Pregnancy Guidelines for Providers

**BACKGROUND**

Early, effective prenatal care can identify mothers at risk of delivering a preterm or growth-retarded infant and provide an array of medical and educational interventions. Studies show a positive relationship between comprehensive prenatal care and a reduction in low birth weight and infant mortality; women who receive early and regular prenatal care are more likely to have healthier infants (NCQA, 2005). Death rates related to complications from pregnancy are four times higher among women who received no prenatal care compared to women who received prenatal care (NCQA, 2010). The table below shows a high level summary of services that should be offered to each member with an uncomplicated pregnancy.

During every visit providers should evaluate the woman’s blood pressure, weight, urine protein and glucose levels, uterine size for progressive growth and consistency with the estimated date of delivery, and fetal heart rate. After the patient reports quickening (and at each subsequent visit), she should be asked about fetal movement, contractions, leakages of fluid, or vaginal bleeding. Ultrasound before 20 weeks of gestation may be indicated for the purpose of dating if there is a size-date discrepancy or if menstrual dates are uncertain.

<table>
<thead>
<tr>
<th>Visit Schedule</th>
<th>History / Physical Exam</th>
<th>Diagnostic Testing / Screening</th>
<th>Education / Counseling</th>
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| **Initial Prenatal Care Visit** | - Complete medical, surgical, obstetrical, and gynecological assessment  
- History including genetic history of parents  
- Physical exam  
- Risk assessment  
- Estimated Date of Delivery calculation | - Hemoglobin / Hematocrit  
- U/A, microscopy and infection screening  
- Blood typing and Rh-D and Antibody screen  
- Rubella titer  
- Hepatitis B surface antigen screen  
- VDRL  
- Offer counseling and HIV testing  
- TB skin test  
- STD testing  
- OB Ultrasound  
- Urine culture  
- Lead level  
- Genetic counseling  
- Depression  
- PAP test, (repeat at post-partum visit if abnormality found on initial PAP, suggestive of HPV / dysplasia) | - Overall care plan  
- Expected course of pregnancy  
- Signs/symptoms that should be reported  
- Nutrition including individualized vitamin and mineral supplementation as needed  
- General health  
- Psychosocial aspects of pregnancy  
- HIV counseling  
- Smoking cessation  
- Avoidance of alcohol and other substance abuse |
| **Subsequent Visits: 0-28 Weeks**  
(visits should occur every 4 weeks) | - Physical assessment including weight and blood pressure, uterine growth, fetal heart rate, fetal movement and presentation (when applicable)  
- Follow-up risk assessments | - Urine protein, glucose  
- Ultrasound at 16 -18 weeks, 32-36 weeks as needed  
- Karyotype at 8-18 weeks when indicated/elected  
- Maternal Serum Alpha Fetoprotein at 16-18 weeks  
- Diabetes screening at 24-28 weeks with GTT  
- Repeat hemoglobin or hematocrit at 24-28 weeks and again at 32-36 weeks  
- STD tests  
- Rh-D and Antibody screen at 24-28 weeks  
- Rh/G Immune Globulin at 28 weeks (RHOGAM at 28 weeks for non-sensitized Rh negative mothers) | - Nutrition including individualized vitamin and mineral supplementation as needed  
- Desired weight gain  
- Activity / Exercise  
- Labor and Delivery process to expect  
- Signs of labor  
- Smoking cessation if member is a smoker |
### Scheduled Early Inductions and Cesarean Delivery

(Source: ACOG, 2010; ACOG, 2009)

#### Induction of Labor

The American College of Obstetricians and Gynecologists (ACOG) (2009) established clinical management guidelines for induction of labor. Indications for induction of labor include:

- Abruptio placentae (premature separation of the placenta from the uterus)
- Chorioamnionitis (inflammation of fetal membranes due to bacterial infection)
- Fetal demise
- Gestational hypertension
- Preeclampsia, eclampsia
- Premature rupture of membranes
- Post-term pregnancy
- Maternal medical conditions (e.g., diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension, antiphospholipid syndrome)
- Fetal compromise (e.g., severe fetal growth restriction, isoimmunization, oligohydraminos)

Labor may be induced for several reasons, including rapid labor, distance from hospital or psychosocial indications. In these instances, it is recommended that term gestation be confirmed by at least one of the following:

- Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater; OR
- Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography; OR
- It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test result; OR
- Establishment of fetal lung maturity (a mature fetal lung test result before 39 weeks of gestation, in the absence of clinical circumstances is not an indication for delivery).

