



P R O V I D E R B U L L E T I N

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To: All Indiana Health Coverage Programs Providers

Subject: New Care Coordination Outcome Report Form

Overview

The purpose of this bulletin is to provide information to providers about the expanded *Care Coordination Outcome Report* form. The expanded *Care Coordination Outcome Report* form is used to report post-pregnancy results for prenatal care coordination services. The postpartum visit (Z5902) is the only service that requires a copy of the *Care Coordination Outcome Report* to be completed by the care coordinator and attached to the claim when billing for the visit. The following information is included in this bulletin:

- The *Care Coordination Outcome Report* is used for reporting statistical data for care coordination services in the state of Indiana.
- The *Care Coordination Outcome Report* guidelines describe the required information that must be indicated on the *Care Coordination Outcome Report* form. The guidelines are included in Table 1.1

Note: For complete billing instructions for prenatal care coordination services, refer to Chapter 8 of the Indiana Health Coverage Programs Provider Manual.

If there are any questions about the information in this bulletin, contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To request a copy of the *Care Coordination Outcome Report* form, send a written request to EDS Forms, P.O. Box 7263, Indianapolis, IN 46207-7263. The form is also available on the Indiana Medicaid Web site at www.indianamedicaid.com. The form can also be reproduced from this bulletin.

Submitting the New Care Coordination Outcome Report Form

The new *Care Coordination Outcome Report* form is effective for dates of service on or after November 20, 2001. Providers have 45 days from the date of this bulletin to use the new form. On November 20, 2001, claims submitted to EDS with the old form attached will be denied.

Field Descriptions

The guidelines in Table 1.1 are provided to clarify questions about the new *Care Coordination Outcome Report* form. The *Care Coordination Outcome Report* form must be completed and attached to the HCFA-1500 claim form for billing the postpartum care coordination visit or the claim will be rejected. Become familiar with each question's intent before completing the new two page *Care Coordination Outcome Report* form. Because questions relate to services provided during the pregnancy, familiarity with the form and guidelines enable the care coordinator to develop questions to be used in the initial assessment, reassessment, and postpartum assessment. These questions enable the care coordinator to complete the form accurately and help ensure that valid data is collected.

Table 1.1 provides the guidelines associated with each field on the new *Care Coordination Outcome Report* form. A copy of the *Care Coordination Outcome Report* form is provided after the guidelines.

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Maternal Identifying Information		
Field Number	Description	Definition
1	Name	<p><i>Last:</i> Record the member's last name as found on the member's Hoosier Health Card, Social Security card, birth certificate, and so forth. Enter one letter in each box. Check for correct spelling.</p> <p><i>First:</i> Record the member's legal name as found on the member's Hoosier Health Card, Social Security card, birth certificate, and so forth. Enter one letter in each box. <i>Do Not Use Nicknames.</i></p> <p><i>Middle Initial:</i> Record the member's middle initial in the single box provided.</p>

(Continued)

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Field Number	Description	Definition
2	RID 12-digit member identification number	Enter the member's 12-digit member identification number (RID number) as it appears on the member's Hoosier Health Card. The RID number is a unique number assigned to an Indiana Health Coverage Programs (IHCP) member and remains the member's number for all Indiana Health Coverage Programs for life. IHCP eligibility can be determined by calling the automated voice response (AVR) system at (317) 692-0819 in the Indianapolis local area or 1-800-738-6770. <i>If a patient is not an IHCP member at the time of the initial interview, complete this field during a subsequent visit.</i>
3	Social security number	Record the nine-digit number from the member's Social Security card. If the member refuses to provide this information, enter zeros in all of the boxes.
4	County of residence	Enter the first five letters of the county in which the member resides. For example, if the member resides in Vanderburgh county, enter Vande .
5	Care Coordinator's IHCP provider number	Record the prenatal care coordinator's nine-digit IHCP provider number. If more than one care coordinator provides services, enter the provider number of the care coordinator that completed the initial assessment.
6	Date of birth	At the initial assessment, record the date of birth of the member. This should be entered in MM/DD/YY format.
7	Highest year of education completed	Enter the number of years of formal education completed by the member. Fill both boxes (for example, a member who completed the eighth grade will be recorded as 08 .) Record completion of GED as 12 .
8.	Ethnicity	Record 01 if the member identifies self as Hispanic or 02 if the member is not Hispanic.
8a	Race	Enter the race of the member as identified by the member. Black-01, White-02, American Indian-03, Asian/Pacific Islander-04, Multiracial-05, or Other-06
9	Marital status	Marital status of the mother at the time of the baby's birth. Single-01, Married-02, Widow-03, Divorced-04, or Separated-05. The mother's marital status may not necessarily relate to the mother's relationship to the baby's father.

