Table of Contents

Practice-level Questions

[1] Practice name. *Pre-populated.* Clinic, group practice or physician name (if practicing independently) where the patient last received prenatal care prior to delivery. The purpose of this field is to identify the site of medical record abstraction – not provider type. It is assumed if a Physician's Assistant, Nurse Practitioner or Midwife provided prenatal care, they were affiliated with a clinic, group practice or physician.

[2] Practice type. Check all that apply. *Must check at least one.*

- ☐ **[2a] Federally Qualified Health Center (FQHC).** A Federally Qualified Health Center as designated by the Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS).
- ☐ **[2b] Perinatal Regional Referral Center.** A referral center for obstetric and neonatal complications as designated by the NYSDOH Bureau of Women's Health.
- ☐ **[2c] Hospital Clinic.** An obstetrical practice associated with a hospital network of health care, whether located on or off campus.
- ☐ **[2d] Independent Practice.** A provider, or group of providers, not affiliated with a FQHC, hospital network, or Perinatal Regional Center.
- ☐ **[2e] Other.** A practice arrangement not defined by one of the above choices.

[3] NYSDOH Medicaid Prenatal Care Standards. 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/

- **Yes.** Select if practice providers have accessed and are informed regarding the 2009 NYSDOH Medicaid Prenatal Care Standards.
- **No.** Select if practice providers have not yet consulted the Medicaid Prenatal Care Standards.

[4] Case management criteria. Check all practice triggers for patient referral to Health Plan High-Risk OB Case Management.

- ☐ **[4a] Assistance scheduling multiple appointments.** Includes routine prenatal care and/or specialist, mental health, social services and dental care.
- ☐ **[4b] Follow up for missed appointments.** Includes routine prenatal care and/or specialist, mental health, social services and dental appointments.
- ☐ **[4c] Tobacco cessation services.** For referrals to the NYSDOH Smokers' Quit Line, a community-based organization, support group or behavioral therapist.
- ☐ **[4d] Alcohol or drug abuse services.** For assessment and referral to a network inpatient or outpatient treatment center, alcohol abuse counselor, behavioral therapist, social worker or community-based organization.
- ☐ **[4e] Facilitation of referrals.** To support care coordination with specialist or ancillary providers.
- ☐ **[4f] Facilitation of 17 alpha hydroxyprogesterone treatment.** To arrange administration at out-of office locations and support adherence.
- ☐ **[4g] Transportation.** For appointments and needed services.
- ☐ **[4h] Home visitation.** May be indicated for monitoring and management of medical conditions, or health education and preparation for childbirth.
- ☐ **[4i] Practice does not refer patients to Health Plan Case Management.** Check if practice provides case management services, or if patients receive no case management assistance. *If 'Practice does not refer patients to Health Plan Case Management' is selected, any earlier checkboxes selected are cleared and become unavailable for entry.*

Practice-level Questions

[5] Vaccine Administration

Does the prenatal practice administer vaccinations?

- **Yes.** Select if the practice is able to provide immunizations during prenatal visits.
- **No.** Otherwise select 'No.'

Practice Demographics

[6] Reviewer. Enter the name of the staff person completing the medical record abstraction, and who can be contacted regarding clarifications and omissions.

[7] Job title. Enter the job title of the staff person completing the medical record abstraction.

[8] Phone number. Enter the phone number of the staff person completing the medical record review.

[9] Extension. Include telephone extension if applicable.

[10] Email address. Enter the email address of the staff person completing the medical record review.

[11] Did patient receive prenatal care at this practice?

- **Yes.** Select if patient was seen for any prenatal care at this practice.
- **No.** Select if patient was not seen for prenatal care at this practice**. If patient was not seen at this practice, save and exit record and select the next patient on the patient sample list for medical record review.**

[12] Did patient transfer into practice/provider's practice?

- **Yes.** Select if patient transferred to this practice or provider during the course of prenatal care because of referral for specialized care, geographic relocation, or other reason.
- **No.** Select if prenatal care was managed solely by this practice or provider.

[13] Did patient transfer out of practice/provider's practice?

- **Yes.** Patient was attributed to this provider because the provider's billing data accounted for the majority of prenatal care. However, select if patient transferred out of prenatal care prior to delivery.
- **No.** Select if patient remained in prenatal care at this location up until time of delivery.

[14] Provider type. Check all that apply. *Must check at least one.*

- ☐ **[14a] Family Medicine.** Physician providing comprehensive, primary health care to patients of all ages.
- ☐ **[14b] Obstetrics and Gynecology.** Physician specializing in medical/surgical care to women with expertise in pregnancy and childbirth.
- ☐ **[14c] Maternal Fetal Medicine.** Physician specializing in medical/surgical management of high-risk pregnancies.
- ☐ **[14d] High-risk OB consultation only.** Physician not providing primary prenatal care, but only consultative services such as comprehensive ultrasound, chorionic villus sampling, genetic amniocentesis, etc.
- ☐ **[14e] Nurse Practitioner or Midwife.** Check if prenatal care also provided by a nurse practitioner, or nurse or lay midwife.
- ☐ **[14f] Physician Assistant.** Check if prenatal care also provided by a physician assistant.

Patient Demographics

[15] Patient's first name. *Pre-populated.* Patient's first name.

[16] Patient's last name. *Pre-populated.* Patient's last name.

[17] DOB: Mother. *Pre-populated.* Mother's date of birth pre-populated from administrative data submitted to the New York State Department of Health.

[18] DOB: Infant. *Pre-populated.* Infant's date of birth pre-populated from administrative data submitted to the New York State Department of Health.

[19] Medicaid ID. *Pre-populated.* Mother's New York State Medicaid Member Client Identification Number.

[20] Gestational age when entered prenatal care. Select gestational age in weeks and days from the dropdown boxes for each time interval, or check the box labeled Unable to Determine. Refers to the gestational age when patient first entered into care; this may not be the gestational age when presented at the reporting provider's practice. *If 'Unable to determine' is selected, the fields Weeks and Days will be unavailable for entry.*

- ☐ **[20a] Gestational age when entered prenatal care. Weeks.**
- ☐ **[20b] Gestational age when entered prenatal care. Days.**
- ☐ **[20c] Gestational age when entered prenatal care. Unable to Determine.**

[21] Gestational age when entered practice. Select gestational age in weeks and days from the dropdown boxes for each time interval, or check the box labeled Unable to Determine. Refers to the gestational age when patient first presented at reporting provider's practice; patient may have transferred into practice. NOTE: If patient was routinely seen at the practice prior to the index pregnancy, please enter '0' for weeks and days. *If 'Unable to determine' is selected, the fields Weeks and Days will be unavailable for entry.*

- ☐ **[21a] Gestational age when entered practice. Weeks.**
- ☐ **[21b] Gestational age when entered practice. Days.**
- ☐ **[21c] Gestational age when entered practice. Unable to Determine.**

[22] Gestational age at delivery. Select gestational age in weeks and days from the dropdown boxes for each time interval, or check the box Unable to Determine. *If 'Unable to determine' is selected, the fields Weeks and Days will be unavailable for entry.*

- ☐ **[22a] Gestational age at delivery. Weeks.**
- ☐ **[22b] Gestational age at delivery. Days.**
- ☐ **[22c] Gestational age at delivery. Unable to Determine.**

[23] Number of prenatal visits. Enter the total number of visits to this provider for the purpose of prenatal care. Do not include an ultrasound visit if not seen by the prenatal provider, and do not include postpartum visits in this count.

[24] Primary language. Select patient's primary language, as documented in the medical record.

- **English**
- **Spanish**
- **Other**
- **Unknown.** Select if patient's primary language is not documented.

[25] Translation service. Were either face-to-face or telephonic translation services provided, as documented in the medical record? Translators/interpreters may include a staff person but not a family member.

- **Yes.** Select if translation services were provided at any visit.

- **No.** Select if language barrier is documented, but an interpreter is not available for any of the visits.
- **Refused.** Select if translation services warranted, but patient refused in favor of having a family member/friend present.
- **No language barrier**. Select if patient and provider speak the same primary language, or do not speak the same primary language but either is bilingual and a translator is not needed.
- **Unknown.** Select if use of translator is not documented.

[26] Were any pre-existing medical conditions identified?

Index pregnancy refers to the pregnancy identified for this review.

- **Yes.** Select if any of the following conditions identified during the index pregnancy will be selected.
- **No.** Select if no pre-existing conditions were identified during the index pregnancy. *If 'No' is selected, all fields regarding pre-existing conditions will be unavailable for entry.*

[27} Diabetes

[27a] Identified

- **Yes.** Select if patient diagnosed with diabetes requiring treatment before this pregnancy.
- **No.** Select if documentation indicates patient does not have diabetes, or there is no documentation regarding diabetes. *If 'No' is selected, the following 3 fields will be unavailable for entry.*

[27b] Addressed in Practice

- **Yes.** Select if provider addressed diabetes in practice, e.g., monitored glucose levels, offered counseling on diet and exercise, and/or prescribed oral agents or insulin.
- **No.** Select if there is no documentation indicating prenatal care provider addressed diabetes.

