HEDIS®
Resource Guide

— Kentucky Women's Health Toolkit —

WellCare®
Beyond Healthcare. A Better You.

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What Is HEDIS®?

HEDIS (Healthcare Effectiveness Data and Information Set) consists of a set of performance measures utilized by more than 90 percent of American health plans that compare how well a plan performs in these areas:

- Quality of care
- Access to care
- Member satisfaction with the health plan and doctors

Why HEDIS Is Important

HEDIS ensures health plans are offering quality preventive care and service to members. It also allows for a true comparison of the performance of health plans by consumers and employers.

The Value of HEDIS to You, Our Providers

HEDIS can help save you time while also potentially reducing healthcare costs. By proactively managing patients' care, you are able to effectively monitor their health, prevent further complications and identify issues that may arise with their care.

HEDIS can also help you:

- Identify noncompliant members to ensure they receive preventive screenings.
- Understand how you compare with other WellCare providers as well as with the national average.

Value of HEDIS to Your Patients, Our Members

HEDIS ensures that members will receive optimal preventive and quality care. It gives members the ability to review and compare plans' scores, helping them to make informed healthcare choices.

What You Can Do

- Encourage your patients to schedule preventive exams.
- Remind your patients to follow up with ordered tests.
- Complete outreach calls to noncompliant members.

Resources Available to Your Patients

- WellCare's 24 hour Nurse/Baby Line **1-855-478-2229**; Option **4**
- WellCare's 24 hour Nurse Line **1-800-919-8807**

If you have questions about **HEDIS** or need more information, please contact your local Provider Relations Representative or your Quality Practice Advisor.

Source: ***www.ncqa.org***

HEDIS®: Pregnancy Measures

Prenatal and Postpartum Care (PPC)

Description

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following elements of prenatal and postpartum care:

- *Timeliness of Prenatal Care*. The percentage of deliveries that received a prenatal care visit as a member of the organization **in the first trimester within 42 days of enrollment in the organization**.
- *Postpartum Care*. The percentage of deliveries that had a postpartum visit **on or between 21 and 56 days after delivery**.

Required Documentation: Timeliness of Prenatal Care

A face-to-face prenatal visit during the first trimester, with an OB/GYN, midwife, family practitioner, or PCP, with a documented pregnancy-related diagnosis code, **AND** at least one of the following:

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used);
- Screening test in the form of an obstetric panel (e.g., hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing);
- An ultrasound (echocardiography) of the pregnant uterus;
- A TORCH antibody panel alone:
  - Toxoplasma
  - Rubella
  - Cytomegalovirus
  - Herpes simplex
- A rubella antibody test **AND** an ABO test on the same or different dates of service
- A rubella antibody test **AND** an Rh test on the same or different dates of service
- A rubella antibody test **AND** an ABO/Rh test on the same or different dates of service.
- A prenatal visit during the first trimester, on the same or different dates of service, **AND** with one of the following:
  - A complete obstetrical history; **OR**
  - A prenatal risk assessment and counseling/education; **OR**
- A prenatal visit with a pregnancy-related diagnosis code during the first trimester, on the same or different dates of service, **AND** with a least one of the following:
  - An obstetric panel; **OR**
  - An ultrasound (echocardiography) of the pregnant uterus.
- Documentation of LMP or EDD in conjunction with either of the following:
  - Prenatal risk assessment and counseling on importance of smoking cessation during pregnancy, education or prenatal vitamins.
  - Complete obstetrical history (at a minimum must include their G/P: e.g., G4 T1 P1 A1 L1, primigravida.

