DUTIES OF THE CASE COORDINATION

The Case Coordinator works closely with members of the health care team and the client in the development and implementation of the care plan.

The Case Coordinator:

1. Acts as liaison between the client and the team to promote effective communication.

2. Maintains close contact with the client throughout pregnancy and the postpartum period.

3. Coordinates development of a complete individualized care plan.

4. Modifies the care plan as the client's condition changes.

5. Assists the client with practical arrangements such as: transportation, translation needs and assistance with tests, referrals and special appointments.

6. Oversees the completion of all recommendations made on the care plan.

7. Ensures that results of tests and referrals are given to appropriate team members and are recorded in the client's chart.

8. Keeps track of the client's attendance at appointments, identifies the reason for a missed appointment, an assists the client with making a new appointment.

9. Ensures communication between team members and encourages care conferences to evaluate the patient's progress and quality of care given.

10. Is available as a contact for problems and questions. Assists the client in problem-solving.

11. Oversees the client's chart for completeness of documentation of care.

12. Ensures provision of appropriate copies of the prenatal record at the hospital during the intra-partum period. Ensures provision of intra-partum records at the outpatient site during the post-partum visits.

-OVER-

COMPREHENSIVE PERINATAL SERVICES PROGRAM

CASE COORDINATION

I. What Is Case Coordination?

A. The implementation of a system for planning and ensuring the provision of comprehensive perintal services to the patient

B. The formal system of record keeping and communication

C. The involvement of all aspects of patient care and all practitioners

II. What Are the Components of Case Coordination?

A. Assessments (obstetrical, nutrition, health education and psychosocial)

B. Written individualized care plan based on all assessments

C. Appropriate interventions/treatments provided according to the care plan

D. Continuous assessments of patient's status and progress relative to care plan interventions with appropriate revision of the care plan

E. Case conferences or other appropriate communication involving all team members regarding each patient's care

F. Comprehensive record system where all information relating to patient care is documented and is available to all team members

G. Record-sharing system to exchange information among providers, especially for referrals, consultations and reporting pregnancy outcome

Case Coordination

Why CPSP case coordination benefits everyone.

- The client receives integrated care that addresses her total needs and promotes her involvement.
- Health care team members have access to up-to-date client information which helps them to provide higher quality care.

What Case coordination helps to ensure that services delivered to clients are appropriate for their needs and are delivered in an efficient manner. It involves organizing the provision of comprehensive perinatal services and includes, but is not limited to supervision of all aspects of client care including antepartum, intrapartum, and postpartum.

How Case coordination is the provider's responsibility and may be delegated to appropriate staff. The responsibilities included in the Case Coordinator's role are identified below.

Individualized Care Plan

The CPSP fee-for-service provider receives a case coordination reimbursement from Medi-Cal if the assessments for the enhanced services are completed within four weeks of the initial OB exam.

The CPSP Case Coordinator works closely with members of the health care team and the client to develop and implement the individualized care plan.

- Coordinate development of a complete individualized care plan.
- Modify the care plan as the client's condition changes.
- Assist the client with practical arrangements such as: transportation, translation needs and tests, referrals and special appointments.
- Oversee the completion of all care plan recommendations.

Communication With the Client

The Case Coordinator acts as an advocate for the client.

- Act as a liaison between the client and the health care team to promote effective communication.
- Maintain close contact with the client throughout pregnancy and the postpartum period.
- Track client's attendance at appointments, identify the reason for a missed appointment, and assist the client with making a new appointment.

Referring Clients for CPSP Mandated Services

Ask your local Perinatal Services Coordinator for assistance with referrals.

CPSP providers must refer clients, when appropriate, to services not specifically included in the Comprehensive Perinatal Services Program. These services must include, but are not limited to:

- Women, Infants, and Children Supplemental Nutrition Program (WIC)
- Genetic screening
- Dental care
- Family planning
- Well Child Care (Child Health and Disability Prevention Program-CHDP)

Women, Infants, and Children (WIC) Supplemental Nutrition Program

WIC serves women, infants, and children by providing nutrition education, breastfeeding support, partnerships to health care services, and nutritious foods to eligible families. WIC is a prevention program providing services in every county in California through more than 80 local agencies. California's WIC Program is 100% federally funded and serves more than one million individuals each month.