Induction of labor is contraindicated for the following reasons:

- Vasa previa (fetal vessels crossing or running in close proximity to the inner cervical os)
- Complete placenta previa (placenta growth covering all or part of the opening to the cervix)
- Transverse fetal lie (crosswise in the uterus)
- Umbilical cord prolapse
- Previous classical cesarean delivery
- Active genital herpes infection
- Previous myomectomy entering the endometrial cavity

| 2-3 weeks) | Group B Strep screen at 26-28 weeks | Avoidance of alcohol and other substance abuse |
| 37+ Weeks (visits should occur weekly) | Amniocentesis, when medically indicated | Childbirth education classes |
| | Depresssion | Infant feeding |
| | Cystic fibrosis screen when indicated | Psychosocial needs |
| | Offer counseling and HIV testing at 28 and 32 weeks | Discussion of VBAC |
| | Perform second HBsAg test at 28-32 weeks if woman tested negative at first visit and are high risk | Nutrition including individualized vitamin and mineral supplementation as needed |

Postpartum Visit 4-6 Weeks Following Delivery

- Interval history
- Physical exam including weight, blood pressure, breasts, abdomen and pelvic exams
- Pap test
- Postpartum visit may occur within 21-56 days (4-6 weeks) after delivery
- Depression

(Source: ACOG, 2014; March of Dimes, 2011; NCQA, 2011)
A 2011 report by the California Maternal Quality Care Collaborative (in conjunction with ACOG), risks of non-medically indicated elective deliveries between 37 and 39 weeks gestation include:

- Increased NICU admissions
- Increased transient tachypnea of the newborn (TTN)
- Increased respiratory distress syndrome (RDS)
- Increased ventilator support
- Increased suspected or proven sepsis
- Increased newborn feeding problems and other transition issues

Elective Cesarean Sections

ACOG (n.d.) states evidence suggests that non-medically indicated obstetrical procedures such as elective inductions performed prior to 39 weeks have risen sharply in the U.S. over the past 20 years, with associated increases in C-sections and late preterm births. The reported rate of labor induction in the United States has more than doubled since 1990, from 9.5% to 22.5% in 2006. Based on the evidence of ACOG, it is recommended that elective cesarean sections not be performed prior to 39 weeks unless the health of mother and/or baby is jeopardized.

ACOG (2011) states that elective cesarean section should only be performed prior to 39 weeks unless the health of mother and/or baby is jeopardized. Complications can include:

- Infection
- Blood loss
- Blood clots in the legs, pelvic organs or lungs
- Injury to the bowel or bladder
- Reaction to medications or to the anesthesia that is used

Issues to Discuss with Pregnant Women

(Source: "CDC, 2014; USPSTF, 2010)

- **Medications** during pregnancy can be dangerous to an expectant mother and her unborn child. Providers should explain the impact of prescription and over the counter medications (including herbal supplements) and that certain medications are safe and can be taken during pregnancy for certain health conditions (e.g., asthma, epilepsy, high blood pressure, depression). If conditions are not treated, a pregnant woman or her unborn baby could be harmed (CDC, 2014).

- **Domestic violence and child maltreatment** are serious problems that can have lasting harmful effects on a child’s life. Encourage mothers to seek help if they or their child(ren) are in danger. Provide a crisis line phone number in the mother’s area, if available.

- **Folic Acid** is a B vitamin that can help prevent major birth defects. Advise pregnant women to take a vitamin with 400 micrograms (mcg) of folic acid every day, before and during pregnancy.

- Existing **high blood pressure** can increase the risk of problems during pregnancy; women should be monitored.

