Section 13
OB/GYN Standards
STD/HIV Screening

Obstetrical/Gynecological Care Resources

- CDPHP Perinatal Health Maintenance Guidelines 13-3
- NYS DOH Medicaid Prenatal Care Standards 13-5
- CDPHP Quality Review Tools
    1. Perinatal Health Maintenance—Data Collection Tool 13-15
    2. Perinatal Health Data Collection—Reviewer Guidelines 13-17

STD/HIV Screening and Reporting Requirements

- HIV Screening and Reporting 13-20
- Amended HIV Testing Public Health Law 13-21
- STD Reporting Requirements 13-23

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

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

All pregnancy-related clinical care and services must be delivered in a high-quality, person-centered, cohesive, and comprehensive manner across all provider types. To accomplish this goal, all providers who deliver care to pregnant/postpartum persons must adopt, where applicable, a clinical practice philosophy that:

1. Is consistent with current standards of care, evidence-based practice, and practice guideline recommendations of professional clinical organizations including (but not limited to) the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), the American Academy of Family Physicians, the American College of Nurse-Midwives,i the Centers for Disease Control and Prevention (CDC), and the U.S. Preventive Services Task Force (USPSTF).
2. Applies a practice framework to protect and promote health and well-being for all, building on a foundation of health equity to eliminate racial and ethnic inequities, implicit bias, and racism.ii Engages with stakeholders, including but not limited to pregnant/postpartum persons, families, and community partners, to improve racial and ethnic equity, trust, and quality of care.
3. Demonstrates cultural humility with and sensitivity to all pregnant/postpartum persons, including but not limited to those with limited English proficiency and diverse cultural and ethnic backgrounds, sexual orientations, gender identities, abilities, family structures, and faith communities. Interpretation services must be offered to pregnant/postpartum persons whose primary language is not English, in-person when practical, or via Medicaid-allowable telehealth modalities[iii] if an in-person translator is not immediately available.
4. Is patient-centered and focused on meeting the unique needs of the pregnant/postpartum person based on their biopsychosocial circumstances and pregnancy risk level. Provides respectful maternity care, defined as a universal human right that encompasses the principals of ethics and respect for the pregnant/postpartum person's feelings, dignity, choices, and preferences. Applies a shared decision-making model with respect for patient autonomy and informed consent.[iv]
5. Promotes timely access to needed services, including timely referral to appropriate levels of prenatal care (basic, specialty, and subspecialty), and supporting continuity of care after the end of pregnancy for post-pregnancy, specialty, and primary care needs.
6. Has systems and protocols in place for tracking, notifying, and engaging pregnant/postpartum persons who need follow-up services or visits, including those who need follow-up visits for abnormal evaluations or test results.
7. Integrates a care approach with an emphasis on continuity of care and prompt communication with all members of the pregnant/postpartum person's care team, including the principal maternal care provider, specialist practitioners, mental health providers, substance use disorder providers, nutritionists, social workers, and community organizations, as needed.
8. Promotes comprehensive early and ongoing biopsychosocial risk assessment to prevent, promptly recognize, and treat conditions associated with maternal and neonatal morbidity and mortality.
9. Conducts quality improvement activities including, but not limited to, the evaluation of the quality, safety, and appropriateness of care provided, and participates in quality improvement activities. Process and outcome data must be tracked, analyzed, and used for improving quality and patient safety.

Principal Maternal Care Provider

Every pregnant/postpartum person must have a principal maternal care provider. The principal maternal care provider functions as the pregnant/postpartum person's main maternal care provider and is responsible for leading and coordinating the pregnant/postpartum person's obstetric care throughout the course of the pregnancy and postpartum period (defined as the 12 weeks immediately following the end of pregnancy).