Codes for Timeliness of Prenatal Care

Prenatal Care & Frequency of Ongoing Prenatal Care: *Prenatal Care - Percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment.* *Frequency of Ongoing Prenatal Care - The percentage of deliveries that had expected prenatal visits.*	
ICD-10-CM Diagnosis	Use appropriate code family: O Z03.71-Z03.75, Z03.79, Z34.00-Z34.03, Z34.80-Z34.83, Z34.90-Z34.93, Z36
ICD-10-CM Procedure	Ultrasonography: BY49ZZZ, BY4BZZZ, BY4CZZZ, BY4DZZZ, BY4FZZZ, BY4GZZZ
Prenatal Care & Frequency of Ongoing Prenatal Care: *Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment.* *Frequency of Ongoing Prenatal Care: The percentage of deliveries that had expected prenatal visits.*	
CPT Codes	E/M: 99201-99205, 99211-99215, 99241-99245, 99500 OB Fetal Monitoring: 76801, 76805, 76811, 76813, 76815-76821, 76825-76828 Prenatal Bundled Codes: 59400, 59425, 59426, 59510, 59610, 59618 OB Panel: 80055 TORCH: • Toxoplasma: 86777, 86778 • Rubella: 86762 • Cytomegalovirus: 86644 • Herpes Simplex: 86694, 86695, 86696 Rubella/ABO/Rh: • Rubella 86762 • ABO: 86900 • Rh: 86901
HCPCS	G0463, H1000-H1004, H1005, T1015

Required Documentation for Postpartum Care:

Postpartum visit to an OB/GYN practitioner or midwife, family practitioner, or other PCP on or between 21 and 56 days after delivery. The medical record must include the date the visit occurred and at least **ONE** of the following:

- Pelvic exam, or
- Evaluation of weight, BP, breasts (notation of "breastfeeding" counts) and abdomen, or
- Notation of postpartum care, including but not limited to: "postpartum care," "PP care," "PP check," "6 week check," or completion of a preprinted "postpartum care" form.

Codes for Postpartum Care

Postpartum Care: *The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.*	
ICD-10-CM Diagnosis	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2, O00.00, O00.01, O00.10, O00.11, O00.20, O00.21, O00.80, O00.81, O00.90, O00.91
ICD-10-PCS	10D00Z0-10D00Z2, 10D07Z3-10D07Z8, 10E0XZZ
CPT Codes	57170, 58300, 59430, 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175, 99501 **Postpartum Bundled Services:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
CPT II Codes	0503F
HCPCS	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

What Doesn't Count?

- Ultrasound and lab results alone are not considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.
- A pap test alone does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate. A colposcopy alone is not compliant for either rate.

PPC: The Intent

- That a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider.
- To assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.

State-Specific Pregnancy Measures

In addition to the HEDIS 2019 pregnancy measures above, the Kentucky Department of Medicaid Services has provided a measure for perinatal screening and counseling.

Perinatal Screening and Counseling

This measure assesses the percentage of pregnant members who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year who had evidence of the following:

- **Screening for tobacco use** during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO;
- **Positive screening for tobacco use** and documentation of positive tobacco use during one of their first two prenatal visits or during one of their first two prenatal care visits following enrollment in the MCO.
- **Intervention for tobacco use:** positive screening for tobacco use and received intervention for tobacco use during one of their first two prenatal visits or during one of their first two prenatal care visits following enrollment in the MCO.
- **Screening for alcohol use** during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO;
- **Positive screening for alcohol use** and documentation of positive alcohol use during one of their first two prenatal visits or during one of their first two prenatal care visits following enrollment in the MCO.
- **Intervention for alcohol use:** positive screening for alcohol use and **received intervention for alcohol use** during one of their first two prenatal visits or during one of their first two prenatal care visits following enrollment in the MCO.
- **Screening for substance/drug use** during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.
- **Positive screening for substance/drug use** and documentation of positive alcohol use during one of their first two prenatal visits or during one of their first two prenatal care visits following enrollment in the MCO.
- **Intervention for substance/drug Use:** positive screening for substance/drug use and received intervention for substance/drug use during one of their first two prenatal visits or during one of their first two prenatal care visits following enrollment in the MCO.
- **Assessment for and/or education/counseling for nutrition** during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO;
- **Assessment for and/or education/counseling for OTC/prescription medication** during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO;
- **Screening for domestic violence** during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO;
- **Screening for depression** during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO;
- **Screening for depression during a postpartum visit**. (A copy of the Edinburgh Postnatal Depression Scale is attached at the end of this guide.)