[27c] Referral/Consultation

- **Yes.** Select if patient was referred to an endocrinologist, maternal fetal medicine (MFM) specialist or other specialist for further evaluation or care, or documentation indicates under the care of a second provider for this problem. Select if referred to a diabetes educator or nutritionist.
- **No.** Select if there is no documentation of referral or care rendered by a second provider. *If 'No' is selected, the following field will be unavailable for entry.*

[27d] Referral type

- **MFM.** Maternal fetal medical specialist.
- **Other medical specialist.** For example, endocrinologist.
- **Multiple specialists.** Select if patient referred to more than one specialist.
- **Ancillary provider.** For example, diabetes educator or nutritionist.
- **Both medical specialist and ancillary provider.**

[28] Chronic hypertension

[28a] Identified

- **Yes.** Select if patient diagnosed with hypertension pre-pregnancy or early in index pregnancy (before 20 weeks gestation). Hypertension is defined as diastolic blood pressure of $\geq$ 90 mmHg OR systolic blood pressure of $\geq$ 140 mmHg OR both.
- **No.** Select if documentation indicates patient did not have pre-existing hypertension, or there is no documentation regarding hypertension. *If 'No' is selected, the following 3 fields will be unavailable for entry.*

[28b] Addressed in Practice

- **Yes.** Select if provider addressed hypertension in practice, e.g., monitored blood pressure, increased visit frequency, initiated home monitoring, provided lifestyle counseling and/or prescribed anti-hypertensive medication.
- **No.** Select if there is no documentation indicating prenatal care provider addressed hypertension.

[28c] Referral/Consultation

- **Yes.** Select if patient was referred to an internist, cardiologist, nephrologist, MFM or other specialist for further evaluation or care, or documentation indicates under the care of a second provider for this problem.
- **No.** Select if there is no documentation of referral or care rendered by a second provider. *If 'No' is selected, the following field will be unavailable for entry.*

[28d] Referral type

- **MFM.** Maternal fetal medical specialist.
- **Other medical specialist.** For example, internist, cardiologist, nephrologist.
- **Multiple specialists.** Select if patient referred to more than one specialist.
- **Ancillary provider.** For example, nutritionist.
- **Both medical specialist and ancillary provider.**

[29] Current asthma

[29a] Identified

- **Yes.** Select if patient reported an episode of asthma or asthma attack within the 12 months prior to pregnancy. Select if asthma required the patient to limit activity or seek medical care within the 12 months prior to pregnancy. Select if patient reported mild, moderate, or severe symptoms, such as wheezing or shortness of breath, during the year prior to index pregnancy. Select if patient was taking medication for asthma in the year prior to or during index pregnancy.
- **No.** Select if documentation indicates patient did not have asthma, or had a history of asthma without recent symptoms. *If 'No' is selected, the following 3 fields will be unavailable for entry.*

[29b] Addressed in Practice

- **Yes.** Select if provider addressed in practice, for example, monitored asthma severity at prenatal care visits, adjusted medication or offered counseling such as limiting exposure to triggers and seeking treatment for illness known to exacerbate asthma.
- **No.** Select if there is no documentation indicating prenatal care provider addressed pulmonary disease.

[29c] Referral/Consultation

- **Yes.** Select if patient was referred to a pulmonologist, allergist, MFM or other specialist, or documentation indicates under the care of a second provider for this problem. Select if referred to an augmented services provider such as an asthma educator.
- **No.** Select if there is no documentation of referral or care rendered by a second provider. *If 'No' is selected, the following field will be unavailable for entry.*

[29d] Referral type

- **MFM.** Maternal fetal medical specialist.
- **Other medical specialist.** For example, pulmonologist or allergist.
- **Multiple specialists.** Select if patient referred to more than one specialist.
- **Ancillary provider.** For example, asthma educator or respiratory therapist.
- **Both medical specialist and ancillary provider.**

[30] Obesity

[30a] Identified

- **Yes.** Select if obesity is specifically noted as a problem, or BMI prior to index pregnancy was $\geq$ 30.00.
- **No.** Select if obesity is not identified, or BMI prior to index pregnancy was < 30.00. *If 'No' is selected, the following 3 fields will be unavailable for entry.*

[30b] Addressed in practice

- **Yes**. Select if provider noted discussion of lifestyle modification in areas of diet, physical activity, and behavioral strategies (e.g., goal setting and record keeping).
- **No.** Select if there is no documentation indicating the prenatal care practice (physician or auxiliary provider) addressed weight management.

[30c] Referral / Consultation

- **Yes.** Select if patient was referred to an endocrinologist, maternal fetal medicine (MFM) specialist or other specialist for further evaluation or care, or documentation indicates under the care of a second provider for this problem. Select if referred to a nutritionist, registered dietician, behavioral therapist or support group.
- **No.** Select if there is no documentation of referral or care rendered by a second provider. *If 'No' is selected, the following field will be unavailable for entry.*

[30d] Referral type

- **MFM.** Maternal fetal medical specialist.
- **Other medical specialist.** For example, endocrinologist, internist or behavioral therapist.
- **Multiple specialists.** Select if patient referred to more than one specialist.
- **Nutritionist**. Select if patient referred to a nutritionist, or classes / support group facilitated by a nutritionist.
- **Both medical specialist and nutritionist.**

[31] Other condition

[31a] Identified

- **Yes.** Select if chronic conditions not specified above are present **and** enter diagnosis/diagnoses on the following line. Comorbid conditions might include heart disease, thromboembolic disorders, hepatitis/liver disease, renal disease, neurologic disorders/epilepsy, autoimmune disorders, thyroid disorders, adrenal insufficiency, hemoglobinopathies, anemia, malignancy or HIV. May select for positive PPD.
- **No.** Select if documentation indicates patient had no co-morbidities, or there is no documentation regarding other chronic conditions. *If 'No' is selected, the following 3 fields, and notes field '**Specify other condition**,' will be unavailable for entry.*

[31b] Addressed in Practice

- **Yes.** Select if at least one chronic condition was managed by the prenatal care provider.
- **No.** Select if there is no documentation indicating prenatal care provider addressed other chronic conditions.

[31c] Referral/Consultation

- **Yes.** Select if patient was referred to a specialist for the chronic condition, or documentation indicates under the care of a second provider for this problem.
- **No.** Select if there is no documentation of referral or care rendered by a second provider. *If 'No' is selected, the following field will be unavailable for entry.*

[31d] Referral type

- **MFM.** Maternal fetal medical specialist.
- **Other medical specialist.** For example, hematologist, gastroenterologist, neurologist, infectious disease specialist.
- **Multiple specialists.** Select if patient referred to more than one specialist.
- **Ancillary provider.** For example, nutritionist.
- **Both medical specialist and ancillary provider.**

[32] Specify other condition. Enter conditions other than those listed above.

[33] Were any pre-existing behavioral health conditions identified?

- **Yes.** Select if patient had an active mental health/behavioral health diagnosis when presented for prenatal care. Diagnoses may include mood disorder (depression, bipolar disorder), thought disorder (schizophrenia), anxiety or eating disorder.
- **No.** Select if documentation indicates patient did not have a mental health diagnosis, or there is no documentation regarding mental illness. *If 'No' is selected, the following 2 checkbox groups will be unavailable for entry.*

[34] Behavioral health conditions. Check all that apply.

- ☐ **[34a] Depression.** Check if clinical depression was identified, patient diagnosed and/or being treated, when presented for prenatal care.
- ☐ **[34b] Bipolar disorder.** Check if patient was diagnosed and/or being treated with mood stabilizers when presented for prenatal care.
- ☐ **[34c] Anxiety.** Check if anxiety was identified, patient diagnosed and/or being treated when initiated prenatal care.
- ☐ **[34d] Schizophrenia / other psychosis.** Check if thought disorder was identified, patient diagnosed and/or being treated for a condition such as schizophrenia, when started prenatal care.
- ☐ **[34e] Other.** May include Attention Deficit Hyperactivity Disorder or an eating disorder, for example.

[35] Consultations / Referrals. Check all that apply.

- ☐ **[35a] MFM.** Check if Maternal Fetal Medicine consultation requested or referral provided regarding the patient's treatment for a mental health condition during pregnancy.
- ☐ **[35b] Psychiatrist.** Check if consultation obtained / referral provided for prescription of mental health treatment during pregnancy.
- ☐ **[35c] Other behavioral health specialist.** Check if referred to a psychologist, therapist/counselor, social worker – or documentation indicates under the care of a non-physician provider for this problem. Select if admitted to an inpatient or outpatient treatment program.
- ☐ **[35d] Ancillary provider.** May include home visitation, support group or community-based program.
- ☐ **[35e] None documented.** Check if there is no documentation of referral or care rendered by a second provider.
- ☐ **[35f] Addressed in practice.** Check if prenatal provider also provided pharmacologic or supportive therapy for a mental health condition.

[36] Were any index pregnancy-related conditions identified?

Index pregnancy refers to the pregnancy identified for this review.

- **Yes.** Select if either of the following pregnancy-related conditions will be selected.
- **No.** Select if neither pregnancy-related condition was identified during the index pregnancy. *If 'No' is selected, all fields regarding pregnancy-related conditions will be unavailable for entry.*

[37] Gestational diabetes

Index pregnancy refers to the pregnancy identified for this review.

[37a] Identified

- **Yes.** Select if patient diagnosed with gestational diabetes during index pregnancy. ACOG August 2013 Practice Bulletin 137 *Gestational Diabetes* recommends the selection of one of two sets of diagnostic criteria based on the three-hour OGTT: Carpenter and Coustan or the National Diabetes Data Group.
- **No.** Select if there was no documentation of diabetes, glucose intolerance, or abnormal glucose challenge results. *If 'No' is selected, the following 3 fields will be unavailable for entry.*

[37b] Addressed in Practice

- **Yes.** Select if provider addressed gestational diabetes in practice, e.g., monitored glucose levels, offered counseling on diet and exercise, and/or prescribed oral agents or insulin.
- **No.** Select if there is no documentation indicating prenatal care provider addressed gestational diabetes.

