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

### Practice-level Questions

**Practice Name** *Pre-populated*

**Practice Type**

Check all that apply

| | |
|---|---|
| | Federally Qualified Health Center |
| | Perinatal Regional Referral Center |
| | Hospital Clinic |
| | Independent Practice |
| | Other |

**Prenatal Care Standards** *Yes, No*

Are clinicians in the practice familiar with the 2009 (updated March 2015) NYSDOH Medicaid Prenatal Care Standards? The Standards are available at www.health.ny.gov/health_care/medicaid/standards/prenatal_care/

**Case Management Criteria**

Check all practice triggers for patient referral to Health Plan High-Risk OB Case Management

| | |
|---|---|
| | Assistance scheduling multiple appointments |
| | Follow up for missed appointments |
| | Tobacco cessation services |
| | Alcohol or drug abuse services |
| | Facilitation of referrals |
| | Facilitation of 17 alpha hydroxyprogesterone treatment |
| | Transportation |
| | Home visitation |
| | Practice does not refer patients to Health Plan Case Management |

**Vaccine Administration**

Does the prenatal practice administer vaccinations? *Yes, No*

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

## Practice Demographics

| | |
|---|---|
| Reviewer | |
| Job Title | |
| Phone | |
| Email | |

| | |
|---|---|
| Did patient receive prenatal care at this practice? | *Yes, No* |
| Did patient transfer into practice? | *Yes, No* |
| Did patient transfer out of practice? | *Yes, No* |

Provider Type. Check all that apply.

| | |
|---|---|
| | Family Medicine |
| | Obstetrics and Gynecology |
| | Maternal Fetal Medicine |
| | High-risk OB consultation only |
| | Nurse Practitioner or Midwife |
| | Physician Assistant |

## Patient Demographics

| | |
|---|---|
| Patient Name | *Pre-populated* |
| Mother DOB | *Pre-populated* |
| Infant DOB | *Pre-populated* |
| Medicaid ID | *Pre-populated* |

| Gestational age | Weeks | Days | UTD |
|---|---|---|---|
| When entered prenatal care | | | |
| When entered practice | | | |
| At delivery | | | |

Prenatal visits with this provider

| | |
|---|---|
| Primary Language | *English, Spanish, Other, Unknown* |
| Translation Services | *Yes, No, Refused, Unknown, No Language Barrier* |

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

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

| Pre-existing condition | Identified | Addressed | Referral / Consultation | Referral Type |
|---|---|---|---|---|
| Diabetes | *Yes, No* | *Yes, No* | *Yes, No* | *MFM, Other specialist, Multiple specialists, Ancillary provider, Both* |
| Chronic hypertension | *Yes, No* | *Yes, No* | *Yes, No* | *MFM, Other specialist, Multiple specialists, Ancillary provider, Both* |
| Current asthma | *Yes, No* | *Yes, No* | *Yes, No* | *MFM, Other specialist, Multiple specialists, Ancillary provider, Both* |
| Obesity | *Yes, No* | *Yes, No* | *Yes, No* | *MFM, Other specialist, Multiple specialists, Nutritionist, Both* |
| Other (Specify) | *Yes, No* | *Yes, No* | *Yes, No* | *MFM, Other specialist, Multiple specialists, Ancillary provider, Both* |

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

Behavioral health conditions. Check all that apply.

| | | | |
|---|---|---|---|
| | Depression | | Schizophrenia / other psychosis |
| | Bipolar disorder | | Other BH diagnosis |
| | Anxiety | | |

Consultations / Referrals. Check all that apply.

| | | | |
|---|---|---|---|
| | MFM | | Ancillary provider |
| | Psychiatrist | | None documented |
| | Other BH specialist | | Addressed in practice |

***Index pregnancy-related conditions***

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

| Pregnancy-related condition | Identified | Addressed | Referral / Consultation | Referral Type |
|---|---|---|---|---|
| Gestational diabetes | *Yes, No* | *Yes, No* | *Yes, No* | *MFM, Other specialist, Multiple specialists, Ancillary provider, Both* |
| Gestational hypertension | *Yes, No* | *Yes, No* | *Yes, No* | *MFM, Other specialist, Multiple specialists, Ancillary provider, Both* |

