Practice Guidelines for Perinatal Care

MVP Health Care® has adopted perinatal care practice guidelines as part of its continuing Quality Improvement Program. These practice guidelines primarily reflect the recommendations put forth in the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (AAP/ACOG) Guidelines for Perinatal Care, Obstetric Care Consensus Volume 133 January 2019.

First Prenatal Visit

The initial prenatal visit should include a comprehensive examination, risk factor assessment, patient education, and the establishment of an estimated date of delivery. The information obtained from this visit should be used to develop an individualized plan of care that will allow for coordinated care during the woman's pregnancy.

Recommended Visit Intervals

Ideally, the first prenatal visit should be as early in the pregnancy as possible. An uncomplicated pregnancy should be followed every four weeks for the first 28 weeks, every two weeks until 36 weeks and weekly from 36 weeks until delivery. Actual visit intervals should be tailored to meet the medical and obstetrical needs of the woman. Ultimately, the frequency of examinations is the individual clinician's decision. A comprehensive prenatal care program should include prenatal care office visits that allow for:

- ongoing risk assessment and care plan development.
- patient education; and
- psychosocial support with the provision of necessary adjunct services.

Post-partum Visit

The post-partum visit should occur at 4-6 weeks after delivery and no later than 8 weeks following delivery (sooner for complicated gestation or delivery). The exact interval of this visit should be based on the specific obstetrical and medical needs of the woman, and should be determined by the clinician.

Key Guideline Messages

Care provided should be comprehensive and should meet established evidence-based standards of care. Clinical standards of care include, but are not limited to, HIV services, dental care, immunizations, lead poisoning prevention, medical indications for ultrasound, screening for genetic disorders, and other tests to determine fetal well-being. Care provided should be offered in a culturally sensitive manner. The comprehensive perinatal care record should include the development of a plan of care. The plan of care should address the following:

- **Risk Assessment** – A comprehensive risk assessment should be completed as early as possible in the pregnancy with review of risk at each subsequent visit. The care plan should address problems identified in the initial risk assessment and focus on conditions of high prevalence and importance with integration of psychosocial and medical care needs. The psychosocial risk assessment, which includes screening, counseling and referral should be conducted at the first visit and should be reviewed at each subsequent visit. The assessment should include a broad range of social, economic, psychological, and emotional disabilities and highlight tobacco use, substance use, domestic violence, and depression.

Table 1. Interpregnancy Care Recommendations

Recommendation	Grade of Recommendation
General	
To optimize interpregnancy care, anticipatory guidance should begin during pregnancy with the development of a postpartum care plan that addresses the transition to parenthood and interpregnancy or well-woman care.	Best Practice
Breastfeeding and Maternal Health	
Health care providers should routinely provide anticipatory guidance and support to enable women to breastfeed as an important part of interpregnancy health.	1A Strong recommendation, high-quality evidence
Interpregnancy Interval	
Women should be advised to avoid interpregnancy intervals shorter than 6 months.	1B Strong recommendation, moderate-quality evidence
Women should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months.	2B Weak recommendation, moderate-quality evidence
Family planning counseling should begin during prenatal care with a conversation about the woman's interest in future childbearing.	Best Practice
Depression	
All women should be screened for depression in the postpartum period, and then as part of well-woman care during the interpregnancy period. Such screening should be implemented with systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	1B Strong recommendation, moderate-quality evidence
Postpartum depression screening also may occur at the well-child visit with procedures in place to accurately convey the information to the maternal care provider.	1B Strong recommendation, moderate-quality evidence
Other Medical Conditions	
Women should be encouraged to reach their prepregnancy weight by 6–12 months postpartum and ultimately to achieve a normal BMI (calculated as weight in kilograms divided by height in meters squared) of 18.5–24.9.	2B Weak recommendation, moderate-quality evidence
Health care providers should offer specific, actionable advice regarding nutrition and physical activity using proven behavioral techniques.	1A Strong recommendation, high-quality evidence
Nonpregnant adult smokers should be offered smoking cessation support through behavioral interventions and U.S. Food and Drug Administration-approved pharmacotherapy.	1A Strong recommendation, high-quality evidence
In the interpregnancy period, all women should be routinely asked about their use of alcohol and drugs, including prescription opioids, marijuana, and other medications used for nonmedical reasons and referred as indicated. Substance use disorder and relapse prevention programs also should be made available.	Best Practice
Health care providers should consider patient navigators, trained medical interpreters, health educators, and promotoras to facilitate quality interpregnancy care for women of low-health literacy, with no or limited English proficiency, or other communication needs.	2C Weak recommendation, low-quality evidence