[37c] Referral/Consultation

- **Yes.** Select if patient was referred to an endocrinologist, maternal fetal medicine (MFM) specialist or other specialist for further evaluation or care, or documentation indicates under the care of a second provider for this problem. Select if referred to a diabetes educator or nutritionist.
- **No.** Select if there is no documentation of referral or care rendered by a second provider. *If 'No' is selected, the following field will be unavailable for entry.*

[37d] Referral type

- **MFM.** Maternal fetal medical specialist.
- **Other medical specialist.** For example, endocrinologist.
- **Multiple specialists.** Select if patient referred to more than one specialist.
- **Ancillary provider.** May include nutritionist or diabetes educator.
- **Both medical specialist and ancillary provider.**

[38] Gestational hypertension

Index pregnancy refers to the pregnancy identified for this review.

[38a] Identified

- **Yes.** Select if hypertension diagnosed during index pregnancy ($\geq$ 140/90 at or after 20 weeks gestation in a woman with no history of chronic – preexisting – hypertension).
- **No.** Select if there was no documentation of gestational hypertension during index pregnancy. *If 'No' is selected, the following 3 fields will be unavailable for entry.*

[38b] Addressed in Practice

- **Yes.** Select if provider addressed gestational hypertension in practice, e.g., increased visit frequency, increased monitoring, initiated home monitoring, provided lifestyle counseling and/or prescribed anti-hypertensive medication.
- **No.** Select if there is no documentation indicating prenatal care provider addressed gestational hypertension.

[38c] Referral/Consultation

- **Yes.** Select if patient was referred to a MFM or other specialist for further evaluation or care, or documentation indicates under the care of a second provider for this problem.
- **No.** Select if there is no documentation of referral or care rendered by a second provider. *If 'No' is selected, the following field will be unavailable for entry.*

[38d] Referral type

- **MFM.** Maternal fetal medical specialist.
- **Other medical specialist.** For example, internist, cardiologist, nephrologist.
- **Multiple specialists.** Select if patient referred to more than one specialist.
- **Ancillary provider.** For example, nutritionist.
- **Both medical specialist and ancillary provider.**

---

[39] Was short cervical length documented during index pregnancy?

Index pregnancy refers to the pregnancy identified for this review.

- **Yes.** Select if cervical length < 25 mm, before 24 weeks gestation, was measured by transvaginal ultrasonography, and noted by provider.
- **No.** Select if short cervical length is not noted during index pregnancy.

[40] Was index pregnancy the patient's first pregnancy?

Index pregnancy refers to the pregnancy identified for this review.

- **Yes.** Select if the patient's first pregnancy is being reviewed. *If 'Yes' is selected, the remaining fields in Section A will be unavailable for entry.*
- **No.** Select if the patient has had prior pregnancies.

[41] Did patient have a prior birth?

- **Yes.** Select if patient delivered at least one birth prior to index pregnancy.
- **No.** Select if patient had not delivered prior to index pregnancy. *If 'No' is selected, the following field will be unavailable for entry.*

[42] Months between birth immediately prior to index delivery, and index delivery

- **< 18 months.** Select if birth interval was less than 18 months.
- **18-23 months.** Select if birth interval was between 18 and 23 months (including partial months).
- **24-35 months.** Select if birth interval was between 24 and 35 months (including partial months).
- **36-60 months.** Select if birth interval was between 36 and 60 months (including partial months).
- **> 60 months.** Select if birth interval was greater than 60 months.
- **Unknown.** Select if date of delivery immediately prior to index delivery unknown.

[43] Were any prior pregnancy complications or poor birth outcomes identified?

- **Yes.** Select if any of the following prior pregnancy complications or poor birth outcomes will be selected.
- **No.** Select if no prior pregnancy complications or poor birth outcomes were identified. *If 'No' is selected, the following checkbox group, and notes field '**Specify other outcome**,' will be unavailable for entry.*

[44] Check all of the following prior pregnancy complications or poor birth outcomes identified.

- ☐ **[44a] History of gestational diabetes.** Check if gestational diabetes in a prior pregnancy is noted.
- ☐ **[44b] History of gestational hypertension.** Check if pregnancy-related hypertension in a prior pregnancy is noted – new hypertension at or after 20 weeks gestation without proteinuria or other features of preeclampsia. May be noted as gestational hypertension (current terminology) or pregnancy-induced hypertension (replaced terminology).
- ☐ **[44c] Preeclampsia/eclampsia.** Check if pre-eclampsia or eclampsia in a prior pregnancy is noted.
- ☐ **[44d] Intrauterine growth restriction and / or small for gestational age.** Check if documentation notes prior intrauterine growth restriction (IUGR), or fetal growth restriction (FGR). Check if newborn was noted to be small for gestational age (SGA).
- ☐ **[44e] Low birth-weight infant.** Check if any prior pregnancies resulted in a live infant weighing less than 2500 grams (5 pounds, 8 ounces) regardless of gestational age.
- ☐ **[44f] History of preterm birth.** Select if any prior births at gestational age < 37 completed weeks are documented. Preterm births may be identified from the format G_ P _ _ _ _ with four entries for Para indicating the number of full-term births, preterm births, abortions and living children. Select Other prior pregnancy complication or poor birth

outcome for spontaneous abortion. *If 'History of preterm birth' is NOT selected, the field '**Was any prior preterm birth spontaneous?**,' the checkbox group '**Given a history of spontaneous preterm birth, check all index pregnancy interventions,**' the checkbox group "**If no 17 alpha hydroxyprogesterone intervention, check all reasons,**' and the field '**Specify other reasons**' will be unavailable for entry.*

☐ **[44g] Other prior pregnancy complications or poor birth outcomes.** Check if patient has a history of other pregnancy complications or poor birth outcomes not specified above **and** enter complication/outcome on the following line. Other complications/outcomes might include HELLP syndrome (hemolysis, elevated liver enzymes, low platelet counts), placenta previa, abruptio placenta, intrauterine fetal demise (IUFD) and prior infant with birth defect. May select for spontaneous abortion. *If '**Other prior pregnancy complications or poor birth outcomes**' is NOT selected, the following the following notes field will be unavailable for entry.*

[45] Specify other outcome. Enter complications or poor outcomes other than those listed above.

[46] Were any prior deliveries by cesarean section documented?

- **Yes.** Select if documentation includes prior delivery by C-section.
- **No.** Otherwise select No.

[47] Was any prior preterm birth spontaneous (preceded by labor or premature rupture of membranes)?

- **Yes.** Select if a prior preterm birth was *not* the result of labor induction or cesarean section.
- **No.** Select if preterm delivery was the result of intervention (induction, cesarean section) medically indicated due to complications putting the mother or fetus at risk (e.g. preeclampsia, intrauterine growth restriction, placental abruption, nonreassuring fetal status).
- **Unable to determine.** Select if unable to determine from documentation whether prior preterm birth was spontaneous or the result of medical intervention. *If 'No' or 'Unable to determine' is selected, the following 2 checkbox groups will be unavailable for entry.*

[48] Given a history of spontaneous preterm birth, check all index pregnancy interventions.

☐ **[48a] 17 alpha-hydroxyprogesterone caproate injections.** May also be documented as 17OHPC, 17OHP, 17P, 17α-OH progesterone, 17 alpha-hydroxyprogesterone, 17 hydroxyprogesterone, or brand name Makena™. Check if medication was prescribed, regardless of the number of weekly injections the patient received. *If '17 alpha-hydroxyprogesterone caproate injections' is selected, the following checkbox group will be unavailable for entry.*

☐ **[48b] Other progestogen formulations.** Check if vaginal suppositories, gels or capsules, or oral progesterone prescribed. Select if medication was prescribed, regardless of the number of doses the patient received.

☐ **[48c] Cervical cerclage.** Check if surgical treatment for incompetent cervix was documented.

☐ **[48d] None of the above.** Check if no hormone therapy or surgical interventions were documented. *If 'None of the above' is selected, any earlier checkboxes selected are cleared and become unavailable for entry.*

[49] If no 17 alpha hydroxyprogesterone intervention, check all reasons.

☐ **[49a] Late presentation for care.** Select if patient presented for prenatal care with gestational age greater than practice protocol for **17 alpha-hydroxyprogesterone caproate** treatment initiation.

☐ **[49b] Multiple gestation.** Select if two or more fetuses were detected during index pregnancy.

☐ **[49c] Medical condition/contraindication.** Select if patient had a medical or other condition which contraindicated administration, e.g., thromboembolic disorder.

☐ **[49d] Patient refusal.** Select if patient refused or would not be adherent with 17 alpha hydroxyprogesterone treatment.

- ☐ **[49e] Difficulty obtaining prior authorization.** Select if practice encountered barriers to timely authorization by managed care organization. Please describe difficulty in free-text box labeled 'Specify other reason.'
- ☐ **[49f] Other reason.** Select if reason not prescribed or initiated is not listed, for example, patient inability to attend clinic weekly due to child care or transportation issues. *If '**Other reason**' is NOT selected, the following the following notes field will be unavailable for entry.*

[50] Specify other reason. Describe any other reason 17 alpha hydroxyprogesterone was not prescribed.

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

- **Addressed in Practice.** Select if, for example, counseling was provided regarding signs/symptoms of pre-term labor and risk reduction. Select if administered aspirin prophylaxis or 17-OH progesterone. Select if long-term medications (e.g., antidepressants) were reviewed, changed or discontinued.
- **Referral/Consultation Obtained.** Select if patient was referred to a maternal-fetal medicine specialist, or documentation indicates under the care of a second provider.
- **Both.** Select if documentation indicates obstetrical history was addressed in practice *and* referrals were made or consultation was obtained. Select if documentation indicates under the care of a second provider.
- **Neither.** Select if documentation shows no evidence of referral, consultation or that obstetrical history was addressed in practice.
- **NA.** Select if no obstetric risk was identified.