- **Smoking during pregnancy** is the single most preventable cause of illness and death among mothers and infants. Advise women about the dangers of smoking and provide resources to help them quit. Alcohol and **illegal drugs** can also pass into a baby’s system via multiple routes during pregnancy. Stress to expectant mothers that there is no known safe amount of alcohol to drink while pregnant. For more information see the Substance Use and Pregnancy section below.

- **Vaccinations** may be needed during pregnancy. Provide any vaccinations needed, including a **flu shot** to protect mother and baby against serious illness from the flu.
• **Infections** can form and a pregnant woman may be unaware due to a lack of symptoms. Discuss the following ways she can reduce her risk to common infections (CDC, 2013). Wash hands often with soap and water when:
  - Using the bathroom
  - Getting saliva (spit) on your hands
  - Preparing food and eating
  - Gardening or touching dirt or soil
  - Handling pets
  Note: If soap and running water are not available, you can use alcohol-based hand gel.

- **Don’t share utensils, cups, and food with young children.**

- **Cook meat until it’s well done** - juices should be clear and there should be no pink inside. Avoid hot dogs and deli meats unless reheated until steaming hot; undercooked processed meats may contain listeria.

- **Avoid unpasteurized (raw) milk and foods made from it.** Avoid soft cheeses (e.g., feta, brie, and queso fresco) unless they have labels that say they are pasteurized. Unpasteurized products can contain listeria.

- **Avoid certain kinds of fish** as they may contain high levels of mercury. Mercury can harm you and your baby (U.S. Department of Health and Human Services, 2013)

- **Do not touch or change dirty cat litter.** If you must change the litter yourself, wear gloves and wash your hands afterwards. Dirty cat litter might contain a harmful parasite called toxoplasmosis.

- **Stay away from wild or pet rodents and their droppings.** Consider a pest control professional to eliminate pests in or around your home. If you have a pet rodent (e.g., hamster or guinea pig) have someone else care for it until after the baby arrives as some might carry lymphocytic choriomeningitis virus (LCMV).

- **Avoid people who have an infection** especially chickenpox or rubella if the patient has not had it or received the vaccine before pregnancy.

- **Environmental and workplace exposure** to harmful substances can affect the health of an unborn baby. Discuss the work environment of expectant mothers to minimize risk to her and her unborn baby.

- **Genetics** and understanding genetic factors and disorders is important for learning more about preventing birth defects, developmental disabilities, and other unique conditions in children. Discuss blood tests to conduct before the baby is born as well as inquire about her family history (as well as her partner’s) to identify possible risks.
  - Prenatal tests made be run to ensure the baby is growing and healthy (March of Dimes, 2011):
    - Amniocentesis (test for certain birth defects)
    - Chorionic villus sampling or CVS (test for certain birth defects)
    - Glucose screening (monitor blood sugar)
    - Cystic fibrosis carrier screening (check for cystic fibrosis gene)
    - Maternal blood screening (check for neural tube defects)

- **Bleeding and clotting disorders** can cause serious problems during pregnancy, including miscarriage. Treat women accordingly who present with a history of such disorders.

- **Travel** within the country or internationally should be discussed with pregnant women.

- **Gestational weight gain** is a common concern. The following chart are suggested guidelines:
### Substance Use and Pregnancy
(Source: WHO, 2014)

The World Health Organization (2014) issued recommendations to identify and manage substance use and substance use disorders during pregnancy.