HEDIS®: Women's Health – Prevention and Screening

Chlamydia Screening (CHL)

Description

Percentage of women 16-24 years of age who were identified as sexually active and had at least one test for chlamydia during the measurement year.

- Two methods identify sexually active women:
  - Pharmacy Data
    - ◇ Members who were dispensed Rx contraceptives during the measurement year
  - Claim/Encounter Data
    - ◇ Members who had a claim or encounter indicating sexual activity or pregnancy during the measurement year

Required Documentation: Chlamydia Screening

- Lab results for chlamydia testing between January 1 and December 31 of the measurement year.
- Urine chlamydia screenings are also acceptable.

Codes for Chlamydia Screening

- CPT Codes
  - 87110, 87270, 87320, 87490, 87491, 87492, 87810

Exclusion Criteria

Members who qualify for the denominator based on a pregnancy test alone (members who have no other evidence of sexual activity and who were not prescribed contraceptives) may be excluded from the measure if they meet either of the following:

- A pregnancy test during the measurement year followed within seven days (inclusive) by a prescription for isotretinoin
- A pregnancy test during the measurement year followed within seven days (inclusive) by an x-ray

Cervical Cancer Screening (CCS)

Description

Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- Women ages 21-64 who had cervical cytology performed every three years
- Women ages 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years

Required Documentation: Cervical Cancer Screening

- Lab results for a pap smear/thin prep test/cervical cytology only between January 1 two years prior to the measurement year, and December 31 of the measurement year, with results.
- Lab results for pap smear/thin prep test/cervical cytology and an HPV test between January 1 four years prior to the measurement year, and December 31 of the measurement year, with results.
- A note indicating when the cervical cytology was performed.

Codes for Cervical Cancer Screening

- CPT Codes
  - Cervical Cytology: 88141-88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164-88167, 88174, 88175
  - HPV Tests: 87620-87622, 87624, 87625
- HCPCS
  - Cervical Cytology: G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
  - HPV Tests: G0476

Exclusion Criteria

Women who have had a total hysterectomy (TAH) with no residual cervix, cervical agenesis or acquired absence of cervix at any time during the member's history through December 31 of the measurement year documented and dated in the medical record are excluded.

- CPT Codes
  - 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135
- ICD-9-CM Diagnosis
  - 618.5,752.43, V88.01, V88.03
- ICD-9 CM Procedure
  - 68.41, 68.49, 68.51, 68.59, 68.61, 68.69, 68.71, 68.79, 68.8
- ICD-10-CM Diagnosis
  - Q51.5, Z90.710, Z90.712
- ICD-10 Procedure
  - 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ
- Medical Record Documentation
  - Documentation from a PCP or OB/GYN in the patient's history anytime through December 31 of the measurement year. Acceptable documentation includes "TAH", "TAH/BSO", "complete", "total," or "radical" abdominal or vaginal hysterectomy, or "hysterectomy with no residual cervix," or cervical agenesis or acquired absence of cervix.
  - This documentation could also be found in the member's medical/surgical history.
  - A lab report with results for a vaginal pap smear anytime in patients' history through December 31 of the measurement year, with documentation of a "hysterectomy" or "no residual cervix."
  - Documentation from the hospital surgical medical record of when the hysterectomy was completed, which can be anytime in the patient's history through December 31 of the measurement year. A copy of the entire operative report is needed, including any related pathology reports.

What Doesn't Count?

- Labs that indicate the sample was inadequate or "no cervical cells were present" cannot be counted.
- Biopsies cannot be counted.
- Documentation of "Hysterectomy" alone cannot be counted. The medical record and/or claims history must indicate total hysterectomy.

Breast Cancer Screening (BCS)

Description

Percentage of women 50-74 years of age who had one or more mammograms to screen for breast cancer any time on or between October 1 two years prior to the measurement year, and December 31 of the measurement year.

Required Documentation: Breast Cancer Screening

- Radiology report for a mammogram between October 1 two years prior to the measurement year, and December 31 of the measurement year. Biopsies, ultrasounds, or MRIs do not count as a breast cancer screening.