Intentionally blank. No reporting elements for this section.

General risk assessment

[52] Environmental exposure to tobacco smoke

[52a] Screened Initial 2 Visits

- **Yes.** Select if patient asked about exposure to second-hand smoke at home, work or socially. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding second-hand smoke.

[52b] Rescreened 3rd Trimester

- **Yes.** Select if repeat assessment occurred during prenatal care; not at hospital admission for labor and delivery. Select if patient asked again about exposure to second-hand smoke. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding second-hand smoke. Select if initial visits occur in the 3rd trimester**.** *If 'No' is selected for both screenings, the following 3 fields will be unavailable for entry.*

[52c] Risk Identified

- **Yes.** Select if documented in the visit notes, or checked as a problem on a general risk assessment checklist.
- **No.** Otherwise select 'No.' *If 'No' is selected, the following 2 fields will be unavailable for entry.*

[52d] Addressed/Referred/Consultation Obtained

- **Yes.** Select if provided information/advised to limit exposure to environmental tobacco smoke. Referral or consultation is not applicable to this risk factor.
- **No.** Otherwise select 'No.'

[52e] Followed up

- **Yes.** Select if documentation includes notation regarding re-assessment of problem, status of problem, or other discussion with patient.
- **No.** Otherwise select 'No.'

[53] Alcohol use during pregnancy

[53a] Screened Initial 2 Visits

- **Yes.** Select if patient asked about past/present use of alcohol. Assessment may or may not include use of a standardized screening tool such as the CAGE, T-ACE, FAST or AUDIT Tests. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding alcohol use in the initial 2 visits.

[53b] Rescreened 3rd Trimester

- **Yes.** Select if repeat assessment occurred during prenatal care; not at hospital admission for labor and delivery. Select if patient asked again about alcohol use or administered a standardized screening tool. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding alcohol use in the 3rd trimester. Select if initial visits occur in the 3rd trimester. *If 'No' is selected for both screenings, the following 3 fields will be unavailable for entry.*

[53c] Risk Identified

- **Yes.** Select if a risk for alcohol use is documented as the result of a screening tool, checked as a problem on a general risk assessment checklist or included in visit notes.
- **No.** Otherwise select 'No.' *If 'No' is selected, the following 2 fields will be unavailable for entry.*

[53d] Addressed/Referred/Consultation Obtained

- **Yes.** Select if advised to quit or provided counseling or literature. Referral or request for consultation may be made to inpatient or outpatient treatment center, alcohol abuse counselor, behavioral therapist, social worker or community-based organization. Select if documentation contains consultation notes, review of consultation notes, or indicates patient was under the care of a second provider or attending a community-based organization.
- **No.** Otherwise select 'No.'

[53e] Followed up

- **Yes.** Select if documentation includes notation regarding re-assessment of problem, status of problem, or other discussion with patient or second provider.
- **No.** Otherwise select 'No.'

[54] Substance abuse

[54a] Screened Initial 2 Visits

- **Yes.** Select if patient asked about past/present use of illegal drugs and/or prescription medication not prescribed for them. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding substance abuse.

[54b] Rescreened 3rd Trimester

- **Yes.** Select if repeat assessment occurred during prenatal care; not at hospital admission for labor and delivery. Select if patient asked again about abuse of illegal drugs and and/or prescription medication. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding substance use in the 3rd trimester. Select if initial visits occur in the 3rd trimester. *If 'No' is selected for both screenings, the following 3 fields will be unavailable for entry.*

[54c] Risk Identified

- **Yes.** Select if use checked as a problem on a general risk assessment checklist or documented in the visit notes. Documentation may state abuses recreational drugs or prescription medication, or note specific drugs such as marijuana, cocaine, heroin, methamphetamine.
- **No.** Otherwise select 'No.' *If 'No' is selected, the following 2 fields will be unavailable for entry.*

[54d] Addressed/Referred/Consultation Obtained

- **Yes.** Select if advised to quit or provided counseling or literature. Referral or request for consultation may be made to inpatient or outpatient treatment center, substance abuse counselor, behavioral therapist, social worker or community-based organization. Select if documentation contains consultation notes, review of consultation notes, or indicates patient was under the care of a second provider or attending a community-based organization.
- **No.** Otherwise select 'No.'

[54e] Followed up

- **Yes.** Select if documentation includes notation regarding re-assessment of problem, status of problem, or other discussion with patient or second provider.
- **No.** Otherwise select 'No.'

[55] Domestic Violence

[55a] Screened Initial 2 Visits

- **Yes.** Select if patient asked about physical, sexual or psychological harm or threats of harm from someone she has a relationship with. Assessment may or may not include use of a standardized screening tool such as HITS, CTS, WEB or ISA-P. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding domestic violence.

[55b] Rescreened 3rd Trimester

- **Yes.** Select if repeat assessment occurred during prenatal care; not at hospital admission for labor and delivery. Select if patient asked again about domestic violence or administered a standardized screening tool. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding domestic violence in the 3rd trimester. Select if initial visits occur in the 3rd trimester. *If 'No' is selected for both screenings, the following 3 fields will be unavailable for entry.*

[55c] Risk Identified

- **Yes.** Select if documented as the result of a screening tool or in the visit notes, or checked as a problem on a general risk assessment checklist.
- **No.** Otherwise select 'No.' *If 'No' is selected, the following 2 fields will be unavailable for entry.*

[55d] Addressed/Referred/Consultation Obtained

- **Yes.** Select if provided counseling or resources, including information/techniques to ensure personal safety. Select if referred to counseling, social services, a community-based organization, advocacy group, legal services or the police.
- **No.** Otherwise select 'No.'

[55e] Followed up

- **Yes.** Select if documentation includes notation regarding re-assessment of problem, status of problem, or other discussion with patient or second provider.
- **No.** Otherwise select 'No.'

[56] Depression

[56a] Screened Initial 2 Visits

- **Yes.** Select if patient asked about current treatment for, or symptoms of, depression. Select if administered a standardized screening tool such as the BDI, CES-D, THE HANDS ™, PHQ-2, PHQ-9 or EPDS (Edinburgh Postnatal Depression Screening Tool). If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding depression.

[56b] Rescreened 3rd Trimester

- **Yes.** Select if repeat assessment occurred during prenatal care; not at hospital admission for labor and delivery. Select if patient asked again about current treatment for, or symptoms of, depression, or administered a standardized screening tool. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding depression in the 3rd trimester. Select if initial visits occur in the 3rd trimester. *If 'No' is selected for both screenings, the following 3 fields and the field **'Was a standardized screen tool used**?' will be unavailable for entry.*

[56c] Risk Identified

- **Yes.** Select if documented as the result of a screening tool or in the visit notes, or checked as a problem on a general risk assessment checklist.
- **No.** Otherwise select 'No.' *If 'No' is selected, the following 2 fields will be unavailable for entry.*

[56d] Addressed/Referred/Consultation Obtained

- **Yes.** Select if plan developed/executed for further evaluation, counseling or medication prescription. Select if referred for further evaluation, counseling or treatment. Referral may have been to a psychiatrist, psychologist, therapist/counselor, social worker, case manager, home visitation or community-based program. Select if admitted to an inpatient or outpatient treatment program.
- **No.** Otherwise select 'No.'

[56e] Followed up

- **Yes.** Select if documentation includes notation regarding re-assessment of problem, status of problem, or other discussion with patient or second provider.
- **No.** Otherwise select 'No.'

Additional questions

Depression

[57] Was a standardized depression screening tool used?

- **Yes.** Select if screening tool is present on medical record or result is recorded in visit or consultation note.
- **No.** Select if there is no documentation of screening tool use.
- **NA.** Not applicable. Select if patient under care for depression prior to presenting for prenatal care, diagnosed by another provider without use of screening tool (patient may have had more in-depth evaluation) or entered into care too late for screening.

Examples of standardized screening tools: BDI (Beck Depression Inventory), CES-D (Center for Epidemiologic Studies Depression Scale), THE HANDS ™ (The Harvard Department of Psychiatry National Depression Screening Day Scale), PHQ-2 (Patient Health Questionnaire 2 item depression screen), PHQ-9 (Patient Health Questionnaire 9 item depression screen).

Tobacco use

[58] Was patient ever a smoker before index pregnancy?

- **Yes.** Select if documentation indicates patient smoked prior to pregnancy, even if quit.
- **No.** Select if documentation specifically notes patient never smoked.
- **Unknown.** Select if smoking history is unknown, or there is no documentation regarding smoking history.

[59] Did patient smoke at any time during index pregnancy?

- **Yes.** Select if smoking during index pregnancy documented in any visit notes, or checked as a problem on a general risk assessment checklist. Select even if patient stopped smoking when realized was pregnant, i.e., any time after conception.
- **No.** Otherwise select 'No.'
- **Unknown.** Select if smoking status during index pregnancy is unknown, or there is no documentation regarding smoking during index pregnancy. *If 'No' or 'Unknown' is selected, the following 3 fields, and the field '**Did patient abstain from tobacco use during the last three months of pregnancy?,**' and the checkbox group **'If tobacco use during pregnancy identified, check all interventions documented,'** will be unavailable for entry.*

[60] Did patient quit smoking during index pregnancy?

