

Section 13
OB/GYN Standards
STD/HIV Screening

Obstetrical/Gynecological Care Resources

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STD/HIV Screening and Reporting Requirements

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CDPHP PERINATAL HEALTH MAINTENANCE

Preconception Counseling:

All women of childbearing age should be afforded preconception counseling to assist in risk factor reduction and health improvement in order to improve pregnancy outcome.

Schedule of prenatal visits

- Every four weeks until the 28th week
- Every two to three weeks until the 36th week
- Weekly after the 36th week

Initial Visit:

History

- Family history including genetic risk factors
- Psychosocial assessment including mental illness and issues of abuse and depression
- Habits, including use of tobacco, alcohol and other drugs
- Nutritional assessment (consider WIC referral)
- Medication (includes history of allergies and drug sensitivities)
- Risk assessment and identification
- Sexual and surgical history

Physical Exam

- Baseline physical with full systems review
- Pelvic exam
- Abdominal exam
- Breast examination

Labs—Initial Evaluation

- H/H (to be repeated again in third trimester)
- Hemoglobin electrophoresis when indicated
- Lead level (blood) test if at risk
- Urine culture
- Blood group and Rh type determinations
- Antibody screen
- Rubella antibody titer measurement
- Hepatitis B surface antigen
- Varicella screen as indicated
- Screen for sexually transmitted diseases as indicated*
- HIV testing should be recommended; if testing is done, appropriate release must be completed which documents pre and post counseling; maintain release in member's chart
- Cervical cytology—Pap smear, if indicated
- Cystic fibrosis offered
- First trimester screening offered
- Hepatitis C (HCV) screening



CDPHP PERINATAL HEALTH MAINTENANCE

Continued

Subsequent visits:

Evaluation:

- Weight
- Blood pressure
- Dipstick urinalysis (if indicated)
- Measurement of fetal development
- Counseling and education
- Tdap in third trimester
- Influenza IIV

Labs:

- MSAFP/Multiple Markers 8–18 weeks (when indicated/elected)
- Blood glucose (1 or 2 hour) between 24–28 weeks
- Rh antibody testing at 26–28 weeks for unsensitized D-neg patients
- Hemoglobin or Hematocrit at 24–36 weeks
- Group B Strep culture at 35–37 weeks as per CDC guidelines
- Chlamydia, gonorrhea and syphilis screening as indicated at 32–36 weeks*
- HIV screening at 36–40 weeks
- Hepatitis C (HCV) screening is recommended once during pregnancy, as per CDC guidelines

Postpartum visit

- Scheduled 21–56 days after a normal spontaneous vaginal delivery (NSVD)
- Re-evaluate risk factors
- Physical examination
- Family planning method identified
- Preconception counseling (example: folic acid, nutrition, alcohol/drug/tobacco, abstinence)
- Review of human immunodeficiency virus (HIV) and sexually transmitted diseases (STDs)
- Adjustment to infant
- Identify infant's MD and follow-up care
- Feeding method
- Assessment for postpartum depression

Adopted from NYS Department of Health, Medicaid Prenatal Care Standards 2009 and AAP/ACOG Guidelines for Perinatal Care.

**CDPHP supports the use of the ACOG Antepartum form.*

(Guidelines reviewed and approved by the CDPHP quality management committee November 2021.)

Medicaid Prenatal Care Standards

Prenatal care standards in New York State (10 NYCRR, Part 85.40) were developed in early 1990 in response to the creation of the Prenatal Care Assistance Program (PCAP), a prenatal care program developed to provide for comprehensive perinatal care to low-income, high-risk pregnant women. The most recent revision of these standards occurred in 2000. Changes in the clinical standards of prenatal care since that time necessitate a review of Part 85.40 standards to compare them to current professional standards of practice which address new challenges and concepts in prenatal care. In order to accomplish this task, the Department partnered with the Island Peer Review Organization (IPRO) to review the existing PCAP standards and compare them to current American College of Obstetricians and Gynecologists (ACOG) guidelines' new recommendations in prenatal care, as well as other national guidelines of obstetric practice to determine the need to modify the prenatal standards as they become applied to all Medicaid prenatal providers.

The Office of Health Insurance Programs, in collaboration with the Division of Family Health, IPRO and a statewide advisory workgroup made up of key stakeholders in the field of prenatal care were charged with the responsibility for developing this revised set of Medicaid Prenatal Care Standards for New York State. Steps in the process included:

- Literature review and comparison of Part 85.40 with current ACOG guidelines and other evidence-based literature;
- Stakeholder meetings to discuss current standards of practice;
- Summary proposal with recommendations for revised standards;
- Revisions to Article 25, New York State Public Health Law; and
- Draft Medicaid Prenatal Care Standards for review and subsequent adoption.

The Department would like to express its appreciation to all the external stakeholders who gave of their time and shared their expertise in the field of prenatal care to assist us in the development of prenatal care standards for the NYS Medicaid Program.

A. Requirements

1. General requirements:
 - a. Prenatal care providers shall create and maintain records and reports that are complete, legible, retrievable and available for review by representatives of the Commissioner of Health upon request. Such records and reports shall include the following:
 - i. a comprehensive prenatal care record for each pregnant woman which documents the provision of care and services received and which is maintained in a manner consistent with medical confidentiality requirements;
 - ii. special reports and data submissions as necessary for the Commissioner of Health;
 - iii. records of internal quality assurance;
 - iv. all written policies and procedures required by this section; and
 - v. data submissions in electronic form as requested by the Commissioner of Health in compliance with the most current Department of Health policies for health information exchange in New York State.
 - b. Prenatal care providers shall comply with all federal, state and local laws and regulations regarding the disclosure of protected medical information when sharing or transferring medical information with other healthcare providers or facilities. Providers shall therefore obtain written informed consent from patients prior to transfer of medical records or information where required by law.
 - c. Prenatal care providers shall comply with the requirements to obtain informed consent for all services described herein, in accordance with all applicable laws and regulations.
 - d. Any subcontracts between the prenatal care providers and other agents or agencies providing care and services shall:
 - i. be available for review and inspection by the Department of Health; and
 - ii. require that subcontractors provide contracted care and services that meet the minimum standards established in this section and are provided in accordance with generally accepted standards of practice and patient care services.
 - e. Prenatal care providers shall participate in quality improvement initiatives as requested by the Commissioner of Health.

2. Provider/Staff requirements:

- a. Prenatal care services, including prenatal diagnostic and treatment services, provided to pregnant women and postpartum women shall meet generally accepted standards of care as described by the most current American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG) guidelines for perinatal care and shall be provided by a qualified provider practicing as:
 - i. a licensed physician practicing in accordance with Article 131 of the New York State Education Law and must be either an obstetrical care physician (MD/DO), Board Certified or Board Eligible in their area of specialty, or have completed an accredited residency program in Family Practice or Obstetrics/Gynecology;
 - ii. a nurse practitioner practicing in accordance with Article 139 of the New York State Education Law;
 - iii. a licensed Midwife practicing in accordance with Article 140 of the New York State Education Law; or
 - iv. a registered physician's assistant practicing in accordance with Part 94 of this Title, Article 37 of the NYS PHL and article 131 of the NYS Education Law.
- b. Prenatal care providers shall promote the delivery of prenatal care services in a culturally sensitive/competent manner to all pregnant women including those with limited English proficiency and diverse cultural and ethnic backgrounds. Interpretation services must be offered to patients whose primary language is not English, in person when practical, or via telephone if a translator is not immediately available.
- c. Prenatal care providers must either have admitting privileges at one or more hospitals or shall develop agreements with planned delivery sites including a system for sharing patient information for continuity and follow-up care.