(Continued)

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Prenatal Care (During Pregnancy)		
Field Number	Description	Definition
10	Month of pregnancy prenatal care began with a prenatal care provider.	Record the month of the pregnancy when the member first visited a prenatal care provider (doctor, nurse practitioner, or midwife). Record the month using 01-09.
10a	Was member in prenatal care prior to initial prenatal care coordination contact?	Record if the member was found through outreach and facilitated into care or if the member was a patient referred for care coordination after in prenatal care and was receiving prenatal care before the first care coordination encounter. If the member was in prenatal care before the first care coordination encounter record, 01 for yes. If the care coordinator encountered the member prior to the first prenatal care visit, record, 02 for no.
11	Number of prenatal medical provider visits.	Record the number of times the member visited the provider's office for prenatal visits. Do not record emergency room visits in this count. Record the total number of visits in the field using two digits, such as 01, 02, 12, and so forth.
12	Did the member miss two or more scheduled prenatal care visits?	Record 01 if the member missed two or more appointments or 02 if the member did not miss two or more appointments. If this question does not apply to the member, record 00 . (Do not leave a field blank.)
13	Reason appointments were missed.	There may be more than one reason a member missed an appointment. Record the two most common reasons the member states for missing appointments. Record the appropriate code for the reason missed. If the member has not missed any appointments record, 00 . (Do not leave a field blank.)
14	Who rescheduled missed appointment?	Record who rescheduled missed appointments. The member, care coordinator, or provider may reschedule the new appointment. If the member has not missed any appointments, record 00 . (Do not leave a field blank.)
15	Weight gained in pounds.	Record the total number of pounds the member gained from prepregnancy weight to weight at delivery. Enter the number (01-04) that corresponds to the range of pounds gained. <i>If the patient does not gain adequate weight or gains too much weight, check the corresponding referral and patient education boxes. (25 and 25a)</i>

(Continued)

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Field Number	Description	Definition
16	Smoking during pregnancy?	The care coordinator should ask about smoking status at each encounter. Record the appropriate code to indicate smoking status. If a member did not smoke before or during the pregnancy, record 00 (Do not leave a field blank) . <i>If the member smokes, check the appropriate box for referral and patient education about smoking.</i>
17	Alcohol use during pregnancy?	Record if the member is drinking alcohol during the pregnancy. Record the appropriate code . If the member does not drink alcohol during the pregnancy, record 00 (Do not leave a field blank) . <i>Check the corresponding referral and education box for those using alcohol or drugs.</i>
17a.	Drug use during pregnancy?	Record if the member is using drugs during the pregnancy. Record the appropriate code . If the member does not use drugs during the pregnancy, record 00 (Do not leave a field blank) . <i>Check the corresponding referral and education box for those using alcohol or drugs.</i>
18	WIC participant?	Record the appropriate code . WIC has been directly correlated with improved pregnancy outcomes. Many WIC projects do not reach eligible members. Care coordinators should assure that every patient is enrolled in WIC. <i>If the member is not on WIC, check the corresponding referral and education code.</i>
18a	Was member on WIC prior to initial prenatal care coordination contact?	Record the appropriate code . Record if the member was enrolled in WIC before any encounters with the care coordinator.
19	How many total risk factors did member have?	Record the total number of risks the patient had based on the <i>Prenatal Risk Assessment Tool</i> . Include all risks determined by the prenatal care provider and the care coordinator until delivery.
20	List top 5 risk factors (01-66)	List the top five risk factors identified during the pregnancy starting with the lowest number. Enter the codes found on the <i>Prenatal Risk Assessment Tool</i> for the corresponding risk. For example, enter 01 if a previous preterm delivery was a risk factor; enter 15 if the mother was in preterm labor during this pregnancy, and so forth.