Women of childbearing age should be screened for intimate partner violence, such as domestic violence, sexual coercion, and rape, and referred for intervention services if they screen positive.	2B Weak recommendation, moderate-quality evidence
Women with histories of sexually transmitted infections before or during pregnancy should have thorough sexual and behavioral histories taken to determine risk of repeat infection or current or subsequent infection with HIV or viral hepatitis.	1A Strong recommendation, high-quality evidence
All women should be encouraged to engage in safe sex practices; partner screening and treatment should be facilitated as appropriate.	1A Strong recommendation, high-quality evidence
As part of interpregnancy care, women at high risk of STIs should be offered screening, including for HIV, syphilis, and hepatitis. Screening should follow guidance set forth by the CDC.	1A Strong recommendation, high-quality evidence
History of High-Risk Pregnancy	
Women with prior preterm births should be counseled that short interpregnancy intervals may differentially and negatively affect subsequent pregnancy outcomes and, as such, the birth spacing recommendations listed in the section "Interpregnancy Interval" are particularly important.	1B Strong recommendation, moderate-quality evidence
Given insufficient evidence of benefit, screening and treating asymptomatic genitourinary infections in the interpregnancy period in women at high risk of preterm birth is not recommended.	1B Strong recommendation, moderate-quality evidence
For women who have had pregnancies affected by congenital abnormalities or genetic disorders, health care providers should review postnatal or pathologic information with the women and offer genetic counseling, if appropriate, to estimate potential recurrence risk.	1C Strong recommendation, low-quality evidence
All women who are planning a pregnancy or capable of becoming pregnant should take 400 micrograms of folic acid daily. Supplementation should begin at least 1 month before fertilization and continue through the first 12 weeks of pregnancy.	1A Strong recommendation, high-quality evidence
All women planning a pregnancy or capable of becoming pregnant who have had a child with a neural tube defect should take 4 mg of folic acid daily. Supplementation should begin at least 3 months before fertilization and continue through the first 12 weeks of pregnancy.	1A Strong recommendation, high-quality evidence
A thorough review of all prescription and nonprescription medications and potential teratogens and environmental exposures should be undertaken before the next pregnancy.	1A Strong recommendation, high-quality evidence
A genetic and family history of the patient and her partner should be obtained. This may include family history of genetic disorders, birth defects, mental disorders, and breast, ovarian, uterine, and colon cancer.	1B Strong recommendation, moderate-quality evidence
Infertility	
Generally, recommendations for the length of the interpregnancy interval should not differ for women with prior infertility compared with women with normal fertility.	2C Weak recommendation, low-quality evidence
Prior Cesarean Delivery	
Women with prior cesarean deliveries, and particularly those who are considering a trial of labor after cesarean delivery, should be counseled that a shorter interpregnancy interval in this population has been associated with an increased risk of uterine rupture and risk of maternal morbidity and transfusion.	1B Strong recommendation, moderate-quality evidence

Abbreviations: BMI, body mass index (calculated as weight in kilograms divided by height in meters squared); CDC, Centers for Disease Control and Prevention; HIV, human immunodeficiency virus; STIs, sexually transmitted infections.

Key Steps in Interpregnancy Care

During Prenatal Care

- Determine who will provide primary care after the immediate postpartum period
- Discuss reproductive life planning and preferences for a method of contraception
- Provide anticipatory guidance regarding breastfeeding and maternal health
- Discuss associations between pregnancy complications and long-term maternal health, as appropriate

During the Maternity Stay†

- Discuss the importance, timing, and location of follow-up for postpartum care
- If desired by the patient, provide contraception, including long-acting reversible contraception or surgical sterilization
- Provide anticipatory guidance regarding breastfeeding and maternal health
- Ensure the patient has a postpartum medical home
- At the Comprehensive Postpartum Visit‡
- Review any complications of pregnancy and birth and their implications for future maternal health; discuss appropriate follow-up care
- Review the reproductive life plan and provide a commensurate method of contraception
- Ensure that the patient has a primary medical home for ongoing care

During Routine Health Care or Well-Woman or Pediatric Visits§

- Assess whether the woman would like to become pregnant in the next year
- Screen for intimate partner violence and depression or mental health disorders
- Assess pregnancy history to inform decisions about screening for chronic conditions (eg, diabetes, cardiovascular disease)
- For known chronic conditions, optimize disease control and maternal health
- Pediatric colleagues to screen during child health visits for women's health issues such as smoking, depression, multivitamin use, and satisfaction with contraception (IMPLICIT Toolkit)

*Timing should take into account any changes in insurance coverage anticipated after delivery.