1. Health-care providers should ask all pregnant women about their use of alcohol and other substances (past and present) as early as possible in the pregnancy and at every antenatal visit.
2. Health-care providers should offer a brief intervention to all pregnant women using alcohol or drugs.
3. Health-care providers managing pregnant or postpartum women with alcohol or other substance use disorders should offer comprehensive assessment and individualized care.
4. Health-care providers should, at the earliest opportunity, advise pregnant women dependent on alcohol or drugs to cease their alcohol or drug use and offer, or refer to, detoxification services under medical supervision where necessary and applicable.
5. Pregnant women dependent on opioids should be encouraged to use opioid maintenance treatment whenever available rather than to attempt opioid detoxification.
6. Pregnant women with benzodiazepine dependence should undergo a gradual dose reduction, using long-acting benzodiazepines.
7. Pregnant women who develop withdrawal symptoms following the cessation of alcohol consumption should be managed with the short-term use of a long-acting benzodiazepine.
8. In withdrawal management for pregnant women with stimulant dependence, psychopharmacological medications may be useful to assist with symptoms of psychiatric disorders but are not routinely required.
9. Pharmacotherapy is not recommended for routine treatment of dependence on amphetamine-type stimulants, cannabis, cocaine or volatile agents in pregnant patients.
10. Given that the safety and efficacy of medications for the treatment of alcohol dependence has not been established in pregnancy, an individual risk benefit analysis should be conducted for each woman.
11. Pregnant patients with opioid dependence should be advised to continue or commence opioid maintenance therapy with either methadone or buprenorphine.
12. A. Mothers with substance use disorders should be encouraged to breastfeed unless the risks clearly outweigh the benefits.
   B. Breastfeeding women using alcohol or drugs should be advised and supported to cease alcohol or drug use; however, substance use is not necessarily a contraindication to breastfeeding.
13. Skin-to-skin contact is important regardless of feeding choice and needs to be actively encouraged for a mother with a substance use disorder who is able to respond to her baby’s needs.
14. Mothers who are stable on opioid maintenance treatment with either methadone or buprenorphine should be encouraged to breastfeed unless the risks clearly outweigh the benefits.
15. Health-care facilities providing obstetric care should have a protocol in place for identifying, assessing, monitoring and intervening, using non-pharmacological and pharmacological methods, for neonates prenatally exposed to opioids.
16. An opioid should be used as initial treatment for an infant with neonatal opioid withdrawal syndrome if required.
17. If an infant has signs of a neonatal withdrawal syndrome due to withdrawal from sedatives or alcohol or the substance the infant was exposed to is unknown, then phenobarbital may be a preferable initial treatment option.
18. All infants born to women with alcohol use disorders should be assessed for signs of fetal alcohol syndrome.

For remarks and additional information, please visit the WHO website (link in Reference section).
Gestational Diabetes
(Source: American Diabetes Association, 2010; CDC, 2013; CDC, n.d.)

The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation [Grade B recommendation] (2014).

A risk assessment should be conducted during the initial prenatal visit to determine if testing for gestational diabetes (GD) should occur prior to 24-28 weeks gestation. Risk factors for GD include:

- Having a previous pregnancy with gestational diabetes
- Having a baby born weighing over 9 pounds
- Being overweight or obese
- Are more than 25 years old
- Have a family history of diabetes
- Are African American, Hispanic, American Indian, Alaska Native, Native Hawaiian, or Pacific Islander
- Are being treated for HIV
- Presence of glycosuria (glucose in the urine)
- Diagnosis of polycystic ovary syndrome (PCOS)

Women with a low risk of GD do not require testing at 24-28 weeks gestation if they meet ALL of the following criteria:

- Age < 25 years
- Weight normal before pregnancy
- Member of an ethnic group with a low prevalence of diabetes
- No known diabetes in first-degree relatives
- No history of abnormal glucose tolerance
- No history of poor obstetrical outcome

Two approaches are recommended for testing at 24-28 weeks gestation (ADA, 2010):

**Two step approach:**
- Perform initial screening by measuring plasma or serum glucose 1 h after a 50-g load of ≥140 mg/dl identifies ~80% of women with GDM, while the sensitivity is further increased to ~90% by a threshold of ≥130 mg/dl.
- Perform a diagnostic 100-g OGTT on a separate day in women who exceed the chosen threshold on 50-g screening.