3. Provider/Specialist/Consultation Requirements:

Prenatal care providers shall provide pregnant women timely access and referral to appropriate levels of prenatal care, (basic, specialty, and subspecialty), based on her assessed risk status in order to prevent, recognize and treat conditions associated with maternal and infant mortality and morbidity.²

- a. Management of pre-existing medical conditions—Providers shall provide or arrange for the provision of care for the specific needs of a pregnant woman with a pre-existing medical condition, according to current standards of practice.
- b. Transfer of care—Practices shall develop criteria requiring transfer of primary responsibility for patient care from a family medicine practice physician, physician's assistant, licensed midwife or nurse practitioner to an obstetrician and/or maternal-fetal medicine specialist (high risk obstetrician or perinatologist).
- c. Specialty physician consultation/referral—Prenatal care providers shall develop criteria for consultation and referral for care to a maternal-fetal medicine specialist, perinatologist, high risk obstetrician, specialty physician, behavioral health specialist, including licensed social worker or other health care specialist as necessary based on the identification of specific risk factors or medical conditions requiring additional specialty monitoring and management. Prenatal care providers should follow AAP/ACOG's early and on-going pregnancy risk specific recommendations for consultation.³ Referrals for specialty provider consultations should include:
 - i. description of the indication for the consult,
 - ii. the role of the consultant during the initial consult
 - iii. the role of the consultant during the follow-up care throughout the stages of pregnancy, and
 - iv. the sharing of patient/clinical information between the primary care obstetrical provider and the special care consultant.⁴

B. Access to Care

1. Any pregnant woman who presents for prenatal care should begin receiving care as quickly as possible, preferably the same day. All prenatal care service providers must provide prenatal care services to recipients determined to be presumptively eligible for medical assistance but are not yet enrolled in Medicaid.
2. Prenatal care providers shall assist or refer women for assistance with application for medical assistance and managed care plan selection in accordance with procedures established by the Commissioner.
3. Prenatal care practices must provide or arrange for the provision of 24 hour/7 day week coverage (after hours and weekend/vacation number to call that leads to a person or message that can be returned by a health care professional within one hour). Pregnant women shall have access to unscheduled or emergency visits on a 24 hour basis.⁵
4. Prenatal care providers must develop systems, or arrange for reminder/call backs to patients needing continued or follow-up services, and for visits requiring follow-up for abnormal test results. Prenatal care providers shall outreach to patients to reschedule missed appointments in a manner that maintains patient confidentiality.
5. Prenatal care providers shall schedule prenatal care visits for an uncomplicated pregnancy consistent with AAP/ACOG

recommendations. Pregnant women with medical, obstetrical and/or psychosocial problems may require more frequent visits. The need for increased surveillance is best determined by the prenatal care provider based on the individual needs of the woman, and the nature and severity of her problems.

C. Prenatal Risk Assessment, Screening and Referral for Care

Prenatal care (PNC) providers shall conduct a comprehensive prenatal care risk assessment for both maternal and fetal risks, at the earliest prenatal care visit, on all pregnant women.

1. The risk assessment shall include but not be limited to an analysis of individual characteristics affecting pregnancy, such as genetic, nutritional, environmental, behavioral health, psychosocial and history of previous and current obstetrical/fetal and medical/surgical risk factors. Historical obstetric risk assessment shall include an evaluation of prior preterm birth, risk for recurrent preterm birth and eligibility for progesterone supplementation as per ACOG recommendations.⁶ Prenatal care providers are encouraged to use a standardized written risk assessment tool, such as the ACOG, Hollister or POPRAS form. Using established criteria for determining high risk pregnancies, the prenatal care provider shall determine the woman's risk status based on generally accepted standards of practice.

The risk assessment shall be:

- a. reviewed at each visit;
 - b. repeated formally early in the third trimester;
 - c. used to form the basis for the development of the care plan and;
 - d. documented clearly in the medical record.
2. Based on results of the risk assessment and the individual woman's increased risk for a poor pregnancy outcome, the prenatal care provider shall refer the pregnant woman for follow-up care. Referrals for such care may include but are not limited to: prenatal case management programs provided by managed care plans, other case management programs, home visitation agencies, or community-based programs for prenatal care coordination.
 3. In accordance with Public Health Law section 2530-a 2.3. Prenatal care providers shall complete a standardized New York State Prenatal Care Risk Screening Form, which summarizes the results of the comprehensive risk assessment (as described in C.1.) for each new pregnancy. The completion of this risk screening form once during the pregnancy and reporting of the information shall be with the pregnant woman's informed written consent and shall be in a format to be developed by the Commissioner. If consent and voluntary participation is obtained, prenatal care providers shall complete the New York State Prenatal Care Risk Screening Form at the earliest prenatal care visit and transmit the information in a confidential manner to be determined by the Commissioner.

D. Psychosocial Risk Assessment, Screening, Counseling and Referral for Care

Prenatal care providers shall conduct a psychosocial risk assessment of all pregnant women during the first prenatal care visit. The assessment should be reviewed at each visit and formally repeated early in the third trimester and postpartum to identify important issues that may have developed over time. The assessment shall include a broad range of social, economic, psychological and emotional problems. Screening should include but not be limited to assessment of barriers to care, unstable housing, communication barriers (i.e. language and /or cultural barriers), nutrition, tobacco use, substance use, depression or other psychiatric illness, safety, domestic abuse, sexual abuse, and stress. Based on the results of this assessment the providers shall identify areas of concern, validate major issues with the patient, provide information, and if indicated, provide treatment or make appropriate referral(s).

The psychosocial risk assessment shall include but not be limited to screening for the following:⁷

1. Tobacco Use—Prenatal care providers shall assess all pregnant women about their past and present use of tobacco and exposure to secondhand smoke. All pregnant women should be advised to avoid or minimize time spent in the presence of tobacco smoke. The patient who smokes should be strongly advised to stop smoking and be provided with tailored counseling to assist in smoking cessation. Patients who smoke shall be offered a referral to an appropriate smoking cessation education and/or treatment program.⁸
2. Substance Use—Prenatal care providers shall assess all pregnant women about their past and present use of all substances, including drugs, alcohol, or the use of any prescription or nonprescription medications, including herbal supplements. The possible effects of any substances used before or during pregnancy should be discussed. A woman who acknowledges the use of any substances should be counseled about the implications of their use during pregnancy, and strongly encouraged to refrain from use of any substances that may negatively affect her or her fetus. If appropriate the woman should be offered a referral to a treatment program.
3. Domestic Violence—Prenatal care providers shall screen all pregnant women for domestic violence. Descriptions of domestic abuse from the patient should be documented in the patient's medical record, safety of the patient and family shall be ascertained and referrals made to appropriate counseling, legal and social-service advocacy programs.

4. Depression-Prenatal care providers shall screen pregnant and postpartum women for depression utilizing an appropriate screening tool, and should have a system in place to ensure that positive screening results are followed by accurate diagnosis, implementation of treatment, and follow-up either within the practice or through referral. Prenatal care providers should refer to information on maternal depression, including current evidence and guidelines, evidence-based screening tools and available follow-up support resources provided on the Department's website.⁹

E. Nutritional Screening, Counseling and Referral for Care

Prenatal care providers shall provide or arrange for the provision of nutritional and physical activity screening, counseling and referral which includes:

1. Individual nutritional risk assessment including an assessment of pre-pregnancy BMI, weight gain to date, if any, and specific nutritional risks at the initial prenatal care visit and continuing reassessments as needed;
2. Documentation of the nutritional assessment, risk status and the plan of care in the patient's medical record;
3. Referral of pregnant women identified as being at nutritional risk for specific nutritional counseling, monitoring and follow-up;
4. Provision of basic nutrition education and counseling for each pregnant woman which includes:
 - a. appropriate dietary intake and recommended dietary allowances during normal pregnancy;
 - b. recording of height and weight at the initial prenatal visit to allow for the calculation of the BMI and sequential weight monitoring at each visit. Parameters of appropriate weight gain should be made based on the pre-pregnancy BMI categories recommended in the 2009 Institute of Medicine (IOM) guidelines.¹⁰
 - c. focused approach to nutrition counseling based on AAP/ACOG guidelines which includes exercise and lifestyle changes for all women, but particularly for women with a BMI in the obese (BMI>30) or underweight (BMI<18.5)¹¹ range; and
 - d. counseling and education regarding infant feeding choices discussed with the woman during prenatal visits and immediately postpartum. Prenatal care providers should support breast feeding by counseling the patient regarding the nutritional advantages of human breast milk and should provide her with information regarding the benefits of breast feeding for both the mother and infant. Exclusive breastfeeding is recommended for the first 6 months of life and should be continued along with supplemental foods through the second half of the first year of life and for as long as desired thereafter. Breastfeeding is not recommended for HIV positive women and may be medically contraindicated in other situations. Income eligible women considering breastfeeding should be referred to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) for breastfeeding education and support.
5. Referral of pregnant women identified as needing to access proper nutrition and assistance in obtaining supplemental food to programs such as the Supplemental Nutritional Assistance Program (SNAP) or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
6. Special considerations for underweight and/or overweight/obese women:
 - a. Prenatal care providers shall assess and counsel underweight and overweight/obese women regarding the increased risk for pregnancy complications related to their weight and encourage these women to participate in a lifestyle improvement program, including diet, exercise, and behavior modification.
 - b. Prenatal care providers shall consider screening obese patients for gestational diabetes upon presentation or in the first trimester, and repeat screening later in the pregnancy if results are initially negative.¹²

F. Health Education

Prenatal care providers shall provide or arrange for the provision of health and childbirth education based on an assessment of the pregnant woman's individual needs. Prenatal care providers should focus on the pregnant woman's ability to comprehend the information and use materials appropriate to the educational, cultural and language needs of the patient as well as her gestational history. Such services shall be provided by professional staff, documented in the medical record and shall include but not be limited to the following:

1. Rights and responsibilities of the pregnant woman;
2. Signs and symptoms of complications of pregnancy;
3. Physical activity, exercise and recommended weight gain during pregnancy;
4. Avoidance of harmful behaviors including the use of alcohol, drugs, non-prescribed medications and nicotine;
5. Sexuality during pregnancy;
6. Occupational and environmental concerns including lead exposure;

7. Risks of HIV infection and risk reduction behaviors;
8. Signs of labor;
9. Labor and delivery process and availability of various delivery options;
10. Relaxation techniques in labor;
11. Obstetrical anesthesia and analgesia;
12. Preparation for parenting including infant development and care, options for feeding and the benefits of breast feeding;
13. Newborn screening program, including the distribution of newborn screening literature;
14. Family planning and optimum inter-pregnancy interval.