(Continued)

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Care Coordination Services		
Field Number	Description	Definition
21	Month of pregnancy prenatal care coordination began.	Record the number of months the member was pregnant at the time of the first encounter with a care coordinator.
22	Was a community health worker involved?	Record if a community health worker had any encounters with the member.
23a	Total number of encounters by care coordinator.	Record the number of total encounters between the member and the care coordinator from the time of the initial assessment to the postpartum assessment. Encounters include home visits, office visits, phone visits, and educational mailings made directly by or on behalf of the member. Record the number of encounters using a two-digit number, such as 01 , 07 , or 10 . Ensure all encounters are documented in the chart.
23b	Total number of encounters by community health worker.	If a community health worker was included in the care coordination program, record the number of total encounters with the member throughout the pregnancy. Record number of encounters, using a two-digit number, such as 01 , 05 , 07 , or 10 . Ensure all encounters are documented in chart.
24	Total number referrals by care coordinator and community health worker.	Record the total number of unduplicated referrals given to a member by both the care coordinator and the community health worker during the pregnancy. If no unduplicated referrals were given, record 00 . (Do not leave a field blank).
Referrals Made		
Field Number	Description	Definition
25	Check all that apply:	<p>Check all types of referrals given to the member or family during the pregnancy.</p> <ul style="list-style-type: none"> a. <i>Substance Abuse</i> – Referral to an outside agency for treatment, counseling, or support for a substance abuse problem. b. <i>Stop Smoking</i> – Referral to a smoking cessation program. c. <i>Parenting</i> – Referral to a specific group session about parenting, life skills, or mentoring. d. <i>Mental Health</i> – Referral to a mental health clinic or agency for counseling and treatment of depression, postpartum depression, domestic violence abuse, or other mental health services.

(Continued)

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Field Number	Description	Definition
25 (Cont.)		<ul style="list-style-type: none"> e. <i>Financial</i> – Referral to consumer credit counseling, financial assistance programs, rent or utility assistance programs, township trustees, Aid to Families with Dependant Children, Medicaid, or food stamps. f. <i>Education</i> – Referral to GED programs, return to school programs, IMPACT, job core, college, or technical or vocational training. g. <i>Prenatal Care</i> – Referral to a prenatal care provider for prenatal care. h. <i>Nutrition/WIC</i> – Referral to a nutritionist for a nutrition problem, referral to WIC, EFNEP, or lactation consultant for breastfeeding support. i. <i>Social Services</i> – Referral to any social agency outside of the project, such as, human service agencies, YWCA, transportation, child care, child protective services, or adoption services. j. <i>Childbirth Education</i> – Referral to a childbirth education class within the care coordination agency or outside the agency. k. <i>Women’s Shelters</i> – Referral to a homeless shelter or domestic violence shelter. l. <i>Postpartum Care</i> – Referral for postpartum care or family planning. m. <i>Employment</i> – Referral to employment counseling or training to help gain employment. n. <i>Food/Clothing Pantry</i> – Referral to a food pantry or a clothing pantry for needed items. o. <i>Infant PMP</i> – Referral to available pediatricians in her community. The mother should chose a pediatrician before the baby is born.

(Continued)

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Field Number	Description	Definition
25a	Education topics taught by care coordinator or community health worker.	<p>Check all topics taught during and after the pregnancy.</p> <ul style="list-style-type: none"> a. <i>Early prenatal care</i> – Should be taught only to members found through outreach not yet in prenatal care. Not appropriate after 12 weeks gestation. b. <i>Preterm labor signs</i> – Should be taught to all members between 20-24 weeks gestation. c. <i>Fetal movement</i> – Should be taught to all members starting in the third trimester. d. <i>Effects of smoking</i> – Should be taught to all members who smoke or who are exposed to secondhand smoke. e. <i>Adequate weight gain</i> – Should be taught at the initial assessment and again as needed. f. <i>HIV risks/testing</i> – Should be taught to all new patients not in care and to members with continued promiscuous sexual behavior. g. <i>Signs of infection</i> – Should be taught at the initial assessment and at each reassessment and postpartum visit. h. <i>Normal discomforts</i> – Should be taught at each assessment in each trimester. i. <i>Keep prenatal appointments</i> – Should be taught to all members. j. <i>Infant sleep position</i> – Should be taught to all members and their families starting in the third trimester. k. <i>Post-partum /NB care</i> – Should be taught to all members in the third trimester. l. <i>Family planning</i> – Should be taught to all members and assistance granted to choose the best plan for that member.
Total Care Coordination Services		
26	Total care coordination services provided.	<p>This section shows the total number of reimbursable services the member received.</p> <ul style="list-style-type: none"> • <i>01-This member received the full range of reimbursable services, including an initial assessment, two reassessments, and a postpartum assessment.</i> • <i>02 -Care coordination began in the second trimester and the member received an initial assessment, one reassessment, and a postpartum visit.</i>