**One step approach** (may be preferred in clinics with high prevalence of GD):
- Perform a diagnostic 100-g OGTT in all women to be tested at 24–28 weeks. The 100-g OGTT should be performed in the morning after an overnight fast of at least 8 h. To make a diagnosis of GDM, at least two of the following plasma glucose values must be found:
  - Fasting ≥95 mg/dl
  - 1-h ≥180 mg/dl
  - 2-h ≥155 mg/dl
  - 3-h ≥140 mg/dl

Educate patients that gestational diabetes (GD) may lead to developing type 2 diabetes after pregnancy and that her baby is likely to weigh more; this may lead to a cesarean section and a longer recovery time after delivery. Encourage patients that have diabetes and are pregnant (or plan to become pregnant) to take the following steps to help prevent birth defects, prematurity, miscarriage and stillbirth:

- Plan pregnancy and get body ready before you get pregnant.
- Eat healthy foods, stay active and maintain a healthy weight.
• Take medication.
• Monitor blood sugar often - control and treat low blood sugar right away.
• Go to all prenatal visits – expectant mothers may even wish to visit a dietician or diabetes educator

The American College of Obstetricians and Gynecologists (ACOG) advises that patients should keep their blood sugar above 70 mg/dL and below these levels:

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<tr>
<th>Time</th>
<th>Level</th>
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<tbody>
<tr>
<td>Before Meals</td>
<td>95 mg/dL or lower</td>
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<tr>
<td>1 Hour After Eating</td>
<td>130 mg/dL or lower</td>
</tr>
<tr>
<td>2 Hours After Eating</td>
<td>120 mg/dL or lower</td>
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Once your patient’s baby is born, encourage her to take these steps to reduce the chance of developing type 2 diabetes:

• Follow up regularly with a provider
• Get tested for diabetes 6 to 12 weeks after your baby is born, then every 1 to 3 years.
• Stay physically active and make healthy food choices to maintain a healthy weight.
• Provide about type 2 diabetes prevention and care after delivery.
• Refer patient to a diettian or a diabetes educator to learn more about type 2 diabetes prevention.

Things to Consider Before Baby Arrives
(Source: CDC, 2008; U.S. National Library of Medicine, 2011)

• **Breastfeeding** education and counseling should be offered to pregnant women and should include:
  - **Benefits.** Babies gain many benefits from breastfeeding as breast milk is easy to digest and has antibodies that can protect them from bacterial and viral infections.
  - **Safety.** Safely preparing and storing expressed breast milk is important to maintain its high quality.
  - **Medication:** Certain medications, including prescription and over-the-counter drugs, vitamins, and dietary or herbal supplements should be avoided while breastfeeding.
  - **Travel.** Travel need not be a reason to stop breastfeeding; it may make traveling easier.
  - **HIV:** Women with HIV should not breastfeed as the virus is in breast milk and can be passed to the baby.

• **Jaundice** can sometimes lead to brain damage in newborns; perform a jaundice bilirubin test prior to discharge.

• **Newborn screenings** are conducted within 48 hours of a baby’s birth. A heel stick can test for treatable diseases; over 98% of all children born in the United States are tested for these disorders.

• **Sudden Infant Death Syndrome (SIDS)** prevention should explained with attention to the following:
  - Always put a baby to sleep on its back, including naps. **DO NOT put a baby to sleep on its stomach - side sleeping is unstable and should also be avoided.** Allowing the baby to roll around on its tummy while awake can prevent a flat spot (due to sleeping in one position) from forming on the back of the head.
  - **Only put babies to sleep in a crib.** NEVER allow the baby to sleep in bed with other children or adults; do NOT put them to sleep on surfaces other than cribs, like a sofa.
  - **Let babies sleep in the same room (not the same bed) as parents, is possible.**
  - **Avoid soft bedding materials.** Babies should be placed on a firm, tight-fitting crib mattress with no comforter. Use a light sheet to cover the baby. Do not use pillows, comforters, or quilts.
  - **Keep the room temperature comfortable.** It should be comfortable for a lightly-clothed adult.
  - **Offer the baby a pacifier when going to sleep.** Pacifiers while sleeping can reduce risk by allowing the airway to open more, or prevent the baby from falling into a deep sleep. A baby that wakes up more easily may automatically move out of a dangerous position. If the baby is breastfeeding, it is best to wait until 1 month before offering a pacifier (as to not interfere with breastfeeding). Do not force a baby to use a pacifier.
• **Breastfeeding** can also reduce the risk of SIDS (American Academy of Pediatrics, 2013).