This measure assesses the use of imaging to detect early breast cancer in women. Therefore, all types and methods of mammograms (screening, diagnostic film, digital, or digital breast tomosynthesis) qualify for compliance.

Codes for Breast Cancer Screening

- CPT Codes
  - 77055-77057, 77061-77063, 77065-77067
- HCPCS
  - G0202, G0204, G0206
- ICD-9-CM Procedure
  - 87.36, 87.37

Exclusion Criteria

Women who have had a diagnosis of bilateral mastectomy are excluded.

Bilateral Mastectomy

- ICD-10-M Procedure
  - 0HTV0ZZ

Unilateral Mastectomy

- ICD-10-Procedure
  - Right Unilateral Mastectomy: 0HTT0ZZ
  - Left Unilateral Mastectomy: 0HTU0ZZ
- CPT Codes
  - 19180, 19200, 19220, 19240, 19303-19307

Bilateral modifier

- CPT
  - Bilateral: 50, 09950; Right: RT; Left: LT

Absence of Breast

- ICD-10-CM Diagnosis
  - Right Breast: Z90.11
  - Left Breast: Z90.12

History of Bilateral Mastectomy

- ICD-10-CM Diagnosis
  - Z90.13

Medical Record Documentation

- Medical record documenting a bilateral/unilateral mastectomy with dates of one or both surgeries. Provider signature must be present on record and need a copy of the entire visit.
- Surgical record from mastectomy completion. Need a copy of the entire operative report.

What Doesn't Count?

- Biopsies, ultrasounds, or MRIs cannot count, as they are not appropriate primary methods of breast screening.

HEDIS® Benefits

Benefits for the Provider

- Following the recommended HEDIS guidelines can help save you time while also potentially reducing healthcare costs. By proactively managing patients' care, providers are able to effectively monitor health, prevent further complications, and identify issues that may arise with their care.
- Following the recommended HEDIS guidelines can also help you with the following:
  - Identify non-compliant members to ensure they receive preventive screenings.
  - Understand how you compare with other WellCare providers as well as with the national average.

Our Members, Your Patients

- Stay Healthy
- Receive Quality Care
- Get Early Detection of Potential Health Concerns

Prenatal Rewards Program

- Attend 6 or more prenatal visits before birth of the baby and 1 postpartum visit 21-56 days after the birth of the baby.
- **See Attached**: Kentucky Medcaid Prenatal Notification Form.
- Prenatal vitamins supplied according to Pharmacy benefits.

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Prenatal/Postpartum Reward Visits Log

To qualify for the prenatal reward, expectant mothers must attend at least six prenatal doctor visits before the birth of the baby. To qualify for for the postpartum reward, members must attend one postpartum visit between 21 and 56 days after the birth of the baby. This log must be dated and signed by you for each of the prenatal visits, and postpartum visit, attended by the member.

Please fill out this form completely.

Member Name: _____

Member ID #: _____ Phone #: _____

Address: _____

Street Number (no P.O. boxes) Apt. # City ST ZIP

Provider Name: _____

Provider Phone #: _____ Provider Fax #: _____

Date of Last Menstrual Period: _____ Expected Date of Delivery: _____

Hospital Where Baby Was Born: _____ Date of Baby's Birth: _____

Please complete the chart below to ensure all prenatal visits are recorded.

Date	Provider Signature

Visit After Delivery (between 21 and 56 days after birth)

Date	Provider Signature

Please fax this form to **1-877-647-7475** no later than 30 days after the postpartum visit for the member to receive the reward.

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Kentucky Medicaid Prenatal Notification Form

Fax 1-877-338-3659 | www.wellcare.com/Kentucky

MEMBER INFORMATION

Last Name:		First Name, Middle Initial:	
Phone:	WellCare ID Number:	Primary Language:	Date of Birth:

PROVIDER INFORMATION

Type:		
Last Name:	First Name:	Office Contact:
WellCare ID Number:	NPI Number:	Participating:
Transfer of Care: ☐ Yes ☐ No	Phone:	Fax:

PREGNANCY INFORMATION

☐ LMP	☐ EDC	☐ Gravida	☐ Para	☐ Full-term	☐ Pre-term	☐ AB	☐ Live

Date of First Visit:	Pregnancy Risk Level: ☐ Routine ☐ High Risk +

PRE-EXISTING MEDICAL CONDITION (Please check if "Yes")

☐ Asthma	☐ Diabetes	☐ Periodontal Disease
☐ Cancer	☐ Drug/Alcohol/Tobacco Use	☐ Renal Disease
☐ Chromosomal or Genetic Disorder	☐ Heart Disease	☐ Sexually Transmitted Disease
☐ Chronic Hypertension	☐ HIV or AIDS	☐ Sickle Cell Disease or Trait
☐ Deep Vein Thrombosis	☐ Neurological Disorder	☐ Obesity
☐ Thalassemia	☐ Thyroid Disorder	☐ Other

SOCIAL RISK FACTORS (Please check if "Yes")

☐ Emotional, Physical or Sexual Abuse	☐ Homelessness	☐ Lack of Transportation	☐ Language or Communication Barriers

*Language Translation and TTY services are available.
Please call Provider Services at 1-877-389-9457, Monday through Friday, between 8 a.m. and 6 p.m.

C	P	PREGNANCY RISKS	C	P	(Please indicate if current "C" or previous "P")
		Abruptio Place; Number of Weeks			Oligohydramnois
		Advanced Maternal Age			Placenta Previa
		Eclampsia/Pre-Eclampsia			Polyhydramnios
		Fetal Anomaly			Pregnancy Induced Hypertension
		Fetal Arrhythmia or Bradycardia			Post-term Pregnancy
		Fetal Demise			PROM or PPROM
		Gestational Diabetes:			Preterm Delivery; Number of Weeks
		Hyperemesis Gravidarum			Preterm Labor
		Incompetent Cervix			Previous Cesarean Section
		IUGR			Spontaneous AB; How Many
		Isoimmunization			Teen Pregnancy; Age 17 and Younger
		Low Birth Weight Infant			Twin-Twin Transfusion Syndrome
		Multiple Gestation			Uterine Anomaly
		Nutritional Deficit			Other Complication

HEALTH SCREENING			
Domestic Violence Screening: ☐ Yes ☐ No		WIC Referral Given: ☐ Yes ☐ No	
HIV Test Declined: ☐ Yes ☐ No		HIV Test Declined: ☐ Yes ☐ No	
Post-Partum Depression or Other: ☐ Yes ☐ No		Mental Health Screening: ☐ Yes ☐ No	
Current Medications:		Form Completed By:	Date:

**Note to OB Provider: This form generates a pregnancy notification and should be submitted to WellCare within thirty (30) days of the initial prenatal visit to expedite the member's placement into WellCare's Prenatal and/or High Risk Program. (Effective 11/01/2011) (Revised March 2016)

Provider Instructions

Edinburgh Postnatal Depression Scale (EPDS)

Remember – The EPDS is a screening tool and should never override clinical judgment. A careful clinical assessment should be carried out to confirm a diagnosis. The scale will not detect patients with anxiety neuroses, phobias or personality disorders.

Administration

1. Ask the patient to circle the response that comes closest to how she has been feeling in the previous seven days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the patient discussing her answers with others. (Answers come directly from the patient, whether pregnant or postpartum.)
4. The patient should complete the EPDS herself, unless she has limited English proficiency or has difficulty with reading. If the patient has a comprehension problem, the provider must make a decision as to how to best administer the EPDS. Ideally, a trained medical interpreter, not a family member, serves as the translator.

Scoring

Each question is scored with a 0, 1, 2 or 3. The higher a score is, the more likely the woman is experiencing some level of perinatal depression. Cox and colleagues* recommend a total score of 12 or greater as an indicator of possible depression. Threshold scores of 9, 10 and 11.5 have also been suggested when the scale is used routinely. When piloting the EPDS in New York ob-gyn offices, the District II task force used a threshold of 10 in an effort to identify many potential cases. Your practice may set its own threshold score; however, setting it lower allows your practice to capture more women with possible depression.