G. Development of a Care Plan and Care Coordination

Prenatal care providers shall develop a care plan jointly with each pregnant woman which addresses the problems identified as a result of the initial and ongoing risk assessments. The care plan shall describe the implementation and coordination of all services required by the pregnant woman, be routinely updated and implemented jointly by the pregnant woman, her family and the appropriate members of the health care team.

1. Care shall be coordinated to:
 - a. Ensure that relevant information is exchanged between the prenatal care provider and other providers, health plan case managers or sites of care including the anticipated delivery site.
 - b. Ensure that the pregnant woman and her family or other designated representative, with her consent, have continued access to information resources and are encouraged to participate in the decisions involving the care and services being provided.
 - c. Encourage and assist the pregnant woman in obtaining necessary medical, dental, nutritional, psychosocial, drug and substance abuse services appropriate to her identified needs.
 - d. Provide the pregnant woman with an opportunity to receive prenatal and postpartum home visitation when medical and/or psychosocial benefits may be derived from the visits.
 - e. Provide to or refer the pregnant woman for needed services as identified in the risk assessment.
 - f. Obtain special tests and services that may be recommended or required by the Commissioner of Health, when necessary to protect maternal and/or fetal health. Pregnant women shall be provided appropriate medical care, counseling and education based on test results.
2. The prenatal care provider shall coordinate labor and delivery services by developing agreements with planned delivery sites which address, at a minimum, the following:
 - a. a system for sharing prenatal medical records, including HIV test results;
 - b. pre-booking of women for delivery by 36 weeks gestation for low risk pregnancies and by 24 weeks gestation for high risk pregnancies;
 - c. scope of services; and
 - d. sharing of delivery/birth outcome information.
3. The prenatal care provider shall arrange for postpartum home visitation care as necessary and available when the mother and/or newborn may derive medical, physical and/or psychosocial benefits from such visits.

H. Prenatal Care Services

Prenatal care providers shall provide or make arrangements for the provision of comprehensive prenatal care services in accordance with generally accepted standards of professional practice, as outlined by the AAP and ACOG.¹³

1. Prenatal diagnostic and treatment services shall include but not be limited to the following:
 - a. Comprehensive assessment—An initial comprehensive assessment including history, review of systems, and physical examination.
 - b. Standard and special laboratory tests—Based on AAP/ACOG recommendations, standard and special laboratory tests and procedures should be performed at the recommended gestational age.

- c. Follow-up, evaluation of results and referral—Follow-up shall be conducted as indicated based on abnormal findings from the comprehensive assessment, results of preliminary abnormal laboratory test findings and repeat testing of women considered to be at high risk. Prenatal care providers shall discuss the following with the pregnant woman:
 - i. findings from the comprehensive assessment,
 - ii. results of all laboratory tests,
 - iii. recommendations for additional testing,
 - iv. treatment options and obtaining informed consent for treatment,
 - v. technological support and referrals as necessary.

2. HIV Services

a. Prenatal HIV Counseling and Testing

Prenatal care providers shall provide HIV counseling to all pregnant women as early as possible in the pregnancy without regard to risk. Counseling shall be provided and informed consent obtained prior to HIV testing and shall be consistent with the requirements described in Article 27F of the Public Health Law and NYCRR Title 10 Section 63.3. A USFDA approved 4th generation antigen/antibody combination immunoassay should be used. A repeat third trimester test, preferably at 28-36 weeks should be routinely recommended to all pregnant women who tested negative early in prenatal care to identify sero-conversion after an initial negative prenatal HIV test.¹⁴ The New York State Department of Health Informed Consent to Perform HIV Testing (DOH Form—2556), allows the pregnant woman to receive counseling for both tests at the initial counseling and to sign for both tests at that time. The CDC recommends that the partner of a pregnant woman undergo HIV testing, when HIV status is unknown, to decrease the risk of exposure during the pregnancy.

The pregnant woman should be counseled about benefits to knowing her HIV status, specifically the significant reduction in risk of mother-to-child HIV transmission with the provision of antiretroviral (ARV) prophylaxis to HIV-positive women during pregnancy, at delivery and to the newborn. ARV therapy containing Dolutegravir (DTG) carries an increased risk for neural tube defects and should be avoided in the first trimester (2018 DHHS Guidelines). The pregnant woman should be informed that if she does not have a prenatal test, she will be HIV-counseled again when she presents for delivery, and that expedited testing will be done on her, with her consent, or on the newborn, without her consent. She should also be told that all newborns are routinely screened for HIV as part of the Newborn Screening Program, as a final safety net to identify exposed infants.

Pregnant women who receive negative test results should be provided with their results and if at continued risk for developing HIV, encouraged to access HIV prevention programs and services appropriate to their risk(s). Pregnant women who receive positive HIV test results should be provided with post-test counseling consistent with Public Health Law section 2781 and Part 63 regulations and will be provided necessary care and/or appropriate referrals for services. HIV-positive women should be expeditiously referred to an HIV-care provider who can manage ART, ideally within three days.¹⁵

Prenatal care providers should transfer information regarding a prenatal patient's HIV counseling and testing status, including a copy of the result, if one exists, to the delivery setting. Routine consent procedures for the transfer of medical records are sufficient to authorize the transfer of HIV-related information to health care providers.

b. Care of an HIV-Positive Pregnant Woman

Management of antiretroviral (ARV) medications during pregnancy should be done by, or in consultation with, an experienced HIV specialist familiar with state and federal clinical guidelines for the care of HIV-positive pregnant women and the prevention of mother-to-child HIV transmission. Breastfeeding is not recommended for HIV-positive women where there are good alternatives.

NYS Department of Health Clinical Guidelines: Prevention of Mother-to-Child HIV Transmission: https://cdn.hivguidelines.org/wp-content/uploads/20181031114745/NYSDOH-AI-Prevention-of-Mother-to-Child-HIV-Transmission-Guideline-PDF_10-31-2018_HG.pdf

3. Dental care

The prenatal care provider shall conduct an assessment of the woman's oral health care needs at the first prenatal care visit. The assessment shall include but not be limited to interviewing the patient regarding current oral health problems, previous dental problems, and the availability of a dental provider. Pregnant women identified as having a current oral health problem or not having a dental visit in the past six months should be referred to a dentist as soon as possible, preferably before 20 weeks gestation. The prenatal care provider shall educate the pregnant woman about the importance of oral health and that dental care is safe during pregnancy. Oral health care should be coordinated between the prenatal care provider and the dentist.¹⁶

4. Immunizations

Pregnancy is not an absolute contraindication to any vaccination. Some vaccines are strongly recommended for pregnant women during the prenatal period. Many women will not be up-to-date and each pregnant woman should be evaluated for immunization status. Prenatal care providers should reference current guidelines for immunizations and be alert for updated recommendations. Guides for immunizing during and after pregnancy are available from the Centers for Disease Control and Prevention (CDC)¹⁷ and the New York State Department of Health Bureau of Immunization.¹⁸