• **Do not use breathing monitors or products marketed as ways to reduce SIDS.** In the past, home apnea monitors were recommended for families with a history of the condition; research found no benefit.

• **Child safety seats** are imperative for the safety of children while riding in an automobile. Motor vehicle crashes are the leading cause of death among children in the United States. The risk of serious and fatal injuries can be reduced by more than 50% with the proper use of a child safety seat that is age- and size-appropriate.

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**Pregnancy Complications and Preterm Labor**

*(Source: March of Dimes, 2013, 2011)*

Discuss how potential complications differ from common pregnancy aches and pains such as anemia, gestational diabetes, high blood pressure and bleeding from the vagina. Infections are also cause for concern (flu, cytomegalovirus, group B strep, listeriosis); discuss precautions women can take. Expectant mothers should call their doctor if they have:

- Heavy bleeding or bleeding for more than 24 hours.
- Fever, chills or severe headaches.
- Vision problems, like blurriness.
- Quick weight gain or your legs and face swell.

Preterm labor occurs in 1 out of 8 babies in the United States and can lead to serious health problems for the baby. Explain the signs of preterm labor and what expectant mothers can do if preterm labor occurs:

- Contractions (when abdomen tightens like a fist) every 10 minutes or more often
- Change in vaginal discharge (leaking fluid or bleeding from the vagina)
- Pelvic pressure—the feeling that the baby is pushing down
- Low, dull backache
- Cramps that feel like a period
- Abdominal cramps with or without diarrhea

*Instruct expectant mothers to call you or go to the hospital if any of the warning signs are present.*

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**Testing and Counseling During Pregnancy**

The United States Preventive Services Task Force made the following recommendations:

- Screening and behavioral counseling interventions to **reduce alcohol misuse** by adults, including pregnant women, in primary care settings (Grade B, April 2004).
- Routine screening for **iron deficiency anemia** in asymptomatic pregnant women (Grade B, May 2006).
- Screening for asymptomatic **bacteriuria** with urine culture for pregnant women at 12 to 16 weeks’ gestation or at the first prenatal visit, if later (Grade A, July 2008).
- Interventions during pregnancy/after birth to **promote and support breastfeeding** (Grade B, October 2008).
- Screening for **chlamydial infection** for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk (Grade B, June 2007).
- Screen all sexually active women for **gonorrhea infection** if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors) (Grade B, May 2005).
- Screening for **gestational diabetes** in asymptomatic pregnant women after 24 weeks of gestation (Grade B, January 2014).
- Screening for **hepatitis B virus** infection in persons at high risk for infection (Grade B, May 2014)
- Screen all pregnant women for **HIV**, including those who present in labor who are untested and whose HIV status is unknown (Grade A, April 2013).
• Rh (D) blood typing/antibody testing during first visit for pregnancy-related care (Grade A, February 2004).
• Repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative (Grade B, February 2004).
• Screen all pregnant women for syphilis infection (Grade A, May 2009).
• Ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke (Grade A, April 2009).

Documentation Standards and Physician Measurement & Assessment

WellCare recommends the use of the American College of Obstetricians and Gynecologists (ACOG) format for documenting patients' pregnancies. The format is available in Appendix A, ACOG Antepartum Record and Discharge/Postpartum Form (ACOG, 2007) and is available for purchase at www.acog.org

In addition, the following items are requested to be completed to ensure compliance with guidelines:

• Adequate documentation of physical examination at each obstetric visit;
• Documentation of prenatal and postpartum depression screening utilizing the Patient Health Questionnaire-2 (PHQ2) Depression Screening tool or the Edinburgh Depression Scale tool (Murray & Cox, 1990);
• Documentation of family planning counseling and services for all pregnant women and mothers; and
• Appropriate postpartum care including a visit on or between 21 and 56 days after delivery with a physician assistants, nurse practitioners, midwives or registered nurses.

REFERENCES


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