(Continued)

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Field Number	Description	Definition
26 (Cont.)		<ul style="list-style-type: none"> • 03-Care coordination began in the third trimester or the member lost follow-up for a time during the pregnancy and only received an initial assessment and a postpartum assessment. • 04-The member was lost, moved, and so forth before the full services were completed. The patient received an initial assessment and one reassessment. • 05-The postpartum assessment was not completed due to loss of follow-up, refusal, and so forth. The member received an initial assessment and two reassessments only. • 06-The member received only an initial assessment and was not found to be at risk or was lost to follow-up, or refused further services.
Birth Data		
Field Number	Description	Definition
27	Was this a live birth?	Record the appropriate response. This question must be answered. Live birth is defined as the birth of an infant who shows signs of life after the infant is entirely outside the mother, regardless of length of gestation or length of survival. If this was a live birth continue with questions a-h. If this was not a live birth go directly to question 29.
27a	Birth weight in pounds and ounces.	Record the number of pounds that the baby weighed at birth in the first two fields. In the third and fourth field, record the number of additional ounces that the baby weighed. For example, a baby that weighed 7 pounds and 11 ounces would be entered as 0-7-1-1. Complete these fields for all live births.
27b	Gestation age at birth in weeks.	This question must be completed for all live births. Record the number of weeks in the pregnancy when the baby was born. Use both fields.
27c	Date of delivery.	Record the birth date of the baby in MM/DD/YY format.
27d	Number of babies born of this pregnancy.	Record the appropriate response using a two-digit number so both fields are filled.
27e	Is the baby hospitalized due birth problem?	Record the appropriate response.

(Continued)

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Field Number	Description	Definition
27f	Did the member want this pregnancy initially?	<p>Obtain this information during the initial assessment. From this assessment, appropriate counseling referrals can be made. All care coordinators should ask this question the following way:</p> <p>Thinking back to just before you were pregnant, how did you feel about becoming pregnant?</p> <p><i>I wanted to be pregnant sooner</i> ___</p> <p><i>I wanted to be pregnant later</i> ___</p> <p><i>I wanted to be pregnant then</i> ___</p> <p><i>I did not want to be pregnant then or ever</i> ___</p> <p><i>I don't know</i> ___</p> <p>If member wanted the baby sooner or at that time, record Yes-01. If the member wanted the baby later, never, or does not know, record No-02.</p>
27g	During the pregnancy, did the member believe her overall support of the pregnancy was:	<p>Obtain this information during the initial assessment. Record the amount of support the member perceived she received. Record the number corresponding to the member's opinion about support of the pregnancy. The following prompting questions should be used to assess the member's perception of support:</p> <ul style="list-style-type: none"> • <i>Was overall support enough</i> ___ <i>too much</i> ___ <i>not enough</i> ___ • <i>Was support from your mother enough</i> ___ <i>too much</i> ___ <i>not enough</i> ___ • <i>Was support from your boyfriend enough</i> ___ <i>too much</i> ___ <i>not enough</i> ___ • <i>Was support from the people you believe are the most important to you enough</i> ___ <i>too much</i> ___ <i>not enough</i> ___

(Continued)