- a. All pregnant women shall be evaluated for serologic evidence of immunity to rubella at their first prenatal visit, unless known to be immune by documentation of a previous test. Varicella immunity shall also be assessed by either a reliable history of disease, laboratory evidence of previous disease or documented receipt of two doses of vaccine.
- b. Influenza vaccine is strongly recommended for all pregnant women due to the increased risk of influenza-related complications among pregnant women. Providers should advocate for influenza vaccination and provide the influenza vaccine to their pregnant patients.¹⁹ Pregnant women should only receive the trivalent inactivated influenza vaccine (TIV), and not the live attenuated influenza vaccine (LAIV), the nasal spray.
- c. The following immunizations are recommended for women at risk for these diseases and who do not have a history of immunity:
 - i. Hepatitis B—A pregnant woman’s risk of acquiring Hepatitis B Virus (HBV) should be assessed along with her risk of acquiring other sexually-transmitted infections. Pregnant women who have been identified as being at risk for HBV infection should be vaccinated. Pregnancy is not a contraindication for HBV vaccination, and limited evidence does not suggest any fetal harm from the HBV vaccine.
 - ii. Tetanus, Diphtheria/Tetanus, Diphtheria, Pertussis booster (Td/Tdap)—Pregnant women who have not received a Td booster within the last 10 years and require immediate protection against tetanus and diphtheria (i.e. wound prophylaxis) should be vaccinated with Td based on the severity of the risk of tetanus and the need to be immunized. Immunization with Td during pregnancy is preferred in the 2nd or 3rd trimester.
 - iii. Due to the burden of pertussis disease in vulnerable newborns, pregnant women should receive a dose of Tdap during each pregnancy, regardless of prior immunization history, optimally between 27 weeks and 36 weeks gestation. Tdap may be given at any time during pregnancy and there is no evidence of adverse fetal effects from administering inactivated viral or bacterial vaccines or toxoids during pregnancy.²⁰ For women who have not previously received Tdap, if Tdap was not administered during pregnancy, Tdap should be administered immediately postpartum. By providing Tdap vaccine to women during pregnancy, infants will gain pertussis antibodies during the time they are most vulnerable—before three months of age. The infant’s immune response to DTaP may not be as strong; however, based on a recent study looking at this issue, this interference does not seem to cause any problems when it comes to protecting infants.²¹ Researchers are still working to better understand this issue. The benefits of vaccinating during pregnancy and protecting a newborn during the most vulnerable time outweigh the potential risk of blunting an infant’s response to DTaP vaccine.²²
- d. Other pregnancy related immunization issues:
 - i. New York State Public Health Law 2500-e requires that every pregnant woman be tested for the presence of hepatitis B surface antigen (HBsAg) and that the test results and the date are documented in the prenatal record. It also requires that infants of women who are hepatitis B surface antigen positive or whose test results are unknown receive treatment at birth with hepatitis B vaccine and hepatitis B immunoglobulin (HBIG).
 - ii. New York State Public Health Law 2112 (effective July 1, 2008) prohibits the administration of vaccines containing more than trace amounts of thimerosal, a mercury-containing preservative, to pregnant women, unless the supply is insufficient. There is no evidence that thimerosal causes harm to the pregnant woman or her fetus.
- e. Postpartum Period—The following vaccinations or a history of immunity are recommended for all postpartum women: influenza, MMR (measles, mumps, rubella), Tdap, varicella and human papilloma virus. An adult schedule should be checked for appropriate indications in regard to age, previous history of disease or prior history of vaccination.²³

Women who plan to breastfeed can and should receive vaccinations as no evidence exists of any risk to a mother or her infant if she is vaccinated while breastfeeding. Breastfeeding is not a contraindication to any vaccination, with the exception of vaccinia vaccine.

5. Lead Poisoning Prevention, Testing and Management

As required by NYS Public Health Law and Regulations (NYCRR Subpart 67-1.5), prenatal health care providers (HCPs) shall provide all pregnant women with anticipatory guidance on preventing lead poisoning, information on the major sources of lead and the means to prevent exposure while pregnant. At the initial prenatal visit, each pregnant woman shall be assessed for exposure to lead by using a risk assessment questionnaire recommended by the State Commissioner of Health.²⁴ If the pregnant woman responds “yes” to even one of the questions, or the provider suspects lead exposure, she is considered to be at risk, and should have a blood lead test and be counseled on how to eliminate lead exposure. HCPs are also required to provide anticipatory guidance on the prevention of childhood lead poisoning at the woman’s first postpartum visit.

The New York State Department of Health (NYSDOH) is in the process of updating the NYSDOH Lead Poisoning Prevention Guidelines for Prenatal Care Providers.²⁵ During the interim, please utilize the 2010 Centers for Disease Control and Prevention “Guidelines for the Identification and Management of Lead Exposure in Pregnant and Lactating Women.” These guidelines are based on the best available scientific information and provide practical considerations regarding preventing lead exposure during pregnancy, assessment and blood lead testing during pregnancy, medical and environmental management to reduce fetal exposure, breastfeeding, and follow-up of

infants and children exposed to lead *in utero*.²⁶ Highlights include pregnant or lactating women with a confirmed venous BLL:

- 5 micrograms per deciliter (µg/dL) or greater, should receive risk reduction counseling and follow-up testing
 - prenatal HCP and pediatrician must communicate to ensure newborn has a lead test at birth and follow-up testing is done as needed
 - encourage breastfeeding and monitor infant's BLL
- 10µg/dL or greater, who may have been occupationally exposed to lead, should be medically removed from the workplace exposure
 - Refer the pregnant woman to the local health department for an evaluation of available services
 - Contact a Regional Lead Resource Centers (RLRC)²⁷ for consultation
- 15 µg/dL or greater, assist local health department with complete exposure source assessment
- 45 µg/dL or greater, should be referred to a RLRC for medical management and possibly chelation therapy

6. Use of Ultrasound

Prenatal care providers must document the medical indication for performing an ultrasound examination of a pregnant patient based on identified need. Ultrasound for gestational dating is recommended, especially before 20 weeks, if there is a size-date discrepancy or imprecise menstrual dates.²⁸ Ultrasonography shall be provided only by physicians or technologists who have undergone training and only when there is a valid medical indication for the examination documented in the woman's medical record by a qualified prenatal care provider.²⁹ AAP/ACOG guidelines should be followed when recommending an ultrasound exam. Common indications for ultrasound include but are not limited to evaluation for gestational age; fetal number, viability, placenta location, abnormal amniotic fluid volume, fetal growth disturbances, fetal anomalies and aneuploidy screening.³⁰

7. Screening for Genetic Disorders

Prenatal care providers shall offer all pregnant women additional maternal/fetal screenings to identify fetal abnormalities/genetic problems as follows:

- a. Birth defects—Prenatal care providers shall offer all pregnant women screening tests to identify birth defects at specific times throughout the prenatal period based on AAP/ACOG recommendations.
- b. invasive diagnostic testing for aneuploidy should be available to all women regardless of maternal age. Early amniocentesis (at less than 15 weeks gestation) should not be performed.³¹
- c. Pregnant women should be counseled regarding the differences between screening and invasive diagnostic testing for aneuploidy including a discussion of the risks and benefits of the invasive test compared with other available screening tests. Pregnant women who choose not to undergo invasive diagnostic testing for aneuploidy shall be offered aneuploidy screening before 20 weeks gestation regardless of maternal age.³²
- d. Prenatal care providers should offer information on cystic fibrosis screening to all couples and cystic fibrosis carrier screening should be offered to all couples regardless of race or ethnicity.³³
- e. Prenatal genetic screening or diagnosis should be offered to pregnant women based on personal and family history. Genetic screening and counseling criteria should be based on AAP/ACOG recommendations. This includes screening for genetic disorders based on racial and ethnic background, such as hemoglobinopathies (sickle cell, α -thalassemia, β -thalassemia), Tay-Sachs disease, Canavans disease and familial dysautonomia, cystic fibrosis and other genetic disorders based on family history.³⁴

8. Fetal Well-Being

Tests of fetal well-being are indicated in the presence of specific maternal and pregnancy-related conditions and shall be performed based on the judgment of a qualified prenatal care provider according to individual patient need.³⁵ There are several tests used in clinical practice to assess fetal status, each test has advantages, disadvantages as well as risks. The prenatal care provider, based on clinical judgment and recommended AAP/ACOG guidelines should choose the test that best meets the needs of the pregnant woman and her fetus and initiate testing at the appropriate gestational age. The test results and the interpretation shall be discussed with the pregnant woman, documented in the medical record and appropriate referrals initiated as soon as possible.

I. Postpartum Services

The prenatal care provider shall schedule a postpartum visit based on the woman's identified needs and in accordance with AAP/ACOG's recommended schedule, (approximately 4–6 weeks after delivery but no later than eight weeks after delivery; women with a complicated gestation or delivery by cesarean section should have a visit scheduled within 7–14 days of delivery). The visit should include an interval history and a physical examination to evaluate the patient's current status and her adaptation to the newborn.

