incremental steps towards meeting LTG
 |  |  |  |  |
| Goals are documented in SMART format (Specific, Measurable, Attainable, Relevant, Time based) |  |  |  |  |
| Documentation (On the Goals tab in the “As Evidenced By” and/or “Potential Barriers” sections), indicate reasons that progress is being made/not made in meeting the Goal and/or whether the Goal was met or not met |  |  |  |  |
| If updating/revising goal, “restates” LTG & STG, if needed. |  |  |  |  |
| Goals closed or deferred when patient status deferred. |  |  |  |  |
|  |  |  |  |  |
| **TASKS** |
| Completed task documenting communication with the PMH or other referral source regarding the status of the Referral. |  |  |  |  |
| Evidence of ongoing communication with providers regarding issues that impact patient’s clinical care. |  |  |  |  |
| Most recent task timeframe is appropriate for status and status is based on patient need. |  |  |  |  |
| Tasks “with patient” involved patient contact.  |  |  |  |  |
| Tasks are documented within 72 clock hours or less of completion, with clear and sufficient notes in the Comment section. |  |  |  |  |
| Tasks selected are being used correctly, in alignment with Task Definitions. |  |  |  |  |
| Unsuccessful tasks documented “attempted”, not “completed”. |  |  |  |  |
| One or more current pending tasks for a patient on active case status. Does not include auto-generated tasks. |  |  |  |  |
| Pending tasks are set at appropriate timeframes. |  |  |  |  |
| Pending tasks contain instructions of what needs to be done. |  |  |  |  |
| Pending tasks are not past due. |  |  |  |  |
| Tasks are clearly and thoroughly documented with patient related events, avoids personal opinions and reviewer would know how to proceed with the patient by reading the previous tasks and current pending task(s), including instructions.  |  |  |  |  |
| Case Status is appropriate for patient needs. |  |  |  |  |

| **PENDING STATUS ANALYSIS** |
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| Codes: √=Yes or Present, 0=No or Absent, NA=Not Applicable | **OB Pending at End of Reporting Period** | **OB Pending at End of Reporting Period** | **OB Pending >30 Days at End of Reporting Period** | **OB Pending >30 Days at End of Reporting Period** |
| **Patient Name** |  |  |  |  |
| **Patient Date of Birth** |  |  |  |  |
| **Patient MID** |  |  |  |  |
| Care manager is attempting to engage the patient with timely outreach efforts, appropriate to the level of need, based on the information from referral source. |  |  |  |  |
| If Pending >30 Days, outreach efforts are close to securing contact and engagement, and documentation reflects ongoing attempted contacts. |  |  |  |  |
| **SUCCESSFUL PRACTICES & QUALITY IMPROVEMENT ACTION STEPS** |
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