The Principal Maternal Care Provider may be:

1. A New York State licensed physician (MD/DO) practicing in accordance with Article 131 of the New York State Education Law, and who is Board Certified or Board Eligible in Family Medicine or Obstetrics & Gynecology, or has completed an accredited residency program in Family Medicine or Obstetrics/ Gynecology;

2. A New York State licensed Midwife practicing within their training level and scope of practice, and in accordance with Article 140 of the New York State Education Law; or

3. A New York State licensed Nurse Practitioner (NP) practicing within their training level and scope of practice, and in accordance with Article 139 of the New York State Education Law.

The principal maternal care provider serves as the pregnant/postpartum person's principal obstetric provider for the pregnant/postpartum person during the pregnancy and postpartum period (the 12 weeks immediately following the end of pregnancy). The designated primary care provider will remain the primary care provider for the pregnant/postpartum person during the pregnancy and postpartum period. When appropriate, the designated primary care provider may also be the principal maternal care provider.

Access to Care

Principal Maternal Care Provider

Pregnant/postpartum Medicaid persons must be offered prenatal care in a timely manner that is aligned with the requirements of the New York State MMC, HIV SNP, and HARP Model Contracts. Providers must, at a minimum, follow these standards but are strongly encouraged to see the pregnant/postpartum person as soon as possible.

Initial prenatal care visit:

- First Trimester : visit must occur within 3 weeks of the request for care.
- Second Trimester : visit must occur within 2 weeks of the request.
- Third Trimester: visit must occur within 1 week of the request.
- Initial Family Planning visit must occur within 2 weeks of the request.

Emergency care must always be available at an Emergency Room.

For specialist referrals and urgent matters during pregnancy:

- Urgent specialist referrals must be seen as soon as clinically indicated, not to exceed 72 hours.
- Non-urgent specialist referrals must be seen as soon as clinically indicated, not to exceed 2 to 4 weeks of when the request was made.
- For non-emergent, but urgent matters, pregnant persons must be seen within 24-hours of request.

Maternal care practices must provide or arrange for the provision of continuous, uninterrupted coverage (24 hours/day, 7 days/week) as follows:

- After hours and weekend/holiday number to call that leads to a person or option for leaving a message that can be returned by a health care professional within one hour.

The access-to-care standards mentioned above only depict the minimum required time frames by which pregnant persons must be seen if they request a visit. However, pregnant persons may require more frequent visits and follow-ups, and may need to be seen much sooner, depending on their unique medical-psychosocial condition and needs. Providers must consider each pregnant person's unique medical profile, health needs, and severity of the issue at hand when scheduling the pregnant person's visits. Providers must always strive to see pregnant persons as soon as possible and as frequently as possible, depending on their medical, obstetric, and/or psychosocial needs.

For routine, periodic, non-acute prenatal care visits, maternal care providers must follow ACOG/AAP recommendations for

prenatal care visit timing and frequency. Telehealth modalities may be utilized where clinically appropriate and in accordance with the Medicaid telehealth policy.

MMC plan networks must include all provider types necessary to furnish the required Medicaid-covered services, to assure appropriate and timely health care access to the maternal population in accordance with the MMC model contract.

MMC plans will have satisfactory methods for identifying persons at risk of, or having, chronic conditions and determining their specific needs in terms of specialist physician referrals, supplies and services

MMC plans are required to establish and implement mechanisms to ensure that participating providers comply with timely access requirements, monitor regularly to determine compliance and take corrective action when these requirements are not met.[v]

Presumptive Eligibility / Medicaid Coverage

Maternal care providers must assist or refer pregnant members for assistance with application for Medicaid and managed care plan selection.[vi]

Effective January 1, 2026, qualified entities who screen pregnant individuals for Presumptive Eligibility (PE) will no longer use the paper *Medicaid Presumptive Eligibility for Pregnant Individuals Screening* form (DOH-5224) or send their Presumptive Eligibility for Pregnant Individual screenings to their local department of social services or the Human Resources Administration. Qualified entities include any Article 28 licensed providers offering prenatal care.