The following services are provided to eligible women, infants, and children up to five years old:

- Nutrition and health education
- Breastfeeding promotion and support
- Nutritious supplemental foods
- Referrals to health care and social services

More than 70 evaluation studies have demonstrated positive health benefits from receipt of WIC services. The documented successes of the WIC Program include:

- Improved access to prenatal care and adequate prenatal care
- Improved prenatal weight gain and dietary intake of pregnant women
- Lowered infant mortality rate by 25 to 66%
- Fewer low birthweight and very low birthweight babies
- Improved breastfeeding rates among WIC mothers by 10 to 25%
- Improved children's diets and intake of important nutrients
- Improved language and memory scores among four and five year olds

Making Successful Referrals

In some cases, you will need to refer a client to an outside resource that specializes in a particular kind of problem or service. After such a referral, the client needs to follow through. At each referral:

- Explain the benefits of the referral and how these meet a need she has identified.
- Describe the process of the referral (what has to happen before she can receive services).
- Praise her for taking care of herself.

Try to relieve any embarrassment she might feel at a referral, especially a psychosocial referral. If she has formed an attachment to you, she might be reluctant to see someone else. Let her know you will still see her at her prenatal visits.

When you or the client calls the referral agency, find out the following as necessary:

- Who is served? Are there any age limits or other restrictions?
- Are people seen on a drop-in basis or is an appointment required?
- How long will it take to get an appointment?
- Is there a waiting list?
- Are there any fees? What are they? Is there a sliding scale?
- What are the staff's language capabilities?
- Where are they located?
- What public transportation is nearby?
- What are their hours and days of service?

You may need to teach the client how to make an appointment. Show her how to ask for the name of the person and to make notes of what she is told.

Prepare her for barriers she may experience

Ask if she thinks she will have any problems in following through with the referral. These may include transportation, child care or other barriers. Find out if the client has a calendar and clock to help her keep appointments. See if she has a map and bus schedule and knows how to use it to locate the agency. Consider her literacy skills.

What if she won't go?

Do your best to make an appropriate referral and encourage her to accept it. Document your efforts. In most cases, you can't make your client follow through. In cases where the client is a danger to herself or others, see Psychosocial Care: *Emotional or Mental Health Concerns*.

If a client thinks she doesn't need help or she feels you can help her with all her problems, she may not want to see someone from an outside agency. Know the limits of your counseling experience and explain them to her. Don't encourage overdependence. Set limits on your time and availability if she becomes overly dependent, so she'll accept outside help and receive an appropriate level of care.

Comprehensive Perinatal Services Practitioners:

***Practitioner Types**

Physician	(MD)	Marriage and Family Therapist	(MFT)
Certified Nurse Midwife	(CNM)	Health Educator	(HE)
Registered Nurse	(RN)	Childbirth Educator	(CE)
Nurse Practitioner	(NP)	Dietitian/Registered	(RD)
Physician Assistant	(PA)	Comprehensive Perinatal Health Worker	(CPHW)*
Social Worker	(SW)	Licensed Vocational Nurse	(LVN)

****Years of Experience**

For MD, CNM, RN, NP, PA, SW, MFCC, HE, LVN-Years of experience in Maternal and Child Health.
For CE, CPHW-Years of experience in perinatal care.
For RD/RDE-Years of experience in perinatal nutrition

Application Update Provider _____
Submitted by_____ Date____ ____
Current Medi-Cal Provider Number _____

*CPHWs must be at least 18 years of age, a high school graduate or equivalent and have at least one year of full-time paid practical experience providing perinatal care. Complete only the shaded fields below.

Practitioners:

Last Name	First	Middle Initial *	*Type or Specialty	CA License, Certificate, Registration Number	Expr. Date of Lic., Cert., or Reg. No. MM/DD/YY	Year Graduated * Degree and Institution/Univ. High school only for CPHWs	Medi-Cal Rendering Provider Number	**Years of Experience *	Obstetrics (applies to Physicians, CNM, NP, PA)	Supervision	Back-up	Client Orientation	Health Education	Nutrition	Psychosocial	Case Coordination	Consultant	Protocol Approval
Add:																		
Delete:																		

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(562) 570-4099 (fax)
karen-prochnow@longbeach.gov

Pasadena City Health Dept.
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Perinatal Service Coordinator
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(626) 744-6092 (phone)
(626) 744- 6112 (fax)
gperry-williams@cityofpasaden.net

CPSP Web Site Address: **www.publichealth.lacounty.gov**

MEDI-CAL AND CPSP RESOURCE LIST

Medi-Cal Billing www.medi-cal.ca.gov	(800) 541-5555
Presumptive Eligibility Cynthia Cannon, Analyst cynthia.cannon@dhcs.ca.gov or Alice Mak, Supervisor alice.mak@dhcs.ca.gov	(800) 824-0088 (916) 552-9499 (916) 552-8002
Electronic Data Systems (EDS) **Perinatal Representatives** Billing Questions	(800) 541-5555 ***For CPSP*** *choose* ***option 15*** *then* ***press 12***
Medi-Cal Provider Enrollment	(916) 323-1945
Medi-Cal Fraud Reporting	(800) 822-6222
State Maternal, Child and Adolescent Health	(916) 650-0300
CA State University, Sacramento (State Contractor for CPSP Trainings) **Training Hotline**	(916) 278-4820 (800) 858-7743
MCH Access Project (For local perinatal access issues, Medi-Cal problems, training on eligibility for M/C, CalWorks, etc. - group meets 3rd Thursday of each month) www.mchaccess.org	(213) 749-4261
March of Dimes www.marchofdimes.com	(213) 637-5050

