New York State Department of Health Office of Quality and Patient Safety
Medicaid Perinatal Care Quality Improvement Initiative

Practice name	*Pre-populated*
ZIP + 4	*Pre-populated*

Before entering individual-level data, please answer three practice-level questions. These questions will not be repeated as you complete the individual patient medical record reviews.

Practice Type

FQHC
Hospital Clinic
Perinatal Regional Referral Center
Independent Practice
Other

Prenatal Care Standards

Yes, No

Are clinicians in the practice familiar with the 2009 NYSDOH Medicaid Prenatal Care Standards? The Standards are available at www.health.ny.gov/health_care/medicaid/standards/prenatal_care/

Care Management Referral

Yes, No

Does the practice have criteria to identify patients with medical and social risk factors for referral to Health Plan OB Care Management programs?

New York State Department of Health – Office of Quality and Patient Safety
Medicaid Perinatal Care Quality Improvement Initiative

Practice Demographics

Provider type: *Family Medicine, OB-GYN, MFM, Other, Multiple provider types*

Reviewer:

Job Title:

Phone: Extension:

Did patient transfer into practice/provider's practice? *Yes, No*

Did patient transfer out of practice/provider's practice? *Yes, No*

Patient Demographics

Patient name: *Pre-populated* Medicaid ID: *Pre-populated*

DOB: Mother: *Pre-populated* DOB: Infant: *Pre-populated*

Primary language: *English, Spanish, Other, Unknown*

Translation services: *Yes, No, Refused, Unknown, No Language Barrier*

Trimester entered practice: *First, Second, Third, Not a patient at this practice*

Gestational age when entered practice: Weeks Days

Number of prenatal visits

Section A – NY Medicaid Standards. Providers/Specialists/Consultations

Were any pre-existing conditions identified? *Yes, No*

	Identified	Addressed	Referral/ Consultation	Referral Type
Diabetes	*Yes, No*	*Yes, No*	*Yes, No*	*MFM, Other specialist, Multiple specialists, Ancillary provider, Both specialist/ancillary provider*
Chronic Hypertension	*Yes, No*	*Yes, No*	*Yes, No*	*MFM, Other specialist, Multiple specialists, Ancillary provider, Both specialist/ancillary provider*
Mental health diagnosis	*Yes, No*	*Yes, No*	*Yes, No*	*MFM, BH specialist, Multiple specialists, Ancillary provider, Both specialist/ancillary provider*
Asthma/other pulmonary	*Yes, No*	*Yes, No*	*Yes, No*	*MFM, Other specialist, Multiple specialists, Ancillary provider, Both specialist/ancillary provider*
Other condition	*Yes, No*	*Yes, No*	*Yes, No*	*MFM, Other specialist, Multiple specialists, Ancillary provider, Both specialist/ancillary provider*
Specify other condition				

Were any index pregnancy-related conditions identified? *Yes, No*

	Identified	Addressed	Referral/ Consultation	Referral Type
Gestational diabetes	*Yes, No*	*Yes, No*	*Yes, No*	*MFM, Other specialist, Multiple specialists, Ancillary provider, Both specialist/ancillary provider*
Gestational hypertension	*Yes, No*	*Yes, No*	*Yes, No*	*MFM, Other specialist, Multiple specialists, Ancillary provider, Both specialist/ancillary provider*

Were any prior poor birth outcomes identified? *Yes, No, NA*

Check all of the following prior poor outcomes:

- ☐ History of gestational DM
- ☐ History of gestational HTN
- ☐ Preeclampsia/eclampsia
- ☐ Delivery by Cesarean section
- ☐ Low birthweight infant
- ☐ Other. Specify:

Was there a history of spontaneous preterm birth? *Yes, No*

If yes, check all index pregnancy interventions:

- ☐ 17 alpha-hydroxyprogesterone caproate
- ☐ Other progestogen formulation
- ☐ Cervical cerclage
- ☐ None of the above – contraindicated
- ☐ None of the above – refused
- ☐ None of the above – or other interventions

Was obstetrical history addressed in practice, patient referred, or consultation obtained?

Addressed in Practice, Referral/Consultation obtained, Both, Neither

New York State Department of Health – Office of Quality and Patient Safety
Medicaid Perinatal Care Quality Improvement Initiative

Section B – NY Medicaid Standards. Access to Care

Intentionally blank. No reporting elements for this section.