- **Yes.** Select if documentation indicates patient quit smoking during index pregnancy.
- **No.** Select if the patient continued to smoke any amount at the time of index pregnancy, or abstinence during pregnancy is not documented.

[61] Did patient quit smoking on their own during index pregnancy?

- **Yes.** Select if documentation indicates patient quit smoking during index pregnancy without intervention, for example, pharmacologic adjunct or counseling.
- **No.** Select if patient utilized medication or supportive counseling to support quit attempts.
- **Unknown**. Select if quit method is not documented.

[62] Was identified risk – smoking – reassessed at any time during index pregnancy?

- **Yes.** Select if documentation includes notation regarding re-assessment of problem, status of problem, or other discussion with patient or second provider.
- **No.** Otherwise select 'No.'

[63] Was patient rescreened for tobacco use during the third trimester?

- **Yes.** Select if repeat assessment occurred during prenatal care; not at hospital admission for labor and delivery. Select if patient asked again about present use of tobacco products.
- **No.** Select if there is no documentation – positive or negative – regarding tobacco use in the 3rd trimester. Select if initial visits occur in the 3rd trimester.

[64] Did patient abstain from tobacco use during the last three months of pregnancy?

- **Yes.** Select if patient did not smoke during the three months of pregnancy prior to delivery.
- **No.** Select if patient smoked any amount during the three months of pregnancy prior to delivery.
- **Unable to determine.** Select if documentation does not address tobacco use during the last trimester of pregnancy.

[65] If tobacco use during pregnancy identified, check all interventions documented.

- ☐ **[65a] Advice to quit.** Select if provider noted advised to stop smoking.
- ☐ **[65b] Pregnancy-tailored counseling / materials.** Select if documentation indicates a pregnancy-tailored discussion and the provision of cessation techniques. May include the provision of pregnancy-specific materials.
- ☐ **[65c] Pharmacologic cessation adjunct.** Select if patient prescribed pharmacological cessation adjuncts such as nicotine chewing gum, transdermal nicotine patches, varenicline (Chantix) or bupropion (Zyban, Wellbutrin).
- ☐ **[65d] Referral to NYS Smokers' Quitline.** Select if documentation shows provider referral on-line, or provision of web address or phone number to patient.
- ☐ **[65e] Referral to other cessation program / support group.** Select if patient referred to a community-based organization, support group or behavioral therapist.
- ☐ **[65f] No intervention documented.** Select if documentation contains no provider response to identified tobacco use during pregnancy. *If 'No intervention documented' is selected, any earlier checkboxes selected are cleared and become unavailable for entry.*

Heroin or other opioid abuse

[66] Was heroin or other opioid abuse during pregnancy documented?

- **Yes heroin abuse.** Select if heroin abuse was documented as the result of an assessment, interview question, screening tool or urine test; was checked as a problem on a risk assessment check list; or included in visit notes.
- **Yes other opioid abuse.** Select if other opioid abuse was documented as the result of an assessment, interview question, screening tool or urine test; was checked as a problem on a risk assessment check list; or included in visit notes. Other opioids such as codeine, fentanyl, morphine, opium, methadone, oxycodone, meperidine, hydromorphone, hydrocodone, propoxyphene or buprenorphine may be noted.
- **Both heroin and other opioid abuse.** Select if both heroin and opioid abuse are documented.
- **Neither heroin or other opioid use.** Otherwise select 'Neither.' Select 'Neither' if patient was already receiving opioid-assisted therapy when becoming pregnant or presenting to the prenatal provider, and enter details in the comments field. *If 'Neither heroin or other opioid use' is selected, the following field will become unavailable for entry.*

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

- **Pharmacologic treatment.** Select if consultation was requested / referral provided to an addiction specialist, such as providers affiliated with a registered methadone maintenance clinic or licensed to dispense buprenorphine.

- **Behavioral treatment.** Select if consultation was requested / referral provided for behavioral treatment, such as cognitive-behavioral therapy.
- **Both pharmacologic and behavioral treatment.** Select if both treatment modalities were documented, in either inpatient or outpatient settings.
- **Neither pharmacologic nor behavioral treatment.** Select if consultation request or referral to neither was documented.

Pre-pregnancy BMI

[68] Pre-pregnancy or Initial 2 Visits BMI (kg/m2) value. Enter the patient's Body Mass Index prior to the index pregnancy, or as recorded during the first two prenatal visits, or check the box labeled Unable to Determine. *If 'Unable to Determine' is selected, the following fields will be unavailable for entry:* ***[68a] Value****,* ***[69a]*** *and* ***[69b] Select timeframe*** *checkboxes,* ***[70] Pre-pregnancy or Initial 2 Visits BMI categorization parameter,*** *and* ***[76] Was gestational weight gain within the IOM-recommended range according to patient's pre-pregnancy BMI category?***

- ☐ **[68a] Value.**
- ☐ **[68b] Unable to Determine.**

[69] Select timeframe. *Selecting either checkbox will disable the other.*

- ☐ **[69a] Pre-pregnancy.** Select if the BMI value entered was obtained prior to index pregnancy.
- ☐ **[69b] Initial 2 Visits.** Select if the BMI value entered was obtained during the first two prenatal visits.

[70] Pre-pregnancy or Initial 2 Visits BMI categorization parameter. Select the patient's pre-pregnancy BMI (Body Mass Index) category.

- **Underweight** (BMI < 18.5)
- **Healthy weight** (BMI 18.5 – 24.9)
- **Overweight** (BMI 25.0 – 29.9)
- **Obese** (BMI 30.0 – 39.9)
- **Extremely Obese** (BMI ≥ 40.0)

Nutritional counseling and referral

[71] Nutritional counseling provided. Check all components of nutritional counseling provided.

- ☐ **[71a] BMI-based appropriate weight gain.** Check if provided counseling as per Institute of Medicine (IOM) Guidelines Recommendations for Total and Rate of Weight Gain During Pregnancy, by Pre-pregnancy BMI.

TABLE 1 NEW RECOMMENDATIONS FOR TOTAL AND RATE OF WEIGHT GAIN DURING PREGNANCY, BY PREPREGNANCY BMI

Prepregnancy BMI	BMI+ (kg/m²) (WHO)	Total Weight Gain Range (lbs)	Rates of Weight Gain* 2nd and 3rd Trimester (Mean Range in lbs/wk)
Underweight	<18.5	28–40	1 (1–1.3)
Normal weight	18.5-24.9	25–35	1 (0.8–1)
Overweight	25.0-29.9	15–25	0.6 (0.5–0.7)
Obese (includes all classes)	≥30.0	11–20	0.5 (0.4–0.6)

+ To calculate BMI go to www.nhlbisupport.com/bmi/
** Calculations assume a 0.5–2 kg (1.1–4.4 lbs) weight gain in the first trimester (based on Siega-Riz et al., 1994; Abrams et al., 1995; Carmichael et al., 1997)*

- ☐ **[71b] Diet, exercise, lifestyle.** Check if provided counseling regarding a varied, well-balanced, nutritional food plan and physical activity. Check if provided literature or referred to WIC for healthy lifestyle promotion education.
- ☐ **[71c] Not specified.** Check if nutritional counseling was provided, but content not specified. This may have occurred when a nutrition element was checked or initialed/dated on a patient education checklist.
- ☐ **[71d] Not provided.** Check if there is no documentation regarding nutrition, diet, exercise or weight gain. *If 'Not provided' is selected, any earlier checkboxes selected are cleared and become unavailable for entry.*

[72] Was patient referred to a nutritionist/dietician/class?

- **Yes.** Select if referral to a nutritionist, dietitian or nutritional education is documented. Select if patient already receiving nutritional guidance.
- **No.** Select if referral is not documented.

[73] Was patient referred to SNAP?

- **Yes.** Select if documentation indicates:

  1. Patient was asked about need for referral to the Supplemental Nutrition Assistance Program (SNAP).
  2. Patient referred, given information or assisted with application for SNAP.
  3. Social services or other community agency is assisting with application for SNAP.
  4. Patient already receiving SNAP services.

- **No.** Select if there is no documentation regarding SNAP services.

[74] Was patient referred to WIC?

- **Yes.** Select if documentation indicates:

  1. Patient was asked about need for referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
  2. Patient referred, given information or assisted with application for WIC.
  3. Social services or other community agency is assisting with application for WIC.
  4. Patient already receiving WIC services.

- **No.** Select if there is no documentation regarding WIC services.

Gestational weight gain

[75] Total gestational weight gain (pounds) as able to ascertain from the medical record. Enter total weight gained (in pounds) during pregnancy as documented in the medical record. If unable to determine gestational weight gain, leave this field blank.

[76] Was gestational weight gain within the IOM-recommended range according to patient's pre-pregnancy BMI category? (See Table 1 below).

- **Yes.** Select if total weight gained during pregnancy fell within the range (in pounds) recommended for the patient's pre-pregnancy BMI category, as per IOM guidelines.
- **No.** Select if total weight gained during pregnancy fell outside of the total recommended weight gain range.
- **Unable to determine.** Select if total weight gained during pregnancy is not available or otherwise not documented.

