Perinatal Care Clinical Practice Guidelines 2016

This guideline is intended to assist the practitioner in clinical decision-making and attempt to define clinical practices that apply to most patients in most circumstances. It is not intended to represent the only or even the preferred method of evaluation and/or treatment for a specific patient. The treating practitioner should make the ultimate decision regarding the care of a particular patient.

If you are a member of ACOG (American Congress of Obstetricians and Gynecologists) and would like to access their guidelines, or would like to join ACOG you can access them at: http://www.acog.org/About-ACOG.

Preconception Care

Preconception care includes identifying those conditions that could affect a future pregnancy or fetus and that may be responsive to intervention. For example, adverse effects on the fetus caused by maternal phenylketonuria or poorly controlled diabetes mellitus, can be reduced if strict metabolic control is achieved before conception and continued throughout pregnancy. It is also intended to evaluate maternal risks of pregnancy, provide appropriate counseling, and an opportunity to maximize maternal health status prior to conception.

Antepartum Care

Women who receive early and regular prenatal care are more likely to have healthier infants. The early diagnosis of pregnancy is important in establishing an individualized management plan. This plan of care should take into consideration the medical, nutritional, psychosocial, and educational needs of the patient and her family, and it should be periodically reevaluated and revised in accordance with the progress of the pregnancy.

Protocols and checklists have been shown to reduce patient harm through improved stratification and communication. Checklists and protocols should be incorporated into systems as a way to help practitioners provide the best evidence-based care to their patients. (ACOG Committee Opinion, April 2015, Clinical Guidelines and Standardization of Practice to Improve Outcomes.)

The frequency of obstetric visits should be individualized. Typically, a woman with an uncomplicated first pregnancy is checked every 4 weeks for the first 28 weeks of gestation, every 2 weeks until 36 weeks of gestation, and weekly thereafter.

During each scheduled visit the provider should evaluate the woman's blood pressure, weight, uterine size for progressive growth, and consistency with the EDD, and presence of fetal heart activity. After the patient reports quickening and at each subsequent visit, she should be asked about fetal movement. She should be asked about contractions, leakage of fluid, or vaginal bleeding. Routine urine testing for protein to assess renal status is recommended.

Later in pregnancy, important topics to discuss with patients during the routine visits include childbirth classes, choosing a provider for the newborn, anticipating labor, preterm labor, breastfeeding, and choice of a postpartum birth control method.

Flow sheets, if used for prenatal care, should include: fundal height (CM), presentation, FHR, Fetal movement, S/S pre-term labor, cervix exam (if indicated), BP, Wt, Urine (Albumin/Glucose), and Edema.

Initial Assessments, Screenings, and Education or Counseling

Family history	Genetic screening and counseling
Medical history	Current medications including OTC meds
Substance abuse, alcohol, tobacco & illicit drugs assessment and education/counseling	Domestic abuse & violence assessment and counseling
Behavioral health issues Screening for depression using a standardized screening tool such as: Edinburgh Postnatal Depression Scale, PHQ-2 & 9, Beck Depression Inventory, Beck Depression Inventory-II.	Environmental & occupational exposures
Obstetric history and Menstrual history Establish EDD (EDC) Family planning & pregnancy spacing	General physical examination Cervical Cancer Screening (if due) Breast self-awareness
Education on high risk conditions	Immunity & immunization status (see below for more information on immunizations during pregnancy)
Assessment of socioeconomic, education, and cultural context	Risk factors for sexually transmitted diseases
Nutrition assessment and education	Infectious disease testing and counseling
General physical exam	Assess barriers to care (transportation, child care issues, work schedule, and language)

High Risk Pregnancy Assessment

Any Pregnancy:	Premature Rupture of Membranes (PROM)
Diabetes Thyroid Disease Chronic Renal Disease Pulmonary Disease (Asthma or other chronic pulmonary disease) Epilepsy Other Chronic Maternal Medical conditions	Exposure to: Mercury and Teratogens

Pregnancy Induced Hypertension (PIH/GHTN) Toxemia/Preeclampsia/Eclampsia/HELLP Syndrome Chronic Hypertension (CHTN)	Prior Stillbirth Prior Preterm Birth Prior Neonate with Genetic or Congenital disorder Multiple pregnancy
STDs	2nd or 3rd Trimester Loss (miscarriage after 15 weeks or stillborn)
Pyelonephritis	
Genital Tract abnormalities	Polyhydramnios / Oligohydramnios
Maternal Age Maternal Weight	Preterm Labor or Delivery < 37 weeks
Incompetent Cervix	IUGR / Intrauterine Growth Restriction (last/latest or current pregnancy)
Current Pregnancy	
Substance Abuse	
Teen Pregnancy (ages 15-19) and Pre-Teen Pregnancy (ages 10-14)	
Advanced Maternal Age (35 yrs and older)	
Pyelonephritis	
Domestic Violence	
Homelessness	