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Field Number	Description	Definition
27h	Now that the baby is born, does she believe support for her and her baby is:	Enter the number corresponding to the member's opinion about support now that the baby has been born. The prompting questions provided in 27g should be used to assess the member's perception of support. If the baby was adopted, made ward of the court, or died since birth, direct the questions to the mother's feeling about support for herself. (If the care coordinator believes that the mother is uncomfortable with her emotions for the baby, appropriate referrals should be made, such as Healthy Families, where available, parenting classes, and so forth. If domestic violence is suspected, referrals should be made to abuse prevention agencies.)
28	Did the baby die before the postpartum care coordination visit?	Only complete this field if the baby was born alive, but died prior to the postpartum visit. Record the correct response.
28a	Age at death.	If the child has died, record the infant's age at death using the codes provided. The postpartum visit can be made anytime up to two months after the birth of the child.
28b	Cause of death.	Enter the reason death occurred, using the codes provided. <i>External</i> is death due to accident or injury, and <i>specific</i> is death due to other causes not listed.
29	If not a live birth, answer the following (If not a live birth, skip questions 29a-29f)	Complete this field only if the baby was not born alive. If the baby was born alive, but later died, do not complete this section. Even if the baby was not born alive, the mother should receive a postpartum assessment to provide appropriate education, support, and referral.
29a	Number of weeks pregnancy terminated.	Enter the number of weeks from conception to termination of this pregnancy.
29b	Reason for pregnancy termination.	Enter the code corresponding to the reason provided by the member. Codes are 01-elective abortion, 02-miscarriage or spontaneous abortion, and 03-stillborn (after 20 weeks).
29c	Number of fetuses from this pregnancy.	Enter the number corresponding to the member's response. Enter zero in front of single digit numbers.
29d	Did the member want this pregnancy, initially?	Obtain this information during the initial assessment so that appropriate counseling referrals can be made. (Refer to question 27f for prompting questions.) Enter the number corresponding to the member's response.

(Continued)

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Field Number	Description	Definition
29e	At the beginning of pregnancy, did the member believe overall support of pregnancy was:	(Refer to question 27g.)
29f	At the postpartum visit, does she believe her support is:	(Refer to question 27h.)
Postpartum		
Field Number	Description	Definition
30	How many weeks postpartum was the care coordination visit made?	Record the number weeks past the delivery date or pregnancy termination date when the home visit was made. The IHCP allows six weeks to complete the postpartum assessment. Because mothers are discharged from the hospital within 24 hours, many hospitals and home health agencies make home visits within the first week. The care coordinator should consider visiting some time during the second through sixth week depending on the needs of the mother.
31	Has postpartum medical exam been completed or scheduled?	Enter the number corresponding to the member's response. If the member answers <i>no</i> ; educate the member on the importance of a postpartum check-up and assist her in making an appointment.
32	Does the member have a birth control plan?	Enter the number corresponding to the member's response. If sexual activity has not resumed, record the member's answer based on her intent regarding birth control when sexual activity resumes. If the member does not want to discuss the subject, enter unknown-99.
33	Number of all children living in the home age five years or younger, including this baby	Enter the number of all children (count all children whether or not the member is their mother) age five or younger who live at home with the member including the new baby.
34	Number of all children living in the home over five years of age.	Enter the number of all children older than five years old (count all children whether or not the member is their mother) who live in the home.
35	Does anyone in the household smoke?	Enter the number corresponding to the member's response Identifies infant's exposure to secondhand smoke.

(Continued)

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Infant Care		
Field Number	Description	Definition
36	Is or will the child live with the birth mother?	Enter the appropriate code based on the member's response. <i>If the answer is no, do not complete the remaining questions.</i>
37	Infant's RID number.	Enter the infant's RID number if a Hoosier Health Card has been received. If a card has not been received, enter zeros in all fields.
38	Does the infant have a primary medical provider?	Enter the number corresponding to the member's response. All IHCP members younger than 21 years old are eligible for the Early and Periodic Screening Diagnosis and Treatment program (EPSDT) called HealthWatch in Indiana. Providers that participate in Hoosier Healthwise are required to provide EPSDT screening. Information about HealthWatch is available in a HealthWatch pamphlet. The HealthWatch pamphlet is available from EDS at 1-800-577-1278 or from the Indiana State Department of Health (ISDH) Family Helpline at 1-800-433-0746. Because the Hoosier Healthwise program is statewide, the mother will need to choose a primary medical provider (PMP) for the newborn. Ideally, this decision should be made prior to the birth of the baby. The mother should call the Hoosier Healthwise toll-free telephone number at 1-800-889-9949 for help selecting a PMP.
39	Was the first check up completed or has an appointment been scheduled?	Enter the number corresponding to the member's response. All newborns should receive a check up during the first month. If the mother and baby left the hospital in less than 24 hours, the baby should have a check-up during the first two or three days. The baby should return to the birth hospital for a newborn screening as soon as possible. Some hospitals make arrangements to have a nurse visit the newborn to perform the newborn blood screening so that the infant will not have to return to the hospital. Care coordinators should make sure that newborn screening has been completed. Obtain test results by calling the ISDH at 1-800-433-0746.