1. The visit shall include but not be limited to the following:
 - a. identify whether any medical, dental, psychosocial (including depression), nutritional (including breastfeeding), tobacco/smoking cessation needs, alcohol and drug treatment needs of the mother or infant are being met;
 - b. provide anticipatory guidance on the prevention of childhood lead poisoning;
 - c. refer the mother or other infant caregiver to resources available for meeting identified needs and provide assistance in meeting such needs where appropriate;

- d. assess family planning/contraceptive needs and provide advice and services or referral when indicated;
 - e. provide appropriate inter-conception counseling including information such as recommended preconception daily intake of folic acid (400 mcg) as per CDC and ACOG guidelines and encourage a preconception visit prior to subsequent pregnancies;
 - f. refer the infant to preventive and special care services appropriate to his/her needs;
 - g. advise the mother/caregiver of the availability of Medicaid eligibility for infants; and
 - h. advise or refer the mother for assistance with an application for on-going medical care assistance for herself, in accordance with her financial status, health assistance program eligibility and the policies and procedures established by the Commissioner of Health and the State of New York.
 - i. recommend that overweight/obese women continue a nutrition and exercise regimen after pregnancy to encourage weight loss before attempting another pregnancy.³⁶
2. The prenatal care provider shall arrange for postpartum home visitation as necessary when the mother and/or newborn may derive medical, physical and/or psychosocial benefits from such visits.
 3. Postpartum documentation by the prenatal provider shall include: delivery outcome, maternal physical exam, health status of the mother/infant including medical, nutritional, psychosocial needs with referrals.

Questions and Answers

- Prenatal Care Providers Questions and Answers https://www.health.ny.gov/health_care/medicaid/rates/apg/docs/prenatal_care_faqs.pdf

References

1. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (AAP/ACOG). Guidelines for Perinatal Care, Sixth Edition. October, 2007.
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3. ACOG Guidelines Appendix B and C pages 385 -388.
4. Maternal Fetal Medicine Society. Recommendations to Address Documentation Guidelines for level of Involvement in Consultation/co-management of Obstetric Patients, pgs. 1—3.
5. AAP/ACOG Guidelines, pg. 87.
6. American College of Obstetricians and Gynecologists. Practice Bulletin Number 130. Prediction and Prevention of Preterm Birth. *Obstet Gynecol* 2012; 120(4):964-973
7. ACOG Committee on Health Care for Underserved Women. Committee Opinion. Psychosocial Risk Factors: Perinatal Screening and Intervention, Vol. 108 (2), August, 2006; pgs. 469—477.
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9. [NYSDOH Maternal Depression: Information for Health Care Providers](#)
10. Institute of Medicine (IOM). *Weight Gain During Pregnancy: Reexamining the Guidelines*. Washington, DC: The National Academies Press. Posted online May 28, 2009.
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12. ACOG Committee on Obstetric Obesity. Committee Opinion. Obesity in Pregnancy, Vol. 106 (3), September, 2005; pgs. 671—675.
13. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (AAP/ACOG). Guidelines for Perinatal Care, Sixth Edition. October, 2007.
14. [NYSDOH 2007 Health Alert: Steps to Further Reduce Mother-to-Child HIV Transmission in New York State](#)
15. [NYSDOH 2005 Guidance for HIV Counseling and Testing and New Laboratory Reporting Requirements, Rev. 2006](#)
16. [NYS Oral Health Guidelines August 2006](#).
17. [Centers for Disease Control and Prevention \(CDC\)](#)
18. [New York State Department of Health Bureau of Immunization](#)
19. ACOG Committee on Obstetric Practice and Immunization Expert Work Group. Committee Opinion. *Influenza Vaccination during Pregnancy* September 2014

20. ACOG Committee on Obstetric Practice. Committee Opinion. *Update on Immunization and Pregnancy: Tetanus, Diphtheria and Pertussis Vaccine*, Vol 121(6). June 2013: pgs. 1411-1414.
21. Centers for Disease Control and Prevention. Tdap for Pregnant Women: Information for Providers.
22. Centers for Disease Control and Prevention. Tdap for Pregnant Women: Information for Providers.
23. New York State Department of Health, Adult Immunization Schedule.
24. New York State Department of Health, Lead Exposure Risk Assessment Questionnaire.
25. New York State Department of Health Lead Poisoning Prevention Guidelines for Prenatal Care Providers
26. 2010 Centers for Disease Control and Prevention “Guidelines for the Identification and Management of Lead Exposure in Pregnant and Lactating Women”
27. Regional Lead Resource Centers (RLRC).
28. AAP/ACOG, pgs. 110-112.
29. AAP/ACOG, pg. 102.
30. ACOG Practice Bulletin, Clinical Management Guidelines for Obstetrician-Gynecologists, Ultrasonography in Pregnancy, Number 101, February, 2009.
31. ACOG Practice Bulletin, Clinical Management Guidelines for Obstetrician-Gynecologists, Invasive Prenatal Testing for Aneuploidy, Number 88, December, 2007.
32. ACOG Practice Bulletin, Clinical Management Guidelines for Obstetrician-Gynecologists. Screening for Fetal Chromosomal Abnormalities. Number 77, January, 2007.
33. ACOG Committee on Genetics. Committee Opinion. Update on Carrier Screening for Cystic Fibrosis, Vol. 106 (6), December, 2005; pgs. 1465-1468.
34. AAP/ACOG. pgs. 84-85.
35. AAP/ACOG, pgs. 111-112.
36. ACOG Committee Opinion Number 315. September, 2005, Vol. 106 (3), pg. 673.



Capital District Physicians' Health Plan, Inc. Perinatal Health—Data Collection Tool—2024

Date: _____ MD: _____

Member Name: _____ DOB: _____

		Answer	Comments
HISTORY			
1.	Social Assessment	Y N	
2.	Medical History	Y N	
3.	Psychological assessment for Depression	Y N	
4.	Was a standardized depression screening tool used?	No PHQ2 PHQ9 Edinburgh Other NA	
If depression is present, then answer 5-6b:			
5.	Was the patient being treated for depression?	Y N NA	
6	Was a f/u visit and 2nd depression screening done?	Y N NA	NOT SCORED INFORMATIONAL ONLY
6B.	Was the patient referred?	Y N NA	NOT SCORED INFORMATIONAL ONLY
7.	Family History	Y N	
8.	Issues of abuse	Y N	
9.	Activity	Y N	
10.	Environmental Risks	Y N	
11.	Tobacco	Y N	
12.	Does patient smoke? (Quit when pregnant) (Informational) <small>SMK accounts for 20-30% of LBW</small>	Y N Quit	NOT SCORED INFORMATIONAL ONLY
13.	Were smoking cessation options discussed? (Informational)	Y N NA	NOT SCORED INFORMATIONAL ONLY
14.	Alcohol	Y N	
15.	Substance Abuse	Y N	
16.	Nutritional Assessment	Y N	
17.	WIC form (if applicable)	Y N NA	
18.	Risk Assessment	Y N	
19.	Oral health needs	Y N	
20.	Allergies documented	Y N	
21.	Exposure to lead assessment	Y N	
22.	Vaccines given during prenatal visits?		
	Influenza	Y N	
	Tetnus	Y N	
	Tdap	Y N	
INITIAL PHYSICAL EXAM			
23.	Full System Review	Y N	
24.	BMI (1st visit)	Y N	
25.	Abdominal Exam	Y N	
26.	Breast Exam	Y N	
27.	Pelvic Exam	Y N NA	
INITIAL LAB WORK			
28.	Blood type /Rh/antibody	Y N	
29.	H/H	Y N	
30.	Cervical cytology, if indicated	Y N NA	
31.	Rubella titer	Y N	
32.	RPR/VDRL	Y N	
33.	Urine culture	Y N	
34.	Hepatitis Screen	Y N	