Presumptive Eligibility for Pregnant Individual screening will be processed electronically, by qualified entity staff, in the new Medicaid Eligibility and Client Management System (MECM) in the Spring of 2026. During the period between January 1, 2026, and the date MECM is ready to handle Presumptive Eligibility for Pregnant Individual screenings, staff from qualified entities can assist pregnant patients with accessing New York State Medicaid coverage through New York State of Health. If assistance is needed in completing the application in New York State of Health, the pregnant individual can be referred to an assistor or the New York State of Health Customer Service Center at (855) 355-5777. A list of application assistors is included on the NY State of Health website, and can be searched by county. The New York State of Health Customer Service Center can also refer the individual to an application assistor in their county.

If the DOH-5224 is received by a local department of social services or the Human Resources Administration for Presumptive Eligibility coverage beginning on or after January 1, 2026, it will not be processed by the district or Human Resources Administration. Instead, the completed DOH-5224 will be forwarded on to New York State of Health to perform outreach to the consumer to start an application. In this situation, there is no guarantee of payment for the date of service. Additionally, there is no way for providers to be notified of the billable Client Identification Number of the patient, other than to contact the patient. If a consumer applies and is determined eligible, coverage will begin the month of application. To avoid delays in coverage for patients and the potential for non-payment of services, providers should not complete Presumptive Eligibility for Pregnant Individual screenings using DOH-5224 on or after January 1, 2026.

All prenatal care service providers must provide prenatal care services to pregnant individuals determined to be presumptively eligible for medical assistance but who are not yet enrolled in Medicaid.

Pregnant Medicaid members, regardless of immigration status, are eligible for Medicaid coverage through 12 months following the end of pregnancy. This Medicaid coverage is inclusive of all Medicaid-covered services that Medicaid members are entitled to.

Comprehensive Prenatal Care Risk Assessment and Approach

The principal maternal care provider must adopt a comprehensive antepartum approach that includes coordinated medical care, ongoing risk assessment, and psychosocial support that optimally begins before pregnancy and extends throughout the postpartum and interpregnancy periods.[vii] The purpose of the comprehensive prenatal care risk assessment and approach is to identify all relevant past and current maternal-fetal biopsychosocial risk factors as early in the pregnancy as possible, so that the identified risk factors can be promptly addressed and prevent harm.

The comprehensive prenatal care risk assessment must be consistent with clinical standards and the most up-to-date AAP and ACOG Guidelines for Perinatal Care, including inclusion of all components in the Antepartum Record and Postpartum Form and the early and ongoing pregnancy risk identification, as relevant per stage of pregnancy.[viii] The comprehensive prenatal care risk assessment should be completed at the first prenatal care visit, or as soon as possible thereafter. It is to include a review all of the relevant past and current maternal-fetal medical, dental, behavioral health, substance use, nutritional, and psychosocial risk factors indicated in the tables below. Ongoing risk assessment should occur throughout the pregnancy.[ix] Electronic medical record systems should support current documentation requirements and remain up-to-date.

The comprehensive prenatal care risk assessment should be:

- Conducted at the first prenatal visit,
- Reviewed at each routine prenatal visit,
- Repeated early in the third trimester,
- Used to form the basis for developing the care plan [see next section],
- Documented clearly in the pregnant person's medical record, and
- In alignment with current clinical guidelines for the provision of perinatal care.