Patient Education

Anesthesia plans	Choosing the child's physician
Toxoplasmosis precautions	Breast feeding or formula feeding
Maternity program enrollment (Mommy Steps) Prenatal classes Options for intrapartum care	Newborn car seat Newborn crib Effects of 2nd/3rd hand smoke-higher risk to newborn for SIDS
Scope of care provided in the office and anticipated schedule of visits & the importance of keeping appointments	Folic acid 0.4 mg per day: • while attempting pregnancy • through pregnancy • for at least four to six weeks after birth and as long as you are breastfeeding

Smoking cessation Alcohol & illicit drug use OTC and Prescription Drug use Domestic Violence Nutrition Depression	Environmental work hazards
Signs & symptoms of labor & pre-term labor. Signs & symptoms to be reported to OB (e.g., vaginal bleeding, rupture of membranes, or decreased fetal movement)	Postpartum birth control & importance of the post- partum visit Preparing the home for the new baby

Routine Testing (First Prenatal Visit or Early in Pregnancy)

ABO Blood type	Chlamydia screening, re-screening performed in three to four months following treatment, if positive
Rh Antibody screen	
Rubella titer	HIV counseling/testing regardless of risk
Cervical Cancer Screening	VDRL/ RPR
Urine culture/screen	Hepatitis B surface antigen screening
Drug Screening	Hepatitis C

Other Screenings and Testing

US for fetal anomaly (18-20 weeks)	Karyotype
Material Serum Screening (Downs/Spina bifada)	Amniotic Fluid (Alpha Fetal Protein)
Amniocentesis/Chorionic Villus Sampling (10-12 wks)	Screening for genetic disorders based on racial & ethnic background and/or based on family history
Nuchal Fold translucency test (First Trimester U/S screening) if appropriate	Culture for asymptomatic bacteriuria (12-16 wks, and re-screen after treatment if positive)
Non-invasive prenatal chromosomal testing in high risk patients	Gp B Strep (35-37 wks)
Cervical Length Screening	

Diabetes Screening and GTT Testing at 28 weeks gestation (earlier if at high risk)

- High Risk patients
- Marked Obesity (BMI > 27)
- Diabetes in first degree relative

- History of Glucose intolerance
- Previous infant with macrosomia (> 4,500 grams)
- Current glycosuria (previous impaired fasting glucose (IFG) with fasting blood glucose 110-125 mg/dl)
- Previous diagnosis of GDM

Screening for gestational diabetes in patients not identified as high risk (28 weeks): Two step approach 50 g (non-fasting) screening followed by a 100 mg OGTT for those who screen positive.

Recommendations by the American Diabetes Association (ADA) for Management of Diabetes in Pregnancy:

GDM should be managed first with diet and exercise, and medications should be added if needed.

The A1c target in pregnancy is < 6% if this can be achieved without significant hypoglycemia. **New recommendation in 2016 SOC: A1c recommendations for pregnant women with diabetes were changed from a recommendation of <6% to a target of 6-6.5%.**

Medications used in pregnancy include insulin, metformin, and glyburide; most oral agents cross the placenta or lack long-term safety date. Insulin is the preferred agent for management because of the lack of long term safety data for noninsulin agents. **New recommendation in 2016 SOC: Glyburide in gestational diabetes mellitus was deemphasized based on new data suggesting that it may be inferior to insulin and metformin. Glyburide may have a higher rate of neonatal hypoglycemia and mascrosomia than insulin or metformin.**

In pregnancy complicated by diabetes and chronic hypertension, target blood pressure goals of SBP 110-129 mmHg and DBP of 65-79 mmHg are reasonable. Lower blood pressure levels may be associated with impaired fetal growth.

During pregnancy, treatment with ACE-I and ARB medications is contraindicated because they may cause fetal damage. Antihypertensive drugs known to be effective and relatively safe in pregnancy include methyldopa, and labetalol. **New recommendation: Potentially teratogenic meds (ACE-I, statins, etc., should be avoided in sexually active women of childbearing age who are not using reliable contraception.**

Chronic diuretic use during pregnancy has been associated with restricted maternal plasma volume, which may reduce uteroplacental perfusion.

Women with Type I diabetes have an increased risk of hypoglycemia in the first trimester. Frequent hypoglycemia can be associated with intrauterine growth restriction.