(Continued)

Table 1.1 – Care Coordination Outcome Report Field Descriptions

Field Number	Description	Definition
40	Have immunizations started?	Enter the number corresponding to the member's response. Many hospitals do not routinely provide Hepatitis B immunizations at birth. According to American Academy of Pediatrics recommendations, the first Hepatitis B immunizations should be given at birth or by one month of age. If the baby's mother tested positive for Hepatitis B, the infant should receive the first Hepatitis B injection and Hepatitis B immune globulin at birth. The second injection should be given at one month, and the third Hepatitis B injection should be given between six and 18 months. For a complete immunization schedule, refer to the HealthWatch pamphlet. The only time NA-99 can be entered is if religious reasons exist for declining immunizations.
41	Is infant enrolled or planning to enroll in WIC?	Enter the appropriate code corresponding to the member's response.
42	Was the infant breastfeeding at the time of hospital discharge?	Enter the appropriate code corresponding to the member's response.
42a	Is infant being placed on its back to sleep?	Enter the appropriate code corresponding to the member's response.
43	Is there any evidence of developmental delays?	Enter the appropriate code based on developmental assessment. Children born very prematurely, of low birth weight, or to mothers with a substance abuse problem throughout the pregnancy should automatically be referred to First Steps. Also, the Indiana Department of Education has a useful tool entitled "From Crib to Kindergarten, A Guide to Your Child's Development" that provides indicators of a child's developmental milestones from one month to five years old. Care coordinators can obtain a supply of this tool from the Department of Education to provide the mother at the postpartum visit by calling 1-800-833-2198 or (317) 232-0857.
43a	If yes or unknown, was a referral made to the medical provider and to the First Steps Agency?	Enter the appropriate response. Infants should also be referred for certain prenatal conditions such as prematurity, low birthweight, small for gestational age. The toll-free number for First Steps is 1-800-441-STEP.

C A R E C O O R D I N A T I O N O U T C O M E R E P O R T

Before completing this form, please refer to the guidelines for clarification of questions.

Note: All appropriate items **must** be completed or the claim will be rejected. A zero must precede all single-digit entries.

P R O J E C T / A G E N C Y :