Was short cervical length documented during index pregnancy? *Yes, No*

***Prior pregnancy complications or poor birth outcomes***

Was index pregnancy the patient's first pregnancy? *Yes, No*

Did patient have a prior birth? *Yes, No*

Months between birth immediately prior to index delivery, and index delivery: *< 18 months, 18-23 months, 24-35 months, 36-60 months, > 60 months, Unknown*

Were any prior pregnancy complications or poor birth outcomes identified? *Yes, No*

| | | | |
|---|---|---|---|
| | History of gestational diabetes | | IUGR and / or SGA |
| | History of gestational hypertension | | Low birthweight infant |
| | Preeclampsia / eclampsia | | History of preterm birth |
| | Other poor birth outcome (Specify) | | |

Were any prior deliveries by cesarean section documented? *Yes, No*

***History of preterm birth***

Was any prior preterm birth spontaneous (preceded by labor or PROM)? *Yes, No, UTD*

Given a history of spontaneous preterm birth, check all index pregnancy interventions

| | |
|---|---|
| | 17 alpha hydroxyprogesterone caproate injections |
| | Other progestogen formulation |
| | Cervical cerclage |
| | None of the above |

If no 17P intervention, check all reasons

| | |
|---|---|
| | Late presentation for care |
| | Multiple gestation |
| | Medical condition/contraindication |
| | Patient refusal |
| | Difficulty obtaining prior authorization |
| | Other reason (Specify) |

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

*Addressed in practice, Referral / consultation obtained, Both, Neither, NA*

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

### *Risk assessment*

| Risk Factor | Screened Initial 2 Visits | Rescreened 3rd Trimester | Identified | Addressed / Referral / Consultation | Followed-up |
|---|---|---|---|---|---|
| Environmental tobacco smoke | *Yes, No* | *Yes, No* | *Yes, No* | *Yes, No* | *Yes, No* |
| Alcohol use during pregnancy | *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* |

### *Depression*

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

### *Tobacco use*

*Yes, No, Unknown* Was patient ever a smoker before index pregnancy?

*Yes, No, Unknown* Did patient smoke at any time during index pregnancy?

*Yes, No* Did patient quit smoking during index pregnancy?

*Yes, No, Unknown* Did patient quit smoking on their own during index pregnancy?

*Yes, No* Was identified risk – smoking – reassessed at any time during index pregnancy?

*Yes, No* Was patient rescreened for tobacco use during 3rd trimester?

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

If tobacco use during pregnancy identified, check all interventions documented

| | | | |
|---|---|---|---|
| | Advice to quit | | Referral to NYS Smokers' Quitline |
| | Pregnancy-tailored counseling / materials | | Referral to other cessation program / support group |
| | Pharmacologic cessation adjunct | | No intervention documented |

### *Heroin or other opioid abuse*

Was heroin or other opioid abuse during pregnancy documented?

*Yes heroin abuse, Yes other opioid abuse,*
*Both heroin and other opioid abuse*
*Neither heroin or opioid use*

If heroin or other opioid abuse during pregnancy was documented, select consultations requested / referrals provided

*Pharmacologic treatment*
*Behavioral treatment*
*Both pharmacologic and behavioral treatment*
*Neither pharmacologic nor behavioral treatment*

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

### *Pre-pregnancy BMI*

| | |
|---|---|
| ☐ | BMI Value |
| ☐ | Unable to determine |

Select timeframe

| | |
|---|---|
| ☐ | Pre-pregnancy |
| ☐ | Initial 2 visits |

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 and referral*

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 services |
| *Yes, No* | WIC services |

### *Gestational weight gain*

| | |
|---|---|
| ☐ | Gestational weight gain |

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

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

### *Care coordination*

Care coordination needs identified

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Scheduling with multiple providers | ☐ | Follow up with missed appointments | ☐ | Transportation |
| ☐ | Social services | ☐ | Health education | ☐ | Telephonic outreach |
| ☐ | Home visits | ☐ | Other care coordination needs | ☐ | No care coordination needs |

Care coordination provided by

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Prenatal care practice | ☐ | Community / government agency | ☐ | No care coordination documented |
| ☐ | Health plan OB case management | ☐ | Patient declined | | |

### *Health education*

| | |
|---|---|
| *Yes, No* | Was breastfeeding education provided? |
| *Yes, No* | Was patient asked if would like to become pregnant in the next year? |
| *Yes, No* | Were contraceptive options discussed antenatally? |