Pregestational Type 2 diabetes is often associated with obesity. Recommended weight gain during pregnancy for overweight women is 15-25 lbs and for obese women 10-20 lbs. Because GDM may represent preexisting undiagnosed Type 2 diabetes, women with GDM should be screened for persistent diabetes or prediabetes at 6-12 weeks postpartum and every 1-3 years

thereafter depending on other risk factors.

Immunization Recommendations

Tdap, Td: Health-care personnel should **administer a dose of Tdap during each pregnancy** irrespective of the patient's prior history of receiving Tdap. To maximize the maternal antibody response and passive antibody transfer to the infant, **optimal timing for Tdap administration is between 27 and 36 weeks of gestation** although Tdap may be given at any time during pregnancy.
Hepatitis A: [Hepatitis A] is an inactivated vaccine, and similar to hepatitis B vaccines, **is recommended if another high risk condition or other indication is present.**
Hepatitis B: **Pregnancy is not a contraindication to vaccination.** Limited data suggest that developing fetuses are not at risk for adverse events when hepatitis B vaccine is administered to pregnant women. Available vaccines contain noninfectious HBsAg and should cause no risk of infection to the fetus. **Pregnant women who are identified as being at risk for HBV infection** during pregnancy (e.g., having more than one sex partner during the previous 6 months, been evaluated or treated for an STD, recent or current injection drug use, or having had an HBsAg-positive sex partner) **should be vaccinated**
Influenza: Women in the second and third trimesters of pregnancy are at increased risk for hospitalization from influenza. **Routine influenza vaccination is recommended for all women who are or will be pregnant (in any trimester) during influenza season.**
HPV (inactivated vaccine): one series for those aged 26 years or younger not previously immunized. HPV may be given before or after pregnancy, if indicated, but is not recommended to be given during pregnancy.
MMR (live vaccine): recommended for those not previously immunized. Not recommended during pregnancy. If given before pregnancy avoid conception for 4 weeks. If given after pregnancy, give immediately postpartum if susceptible to rubella.
Varicella vaccine (live vaccine): recommended one series for those without evidence of immunity. Not recommended during pregnancy. If given before pregnancy avoid conception for 4 weeks. If given after pregnancy, give immediately postpartum if susceptible to rubella.

Height and Weight/Body Mass Index (BMI)

The BMI should be calculated at the first prenatal visit, and weight gain during pregnancy should be monitored at each subsequent prenatal visit.

The Institute of Medicine has devised recommendations for total weight gain and the rate of weight gain based on the pre-pregnant or initial pregnant BMI (if pre-pregnant BMI is not known). A table is shown below that has been modified from the report of the Institute of

Medicine.

Pre-pregnant or Initial Pregnant BMI	BMI (kg/m2) (WHO calculations)	Total Weight Gain Range (pounds)	Rate of Weight Gain in Second Trimesters (lbs/wk)
Underweight	<18.5	28-40	1 (range 1.0 to 1.3)
Normal Weight	18.5-24.9	25-35	1 (range 0.8 to 1.0)
Overweight	25.0-29.9	15-25	0.6 (range 0.5 to 0.7)
Obese (includes all classes)	≥30.0	11-20	0.5 (0.4 to 0.6)

Women who are pregnant with twins are given provisional guidelines. Those in the normal BMI category should aim to gain 37-54 pounds; overweight women, 31-50 pounds; and obese women, 25-42 pounds.

Intrapartum Care

The goal of all labor and delivery units is safe birth for all mothers and their newborns. Because intrapartum complications can arise, sometimes quickly and without warning, ongoing risk assessment and surveillance of the mother and fetus are essential.

Admission

Any pregnant woman presenting to a hospital for care should, at a minimum, be assessed for the following: ⇨	Fetal heart rate Maternal vital signs Uterine contractions
The responsible obstetric caregiver should be informed promptly if any of the following findings are present: ⇨	Vaginal bleeding Acute abdominal pain Temperature of 100.4 or higher Preterm labor Preterm premature rupture of membranes Hypertension Non-reassuring fetal heart rate Tachycardia Headache/visual symptoms/seizures