Maternal Identifying Information															
1. Name	Last:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(1)
	First:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Middle Initial:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. RID 12-digit member identification number		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(2)
3. Social security number (if no number, enter zeros)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(3)
4. County of residence (first five letters)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(4)
5. Care coordinator's IHCP provider number		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(5)
6. Date of birth (MM/DD/YY)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(6)
7. Highest year of education completed (GED-12)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(7)
8. Ethnicity Hispanic Yes-01 No-02		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(8)
8a. Race Black-01, White-02, American Indian-03, Asian/Pacific Islander-04, Multiracial-05, Other-06		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(8a)
9. Marital status (At baby's birth) Single-01, Married-02, Widow-03, Divorced-04, Separated-05		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(9)
Prenatal Care (During Pregnancy)															
10. Month of pregnancy prenatal care began with a prenatal care provider.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(10)
10a. Was member in prenatal care prior to initial prenatal care coordination contact?	Yes-01, No-02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(10a)
11. Number of prenatal medical provider visits (total).		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(11)
12. Did the member miss two or more scheduled prenatal care visits?	NA-00, Yes-01, No-02,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(12)
13. Reason appointments were missed. (Select the two most common)	NA-00, Transportation-01, Childcare-02, Weather-03, Forgot-04, Illness-05, Appt. Hours Inconvenient-06, Job/School-07, Did not want to go-08, Unk-99	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(13)
14. Who rescheduled missed appt?	NA-00, Drs. Office-01, Member-02, Care Coordinator-03, Other-04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(14)
15. Weight gained in pounds.	<15 lbs.- 01, 15-24 lbs. - 02, 25-40 lbs.- 03, >40 lbs.- 04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(15)
16. Smoking during pregnancy?	NA-00, Began-01, Stopped-02, Decreased-03, Increased-04, Continued-05, Unknown-99	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(16)
17. Alcohol use during pregnancy?	NA-00, Began-01, Stopped-02, Decreased-03, Increased-04, Continued-05	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(17)
17a. Drug use during pregnancy	NA-00, Began-01, Stopped-02, Decreased-03, Increased-04, Continued-05	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(17a)
18. WIC participant?	Yes-01, No-02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(18)
18a. Was member on WIC prior to initial prenatal care coordination contact?	Yes-01, No-02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(18a)
19. How many total risk factors did member have? (From Prenatal Risk Assessment Tool)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(19)
20. List top 5 Risk Factors (01-66)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(20)
Care Coordination Services															
21. Month of pregnancy prenatal care coordination began. (01-09)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(21)
22. Was a community health worker involved?	Yes-01, No-02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(22)
23. Total number of encounters: a) By care coordinator.	<input type="checkbox"/>	<input type="checkbox"/>	b) By community health worker.	<input type="checkbox"/>	<input type="checkbox"/>										(23ab)
24. Total number of referrals by care coordinator and community health worker? None-00		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(24)
25. Referrals Check all that apply:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Substance Abuse (a)		Stop Smoking (b)		Parenting (c)										
	Mental Health (d)	<input type="checkbox"/>	Financial (e)	<input type="checkbox"/>	Education (f)	<input type="checkbox"/>	Prenatal Care (g)	<input type="checkbox"/>							
	Nutrition/WIC (h)	<input type="checkbox"/>	Social Services (i)	<input type="checkbox"/>	Child Birth Education (j)	<input type="checkbox"/>	Women's Shelters (k)	<input type="checkbox"/>							
	Post Partum Care (l)	<input type="checkbox"/>	Employment (m)	<input type="checkbox"/>	Food/Clothing Pantry (n)	<input type="checkbox"/>	Pediatrician (o)	<input type="checkbox"/>							
25a. Education topics taught by care coordinator or community health worker Check all that apply:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Early prenatal care (a)		Preterm labor signs (b)		Fetal movement (c)		Effects of smoking (d)								
	Adequate wt. gain (e)	<input type="checkbox"/>	HIV risks/testing (f)	<input type="checkbox"/>	Signs of infections (g)	<input type="checkbox"/>	Normal discomforts (h)	<input type="checkbox"/>							
	Keep prenatal appts.(i)	<input type="checkbox"/>	Infant sleep position (j)	<input type="checkbox"/>	Post partum/NB care (k)	<input type="checkbox"/>	Family planning (l)	<input type="checkbox"/>							