TABLE 1 NEW RECOMMENDATIONS FOR TOTAL AND RATE OF WEIGHT GAIN DURING PREGNANCY, BY PREPREGNANCY BMI

Prepregnancy BMI	BMI+ (kg/m²) (WHO)	Total Weight Gain Range (lbs)	Rates of Weight Gain* 2nd and 3rd Trimester (Mean Range in lbs/wk)
Underweight	<18.5	28–40	1 (1–1.3)
Normal weight	18.5-24.9	25–35	1 (0.8–1)
Overweight	25.0-29.9	15–25	0.6 (0.5–0.7)
Obese (includes all classes)	≥30.0	11–20	0.5 (0.4–0.6)

+ To calculate BMI go to www.nhlbisupport.com/bmi/
** Calculations assume a 0.5–2 kg (1.1–4.4 lbs) weight gain in the first trimester (based on Siega-Riz et al., 1994; Abrams et al., 1995; Carmichael et al., 1997)*

[77] Care coordination needs identified

Check all needs identified.

- ☐ **[77a] Scheduling appointments with multiple providers.** Includes specialist, mental health, social service and dental appointments.
- ☐ **[77b] Follow-up with missed appointments.** Includes routine prenatal care and referral appointments.
- ☐ **[77c] Transportation.** For appointments and needed services.
- ☐ **[77d] Social services.** Includes housing, food and childcare needs.
- ☐ **[77e] Health education.** Ongoing, comprehensive health education beyond routine prenatal care counseling.
- ☐ **[77f] Telephonic outreach.** Routine contact for assessment, problem solving and support with self-management.
- ☐ **[77g] Home visits.** Face-to-face visits for assessment, monitoring, 17P administration and/or other nursing services.
- ☐ **[77h] Other care coordination needs.** May include services such as HIV care coordination.
- ☐ **[77i] No care coordination needs.** Check if patient has adequate resources and support to enable adherence to plan of care. *If 'No care coordination needs' is selected, any earlier checkboxes selected are cleared and become unavailable for entry. The following checkbox group will also be unavailable for entry.*

[78] Care coordination providers

Check all entities involved with care coordination for this patient.

- ☐ **[78a] Prenatal care practice.** Check if patient seen by practice case manager or social worker, or care coordination managed by other clinic staff.
- ☐ **[78b] Health plan OB case management.** Check if referral made to health plan case management services. Select if documentation indicates patient contacted by health plan OB case manager (even if not the result of provider referral).
- ☐ **[78c] Other community/government agency.** Check if documentation indicates patient was referred to or seen by another service provider (e.g., department of health nurse-family partnership program).
- ☐ **[78d] Declined case management/social services.** Check if patient declined all care coordination services.
- ☐ **[78e] No care coordination documented.** Check if there is no evidence of care coordination services. *If 'No care coordination' is selected, any earlier checkboxes selected are cleared and become unavailable for entry.*

[79] Was breast feeding education provided?

- **Yes.** Select if breast feeding education occurred during prenatal care; not during hospitalization for labor and delivery. Select if provided counseling regarding maternal/infant benefits of breastfeeding and the nutritional advantages of breast milk. Check if recommended exclusive breastfeeding for the first six months of life, followed by continuation of breastfeeding and supplemental foods. Check if referred to WIC or other lactation support group.
- **No.** Otherwise select 'No.'

[80] Was patient asked if they would like to become pregnant in the next year?

- **Yes.** Select if patient was asked about plans for future pregnancy – specifically if would like to become pregnant in the next year.
- **No.** Select if documentation does not include a discussion of patient's future pregnancy plans.

[81] Were contraceptive options discussed antenatally?

- **Yes.** Select if documentation notes a discussion regarding contraception occurring during a prenatal visit.
- **No.** Select if a discussion of contraception is not noted prior to delivery or the postpartum visit.

Diagnostic screening and testing

[82] Bacteriuria. Urine culture obtained at 12-16 weeks gestation (or 1st visit if later).

- **Yes, urine culture obtained at 12-16 weeks gestation.** Select if culture obtained at 12-16 weeks, or at time of 1st visit if later than 16 weeks gestation.
- **No, but urine culture obtained at < 12 weeks gestation.** Select if culture obtained at <12 weeks only (and not repeated at 12-16 weeks gestation).
- **No, urine culture not obtained.** Select if urine culture was not documented during this timeframe.

[83] Diabetes screening time frames. Select time frame when diabetes screening performed.

- **At initial visit.** Select if diabetes screening performed at first or second prenatal visit.
- **At 24-28 weeks gestation.** Select if diabetes screening done at 24 to 28 weeks gestation.
- **At both initial visit and at 24-48 weeks gestation.** Patient may have screened negative initially, and been rescreened.
- **No screening documented.** Select if there was no documentation of diabetes screening antenatally.
- **Screening not indicated.** Select if patient diagnosed with diabetes requiring treatment before this pregnancy.

[84] Group B streptococcus. Vaginal culture obtained at 35-37 weeks gestation.

Index pregnancy refers to the pregnancy identified for this review.

- **Yes at 35-37 weeks gestation.** Select if culture obtained at 35-37 weeks gestation.
- **Yes prior to 35 weeks and culture positive.** Select if screened early due to risk of preterm delivery and culture positive (intrapartum antibiotics indicated).
- **Yes prior to 35 weeks, culture negative and delivered earl**y. Select if screened negative and delivered before 35 weeks gestation.

  NOTE if early screen negative but NOT delivered early, culture should be repeated, and 'Yes at 35-37' weeks can be selected. If culture was not repeated, 'No' should be selected.

- **No.** Select if culture was not documented at one of the above time intervals.
- **Not indicated.** Select if mother has (1) had GBS bacteriuria during index pregnancy or (2) has previously had an infant with invasive GBS disease (intrapartum antibiotics already indicated).
- **NA.** Select if mother delivered unexpectedly prior to 37 weeks or transferred out of practice.

Aneuploidy screening and testing

[85] Was discussion / counseling regarding aneuploidy screening and invasive testing documented?

- **Yes.** Select if discussion or counseling regarding screening and invasive testing options, risks and benefits is documented. If results are documented, counseling is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation regarding such discussion or counseling.
- **NA**. Select if patient entered care too late for screening or invasive testing, or transferred out of practice prior to screening.

[86] Was aneuploidy screening performed?

- **Yes.** Select if results are documented for aneuploidy screening such as cell-free DNA screening and/or first and second trimester ultrasound and biochemical markers:

  1. First trimester combined serum screening (pregnancy associated plasma protein A and free β-hCG) *plus* fetal nuchal translucency ultrasound at 10-13 weeks *plus* second trimester maternal serum AFP, MSAFP.

2. Second trimester triple screen (AFP, β-hCG, estriol).

3. Second trimester quadruple screen (AFP, β-hCG, estriol, inhibin-A). Inhibin A is also referred to as DIA for dimeric inhibin-A.

- **No.** Select if no aneuploidy screening results documented.
- **Declined.** Select if patient declined screening.
- **NA.** Select if entered care too late for screening.

[87] Was invasive testing performed?

- **Yes.** Select if test results for amniocentesis or chorionic villous sampling (CVS) are present or noted.
- **No.** Select if there is no documentation of invasive test results.
- **Declined.** Select if patient declined invasive testing.
- **NA.** Select if entered care too late for testing or invasive testing was not indicated.

[88] Was patient at high risk for aneuploidy?

- **Yes.** Patients with an increased risk of fetal aneuploidy include, for example, women with a previous fetus or child with an autosomal trisomy or sex chromosome abnormality, one major or at least two minor fetal structural defects identified by ultrasonography, either parent with a chromosomal translocation or chromosomal inversion, or parental aneuploidy.
- **No.** Select if documentation indicates patient not at high risk for aneuploidy, or there is no documentation regarding risk.

HIV services

[89] Tested at initial visit

- **Yes.** Select if test performed within first two visits for prenatal care.
- **No.** Select if laboratory orders or testing not documented at first two visits for prenatal care.
- **Not indicated.** Select if patient is known to be HIV-positive.
- **Declined.** Select if patient refused HIV testing.

[90] Tested during 3rd trimester

- **Yes.** Select if test performed at 28-41 weeks gestation.
- **No.** Select if a test was not performed at 28-41 weeks gestation.
- **Not indicated.** Select if patient is known to be HIV-positive.
- **Declined.** Select if patient refused HIV testing.
- **NA.** Select if patient entered prenatal care/practice late and received initial testing at this time. Select if patient delivered early or transferred out of practice.

Lead exposure

[91] Lead exposure risk assessed, or blood lead level tested

- **Yes.** Select if documentation indicates patient was queried regarding potential sources of lead exposure (for example, lead based paint, non-commercially prepared pottery, folk remedies/cosmetics, hobbies or pica – eating non-food materials). Select if a blood lead level is documented.
- **No.** Select if there is no documentation – positive or negative – regarding assessment or testing.

Dental care

[92] Oral health care needs assessed

- **Yes.** Select if results of oral examination, or date of last dental appointment, is documented. If dental referral made, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding oral health. *If 'No' is selected, the following field will be unavailable for entry.*

[93] Problem identified/without care > 6 months

- **Yes.** Select if documentation indicates bleeding, decay or pain, or no dental visit for over six months.
- **No.** Otherwise select 'No.'

[94] Referred for dental care

- **Yes.** Select if documentation indicates patient was advised to see her dentist, referred to a specific dentist, or otherwise assisted with access to dental care.
- **No.** Select if no direction, referral or assistance is noted.

Immunizations

[95] Hepatitis B

[95a] HBsAg test result

- **Positive.** Select if hepatitis B surface antigen test result was positive. *If 'Positive' is selected, the following 2 fields will be unavailable for entry.*
- **Negative.** Select if hepatitis B surface antigen test result was negative.
- **Not tested.** Select if no tests results documented. *If 'Not tested' is selected, the field* ***'Hepatitis B vaccine administered****' will be unavailable for entry.*

[95b] Was patient assessed for hepatitis B risk factors?