Psychosocial screening should be completed for all pregnant persons, on a regular basis and documented in the pregnant person's medical record[x] Verbal screening for substance use, not testing biological specimens, should be conducted routinely for all pregnant persons using a validated screening tool as per ACOG, AAP and USPSTF recommendations.[xi, xii, xiv] Screening tools for drug use are not meant to diagnose drug dependence, abuse, addiction, or drug use disorders. Persons with positive screening results may, therefore, need to be offered or referred for diagnostic assessment.[xv]

ACOG advises that any specimen testing for substance use be completed only with the pregnant person's informed consent and in compliance with state and local laws.[xvi, xvii] Additionally, the New York State Department of Health and the Office of Addiction Services and Supports note that substance use alone – whether disclosed through a Plan of Safe Care, self-report, screening, toxicology, or newborn symptoms – is not evidence of child maltreatment.[xviii] Principal maternal care providers and health systems are to follow current New York mandated reporter guidelines.[xix]

If the comprehensive prenatal care risk assessment identifies a maternal-fetal risk factor at any point in the pregnancy, the maternal care provider must address the identified risk factor as soon as possible using the appropriate means, whether by providing treatment, counseling, education, or referral to the appropriate specialists or community resources for evaluation and management of the identified risk factor.

Specialists and community resources may include, but are not limited to, the following:

Asthma Educator	Domestic/Intimate Partner Violence Services	Mental Health Provider	Substance Use Provider
Childcare Resources[xx]	Doula	Nutrition/Lactation Counseling	Supplemental Nutrition Assistance Program (SNAP)
Community Health Worker	Health Home	Office Case Manager	Tobacco Dependence Treatment
Community Case Manager	Health Plan Case Manager	Peer Family Navigator	Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
Dental Care	High-Risk OB	Remote Patient Monitoring	
Diabetes Educator	Home Visit Provider	Social Care Networks	

Care Plan

Principal maternal care providers must develop a care plan jointly with each pregnant/postpartum person, their designated family member(s) and appropriate members of the health care team, that addresses the problems identified as a result of initial and ongoing risk assessments. The care plan shall describe the implementation and coordination of all services required by the pregnant/postpartum person and be routinely updated.

Principal Maternal Care Provider

The principal maternal care provider, within the context of a team care approach, must ensure:

1. That relevant information is exchanged between the principal maternal care provider and other healthcare providers, human service and community-based service providers, health plan case managers, and sites of care, including the anticipated delivery site.
2. Ongoing communication between the provider and the pregnant/postpartum person's health plan to facilitate plan's timely awareness of the person's pregnancy, health insurance application, and health needs.
3. The pregnant/postpartum person has continued access to information and resources and is encouraged to participate in the decisions involving the care and services being provided. With the consent of the pregnant/postpartum person, access to this information and resources should be extended to their family or other designated representative.
4. The pregnant/postpartum person is assisted in obtaining necessary medical, dental, mental health, substance use, nutritional, and psychosocial services appropriate to their identified needs. (Refer to the appropriate specialists or community resources as outlined in the prior section.)
5. The pregnant/postpartum person has the opportunity to receive prenatal and postpartum home visiting services.
6. The pregnant/postpartum person is provided with timely and appropriate medical care, counseling, and education based on their evaluations and test results.
7. Facilitation of education, timely recognition, and appropriate intervention of early warning signs during and up to one year after pregnancy.[xxi]
8. Facilitation of connections to preventive services, community health worker, doula services and Social Care Networks/community-based organizations offering additional supports, such as for social care needs.
9. Obtain special tests and services recommended or required by the Commissioner of Health when necessary to protect maternal and/or fetal health. The following tests or services are required by law and/or regulation, and the provider must follow current standards of care, evidence-based practice, and practice guideline recommendations for tests and services:
    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 be 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 prohibits the administration of vaccines containing more than trace amounts of thimerosal, a mercury-containing preservative, to pregnant women, unless the supply is insufficient.
    iii. New York State Public Health Law and Regulations (New York CRR Subpart 67-1.5) requires that prenatal care providers 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. If considered to be at risk, the pregnant person should have a blood lead test and be counseled on how to eliminate lead exposure. Providers are also required to provide anticipatory guidance on the prevention of childhood lead poisoning during prenatal and postpartum visits.