Question 10 on the EPDS tool addresses suicidal ideation. If a patient scores higher than 0 specifically on question 10, immediate action is needed. An immediate emergency referral to a mental health professional may be the most appropriate next step if a patient has suicidal ideation.

The EPDS serves to guide best practices. However, **the most essential best practices are recognizing the need to evaluate each patient individually and always utilizing sound clinical judgment**. The EPDS is only a screening tool and should never override clinical judgment.

Member Questionnaire

Edinburgh Postnatal Depression Scale (EPDS)

Please circle the response that comes closest to how you have been feeling IN THE PAST SEVEN DAYS. Please answer all questions.

Below is an EXAMPLE already completed.

I have felt happy:

0 Yes, all the time
1 Yes, most of the time
2 No, not very often
3 No, not at all

This would mean: "I have felt happy most of the time" during the past week.

Please complete the other questions in the same way.

Please answer all questions below:

(Circle one answer in each question)

In the past seven days

1. I have been able to laugh and see the funny side of things

0 As much as I always could
1 Not quite so much now
2 Definitely not so much now
3 Not at all

2. I have looked forward with enjoyment to things

0 As much as I ever did
1 Rather less than I used to
2 Definitely less than I used to
3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong

3 Yes, most of the time
2 Yes, some of the time
1 Not very often
0 No, never

4. I have been anxious or worried for no good reason

0 No, not at all
1 Hardly ever
2 Yes, sometimes
3 Yes, very often

5. I have felt scared or panicky for no very good reason

3 Yes, quite a lot
2 Yes, sometimes
1 No, not much
0 No, not at all

6. Things have been getting on top of me

3 Yes, most of the time I haven't been able to cope at all
2 Yes, sometimes I haven't been coping as well as usual
1 No, most of the time I have coped quite well
0 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping

3 Yes, most of the time
2 Yes, sometimes
1 Not very often
0 No, not at all

8. I have felt sad or miserable

3 Yes, most of the time
2 Yes, quite often
1 Not very often
0 No, not at all

9. I have been so unhappy that I have been crying

3 Yes, most of the time
2 Yes, quite often
1 Only occasionally
0 No, never

10. The thought of harming myself has occurred to me

3 Yes, quite often
2 Sometimes
1 Hardly ever
0 Never

For Office Use Only	Screen Administration
Patient #: _____	Self-Administered: _____
Administered/Review by _____	Assisted: _____
Screened During	**Score**
Week/Date: _____	Total: _____
Week/Date: _____	#10 Score: _____
Week/Date: _____	

**Source: J.L. Cox, J.M. Holden, R. Sagovsky, 1987. Detection of postnatal depression: Development of the 10-item Edinburg Postnatal Depression Scale. British Journal of Psychiatry 150:782-786.*

Source: K.L Wisner, B.L Parry, C.M. Piontek, Postpartum Depression N Eng J Med vol. 347, No 3, July 18, 2002, 194-199.

Documentation Standards

Obstetrical Records

The documentation listed below applies to ALL obstetrical records

1. OB Physical Assessment
   - Most guidelines recommend measurement at each prenatal visit – maternal weight, blood pressure measurements, fundal height and fetal heart auscultation.
     - Blood pressure screening is recommended at all prenatal visits throughout the pregnancy.
     - Measurement of fundal height should be performed at each visit during the second and third trimesters of pregnancy.
     - Fetal heart tones should be identified at 10–12 weeks and thereafter.

2. Nutritional Assessment and Counseling
   - Individual nutritional risk assessment including an assessment of pre-pregnancy body mass index (BMI), weight gained to date, if any, and specific nutritional risks at the initial prenatal care visit and continuing reassessment as needed

3. Blood Type, D (Rh) and Antibody Screen
   - D (Rh) blood typing and antibody screening is recommended for all pregnant women at their first trimester.
   - The date of the labs and results need to be in the medical record or the lab results.

4. Rubella Titer
   - Rubella antibody testing should be completed in all women of childbearing age who lack evidence of immunity.
   - The medical record should contain documentation that a rubella titer was completed preconception or during first trimester. Both the date and the results should be documented.