- **Yes.** Select if documentation demonstrates patient was asked about risk factors such as injection drug use, more than one sex partner in the previous six months or an HBsAg-positive sex partner, evaluation or treatment for a sexually-transmitted disease.
- **No.** Select if patient was not asked about risk factors, or documentation does not note a discussion regarding risk factors for hepatitis B.

[95c] Hepatitis B vaccine administered

- **Yes.** Select if the Hepatitis B three-vaccine series was started during pregnancy. Trade names include Engerix-B, Recombivax HB and Twinrix.
- **No.** Select if vaccine series was not started.
- **Not indicated – vaccination current.** Select if patient was not in need of re-vaccination.
- **Not indicated – not at risk.** Select if patient had no risk factors for hepatitis B.
- **Declined.** Select if patient refused vaccination.

Tdap

[96] Tdap vaccine administered

Index pregnancy refers to the pregnancy identified for this review.

- **Yes.** Select if patient received tetanus, diphtheria and pertussis vaccination during the index pregnancy. Trade names include Boostrix and Adacel.
- **No.** Select if vaccine was not administered during index pregnancy.
- **Not indicated.** Select if already vaccinated during index pregnancy, or known to have had a serious adverse reaction to the Tdap vaccination.
- **Declined.** Select if patient refused vaccination.

[97] Influenza

[97a] Influenza vaccine offered

- **Offered vaccine.** Select if documentation indicates patient was offered vaccination, or vaccinated at a prenatal visit.
- **Referred for vaccine.** Select if patient was directed to a site other than prenatal practice for vaccination, for example primary care physician's office.
- **No.** Select if there is no documentation regarding discussion of influenza vaccination.
- **Not indicated.** Select if patient already received annual vaccination, has an egg allergy, history of hypersensitivity to flu vaccine or history of Guillain-Barre.
- **NA.** Select if patient not seen for prenatal care during flu season (October to June). *If 'No,' 'Not indicated' or 'NA' is selected, the following field will be unavailable for entry.*

[97b] Influenza vaccine received

- **Yes in office.** Select if patient accepted and received influenza vaccination in prenatal care provider's office. Documentation may include trade names such as Fluarix, Fluvirin, Fluzone, FluLaval, Afluria, Agriflu.
- **Yes at referral site.** Select if patient received vaccination at site other than prenatal practice, for example primary care physician's office, work site or drug store.
- **No declined.** Select if patient refused vaccination.
- **No other reason.** Select, for example, if patient unable to travel to referral site, or vaccine unavailable.
- **Unable to determine.** Select if unknown whether patient received vaccine.

---

[98] Was low-dose aspirin prescribed for preeclampsia risk?

- **Yes.** Select if low-dose aspirin (acetylsalicylic acid or ASA) was prescribed (even if reason is not specified).
- **No.** Select if low-dose aspirin was not prescribed.
- **Contraindicated.** Select if aspirin therapy contraindicated for this patient.
- **Not indicated.** Select if patient had no risk factors.

The postpartum visit

[99] Postpartum visit documented

- **Yes.** Select if an outpatient visit specifically for postpartum care was documented.
- **No.** Select if no postpartum visit is documented. *If 'No' is selected, all text fields regarding the postpartum visit will be unavailable for entry. Patients having transferred out of practice will be excluded from analysis of this section.*

[100] Time from delivery

Check all time intervals between delivery and postpartum visits which apply.

- ☐ **[100a] < 4 weeks**
- ☐ **[100b] 4- 8 weeks**
- ☐ **[100c] > 8 weeks**

Postpartum psychosocial risk assessment

[101] Alcohol abuse

[101a] Screened

- **Yes.** Select if patient asked about present use of alcohol. Assessment may or may not include use of a standardized screening tool such as the CAGE, T-ACE, FAST or AUDIT Tests. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding alcohol abuse postpartum. *If 'No' is selected, the following 2 fields will be unavailable for entry.*

[101b] Risk Identified

- **Yes.** Select if a risk for alcohol abuse is documented as the result of a screening tool, checked as a problem on a general risk assessment checklist or included in visit notes.
- **No.** Otherwise select 'No.' *If 'No' is selected, the following field will be unavailable for entry.*

[101c] Addressed/Referred

- **Yes.** Select if advised to quit or provided counseling or literature. Referral may be made to inpatient or outpatient treatment center, alcohol abuse counselor, behavioral therapist, social worker or community-based organization. Select if documentation indicates patient was under the care of a second provider or attending a community-based organization.
- **No.** Otherwise select 'No.'

[102] *Substance abuse*

[102a] Screened

- **Yes.** Select if patient asked about present use of illegal drugs and/or prescription medication not prescribed for them. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding substance use. *If 'No' is selected, the following 2 fields will be unavailable for entry.*

[102b] Risk Identified

- **Yes.** Select if abuse checked as a problem on a general risk assessment checklist or documented in the visit notes. Documentation may state abuses recreational drugs or prescription medication, or note specific drugs such as marijuana, cocaine, heroin, methamphetamine.
- **No.** Otherwise select 'No.' *If 'No' is selected, the following field will be unavailable for entry.*

[102c] Addressed/Referred

- **Yes.** Select if advised to quit or provided counseling or literature. Referral may be made to inpatient or outpatient treatment center, substance abuse counselor, behavioral therapist, social worker or community-based organization. Select if documentation indicates patient was under the care of a second provider or attending a community-based organization.
- **No.** Otherwise select 'No.'

[103] Domestic Violence

[103a] Screened

- **Yes.** Select if patient asked about physical, sexual or psychological harm or threats of harm from someone she has a relationship with. Assessment may or may not include use of a standardized screening tool such as HITS, CTS, WEB or ISA-P. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding domestic violence. *If 'No' is selected, the following 2 fields will be unavailable for entry.*

[103b] Risk Identified

- **Yes.** Select if documented as the result of a screening tool or in the visit notes, or checked as a problem on a general risk assessment checklist.
- **No.** Otherwise select 'No.' *If 'No' is selected, the following field will be unavailable for entry.*

[103c] Addressed/Referred

- **Yes.** Select if provided counseling or resources, including information/techniques to ensure personal safety. Select if referred to counseling, social services, a community-based organization, advocacy group, legal services or the police.
- **No.** Otherwise select 'No.'

[104] Depression

[104a] Screened

- **Yes.** Select if patient asked about symptoms of depression. Select if administered a standardized screening tool such as the EPDS (Edinburgh Postnatal Depression Screening Tool), BDI, CES-D, THE HANDS ™, PHQ-2, PHQ-9. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding depression. *If 'No' is selected, the following 2 fields will be unavailable for entry.*

[104b] Risk Identified

- **Yes.** Select if documented as the result of a screening tool or in the visit notes, or checked as a problem on a general risk assessment checklist.
- **No.** Otherwise select 'No.' *If 'No' is selected, the following field will be unavailable for entry.*

[104c] Addressed/Referred

- **Yes.** Select if plan developed/executed for further evaluation, counseling or medication prescription. Select if referred for further evaluation, counseling or treatment. Referral may have been to a psychiatrist, psychologist, therapist/counselor, social worker, case manager, home visitation or community-based program. Select if admitted to an inpatient or outpatient treatment program.
- **No.** Otherwise select 'No.'

[105] Tobacco use

[105a] Screened

- **Yes.** Select if patient asked about present use of tobacco products. If a problem is identified, assessment is assumed, and 'Yes' should be selected.
- **No.** Select if there is no documentation – positive or negative – regarding tobacco use. *If 'No' is selected, the following 2 fields, and the checkbox group **'If tobacco use identified, check all interventions documented,'** will be unavailable for entry.*

[105b] Risk Identified

- **Yes.** Select if use documented in the visit notes, or checked as a problem on a general risk assessment checklist.
- **No.** Otherwise select 'No.' *If 'No' is selected, the following field and checkbox group will be unavailable for entry.*

[105c] Addressed/Referred

- **Yes.** Select if any discussion, treatment or referral for tobacco cessation is documented. Detail will be requested at additional questions below.
- **No.** Otherwise select 'No.'

[106] If tobacco use identified, check all interventions documented.

- ☐ **[106a] Advice to quit.** Select if provider noted advised to stop smoking.
- ☐ **[106b] Counseling / literature.** Select if documentation indicates discussion regarding cessation techniques. May include the provision of literature.
- ☐ **[106c] Pharmacologic cessation adjunct.** Select if patient prescribed pharmacological cessation adjuncts such as nicotine chewing gum, transdermal nicotine patches, varenicline (Chantix) or bupropion (Zyban, Wellbutrin).
- ☐ **[106d] Referral to NYS Smokers' Quitline.** Select if documentation shows provider referral on-line, or provision of web address or phone number to patient.
- ☐ **[106e] Referral to other cessation program / support group.** Select if patient referred to a community-based organization, support group or behavioral therapist.
- ☐ **[106f] No intervention documented.** Select if documentation contains no provider response to continued tobacco use. *If 'No intervention documented' is selected, any earlier checkboxes selected are cleared and become unavailable for entry.*

Postpartum counseling and referral

Family planning needs / contraception

[107] Location contraception received

- **Immediately post delivery.** Select if postpartum documentation indicates patient received contraception immediately following delivery.
- **Postpartum visit.** Select if documentation indicates patient received contraception at the postpartum visit.
- **Offered but declined postpartum.** Select if patient was offered but refused contraception. *If 'Offered but declined postpartum' is selected, the following field will be unavailable for entry.*
- **No documentation offered / received contraception.** Select if there is no documentation regarding contraception in the postpartum visit notes. *If 'No documentation offered / received contraception' is selected, the following field will be unavailable for entry.*

[108] Type of contraception

- **Sterilization.** Select if patient had a hysterectomy or tubal ligation.
- **LARC.** Long-acting reversible contraception. Select if patient had a contraceptive implant or intrauterine device (IUD) placed.
- **Moderately effective method.** Select if patient received Depo-Provera injection, oral contraceptive pills, patch, ring, or diaphragm.
- **None of the above.** Select if patient did not receive a highly or moderately effective method of contraception. Select if patient chose one of the least effective methods, such as condom or spermicide.