iv. New York State Public Health Law, Article 23 Section §2308; New York Code of Rules and Regulations, Title 10, §69-2.2 requires that pregnant women be screened for syphilis with a blood test at their first prenatal visit, in thethird trimester and again at delivery. It is strongly recommended to pair this third trimester screening with third trimester HIV testing.xxii

v. New York State Public Health Law §2500-L. Every physician or other authorized practitioner attending a pregnant person in the state shall order a hepatitis C virus (HCV) screening test and if the test is reactive, an HCV RNA test must be performed on the same specimen, or a second specimen collected at the same time as the initial HCV screening test specimen, to confirm diagnosis of current infection. The health care provider shall either offer all persons with a detectable HCV RNA test follow-up HCV health care and treatment or refer the individual to a health care provider who can provide follow-up HCV health care and treatment. The HCV results shall be recorded in the medical record at or before the time of hospital admission for delivery.[xxiii]

The principal maternal care provider, along with the maternal care team, shall coordinate labor and delivery services by developing agreements with planned delivery sites which address, at a minimum, the following:

1. A system for sharing prenatal medical records, including HIV test results;
2. Pre-booking of pregnant person for delivery by 36 weeks gestation for low-risk pregnancies and by 24 weeks gestation for high-risk pregnancies;
3. Scope of services; and
4. Sharing of delivery/birth outcome information.

MMC Plans

MMC plans must offer care coordination services to all pregnant and postpartum members in the perinatal period, and must have in place policies and procedures that address, at a minimum, the following activities:

1. Ensure that relevant information is exchanged between the principal maternal care provider and other providers, human service and community-based service providers, health plan case managers, or sites of care including the anticipated delivery site.
2. Ensure ongoing communication between the pregnant/postpartum person's health plan and the provider(s) to facilitate the plan's timely awareness of pregnant/postpartum person's pregnancy, health insurance application, and health needs.
3. Ensure proactive, ongoing outreach and communication from the health plan to the member regarding finding a provider, practice enrollment, adherence to evidence-based care and current practice standards, and health needs and benefits."

As part of the MMC benefit package, MMC plans are required to provide preventive health services which are essential for promoting health and preventing illness. These preventive health services include childbirth education classes, parenting classes covering topics such as bathing, feeding, injury prevention, sleeping, illness prevention, steps to follow in an emergency, growth and development, discipline, signs of illness, nutrition counseling, etc., with outreach to pregnant/postpartum persons, and extended care coordination, for pregnant/postpartum persons. In addition, the MMC plan shall coordinate care for members with family planning clinics, community health centers, migrant health centers, rural health centers and prenatal care providers; and Special Supplemental Nutrition Program for Women Infants and Children (WIC) referrals, as applicable.[xxiv]

Home Visits

The Medicaid reimbursable visit is a skilled nursing home visit provided by agencies that are certified or licensed under Article 36 of the Public Health Law and are either a Certified Home Health Agency (CHHA) or a Licensed Home Care Service Agency (LHCSA). Other home visit providers may include, but are not limited to, Nurse-Family Partnership Programs, local health departments, and community health worker programs, which may or may not be covered as a Medicaid benefit.

Prenatal home visits must be provided as a benefit to pregnant persons if ordered by the principal maternal care provider and if they are medically necessary for managing the pregnant person's perinatal course or perinatal issue at hand.

All postpartum persons are eligible for one initial postpartum home visit after they give birth. Additional postpartum home visits could be covered depending on the postpartum person's unique medical, obstetrical, and/or psychosocial profile.