5. Urinalysis
   - At each prenatal visit, a urine specimen should be checked (by dipstick) for the presence of sugar and/or protein.
   - The date and results should be documented in the record.

6. Pap Smear Test
   - The first prenatal examination provides an opportunity for cervical cancer screening with a Papanicolaou (Pap) test in women who have not been screened recently.
   - The date and results of the Pap test need to be documented, including if screened recently.

7. STD Testing
   - All women found to be at high risk for sexually transmitted diseases should be screened for Neisseria gonorrhea and Chlamydia trachomatis at a preconception visit or during the first trimester.
   - The date of the labs and results need to be in the medical record or the lab results.

8. Syphilis (VDRL or RPR) Testing
   - It is recommended that all pregnant women be screened for syphilis with serologic testing at the first prenatal visit and after exposure to an infected partner and at the time of delivery.
   - The date of testing and the results should be documented in the medical record or the lab results should be in the medical record.

9. Hemoglobin (Hgb) Assessment
   - An Hgb test should be done to assess for anemia.
   - The results and date of test should be documented in the medical record or the lab results should be in the medical record.

10. HIV Counseling and Testing
    - All pregnant women should receive education and counseling about HIV testing as part of their routine prenatal care. HIV testing should be recommended at the first prenatal visit for all pregnant women with their consent.
    - In the event of a refusal of testing, the refusal should be documented.

11. Hepatitis B surface antigen (HBsAg) Screening
    - Routine screening is recommended for all pregnant women during their first trimester.
    - The result and date of screening should be documented in the medical record, or the lab results should be in the medical record.
    - If the patient refuses the testing, that should be documented.

12. Depression Screening
    - Prenatal and postpartum screening should be conducted.
    - The screening can be subjective as well as objective.
    - Screening tools such as the EPDS (Edinburgh Postnatal Depression Scale) can be used.
    - All screenings need to be documented in the medical record.

13. Preterm Delivery Risk Assessment
    - Preterm labor (PTL) risk includes medical and obstetrical history that might cause a woman to be a high risk for preterm delivery. Risk factors associated with preterm birth may include, but are not limited to, the following:
      - Demographics: African-American, low socioeconomic status, under age 18 or over age 35
      - History: Prior preterm delivery, any 2nd trimester loss, mental illness, cervical cerclage
      - Lifestyle: Substance abuse, domestic violence, family stress
      - Infection/Inflammation: Periodontal disease, pyelonephritis, sexually transmitted infections
      - Decidual Hemorrhage: Trauma, vaginal bleeding after 12 weeks this pregnancy
      - Pathologic Distention of the Uterus: Multiple gestations, uterine fibroids, polyhydramnios

14. Alpha Fetoprotein Screening
    - Screening should be offered in the second trimester.
    - Triple Screen, Quad Screen and AFP are acceptable.
    - If the patient refuses testing, this should be documented.
    - The date the screening was conducted and the results should be in the medical record.

15. Diabetes Screening/GTT
    - Testing should be done during the 24th and 28th weeks of gestation.
    - The date and results of testing should be in the medical record.
    - In the event of a refusal of testing, the refusal should be documented.

16. Group B Strep Screen
    - CDC's guidelines recommend that a pregnant woman be tested for group B strep when she is 35 to 37 weeks pregnant.
    - Date of testing and results should be in the medical record.
      - In the event of a refusal of testing, the refusal should be documented.

17. Postpartum Visit 6 Weeks After Delivery
    - A postpartum visit normally occurs within 4 to 6 weeks after delivery.
    - It should be documented in the medical record if the patient does not come in for a postpartum visit.

18. Psychosocial Risk Assessment Conducted During the First Prenatal Care Visit
    - A psychosocial risk assessment should be conducted and documented in the medical record.

19. Psychosocial Risk Assessment Conducted During the Postpartum Visit
    - A psychosocial risk assessment should be conducted and documented in the medical record.
    - It should be documented in the medical record if the patient does not come in for a postpartum visit.

20. Documentation of Referrals for Psychosocial Risk Made, if Indicated
    - If a referral is deemed necessary, it should be documented in the medical record.

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Quality care is a team effort.
Thank you for playing a starring role!

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