†See Guidelines for Perinatal Care, Eighth Edition, for more information.

‡See Committee Opinion 736, Optimizing Postpartum Care, for more information.

§See Committee Opinion 755, Well-Woman Visit, and www.acog.org/wellwoman for more information.

||Implicit Toolkit Family Medicine Education Consortium. IMPLICIT interconception care toolkit: incorporating maternal risk assessment into well-child visits to improve birth outcomes. Dayton (OH): FMEC; 2016.

The AAP/ACOG guidelines are available on the ACOG website. The guidelines are free to ACOG members. Non-members and members of the public can purchase the guidelines in printed form at the online store. To access any of the ACOG practice

guidelines via the Internet go to the ACOG homepage and follow the publications link to guidelines: https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/01/interpregnancy-care

CDC, NYS DOH and ACOG all agree on guidelines for HIV testing in pregnancy. All pregnant women should be tested as early as possible during the pregnancy, preferably at the first visit. Testing should be routinely recommended during the third trimester (preferably between 34 and 36 weeks) and those with specific risk factors should be strongly encouraged to be tested at this time. Women presenting in labor without prior testing during the current pregnancy or known HIV positive status should have expedited testing with consent. If maternal testing is declined the newborn must have expedited testing performed. Maternal consent is not required for newborn testing.

HIV Testing in Pregnancy Resources:

https://www.hivguidelines.org/whats-new/reducing-hiv-transmission-during-pregnancy-labor-and-delivery-and-postpartum-care-guideline/

CDC 2006 Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. Available:

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

NYS DOH Frequently Asked Questions regarding the HIV Testing Law. Available:

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

AIDS Institute Guidelines, HIV Testing During Pregnancy and at Delivery. Available:

http://www.hivguidelines.org/clinical-guidelines/perinatal-transmission/hiv-testing-during-pregnancy-and-at-delivery/

In addition to the AAP / ACOG guidelines, all clinicians who provide care for MVP Medicaid Managed Care patients should be aware of, and follow, the New York State Medicaid guidelines. To access the New York State Medicaid prenatal care guidelines via the internet go to: http://www.nyhealth.gov/health_care/medicaid/standards/prenatal_care/. These standards were first developed in 2000 to follow the AAP / ACOG recommendations while incorporating the special needs of the Medicaid population. They were subsequently revised, (Chapter 484 of the laws of 2009; Public Health Law and Social Services Law) eliminating PCAP designation, certification and enhanced rates and authorizing establishment of new prenatal care practice management standards for all Medicaid providers.

In Conjunction with these guidelines, MVP Health Care offers a high-risk prenatal care program called *Little Footprints*. The *Little Footprints* program includes phone calls from a registered nurse specializing in high-risk maternity for one-on-one education, case management support, and intervention during a high-risk pregnancy. Those members who are not eligible for the *Little Footprints* program are referred to the *Healthy Starts* program for an educational packet via mail. The *Healthy Starts* program gives mothers-to-be information

that helps them stay healthy, learn about pregnancy, and prepare for delivery. MVP Medicaid Managed Care members who are not eligible or decline the high-risk program, will receive the same mailings as those enrolled in Little Footprints. If you would like to refer one of your patients to either of these programs, please call the Health Care Operations Department at **866-942-7966**

This guideline is not intended to replace the role of clinical judgment by the physician in the management of this, or any other disease entity. It is an educational guideline to assist in the delivery of good medical care. All treatment decisions are ultimately up to the physician. Where medication recommendations are made, please refer to each health plan's formulary for coverage considerations.

MVP Health Care reviews its clinical guidelines annually. The review process is also initiated when new scientific evidence or national standards are published. Practitioners are alerted via the web site and by written notices from the plan via fax or newsletter. A hard copy of the clinical guideline can be requested by calling the MVP Quality Improvement Department at **(800) 777-4793 extension 2247**