The skilled nursing home visits are designed to:

- Assess medical health status, obstetrical history, current pregnancy-related problems; and
- Assess psychosocial and environmental risk factors such as unstable emotional status, inadequate resources or parenting skills; and
- Provide skilled nursing care for identified conditions requiring treatment, counseling, referral, instructions or clinical monitoring.[xxv]

Criteria for medical necessity for prenatal home visits and additional postpartum home visits, beyond the initiation postpartum visit, are as follows:

- High medical risk pregnancy as defined by the ACOG and the AAP Guidelines for Perinatal Health (Early Pregnancy Risk Identification for Consultation); or
- Need for home monitoring or assessment by a nurse for a medical condition complicating the pregnancy; or
- Pregnant person otherwise unengaged in prenatal care (no consistent visits); or
- Need for home assessment for suspected environmental or psychosocial risk including, but not limited to, intimate

partner violence, substance use, unsafe housing, nutritional risk, unstable mental health, and inadequate resources or parenting skills.[xxvi]

The number and frequency of the home visits must be guided by what is medically necessary to manage the pregnant/postpartum person's perinatal course or perinatal issue at hand, based on the pregnant/postpartum person's unique medical, obstetrical and/or psychosocial profile.

The prenatal home visit assessment and its findings must be sent to the pregnant/postpartum person's principal maternal care provider, other treating providers, and if relevant, their health plan case manager and newborn's pediatric provider for next steps as needed to manage any issues that are identified in the home visit assessment (such as referral to specialists and other community resources for evaluation and management).[xxvii]

Initial Postpartum Home Visit

The purpose of the initial postpartum visit is to address acute postpartum issues, as per ACOG/AAP postpartum recommendations.

All principal maternal care providers and/or birthing hospitals must offer and arrange for the initial postpartum home visit with all postpartum persons. All birthing hospitals must have a system in place to arrange and schedule the postpartum person's first/initial postpartum home visit prior to discharge.

If a postpartum person agrees to receive the initial postpartum home visit, then the birthing hospital is responsible for arranging and scheduling the initial postpartum home visit for the postpartum person, and the postpartum home visit should take place 36 to 72 hours after the postpartum person's discharge.

Initial and Comprehensive Postpartum Visits Provided by the Principal Maternal Care Provider

All postpartum persons are to have an initial assessment by their principal maternal care provider within the first 3 weeks postpartum either in-person or via telehealth to address acute postpartum issues. Ongoing follow-up care must be individualized and provided as needed. Postpartum persons with a complicated gestational history or delivery by cesarean section must have an initial visit scheduled as early as possible or within 7 days of delivery.

The comprehensive postpartum visit must occur in-person no later than 12 weeks after birth. The timing must be individualized and person-centered. The purpose of the comprehensive postpartum visit is to conduct a full assessment of all relevant maternal and child physical, social, and psychological well-being factors, as per ACOG/AAP postpartum recommendations, and to facilitate timely intervention for warning signs associated with postpartum morbidity and mortality.[xxviii,xxix] For example, the comprehensive visit must include, but not be limited to, the following:

1. Identify whether any medical, dental, psychosocial (including depression, anxiety and preexisting mental health disorders), nutritional (including breast-/chestfeeding), tobacco/smoking cessation, and alcohol and drug treatment needs of the postpartum person or infant are being met;
2. Refer the postpartum person or other infant caregiver to primary care, subspecialist health providers or resources available for meeting identified needs, including follow-up related to pregnancy complications and/or chronic disease management, and provide assistance in meeting such needs where appropriate;
3. Assess family planning/contraceptive needs and provide advice and services or referral when indicated;
4. Provide guidance regarding well-person and interpregnancy care, including health maintenance and appropriate screening, patient-centered birth spacing and contraceptive counseling and care, and attainment of a healthy body weight; [xxx, xxxi, xxxii]
5. Advise or refer the postpartum person for assistance with an application for ongoing medical care assistance for themselves, in accordance with their financial status, health assistance program eligibility, and the policies and procedures established by the Commissioner of Health and the State of New York;
6. Provide communication and collaboration with non-principal maternity care providers to ensure care coordination, seamless transition of and ongoing connection to care/services;

7. Refer the infant to preventive and special care services appropriate to their needs;
8. Provide anticipatory guidance on pediatric health topics, such as vaccinations, the prevention of childhood lead poisoning and safe sleep practices; and
9. Advise the postpartum person/caregiver of the availability of Medicaid eligibility for infants and other family members.