35.	HIV offered	Y	N		
36.	HIV testing	Y	N		
37.	Hgb Electrophoresis	Y	N	NA	
38.	Lead (if at risk)	Y	N	NA	
39.	STD screen - GC/Chlamydia	Y	N		
SUBSEQUENT LAB WORK					
40.	8-20 WKS Genetic Screening (MSAFP/Multiple Markers, AFP, triple screen)	Y	N	NA	
41.	24-36 wks H/H	Y	N	NA	
42.	24-28 wks (1 or 2 hours) glucose	Y	N	NA	
43.	26-28 wks RPR/VDRL	Y	N	NA	
44.	32-36 wks GC / Chlamydia	Y	N	NA	
45.	35-37 wks GBS culture	Y	N	NA	
46.	36-40 wks HIV (will be scored in 2016)	Y	N	NA	
SUBSEQUENT VISITS					
47.	Every 4 weeks until 28 wks	Y	N		
48.	Every 2-3 wks until 36 wks	Y	N		
49.	Weekly after 36 wks	Y	N		
Number of prenatal visits kept					
SUBSEQUENT VISITS SHOULD INCLUDE:					
50.	Weight	Y	N		
51.	Blood pressure	Y	N		
52.	Fetal heart rate	Y	N		
53.	Fetal growth	Y	N		
54.	Risk Assessment	Y	N		
EDUCATION					
55.	Health Education	Y	N		
56.	Childbirth classes	Y	N		
POST-PARTUM					
57.	Post-partum visit (If no, enter in comments why)	Y	N		
58.	Within 7-84 days	Y	N		
59.	Delivery Outcome	Y	N		
60.	Re-evaluate risk factors	Y	N		
61.	Smoking addressed	Y	N		
62.	Physical examination	Y	N		
63.	BMI post-partum	Y	N		
64.	Depression screening done	Y	N		
65.	If positive for depression, is she being treated?	Y	N	NA	
65B.	If positive for depression, a f/u visit and 2nd screening done by GYN?	Y	N	NA	NOT SCORED INFORMATIONAL ONLY
66.	Family planning counseling	Y	N		
67.	Exercise assessed/education	Y	N		
68.	Review HIV & STD risk	Y	N		
69.	Adjustment to infant	Y	N		
70.	Identify infant's MD	Y	N		
71.	Documentation that infant had MD follow-up care	Y	N		
72.	Feeding method documented	Y	N		
73.	Type of feeding method a) breast b) bottle c) both	A	B	C	

Perinatal Health Data Collection Reviewer Guidelines

Exclude from Study. Check box if member should not be in study.

Initial History:

1. Social Assessment: Documentation should include father of baby (FOB) involvement, domestic violence screen, sexual assault issues, employment status, family make-up, and living situation. This assessment is aimed towards early detection of potential psychological, economic, emotional, and/or social issues. Acceptable documentation includes completion of psychosocial section of a standardized form or a progress note including a full assessment. A check list on a standardized form that does not include the assessment elements (simply stats psychosocial assessment completed) is accepted as minimal for a “yes” response. Y N
2. Medical History: Data relating to the patient’s medical history such as chronic illnesses (DM, HTN, Cancer); past surgeries, hospitalizations, and/or accidents. Y N
3. Psychological assessment: Was screening conducted? Y N (If member already has a diagnosis of depression, answer “yes”)
4. Was a standardized depression screening tool used? No PHQ2 PHQ9 Edinburgh Other NA. Informational only.
5. If depression present, was the patient being treated for depression - was an anti-depressive medication prescribed? Y N NA (if no diagnosis of depression)
6. If depression present, was a follow-up visit and second depression screening done? Y N NA (if no depression). Informational only.
- 6B. Was the patient referred? Y N NA (if no depression). If member already under the care of another physician, answer “yes.” Informational only.
7. Family history: Documentation should include pertinent family medical history, including chronic family illnesses, psychological issues, and genetic screening results. Y N
8. Issues of abuse: Screening/Counseling for issues of abuse. Y N
Documentation should indicate that the patient was assessed for psychological issues.
9. Activity: Documentation of exercise or occupational activity such as heavy lifting at work, skiing, aerobics, horse-back riding, etc. Y N
10. Environmental Risks: Assessment of exposure to harmful chemicals, lead, second-hand smoke, or toxoplasmosis (soiled cat litter) in the home and/or work environment. Y N (includes lead screening or lead test)
11. Tobacco Screening. Score “yes” if there is screening. Score “no” if screening is not found. Y N
12. Does patient smoke? This is informational only. Mark “yes”, “no” or “Quit when pregnant”. Informational only.
13. If yes to #12, were smoking cessation options discussed? Y N NA. Informational only.
14. Alcohol Screening/Counseling. Score “yes” if there is screening and counseling is documented for positive use. Score “no” if screening is not found. Y N
15. Substance Abuse Screening. Score “yes” if there is screening. Score “no” if screening is not found or if there is no documentation of counseling for a positive use. Y N
16. Nutritional Assessment: encouraged to be done at the first prenatal visit, but adequate if done within the first trimester. Documentation of nutritional assessment to include screening for specific nutritional risk conditions, understanding of and compliance with basic nutritional needs in pregnancy, and provision, if eligible, for enrollment in a supplemental food program (ie. Women Infant and Children). Y N
17. WIC: Members qualify for WIC if they receive Medicaid, public assistance, food stamps, or meet income and family size guidelines. Is there a notation of referral to WIC or if member is already on WIC, or documentation pertaining to nutritional needs (WIC/SNAP)? Y N NA (NA if the patient is already on WIC – hence no paperwork) (NOTE: if no WIC form, what is the office process to refer a member?)—Document in the COMMENT section of the database.
18. Risk Assessment: Documentation of assessment for high-risk pregnancy status, to include an analysis of genetic, nutritional (i.e. PKU, anorexia), psychosocial, medical-surgical, and obstetric risk factors. Assessment must include, at a minimum, a history of health (medical), obstetrical, and psychosocial risk factors. The assessment information may be recorded on a standard risk assessment tool, or may be pulled from different locations within the medical record. Assessment should be performed at the initial visit, but may occur during the first two visits. Y N
19. Assessment of oral health needs. Y N
20. Allergies Documented: Documentation of allergies, or lack of, in the medical record, not just on the chart cover. Y N

21. Lead exposure Assessment. Y N NA (NA if lead test done instead)

22. Vaccines given during prenatal visits?

Influenza – Should only receive the Trivalent Inactivated Influenza vaccine (TIV) and not the Live Attenuated Influenza Vaccine (LAIV), the nasal spray.

Tetanus – Tetanus, Diphtheria, should be given every 10 years.

Tdap – Due to pertussis disease in vulnerable newborns, pregnant women should receive a dose of Tdap during each pregnancy per NYSDOH.

Initial Physical Exam:

23-27. Exam: Documentation of Full System Review should include enough detail to verify that an exam was completed and should include pelvic, breast, and full system review (head, heart, lungs, extremities, and abdomen). PE = WNL is NOT acceptable. Height, weight and blood pressure should also be documented. Y N (Score No even if exam was deferred because the patient had a GYN exam within the past year. A physical exam should be done.) If known, enter in the comment field why the exam was not done.

23. Full System Review Y N (see Page 6, Section H of DOH guidelines)

24. Is the patient's BMI documented at the first visit? Y N

25. Abdominal Exam Y N

26. Breast Exam Y N

27. Pelvic Exam Y N

Initial Labwork:

Screening labs should be ordered on the initial visit and reviewed by the provider and followed up as appropriate. Y N NA—if member refused or fails to comply

28. Blood Type, Rh, and Antibody screen Y N NA

29. Hemoglobin and Hematocrit Y N NA

30. Cervical Cytology: If indicated. Y N NA—if not indicated as per CDPHP Preventive Guidelines or if member refused.

31. Rubella Titer: may be drawn with the initial labs, or determined from prior testing. Y N NA

32. Syphilis Screening: VDRL/RPR in the first trimester. REQUIRED BY LAW. Y N NA

33. Urine culture: should include a test for asymptomatic bacteriuria. Should not be a dipstick Y N NA

34. Hepatitis B Surface Antigen. REQUIRED BY LAW Y N NA

35. HIV Test offered: should be offered on the first visit, but may be offered at any time during the prenatal period. Score “yes” if the test is offered, score “no” if testing not offered. Score “NA” if patient is known HIV positive. Y N NA

36. HIV Testing: score “yes” if the patient agrees to testing, score “no” if patient did not agree to testing, and “NA” if patient is known HIV positive. Y N NA

37. Hemoglobin Electrophoresis should be drawn based on risk for hemoglobinopathies (thalassemia, sickle cell) due to genetic heritage, country of origin or family history. Ethnic populations considered to be at risk include African-American, Arabic, Asiatic Indian, Caribbean, Central/South American, Egyptian, Hispanic, Iranian, Italian, Southeast Asian, and Turkish. Score “no” if sickle cell prep is done instead. Score “NA” if the woman is not at risk, has a known positive sickle cell trait or other hemoglobinopathy, has had a negative screen in the past, or race/ ethnicity cannot be determined. Y N NA

38. Lead level (if at risk) Y N NA

If # 21 is yes and there is no risk, and no lead level was drawn answer # 37 with NA

If # 21 is yes and there is a risk, and no lead level was drawn answer # 37 with No

If #21 is no and no lead level was drawn answer # 37 with No

39. STD Screen: GC and Chlamydia- high risk, Select Plan, Family Health Plus, and Child Health Plus members must have screening done at initial visit. Should be repeated in third trimester as clinically indicated. Score “yes” if cultures obtained, “no” if not done. For all LOB. Y N NA