Sections C/D – NY Medicaid Standards. Psychosocial Risk Assessment, Screening, Counseling and Referral for Care

	Screened Initial 2 Visits	Screened 3rd Trimester	Risk Identified	Addressed/ Referral/ Consultation	Followed-up
Environmental exposure to tobacco smoke	Yes, No	Yes, No	Yes, No	Yes, No	Yes, No
Alcohol abuse	Yes, No	Yes, No	Yes, No	Yes, No	Yes, No
Substance abuse	Yes, No	Yes, No	Yes, No	Yes, No	Yes, No
Domestic violence	Yes, No	Yes, No	Yes, No	Yes, No	Yes, No
Depression	Yes, No	Yes, No	Yes, No	Yes, No	Yes, No
Tobacco use	Yes, No	Yes, No	Yes, No	Advice to quit, Tailored counseling, Referral, Medication, More than one approach, Not addressed or referred	

Was tobacco use followed-up? Yes, No

Did patient abstain from tobacco use during the last 3 months of pregnancy? Yes, No, UTD

Was a standardized screening tool used for depression assessment? Yes, No, NA

Section E – NY Medicaid Standards. BMI Screening, Counseling and Referral for Care

Pre-pregnancy or Initial Visit BMI category:

Underweight (<18.5),
Healthy weight (18.5-24.9)
Overweight (25.0-29.9)
Obese (30.0-39.9)
Extremely obese (≥40.0)
Unknown

Nutritional counseling provided:

- ☐ BMI-based appropriate weight gain
- ☐ Diet, exercise, lifestyle
- ☐ Not specified
- ☐ Not provided

Nutritional referrals provided:

- Yes, No — Nutritionist/dietician/class
- Yes, No — SNAP/WIC services

Gestational weight gain:

Total gestational weight gain (pounds) as able to ascertain from the medical record:

Was gestational weight gain within the IOM-recommended range according to patient's pre-pregnancy BMI category? Yes, No, UTD

Section F/G – NY Medicaid Standards. Health Education, Development of Care Plan and Care Coordination

Care coordination needs identified (check all):

- ☐ Scheduling with multiple providers
- ☐ Follow-up with missed appointments
- ☐ Transportation
- ☐ Social Services
- ☐ Telephonic outreach/home visits
- ☐ Health education
- ☐ No care coordination needs

Care coordination providers (check all):

- ☐ Prenatal care practice
- ☐ Health plan OB case management
- ☐ Other community/government agency
- ☐ Declined case management/social services
- ☐ No care coordination documented

Was breastfeeding education provided? Yes, No

Section H – NY Medicaid Standards. Prenatal Care Services

Diagnostic testing and screening

Bacteriuria

Urine culture obtained at 12-16 weeks gestation (or first visit if later)

Yes, urine culture obtained at 12-16 weeks gestation
No, but urine culture obtained at < 12 weeks gestation
No, urine culture not obtained

Group B streptococcus

Vaginal/rectal culture obtained at 35-37 weeks gestation — *Yes, No, NA*

HIV

Tested at initial visit — *Yes, No, Declined, NA*

Retested third trimester — *Yes, No, Declined, NA*

Aneuploidy testing

Response	Item
Yes, No, NA	**Screening**. Counseling documented.
Yes, No, Declined, NA	**Screening**. Testing performed.
Yes, No, NA	**Invasive testing.** Counseling documented
Yes, No, Declined, NA	**Invasive testing.** Testing performed.

Immunizations

Response	Item
Positive, Negative, Not Tested	HBsAg test result
Yes, No, Declined, NA	Hepatitis B vaccine administered
Yes, No, Declined, NA	Tdap vaccine administered
Yes, No, Declined, NA	Influenza vaccine administered

Lead exposure assessment

Response	Item
Yes, No	Anticipatory guidance documented
Yes, No	Risk assessed
Yes, No	Risk identified
Yes, No, NA	Blood lead level tested

Dental care

Response	Item
Yes, No	Oral health care needs assessed
Yes, No	Problem identified/without care $\geq$ 6 months
Yes, No	Referred for dental care

Section I – NY Medicaid Standards. Postpartum Services

Response	Item
Yes, No	Postpartum visit documented
Yes, No	Postpartum visit at < 4 weeks following delivery
Yes, No	Postpartum visit at 4-8 weeks following delivery

Postpartum psychosocial risk assessment

	Screened	Risk Identified	Addressed/ Referred
Alcohol abuse	*Yes, No*	*Yes, No*	*Yes, No*
Substance abuse	*Yes, No*	*Yes, No*	*Yes, No*
Domestic violence	*Yes, No*	*Yes, No*	*Yes, No*
Depression	*Yes, No*	*Yes, No*	*Yes, No*
Tobacco use	*Yes, No*	*Yes, No*	*Advice to quit, Tailored counseling, Referral, Medication, More than one approach, Not addressed or referred*

Postpartum counseling and referral

Assessment of family planning needs with provision of advice, services or referral

Yes, No

Postpartum/interconception counseling components provided:

- ☐ Nutrition/activity/weight management
- ☐ Folic acid supplementation
- ☐ Immunizations
- ☐ Chronic condition management
- ☐ Future pregnancy risk
- ☐ None of the above

Postpartum immunizations

	Status Assessed	Vaccine Administered
Influenza	*Yes, No, NA*	*Yes, No, Declined, NA*
HPV	*Yes, No, NA*	*Yes, No, Declined, NA*

Additional Information

Medical documentation

Yes, No Was an updated medical record, including all prenatal laboratory test results, sent to the delivery site prior to delivery?

Yes, No Does the practice use an Electronic Health Record?

Enter any comments which will be helpful in interpreting the information provided.