Breastfeeding/Chestfeeding

In accordance with ACOG and USPSTF recommendations, health care providers are to educate and counsel pregnant and postpartum persons about infant feeding decisions and breast-/chestfeeding at all prenatal visits, the maternity stay, and postpartum. Exclusive human milk feeding is recommended for approximately the first 6 months after birth[xxxiii]. Continued human milk feeding is recommended, along with the introduction of complementary foods at about 6 months, as long as mutually desired by parent and child for 2 years or beyond. Providers are to educate pregnant and postpartum persons about the known nutritional advantages and health benefits of human milk/breast-/chestfeeding for both the birthing person and the infant. Given that racial biases and practices contribute to breast-/chestfeeding disparities, providers are to implement policies and practices in their offices and hospitals to provide culturally sensitive, equitable breast-/chestfeeding education, lactation counseling, and maternity care[xxxiv]

All health care providers who care for pregnant and postpartum persons or newborns are to be knowledgeable about breast-/chestfeeding and competent to provide lactation guidance, education, assessment, and referrals to the full range of lactation support providers, including International Board Certified Lactation Consultants, to support a person's efforts to breastfeed/chestfeed. Referrals should be made to the appropriate level of lactation support providers based on the breast/chestfeeding person's needs.xxxv Pregnant and postpartum persons must also be referred to community breast-/chestfeeding support groups and WIC for prenatal, postpartum, infant and child nutrition, and breast-/chestfeeding education and support. For parents who are separated from their infant or returning to work or school, additional lactation support and counseling may be needed to ensure breast-/chestfeeding success.

Pregnant or postpartum persons with HIV who have questions about breast-/chestfeeding or who want to breast-/chestfeed need patient-centered, evidence-based counseling on infant feeding options to allow for shared decision-making.[xxxvi, xxxvii] Breast-/chestfeeding may be medically contraindicated in certain situations.[xxxviii]

Pregnant and postpartum persons are to be educated about New York State and federal laws that protect breast-/chestfeeding in public places and maternity care facilities, provide the rights to express milk in the workplace in a private, non-bathroom space, reasonable accommodations, protection from retaliation, reasonable break time; the availability, indications and use of breast pumps; and safe storage of human milk.

New York Laws:

1. New York Paid Family Leave Law provides eligible employees with up to 12 weeks of job protected, paid time off to bond with a new child, care for a family member with a serious health condition, or to assist loved ones when a family member is deployed abroad on active military service. This time can be taken all at once, or in increments of full days. Employees receive 67% of their weekly wage, up to a cap of 67% of the Statewide Average Weekly Wage. Full-time employees who work a regular schedule of 20 or more hours per week are eligible after 26 consecutive weeks of employment and part-time employees who work a regular schedule of less than 20 hours per week are eligible after working 175 days, which do not need to be consecutive. Employees with irregular schedules should look at their average schedule to determine if they work, on average, fewer than 20 hours per week.

2. New York State Labor Law § 206-c Right of nursing mothers to express breast milk. This law provides all employees with the right to paid break time to express breast milk in the workplace regardless of the size of their employer or the industry they work in for up to three years following the birth of a child. Employers are required to tell employees about their rights regarding breast milk expression by providing them the New York State Department of Labor Policy on the Rights of Employees to Express Breast Milk in the Workplace when they start a new job and annually thereafter.

3. New York Civil Rights Law § 79-e Right to breast feed. Notwithstanding any other provision of law, a mother may breast feed her baby in any location, public or private, where the mother is otherwise authorized to be, irrespective of

whether or not the nipple of the mother's breast is covered during or incidental to the breast feeding.