Labor

Any patient suspected to be in labor or who has rupture of the membranes or vaginal bleeding should be evaluated promptly in an obstetric service area. Whenever a pregnant women is evaluated for labor, the following factors should be assessed and recorded: ⇨	Blood pressure Pulse Temperature Frequency and duration of uterine contractions. Documentation of fetal well-being, group B beta strep status and treatment. Clinical estimation of fetal weight & assessment of maternal pelvis Urinary protein and glucose Cervical dilatation and effacement, unless contraindicated (known or suspected placenta previa). Fetal presentation and station of the presenting part. Status of the membranes. Date and time of the patient's arrival and notification of provider.
If a woman has had prenatal care and a recent examination has confirmed the normal progress of pregnancy, her admission evaluation may be limited to: *For those patients who have not had any previous prenatal testing routine laboratory testing should be done at the time of admission.*	Interval history. Physical examination directed at presenting complaint. Previously identified risk factors should be record- ed in the prenatal record.
If no new risk factors are found, attention may be focused on the following historical factors: ⇨	Time of onset and frequency of contractions. Status of the membranes. Presence or absence of bleeding. Fetal movement. History of allergies. Time, content and amount of the most recent food or fluid ingestion. Use of any medication.

Onset of true labor is established by observing progressive changes in a women's cervix.	Two or more cervical examinations may be required. The exams should be separated by an adequate time to observe change. Vaginal exams should be limited to those necessary for proper evaluation and management.
Premature rupture of membranes (PROM) is considered to be present when there is leakage of amniotic fluid before the onset of labor.	Preparations for labor should begin when PROM occurs, whether at or before term, because labor frequently ensues.

Management of Labor

Patients in active labor should avoid oral ingestion of anything except sips of clear liquids, occasional ice chips, or preparations for moistening the mouth and lips.	When significant amounts of hydration and energy substrate are needed because of a long labor, they should be given by intravenous infusion.
Progress of labor should be evaluated by periodic vaginal exams.	For women who are at no increased risk of complications, evaluation of the quality of uterine contractions and pelvic examinations should be sufficient to detect abnormalities in the progress of labor. *Vital signs should be recorded at regular intervals, at least every 4 hours. The frequency may be increased, particularly as active labor progresses according to signs and symptoms, or if abnormal findings are present.*
Documentation of the course of labor may include, but need not be limited to:	Presence of physicians or nurses, position changes, cervical status, oxygen and drug administration, blood pressure, temperature, amniotomy or spontaneous rupture of membranes, color of amniotic fluid, and Valsalva's maneuver.

Fetal Heart Rate Monitoring

Fetal heart rate monitoring to reflect fetal status during labor can be done by intermittent auscultation or continuous electronic means.	If intermittent auscultation is used, determine & record the auscultated FHR just after a contraction. If continuous fetal monitoring is used, the FHR tracing should be evaluated based on the recommended frequency for the risk factor & stage of labor.
If no risk factors *are present at the time of the patient's admission:* First Stage- at least every 30 minutes Second Stage- at least every 15 minutes.	***If risk factors*** *are present at admission or appear during the course of labor:* First Stage—at least every 15 minutes. Second Stage—at least every 5 minutes.

Induction and Augmentation of Labor

Labor is induced when the benefits to either the woman or the fetus outweigh those of continuing the pregnancy.	When labor is induced, a physician who has privileges to perform cesarean deliveries should be readily available.
If oxytocin is used, the infusion should be administered by a device that permits precise control of the flow rate to ensure accurate, minute-to-minute control.	Oxytocin is also used to augment labor and enhance inadequate uterine contractions in women for whom an assessment of the relationship between the maternal pelvis and fetal size is otherwise normal. Buccal, nasal or IM administration of Oxytocin should not be used to induce or augment labor.
Follow the FHR monitoring schedule for risk factors.	Pelvic/Maternal/Fetal evaluation should be documented prior to induction. Bishop Score or other description of cervical status should be documented for induction of labor.

Analgesia and Anesthesia

Management of discomfort and pain during labor and delivery is a necessary part of good obstetric practice. Maternal request is sufficient justification for providing pain relief during labor.	Pain relief through the general principles of education, support, relaxation, paced breathing, focusing and touch. Unless contraindicated, pharmacological analgesics to ameliorate the pain of contractions should be made available on request to women in labor. Parenteral opioids provide some degree of pain relief with minimal risk. Lumbar epidural block is the most flexible, effec- tive and least depressing to the CNS. It is however, associated with slower progress in the active phase of labor and increase in risk for operative vaginal delivery and cesarean section Paracervical block may result in fetal bradycardia. Because it results in profound motor and sensory blockade which impairs the maternal expulsive efforts, spinal anesthesia is typically not administered until delivery is imminent or a decision has been made to perform an operative delivery.
For most cesarean deliveries properly adminis- tered regional or general anesthesia is effective and has little adverse effect on the newborn. The following factors place a woman at increased risk during anesthesia care and should be communicated to the anesthesia care provider in advance of delivery to permit formulation of a management plan: ⇨	Marked maternal obesity. Severe maternal facial and neck edema. Maternal extreme short stature. Difficulty opening her mouth. Small mandible, protuberant teeth or both. Arthritis of the neck. Short neck. Anatomic abnormalities of the face or mouth. Large thyroid. Asthma or other chronic pulmonary disease. Cardiac disease.