[109] Was patient asked if they would like to become pregnant in the next year?

- **Yes.** Select if patient was asked about plans for future pregnancy – specifically if would like to become pregnant in the next year.
- **No.** Select if documentation does not include a discussion of patient's future pregnancy plans.

Interconception counseling

[110] Check all of the following counseling components documented.

☐ **[110a] Nutrition/activity/weight management.** Discussion may include diet, exercise program, goals for ideal weight, referral to nutritionist or community resources.

☐ **[110b] Folic acid supplementation.** Discussion may include advice to take multivitamins.

☐ **[110c] Immunizations.** Discussion may include vaccination for Hepatitis B, HPV, MMR, Varicella, Meningococcal conjugate, Tdap or Influenza (see following question) as appropriate.

☐ **[110d] Chronic condition management.** Notation may reference obesity, smoking, substance abuse, anemia, diabetes, hypertension, asthma, hypo/hyperthyroidism or seizure disorder, for example.

☐ **[110e] Future pregnancy risk.** Discussion may focus on identified risk factor (e.g., delaying pregnancy until a more normal weight is obtained).

☐ **[110f] None of the above.** Check if documentation does not indicate counseling covered any of the above topics. *If 'None of the above' is selected, any earlier checkboxes selected are cleared and become unavailable for entry.*

Postpartum immunizations

[111] Influenza

[111a] Status assessed

- **Yes.** Select if assessed need for vaccination. If vaccination is documented, assessment is assumed, and 'Yes' should be selected.
- **No.** Otherwise select 'No.'
- **NA.** Select if patient not seen for postpartum care during flu season (October to June). *If 'No' or 'NA; is selected, the following field will be unavailable for entry.*

[111b] Vaccine administered

- **Yes.** Select if influenza vaccination administration documented. Trade names include Fluarix, Fluvirin, Fluzone, FluLaval, Afluria, Agriflu.
- **No.** Select if there is no documentation regarding influenza vaccination.

- **Not indicated.** Select if patient already received annual vaccination, has an egg allergy, history of hypersensitivity to flu vaccine or history of Guillain-Barre.
- **Declined.** Select if patient refused vaccination.

[112] Human papillomavirus

[112a] Status assessed

- **Yes.** Select if assessed need for vaccination. If vaccination documented, assessment is assumed, and 'Yes' should be selected.
- **No.** Otherwise select 'No.'
- **NA.** Select if patient not eligible due to age. *If 'No' or 'NA' is selected, the following field will be unavailable for entry.*

[112b] Vaccine administered

- **Yes.** Select if HPV vaccination (first, second or third dose) at postpartum visit documented. Trade names include Gardasil and Cervarix.
- **No.** Select if there is no documentation regarding HPV vaccination.
- **Not indicated.** Select if patient received vaccination before leaving hospital, had completed primary series and vaccination is not indicated, or is allergic/otherwise ineligible to be vaccinated.
- **Declined.** Select if patient refused vaccination.

---

[113] Was follow-up arranged for linkage to ongoing care?

- **Yes.** Select if documentation shows patient was advised, referred, or scheduled an appointment with her primary care provider, or with at least one specialist or ancillary provider for management of a pre-existing or newly diagnosed condition.
- **No.** Otherwise select 'No.'

[114] Diabetes screening

- **Yes.** Select if diabetes screening was discussed, recommended, patient referred or testing scheduled at the post partum visit.
- **No.** Select if there was no documentation regarding postpartum diabetes screening.
- **Not indicated.** Select if patient not at risk for diabetes, or had history of prepregnancy diabetes.

Additional Information

Medical Documentation

[115] Was an updated medical record, including prenatal laboratory test results, sent to the delivery site prior to delivery?

- **Yes.** Select if prenatal record sent to the delivery site prior to delivery. Ideally, the medical record should be sent by 24 weeks gestation for a high-risk pregnancy or 36 weeks gestation for a low-risk pregnancy. Select if a centralized EMR is available to both the prenatal practice and Labor and Delivery site.
- **No.** Select if there is no evidence the patient's medical record was sent to the delivery site prior to delivery.

[116] Does the practice use an Electronic Health Record?

- **Yes.** Select if the practice uses an Electronic Health Record, for all or a portion of documentation.
- **No.** Otherwise select 'No.'

Comments

[117] Comments. Enter comments relevant to interpretation of this medical record review.

Acronyms

AFP. Alpha-Fetoprotein.

AUDIT. (Alcohol screening tool). Alcohol Use Disorders Identification Test. A ten-question test covering quantity and frequency of alcohol consumption, drinking behavior and alcohol-related problems.

β-hCG. Beta subunit of human chorionic gonadotropin.

BDI. (Depression screening tool). Beck Depression Inventory.

BMI. Body Mass Index.

CAGE. (Alcohol screening tool). A four-question test that diagnoses alcohol problems over a lifetime. C – Have you ever felt you should **cut** down on your drinking? A- Have people **annoyed** you by criticizing your drinking? G – Have you ever felt bad or **guilty** about your drinking? E- **Eye opener:** Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

CES-D. (Depression screening tool). Center for Epidemiologic Studies Depression Scale.

CHWP. Community Health Worker Program.

CIN. Medicaid Member Client Identification Number.

CTS. (Domestic violence screening tool). Conflict Tactics Scale. A 19-item questionnaire that measures the use of reasoning, verbal aggression and physical violence in resolving family conflicts.

CVS. Chorionic villous sampling.

DIA. Dimeric inhibin-A.

DOB. Date of Birth.

EPDS. (Depression screening tool). Edinburgh Postnatal Depression Screening tool.

FAST. (Alcohol screening tool). Fast Alcohol Screen Test. A four-question test that measures hazardous drinking in the past year.

FGR. Fetal growth restriction.

FPBP. Family Planning Benefit Program.

FPEP. Family Planning Extension Program.

GBS. Group B streptococcus.

GCT. Glucose Challenge Test.

GDM. Gestational diabetes mellitus.

GDM – ACOG diagnostic criteria based on the 3-hour OGTT: Carpenter and Coustan. Plasma or serum glucose levels: Fasting 95 mg/dl, 1 hour 180 mg/dl, 2 hour 155 mg/dl, 3 hour 140 mg/dl).

GDM – ACOG diagnostic criteria based on the 3-hour OGTT: National Diabetes Data Group. Plasma glucose levels: Fasting 105 mg/dl, 1 hour 190 mg/dl, 2 hour 165 mg/dl, 3 hour 145 mg/dl.

GTT. Glucose Tolerance Test.

HBsAg. Surface antigen of the hepatitis B virus (HBV). A blood test positive for HBsAg indicates current hepatitis B infection.

HELLP. Hemolysis, elevated liver enzymes and low platelet counts.

Acronyms

HFNY. Healthy Families New York home visitation program.

HHS. United States Department of Health and Human Services.

HITS. (Domestic violence screening tool). Hurt-Insult-Threaten-Scream. A four-question test to screen for intimate partner violence.

HIV. Human immunodeficiency virus.

HPV. Human papillomavirus. Human papillomavirus vaccine.

HTN. Hypertension.

IPRO. Island Peer Review Organization.

ISA-P. (Domestic violence screening tool). Index of Spouse Abuse – Physical Scale. A fifteen-item questionnaire which measures physical abuse.

IUD. Intrauterine device.

IUGR. Intrauterine growth restriction.

LARC. Long-acting reversible contraception.

MFM. Maternal-fetal medicine specialist.

mm. millimeters

MMR. Measles, mumps, rubella vaccine.

MR. Medical record.

MSAFP. Maternal Serum Alpha Fetoprotein.

NA. Not applicable.

NFP. Nurse Family Partnership home visitation program.

NYSDOH. New York State Department of Health.

OB-GYN. Obstetrics-gynecology.

OGTT. Oral Glucose Tolerance Test.

PHQ-2. (Depression screening tool). Patient Health Questionnaire 2-item depression screen.

PHQ-9. (Depression screening tool). Patient Health Questionnaire 9-item depression screen.

SNAP. Supplemental Nutrition Assistance Program. Sponsored by the United States Department of Agriculture Food and Nutrition Service

SGA. Small for gestational age.

T-ACE. (Alcohol screening tool). A four-question test that diagnoses alcohol problems over a lifetime. T – Does it **take** more than three drinks to make you feel high? A – Have you ever been **annoyed** by people's criticism of your drinking? C – Are you trying to **cut** down on drinking? E – Have you ever used alcohol as an **eye opener** in the morning?

Tdap. Tetanus, diphtheria and pertussis vaccine.

THE HANDS™. (Depression screening tool). The Harvard Department of Psychiatry National Depression Screening Day Scale.

WEB. (Domestic violence screening tool). Women's Experience with Battering Scale. A ten-item questionnaire that measures battering by characterizing a woman's perception of physical/psychological vulnerability and loss of control in partnerships with male partners.

WIC. Special Supplemental Nutrition Program for Women, Infants and Children. Sponsored by the United States Department of Agriculture Food and Nutrition Service.