4. New York Penal Law § 245.01 Exposure of a person . An individual breastfeeding an infant is not subject to penal law that punishes exposure of a private or intimate part of their body.
5. New York Correction Law § 611 allows a mother of a nursing child to be accompanied by her child if she is committed to a correctional facility at the time she is breastfeeding. This law also permits a child born to a committed mother to return with the mother to the correctional facility. The child may remain with the mother until one year of age if the woman is physically capable of caring for the child.
6. New York Public Buildings Law § 144 requires that a covered public building shall contain a lactation room that is made available for use by a member of the public to breastfeed or express breast milk.
7. New York Judiciary Law § 517 amends the Judiciary Law, provides an exemption from jury duty for breastfeeding women, allows that such breastfeeding mother's jury duty shall be postponed up to a certain period after the date on which such service otherwise to commence.
8. New York Social Services Law § 365-a includes pasteurized donor human milk, which may include fortifiers as medically indicated for in-person use, under standard coverage for medical assistance for qualifying infants.
9. 2015-S8, New York Executive Law §§ 292, 296 Pregnant Workers Fairness Act requires employers to make reasonable accommodations for workers with pregnancy-related conditions, unless the accommodations would pose an undue hardship on the employer. An employer can request documentation to verify the existence of the pregnancy-related condition, or to have information that is necessary for an accommodation. Applies to public and private employers with four or more employees.
10. The New York State Human Rights Law bans pregnancy-related discrimination, and covers all workplaces, regardless of size.

Federal Laws:

1. Title VII of the Civil Rights Act, 42 U.S.C. §2000e-2, 42 U.S.C. § 2000e(k), 29 C.F.R. § 1604.10, prohibits sex discrimination in employment on the basis of pregnancy, childbirth, and related medical conditions, such as breastfeeding and lactation. Employees must be given the same type of accommodations as others with temporary medical conditions for all employment-related purposes
2. Title IX of the Education Amendments of 1972, 20 U.S.C. §1681 et seq, 34 C.F.R. § 106.40(b)(1), prohibits sex discrimination in educational institutions that receive federal funds and discrimination against students based on parental status, pregnancy, childbirth, recovery from childbirth, and related conditions. It requires that pregnant students and those recovering from childbirth-related conditions be given the same accommodations and support services given to other students with similar temporary medical needs.
3. Section 7 of the Fair Labor Standards Act , 29 U.S.C. § 207(r), requires all employers to provide a private, non-bathroom space and reasonable unpaid break time to express breastmilk for up to one year. Employers with less than 50 employees who can demonstrate undue hardship are exempt from this law.
4. Friendly Airports for Mothers (FAM) and FAM Improvement Act requires all airports to provide a clean, non-bathroom space in each terminal for the expression of breastmilk and a baby changing table in one men's and one women's restroom in each passenger terminal building.
5. Family and Medical Leave Act (FMLA) provides eligible employees up to 12 weeks of job-protected, unpaid time off work per year to address serious health needs (including pregnancy), bond with a new child, care for a seriously ill or injured family member, or address certain military family needs.
6. Pregnant Workers Fairness Act provides for reasonable accommodations for qualified applicants or employees who have known limitations related to pregnancy, childbirth, or related medical conditions.

7. The PUMP for Nursing Mothers Act ("PUMP Act", S. 1658/H.R. 3110) , expands the legal right to receive pumping breaks and private space to nearly 9 million more workers, including teachers, registered nurses, farmworkers, and many others. The legislation requires the provision of lactation break time and space to previously uncovered workers, as well as protecting employees are from retaliation.

8. Pregnancy Discrimination Act prohibits discrimination on the basis of pregnancy, childbirth, or related medical condition.

9. The Americans with Disabilities Act 42 U.S.C. § 12182 grants workers the right to unpaid, job-protected time off for workers with a pregnancy-related disability.

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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) SMK accounts for 20-30% of LBW	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? ❑ Y ❑ N ❑ 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 con- sent.
- 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

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.