# New York State Department of Health – Office of Quality and Patient Safety
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## NY Medicaid Standards Section H – Prenatal Care Services

### *Diagnostic screening and testing*

| | |
|---|---|
| **Bacteruria:** Urine culture at 12-16 weeks gestation | *Yes obtained at 12-16 weeks, No but obtained at < 12 weeks, Not obtained* |
| **Diabetes screening:** Timeframe | *Initial visit, 24-28 weeks gestation, Both initial visit and 24-48 weeks, No screening documented, Screening not indicated* |
| **Group B streptococcus:** Vaginal culture at 35-37 weeks | *Yes at 35-37 weeks gestation, Yes prior to 35 weeks / culture positive, Yes prior to 35 weeks / culture negative / delivered early, No, Not indicated, NA* |

### *Aneuploidy screening and invasive testing*

| | |
|---|---|
| Was discussion / counseling regarding aneuploidy screening and invasive testing documented? | *Yes, No, NA* |
| Was aneuploidy screening performed? | *Yes, No, Declined, NA* |
| Was invasive testing performed? | *Yes, No, Declined, NA* |
| Was patient at high risk for aneuploidy? | *Yes, No* |

### *HIV services*

| | |
|---|---|
| Tested initial visit | *Yes, No, Not Indicated, Declined* |
| Tested third trimester | *Yes, No, Not Indicated, Declined, NA* |

### *Lead exposure*

| | |
|---|---|
| Risk assessed or blood level tested | *Yes, No* |

### *Dental care*

| | |
|---|---|
| Oral health care needs assessed | *Yes, No* |
| Problem identified / no care > 6 months | *Yes, No* |
| Referred for dental care | *Yes, No* |

### *Prenatal immunizations: hepatitis*

| | |
|---|---|
| HBsAg test result | *Positive, Negative, Not tested* |
| Risk factors assessed | *Yes, No* |
| Vaccine administered | *Yes, No, Not Indicated –vaccination current, Not indicated – not at risk, Declined* |

### *Prenatal immunizations: other*

| | |
|---|---|
| Tdap vaccine administered | *Yes, No, Not Indicated, Declined* |
| Influenza vaccine offered | *Offered vaccine, Referred for vaccine, No, Not indicated, NA* |
| Influenza vaccine received | *Yes in office, Yes at referral site, No declined, No other reason, UTD* |

***Aspirin prophylaxis:*** Was low dose aspirin prescribed for preeclampsia risk? *Yes, No, Contraindicated, Not indicated*

## NY Medicaid Standards Section I – Postpartum Services

Was a postpartum visit documented? *Yes, No*

Time from delivery (check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| | < 4 weeks | | 4 – 8 weeks | | > 8 weeks |

### *Postpartum psychosocial risk assessment*

| Risk Factor | 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* | *Yes, No* |

If tobacco use identified, check all interventions documented

| | |
|---|---|
| | Advice to quit |
| | Counseling / literature |
| | Pharmacologic cessation adjunct |
| | Referral to NYS Smokers' Quitline 1-866-697-8487 |
| | Referral to other cessation program / support group |
| | No intervention documented |

### *Family planning needs / contraception*

| | |
|---|---|
| Location contraception received | *Immediately post delivery, Postpartum visit, Offered but declined postpartum, No documentation offered / received contraception* |
| Type of contraception | *Sterilization, LARC, Moderately effective method, None of the above* |

Was patient asked if would like to become pregnant in the next year? *Yes, No*

### *Postpartum / interconception counseling*

Check all components provided

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

### *Postpartum immunizations*

| | |
|---|---|
| Influenza | |
| Status assessed | *Yes, No, NA* |
| Vaccine administered | *Yes, No, Not indicated, Declined* |
| HPV | |
| Status assessed | *Yes, No, NA* |
| Vaccine administered | *Yes, No, Not indicated, Declined* |

Was follow-up arranged for linkage to ongoing care? *Yes, No*

Was diabetes screening addressed at the postpartum visit? *Yes, No, Not indicated*

**Additional information – medical documentation**

| | |
|---|---|
| *Yes, No* | Was an updated medical record, including prenatal laboratory test results, sent to the delivery site prior to delivery? |
| *Yes, No* | Does the practice use an Electronic Health Record? |

**Comments** Please enter any comments which will be helpful in interpreting the information provided.