Subsequent Labwork:

40. Genetic Screening 8-20 weeks: (MSAFP/Multiple Markers, Maternal Triple Screen, AFP) (if indicated). Score “yes” if results are in chart, score “no” if not offered, score “NA” if patient refuses or if gestational age is greater than 20 weeks on initial visit.
41. Hemoglobin & Hematocrit at 24-36 weeks: score “NA” if patient fails to comply.
42. Blood Glucose (1 or 2 hour): 24-28 weeks, Score “yes” if results in chart, score “no” if not offered, score “NA” if patient is instructed and fails to comply, or is a known diabetic.
43. RPR/VDRL: based on risk between 26-28 weeks, Score “NA” if patient fails to comply.
44. GC/Chlamydia: based on risk between 32-36 weeks. Score “yes” if cultures were done, score “no” if not done when risk factors are documented. Score “NA” if there is no clinical indication that STD cultures should be obtained.
45. GBS: group B strep: 35-37 weeks per CDC guidelines. Score “yes” if cultures are present, score “no” if not done, score “NA” if delivery is prior to 36 weeks (and cultures could not be done)
46. HIV: 36-40 weeks per CDC guidelines. Any negative HIV test should be retested in 3rd trimester at 34-36 weeks. Score “yes” if lab tests are present, score “no” if not done, score “NA” if delivery is prior to 34 weeks or if patient refuses or fails to comply or if the initial HIV test was positive (see NYSDOH guidelines, Page 7, HIV Services).

Subsequent Visits:

47. Every 4 weeks until 28 weeks
48. Every 2-3 weeks until 36 weeks
49. Weekly after 36 weeks

Number of prenatal visits kept. Informational only.

There may be deviation from these schedules due to missed appointments/cancellations, score “no” if patient is a No-Show, even if the provider has attempted to bring the patient in for scheduled visits. More frequent visits may be required to monitor conditions including proteinuria, decreased fetal movement, risk of pre-term labor, multiple gestation, history of adverse pregnancy outcome, diabetes, heart disease, heart disease, substance abuse and pregnancy induced hypertension (PIH). Y N

Assessment at Subsequent Visits: Y N and should include:

50. Weight
51. Blood Pressure
52. Fetal Heart Rate: may be documented with an actual rate or + sign. May not be heard prior to 11 weeks (NA)
53. Fetal Growth: can be assessed by fundal height, or ultrasound exam. Measurement usually begins in the 2nd trimester.
54. Risk Assessment: should include emerging OB and/or medical/surgical risks/problems. Documentation should include any previously identified problems with ongoing assessment, as well as assessment of new issues. I.e. HA, N/V, Fetal movement, premature ROM, etc.

Education:

55. Health Education: Services should be offered based on need, may be documented on checklist, flow chart, or narrative not. The following topics should be discussed in the prenatal period: S/S of pregnancy complications (including PTL), Physical activity and exercise, avoidance of harmful practices/substances, sexuality during pregnancy, occupational concerns, S/S of labor, L&D process, pediatrician selection, preparation for parenting, feeding method, family planning. Y N
56. Childbirth Education: Parents should be encouraged to attend childbirth prep classes. Score “yes” if offered, encouraged, or attended. Score “no” if there is no documentation of classes being offered, encouraged or attended. Score “NA” if there is no need for classes (second pregnancy, or documentation that the parent understands the process), or if declined. Y N NA

Post-Partum:

57. Post-Partum Visit—Y N If No, answer “NO”
58. Within 7-84 days Y N
59. Documentation of delivery outcome (can include delivery complications/ no complications and gestational age) Y N
60. Re-evaluation of risk factors. Y N NA (NA is no perinatal risk factors)
61. Smoking assessed—to determine if member began or restarted smoking after delivery Y N

62. Physical exam: should include pelvic, abdominal, breast exam, weight and blood pressure. Score “no” if any items are not documented. Y N
63. BMI in postpartum period Y N
64. Assessed for depression Y N
65. If yes for depression in #64, documentation that the patient was being treated for her depression. Y N NA—if no depression
- 65B. If yes for depression in #64, was a follow-up visit and second depression screening done by the GYN?
Informational only – NOT SCORED.
66. Family planning/counseling—Preconception planning (can include recommendation for folic acid prior to pregnancy, contraception needs/prescribed, counseled to achieve healthy weight if member overweight/obese) Answer “yes” if tubal ligation is documented as this is evidence that family planning needs were addressed. Y N
67. Exercise – was member’s exercise/physical activity assessed or education given Y N
68. Review HIV/STD risks including infant HIV testing results, coitus since delivery, or prior history of STDs. This should be reviewed at the post-partum visit, even if no risks were found antepartum. Y N
69. Adjustment to infant should include assessment of support structures, amount of rest mother is getting, and how partner/siblings are adjusting to infant. Y N
70. Infant MD: practitioner should be identified. Need name of provider. Documentation on the hospital record of the pediatrician is acceptable. Y N
71. Documentation that infant had MD follow-up care. Parents must also understand the importance of continued follow-up to assure identification medical/behavioral health issues that may arise. Need documentation of follow up appointment. Y N
72. Feeding method documented Y N
73. Type of feeding method (breast, bottle or both).

References:

- https://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/
- ACOG form
- NYSDOH Prenatal Care Study 12/6/2013 (emailed to Quality staff)
- file:///K:/Dept/MEDICAL%20AFFAIRS/Shared/Quality%20Studies/2022%20Quality%20Studies/Prenatal%20Study/CDC%20Detailed%20STD%20Facts%20-%20STDs%20&%20Pregnancy.html
- <https://www.cdc.gov/std/pregnancy/stdfact-pregnancy.htm>

Other Obstetrical/Gynecological Care Forms Available

Among many other resources available to you under “Health Practice Guides” in the Provider section of www.cdphp.com are the following:

- High risk pregnancy referral form
- OB/GYN Tip Sheet

NOTE: Each form is developed from guidelines that are reviewed and updated at a minimum of every two years or as needed by the CDPHP Quality Management Committee.

STD/HIV Screening and Reporting

- NYS DOH HIV Testing Toolkit
https://www.health.ny.gov/diseases/aids/providers/testing/docs/testing_toolkit.pdf
- STD Screening and Reporting
NYS Public Health Law (PHL) Article 21 (Chapter 163 of the Laws of 1998) requires the reporting of persons with HIV as well as AIDS to the NYSDOH. The law also requires that reports contain the names of sexual or needle-sharing partners known to the medical provider or whom the infected person wishes to have notified.
https://www.health.ny.gov/diseases/aids/providers/regulations/partner_services/index.htm

Amended HIV Testing Public Health Law

Effective March 28, 2017, Chapter 461 of the Public Health Law, sections 2786 and 2139 allows disclosure of confidential HIV-related information to qualified researchers for medical research purposes upon the approval of a research protocol under applicable State or federal law. Key provisions of these regulation amendments implementing the legislation include:

- Removes the requirement for informed consent prior to ordering an HIV-related test, including elimination of written consent for HIV testing in New York State correctional facilities, and removing references to consent forms.
- Minors have the ability to consent to an HIV test without parental involvement. They should be provided the required information about HIV and be told they have the right to decline an HIV test. Updates to public health regulations in 2016 also now allow minors to consent to HIV treatment and HIV preventive services, including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).
- Adds a provision stating that performing an HIV test as part of routine medical care requires at a minimum advising that an HIV-related test is being performed, prior to ordering an HIV-related test.
- Removes the reference to expiration of an individual's informed consent.
- Adds a provision authorizing local and state health departments to share HIV surveillance information with health care providers, including entities engaged in care coordination, for purposes of patient linkage and retention in care.
- Clarifies language pertaining to reporting by blood and tissue banks.
- Inserts updates to the list of reportable HIV-related test results that need to be reported. These updates are consistent with CDC and Association of Public Health Laboratories guidance related to the diagnosis of HIV infection. Additionally, reporting of results for NYS residents and NYS-located clinicians is explicitly required. This change was designed to address known gaps in reporting.
- Includes language specifically stating that reports must include the requesting provider and facility. The requirement is expected to improve the quality of provider data and lead to more complete data. This should improve accuracy of the Department's surveillance data and, consequently, the National HIV/AIDS Strategy retention and care measures.
- Removes the requirement that the information on HIV provider reporting forms associated with newly diagnosed cases of HIV infection be reported within 60 days.
- Adds individuals who were previously diagnosed as HIV positive, and who are at elevated risk of transmitting HIV to others, to the contact notification prioritization process.
- Removes the requirement that data on the partners of HIV cases be destroyed after three years, and stating that the Department will establish a policy for "record retention and schedule for disposition."
- Eliminates the upper age limit of 64 for the offering of HIV testing. Every individual age 13 and older should be offered an HIV test, at least once, as part of routine care.
- Allows the disclosure of HIV related information to qualified researchers in compliance with State and federal law.
- For up-to-date guidance on the implementation of this legislation, please refer to www.health.ny.gov/diseases/aids/providers/testing/index.htm#publichealthlaw

Consent for HIV Testing

At a minimum, patients must be orally informed that HIV testing is going to be conducted and have the right to refuse an HIV test.