Total Care Coordination Services									
26. Total care coordination services provided <input type="checkbox"/> <input type="checkbox"/> (26)									
Initial assessment + 2 reassessments + outcome = 01				Initial assessment + 1 reassessment = 04					
Initial assessment + 1 reassessment + outcome = 02				Initial assessment + 2 reassessments = 05					
Initial assessment + outcome = 03				Initial assessment = 06					
Birth Data									
27. Was this a live birth? Yes-01 (if yes, answer the following), No-02 (if no, go to questions 29) <input type="checkbox"/> <input type="checkbox"/> (27)									
A. Birth weight in pounds and ounces.				Example 0711		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> (27a)	
B. Gestation age at birth in weeks. <input type="checkbox"/> <input type="checkbox"/> (27b)									
C. Date of delivery. (MM/DD/YY)						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> (27c)	
D. Number of babies born of this pregnancy? <input type="checkbox"/> <input type="checkbox"/> (27d)									
E. Is the baby hospitalized at birth or shortly after birth?						Yes-01, No-02, NA-99			
F. Did the member want this pregnancy initially? <i>See Guidelines</i> – Yes-01, No-02 <input type="checkbox"/> <input type="checkbox"/> (27f)									
G. During this pregnancy, did the member believe her overall support of the pregnancy was: <i>See guidelines</i> <input type="checkbox"/> <input type="checkbox"/> (27g)									
Enough-01, Not Enough-02, Too Much-03									
H. Now that the baby is born, does she believe support for her and her baby is: <i>See guidelines</i> <input type="checkbox"/> <input type="checkbox"/> (27h)									
Enough-01, Not Enough-02, Too Much-03									
28. Did the baby die before the postpartum care coordination visit? Yes-01, No-02 <input type="checkbox"/> <input type="checkbox"/> (28)									
A. Age at death.				<1 hour=01, <1 day=02, <1 week=03, <1 month=04, Unk=99					
B. Cause of death				Premature-01, Congenital-02, SIDS-03, Asphyxia-04, External-05, Specific-06, Infectious-07, Unknown-99					
29. If not a live birth , answer the following: (If 27=No, complete 29 A-F) (29)									
A. Number of weeks pregnancy terminated. <input type="checkbox"/> <input type="checkbox"/> (29a)									
B. Reason for pregnancy termination.				Abortion-01, Miscarriage-02, Stillborn-03					
C. Number of fetuses from this pregnancy. <input type="checkbox"/> <input type="checkbox"/> (29c)									
D. Did the mother want this pregnancy, initially? Yes-01, No-02, Undecided-03 <i>See guidelines</i> <input type="checkbox"/> <input type="checkbox"/> (29d)									
E. At the beginning of pregnancy, did the member believe overall support of pregnancy was: <input type="checkbox"/> <input type="checkbox"/> (29e)									
Enough-01, Not Enough-02, Too Much-03									
F. At the postpartum visit, does she believe her support is: Enough-01, Not Enough-02, Too Much-03 <input type="checkbox"/> <input type="checkbox"/> (29f)									
Postpartum									
30. How many weeks postpartum was the care coordination visit made? <input type="checkbox"/> <input type="checkbox"/> (30)									
31. Has postpartum medical exam been completed or scheduled?						Yes-01, No-02			
32. Does member have a birth control plan? <input type="checkbox"/> <input type="checkbox"/> (32)									
Abstinence-01, Any method-02, No-03, Unknown-99									
33. Number of all children living in the home age five years or younger, including this baby <input type="checkbox"/> <input type="checkbox"/> (33)									
34. Number of all children living in the home over five years of age <input type="checkbox"/> <input type="checkbox"/> (34)									
35. Does anyone in the household smoke? Yes-01, No-02 <input type="checkbox"/> <input type="checkbox"/> (35)									
Infant Care									
36. Is or will the child live with the birth mother? Yes-01, No-02 <input type="checkbox"/> <input type="checkbox"/> (36)									
<i>If the answer to question 36 is No, do not answer the remaining questions</i>									
37. Infant's RID number. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (37)									
(12-digit identification number) If no number, enter zeros									
38. Does the infant have a primary medical provider? Yes-01, No-02 <input type="checkbox"/> <input type="checkbox"/> (38)									
39. Was the first check-up completed or has an appointment been scheduled? Yes-01, No-02 <input type="checkbox"/> <input type="checkbox"/> (39)									
40. Have immunizations started? NA-00, Yes-01, No-02 <input type="checkbox"/> <input type="checkbox"/> (40)									
41. Is the infant enrolled or planning to enroll in WIC? Yes-01, No-02, NA-99 <input type="checkbox"/> <input type="checkbox"/> (41)									
42. Was the infant breastfeeding at the time of hospital discharge? Yes-01, No-02 <input type="checkbox"/> <input type="checkbox"/> (42)									
42a. Is infant being placed on its back to sleep? Yes-01, No-02 <input type="checkbox"/> <input type="checkbox"/> (42a)									
43. Is there any evidence of developmental delays? Yes-01, No-02, Unknown-99 <input type="checkbox"/> <input type="checkbox"/> (43)									
43a. If yes or unknown, was a referral made to the medical provider and to the First Steps Agency? <input type="checkbox"/> <input type="checkbox"/> (43a)									
Yes-01, No-02, NA-00 (also refer to First Steps for certain prenatal conditions, see guidelines)									