LA County CPSP Website: www.publichealth.lacounty.gov

PROCEDURE FOR INDIVIDUALIZED CARE PLAN (ICP) EVALUATION TOOL

Purpose: To evaluate the quality of the CPSP Individualized Care Plan (ICP) by determining that: 1) required ICP components are completed; and 2) goals and interventions are appropriate to improve maternal/infant health.

Procedure: Each reviewer will use the ICP Evaluation Tool to review assessments, reassessments, and care plans, preferably for postpartum patients (to give a complete view of the services provided throughout the perinatal period.

During the review process, distinguish between what is written and what really happens by interviewing staff when necessary. Excellent service may be poorly documented; perfect documentation does not ensure that services were provided as stated. Assign a score of 0, 1, or 2 according to documentation, but note discrepancies between actual services (as reported by staff) and documentation in "Findings."

INDICATORS:

1. **Case Coordinator identified for each client –** Name of case coordinator appears on ICP or elsewhere on patient record.

2. **Patient strengths –** List all strengths and/or support the client has available to assist her through the pregnancy. Depending on ICP being used, strengths may need to be matched to specific risks/problems, e.g. problem = no knowledge of pregnancy or newborn care; strength = completed high school, likes to read, etc.

3. **Documentation of risk conditions/problems identified during initial OB & CPSP assessments** - Review ICP for problems/needs/risk conditions (if any) for each CPSP component: obstetric, nutrition, health education and psychosocial and compare to information found on OB medical record and CPSP Initial Assessment. It is expected that all problems are on the ICP; however, in cases where a patient has numerous problems, it may be more practical to list only the significant problems on the initial ICP and "hold" the other problems on a problem list until they can be added to the ICP or are resolved.

   If no problems are identified during the assessment for a specific discipline, e.g. psychosocial, note in the findings if there is any documentation on the ICP or elsewhere stating, for example, "no p/s problems."

4. **Proposed interventions per protocol** - CPSP providers are responsible for providing individual or group interventions for problems identified during assessments/reassessments. Interventions should be consistent with site protocols and appropriate for the individual client and problem being addressed. In other words, are interventions likely to improve outcome; or are they done for every patient, regardless of need, e.g. all patients get smoking cessation/substance use class, even if they have no identified risk.

5. **Goal/Desired Outcome** – 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 (e.g., stabilize blood sugar level by next visit).

6. **Time frame** - projected length of time (or date) by which goals (outcome objectives) will be achieved (e.g. 6 weeks or 12/10/06).

7. **Parties Responsible** - staff person (e.g., physician, RN, RD, CPHW) responsible for carrying out each proposed intervention.

8. **Used by all members of care team** – since CPSP is a multidisciplinary program and the ICP is the care coordination document, it is essential that all members of the care plan contribute to the plan, or at least review the content. This will be evident if ICP documentation is done by various staff members or based on information obtained during staff interview.

9. **Appropriate referrals made and outcome noted** – medical, health education, nutrition, and psychosocial referrals are made in accordance with site protocols. Documentation includes date referral was made, appointment kept (or reason patient did not comply), and notes from consultant or referral agency as to outcome of referral and recommended f/u.

10. **ICP updated at least once each trimester** – previously identified problems/risks and interventions are evaluated and modified, as needed, based on progress toward achieving goal. New problems identified on 2nd & 3rd trimester reassessments are added to ICP, including information as noted in #4-8 above. ICP may need to be updated more frequently than once a trimester, depending on time frame listed for each problem.

11. **ICP updated in postpartum period** – progress toward goals for previously identified problems are evaluated and ICP updated as needed. New problems identified during postpartum assessment are added to ICP. It is recommended that the postpartum care plan include interconception care planning.

12. **Client orientation** – documentation of all orientation topics covered or reference to standardized orientation protocols.

13. **Weight gain grid plotted each visit** – use of appropriate weight gain grid, based on accurate determination of pregravida weight; patient's weight at **each OB visit** should be plotted correctly.

14. **Food Intake –** required component of each nutrition assessment, trimester reassessment, and postpartum assessment. Either a Perinatal Food Frequency Questionnaire (PFFQ) or 24-hour food recall should be completed at least each trimester and postpartum and must be kept on the chart.