Prior to asking for consent to perform the HIV test, the following key points must be provided. The key points may be delivered orally, in writing, through office signage or any other patient-friendly A-V means.

- HIV testing is voluntary and all HIV test results are confidential (private).
- HIV can be spread through unprotected sex, sharing needles, childbirth or by breastfeeding.
- Treatment for HIV is effective, has few or no side effects and is easy to take.
- Partners can keep each other safe by knowing their HIV status and getting HIV treatment or taking HIV pre-exposure prophylaxis. Not sharing needles and practice safer sex will help protect against HIV, hepatitis C and STDs.
- It is illegal to discriminate against a person because of their HIV status.
- Anonymous HIV testing (without giving your name) is available at certain public testing sites.
- HIV testing is a routine part of health care but you have the right to decline an HIV test. If you wish to decline HIV testing, inform the health care provider.

Key Messages for Pregnant Women about HIV:

- A woman living with HIV can pass the virus to her child during pregnancy, child birth, or through breastfeeding.
- It is much better to know your HIV status before or early in pregnancy so you can make important decisions about your own health and the health of your baby.
- HIV testing is conducted as early as possible in your pregnancy and again in the third trimester with patient consent.
- If you are pregnant and have HIV, treatment is available for your own health and to prevent passing HIV to your baby.
- If you have HIV and do not get treatment, the chance of passing HIV to your baby is one in four. If you get treatment, your chance of passing HIV to your baby is much lower.
- If you are not tested during pregnancy, your provider will recommend testing when you are in labor. In all cases, your baby will be tested after birth. If your baby's test is positive, it means that you have HIV and your baby has been exposed to the virus.
- HIV testing is voluntary and all HIV test results are confidential (private).
- HIV can be spread through unprotected sex, sharing needles, childbirth, or by breastfeeding.
- Treatment for HIV is effective, has few or no side effects and may involve taking just one pill a day.
- Partners can keep each other safe by knowing their HIV status and getting HIV treatment or taking HIV pre-exposure prophylaxis (PrEP). Not sharing needles and practicing safer sex will help protect against HIV, hepatitis C and other STDs.
- It is illegal to discriminate against a person because of their HIV status.
- Anonymous HIV testing (without giving your name) is available at certain public testing sites.
- HIV testing is a routine part of health care but you have the right to object or decline an HIV test.
- If you wish to decline HIV testing, inform the health care provider.

New York State HIV Reporting and HIV Partner Notification Information:

NYS Public Health Law (PHL) Article 21 (Chapter 163 of the Laws of 1998) requires the reporting of persons with HIV as well as AIDS to the NYSDOH. The law also requires that reports contain the names of sexual or needle-sharing partners known to the medical provider or whom the infected person wishes to have notified. The Medical Provider Report Form (PRF) (DOH-4189), must be completed within 14 days of diagnosis for persons with the following diagnoses or with known sex or needle-sharing partners:

1. Initial/New HIV diagnosis—First report of HIV positive test results.
2. Previously diagnosed HIV (non-AIDS)—Applies to a medical provider who is seeing the patient for the first time.
3. Initial/New diagnosis of AIDS – Including <200 CD4 cells/μL or an opportunistic infection (AIDS-defining illness).
4. Previously diagnosed AIDS—Applies to a medical provider who is seeing the patient for the first time.
5. Known sex or needle-sharing partners of persons with diagnosed HIV infection

NYS Public Health Law requires that medical providers talk with HIV-diagnosed individuals about their options for informing their sexual and needle-sharing partners that they may have been exposed to HIV. The NYSDOH Partner Services program provides assistance to HIV-positive individuals and to medical providers who would like help notifying partners. Call your local Health Department or NYSDOH Regional Contacts for Partner Services for STD/HIV for assistance.

From: https://www.health.ny.gov/diseases/aids/providers/testing/docs/testing_toolkit.pdf

Sexually Transmitted Disease (STD) Reporting

New York State Department of Health Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10).

The primary responsibility for reporting rests with the physician; moreover, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d), and state institutions.

For more information, and a list of communicable diseases and NYS reporting form, go to: <http://www.health.state.ny.us/professionals/diseases/reporting/communicable>

Summary: HIV Reporting and Partner Notification

Chapter 163 of the Laws of 1998 amended PHL Article 21 (“Control of Acute Communicable Diseases”) to require the reporting of persons with 1) HIV, 2) HIV related illness and 3) AIDS by NYS physicians and other medical (physician assistants, nurse practitioners, midwives) providers who make diagnoses and by laboratories performing diagnostic tests. (*Note:* HIV tests performed for research purposes only are not included.) The new law also requires that the reports contain names of sexual or needle-sharing partners known to the medical provider or who the infected person wishes to have notified. Reporting should occur no later than 14 days after a positive result or diagnosis.

The law reflects the recognized need to better track the epidemic in order to target resources and plan services appropriately, given new pharmaceuticals which delay the progression from HIV to AIDS significantly. AIDS reporting alone is no longer an effective public health tool. Also, provisions requiring notification of exposed persons reflect a traditional public health intervention to limit the spread of communicable disease.

Briefly, the implementing regulations (10 New York Code Rules and Regulations Part 63) and protocols provide:

- Physicians, nurse practitioners, physician assistants and midwives to report identifying information including patient name on standard forms to the NYS Commissioner of Health, except in NYC where medical provider reports are to be sent into the NYC Department of Health (following the established protocol for AIDS reporting which has been in effect since 1985) Form NYS PRF (DOH-4189).
- Clinical laboratories (including blood banks) will electronically report HIV tests to the NYS Commissioner. For the purpose of the regulation, reportable HIV tests include: HIV antibody tests, HIV nucleic acid detection tests, and CD4 lymphocyte counts less than 500 unless such tests are known to be performed for reasons other than HIV infection/diagnosis (e.g. related to cancer monitoring). Encryption and electronic security protocols (firewall, passwords, etc.) have been put in place for these transfers.
- Medical providers will be asked to complete a timely report listing sexual and needle-sharing partners known to the medical provider (e.g. spouses), or who the infected person wishes to have notified indicating if notification of these partners has been already performed and identifying whether a domestic violence screening protocol has been conducted on the patient and/or contacts. Trained public health staff (in some cases, state employees; in other cases county/NYC health staff) may contact providers to verify information and, when appropriate, notify partners to ensure they are aware of their exposure. Such partners will be counseled and offered HIV testing. In all partner notification activities the name of the infected person is never disclosed.
- Partner names will be maintained no longer than one year after case closure.
- Anonymous testing is specifically exempted from the reporting requirement; anonymous counseling and testing services will continue to be available.
- Disclosing existing HIV information in certain listed occupational settings to persons who have been exposed to blood and body fluids is permitted under the new statute and regulations (10 NYCRR § 63.8(m)) when:
 - the exposure incident occurred to staff/employees/volunteers in their employment or professional duties in: a medical/dental office; in a facility regulated by DOH, OMH, OMRDD, OCFS, OASAS, DOCS or involved an emergency response employee (fire, police, etc.)
 - the incident is documented with supervisory staff
 - a request for disclosure is made by the provider of the exposed person stating information is necessary for decisions on treatment
 - the exposed person is HIV negative or has consented to an HIV test him/herself and if the test returns positive prior to disclosure, no disclosure will occur
 - documentation is placed in the chart of the exposed person; however the name of the person whose HIV test result is released is not given to the exposed person.
 - the medical provider for the source of the exposure determines that a risk of transmission is likely to have occurred.

Note: this addresses disclosure of existing HIV information in a person’s record, it does NOT permit testing of the source.

- Liability provisions in PHL § 2136: good faith reporting or disclosure shall not constitute libel or slander, or violations of the right to privacy or protections of privileged communications. Immunity is granted with respect to civil or criminal liability for any person complying in good faith with the law.
- Disclosure of partners is a voluntary activity; no criminal or civil liability arises for non-disclosure of contacts by the patient.

From: <http://www.health.state.ny.us/diseases/aids/regulations/index.htm>

Note: Consult the Public Health Law and applicable regulations for their provisions, obligations and requirements.

This summary does not contain any advice on which you can rely.