NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

Prenatal Plus Program
Care Coordinator Checklist

First month of enrollment:

1. Complete the Prenatal Plus Program Intake Assessment Packet [(1) Intake Assessment, (2) Resources List, and (3) EPDS]:
   a. Patient sign and date.
   b. Care coordinator sign and date.
   c. Clinician sign and date.
   d. Send copy of completed Prenatal Plus Intake Packet to patient's MCO:
      - Nebraska Total Care email address: cmcoordinators@nebraskatotalcare.com
      - Molina Healthcare email address: ne_cm@molinahealthcare.com
      - United Healthcare email address: ne_uhcmltc_ppp@uhc.com
   e. Submit claim to patient's MCO with CPT code 96160 and HCPCS code H1002 when the Prenatal Plus Intake Packet is completed.

2. Prepare an individualized Care Plan with the patient based on the patient's needs.

3. Connect with the patient's MCO Care & Case management nurse for collaboration and assistance with providing for the patient's clinical and non-clinical needs.

4. Refer the patient to DHHS MIECHV Home Visiting program if applicable.
   See link for local contact information: https://dhhs.ne.gov/Pages/MIECHV-Programs.aspx

5. Nutrition counseling:
   a. Referral to Licensed Medical Nutrition Therapist as needed:
      - Provider's name:_____
      - Date of scheduled appointment:_____
      - Transportation arranged:_____
      - Telehealth arranged:_____
   b. Patient's goals:

   c. Action steps:

   d. Follow up scheduled for:_____(date)

6. Psychosocial counseling and supports:
   a. Referral to licensed Mental Health provider as needed:
      - Provider's name:_____
      - Date of scheduled appointment:_____
      - Transportation arranged:_____
      - Telehealth arranged:_____

b. Patient's goals:

c. Action steps:

d. Follow up scheduled for:_____(date)

7. Breastfeeding support:
   a. Referral to breastfeeding education class, for example, the Breastfeeding Instruction Session as needed:
      - Location of the class:_____
      - Date of scheduled class:_____
      - Transportation arranged:_____
      - Telehealth arranged:_____

   b. Patient's goals:

   c. Action steps:

8. General patient education and health promotion:
   a. Provide education from the Prenatal Plus Program Education and Health Promotion List:
      - Initial and enter the date the education was provided.

   b. Patient's goals:

   c. Action steps:

9. Targeted Case Management:
   a. Provide additional resources and schedule referrals based on patient's needs.
   b. Engage family members, clinicians or other entities as indicated.
   c. Check for and remove barriers to ongoing care.
   d. Arrange for follow up visits.
   e. Other activities:

Subsequent encounters

1. Nutrition counseling:
   a. Referral to Licensed Medical Nutrition Therapist as needed:
      - Provider's name:_____
      - Date of scheduled appointment:_____
      - Session number ___ of five sessions, on _____ (date)
      - Transportation arranged:_____
      - Telehealth arranged:_____

   b. Patient's goals:

   c. Action steps:

2. Psychosocial counseling and supports:
   a. Referral to licensed Mental Health provider as needed:
      - Provider's name:_____
      - Date of scheduled appointment:_____
      - Transportation arranged:_____
      - Telehealth arranged:_____

   b. Patient's goals:

   c. Action steps:

   d. Follow up scheduled for:_____(date)

3. Breastfeeding support:
   a. Referral to breastfeeding education class, for example, the Breastfeeding Instruction Session as needed:
      - Location of the class:_____
      - Date of scheduled class:_____
      - Transportation arranged:_____
      - Telehealth arranged:_____

   b. Patient's goals:

   c. Action steps:

4. General patient education and health promotion:
   a. Provide education from the Prenatal Plus Program Education and Health Promotion List:
      - Initial and enter the date the education was provided.
   b. Patient's goals:
   c. Action steps:

5. Targeted Case Management:
   a. Provide additional resources and schedule referrals based on patient's needs.
   b. Engage family members, clinicians or other entities as indicated.
   c. Check for and remove barriers to ongoing care.
   d. Arrange for follow up visits.
   e. Other activities:
   f. Revision to the Care Plan:
   g. Monitor that action steps are completed.