Delivery

Vaginal Delivery	Vaginal birth is associated with less risk of operative and postoperative complications than cesarean delivery and results in shorter hospital stays.
Vaginal Birth after Cesarean Delivery	The risks & benefits of a trial of labor versus repeat cesarean delivery should be discussed with the patient. The decision to attempt vaginal delivery after cesarean delivery or to undergo a repeat cesarean delivery should be made by the informed patient & her physician. Informed consent should be documented. No woman should be mandated to undergo a trial of labor.
Cesarean Delivery	All hospitals offering labor and delivery services should be equipped to perform emergency cesarean delivery. Hospitals should have the capability of beginning a cesarean delivery within 30 minutes of the decision to-operate.
Examples of indications for cesarean delivery requiring expeditious response time include (among others):	Hemorrhage from placenta previa, abruptio placentae, prolapsed umbilical cord and uterine rupture.

Before elective low risk repeat cesarean delivery, the maturity of the fetus should be established. Fetal maturity may be assumed if one of the following is met:	Fetal heart tones documented for 20 weeks by non-electronic fetoscope or for 30 weeks by Doppler ultrasound. Thirty-six weeks have elapsed since positive results were obtained from a serum or urine cho- rionic gonadotropin pregnancy test performed by a reliable laboratory. An ultrasound measurement of the crown-rump length obtained at 6-11 weeks gestation supports a current gestational age of 39 weeks or more. Clinical history and physical ultra- sound examinations performed at 12-20 weeks of gestation support a current gestational age of 39 weeks or more.
Fetal surveillance should continue until abdominal sterile preparation has begun.	
Neonatal Care Both routine assessment and care of the baby at the time of delivery and possible provision of extensive resuscitation should be provided in accordance with the American Heart Association/ American Academy of Pediatrics Neonatal Resuscitation Program. At least one person who is skilled in initiating resuscitation should be present at every delivery.	Apgar score. Maintenance of body temperature. Suctioning. Ventilation. External cardiac massage. Drugs and volume expansion. Acidosis, Bradycardia, Hypovolemia. Narcotic induced respiratory depression.

Assessment of the Newborn

Intrauterine Growth Status	The pediatrician should assign gestational age after all data, both pediatric and obstetric, have been assessed.

Risk Assessment	No later than two hours after birth, nursery admitting personnel should evaluate the neonate's status and assess risk.
Immediate Care	Temperature, heart and respiratory rates, skin color, adequacy of peripheral circulation, type of respiration, level of consciousness, tone and activity should be monitored and recorded at least once every 30 minutes until the neonate's condition has remained stable for 2 hours.
Eye Care	Prophylaxis against gonococcal ophthalmia neonatorum is mandatory for all neonates.
Vitamin Care	Every newborn should receive a single parenteral 0.5-1.0 mg dose of natural Vitamin K within one hour of birth.
Preventive Care	Hepatitis B immunization
Hearing Screening	Detection of hearing loss as early as possible, preferably before three months of age, facilitates early intervention and the possibility of improved functional outcome.

Immediate Postpartum Care

Monitoring of maternal status postpartum is dictated in part by the events of the delivery process, the type of anesthesia or analgesia used & the complications identified. B/P levels & pulse should be monitored at least every 15 minutes & more frequently if complications are encountered; the temperature should be taken at least every 4 hours.
After cesarean delivery, policies for postanesthesia care should not differ from those applied to nonobstetric surgical patients receiving major anesthesia.

Post anesthesia observation	Mothers who have had regional or general anesthesia for vaginal or cesarean delivery.

Postpartum sterilization	If the delivery has been uncomplicated from a maternal standpoint, and anesthesia can be continued safely, there is no contraindication to proceeding with tubal ligation.

Subsequent Postpartum Care

In the postpartum period, staff should help the mother in learning how to care for herself and her baby. This includes:

Bed rest, ambulating, and diet:	The new mother should be allowed to sleep and regain strength. Regular diet, if there are no complications, as soon as she wishes.
Care of the vulva:	Proper cleansing technique. Ice bag to perineum in the first 24 hours after delivery to reduce edema, pain and swelling. Oral analgesics for episiotomy pain. Be alert for hematoma formation. Beginning 24 hours after delivery, moist heat in the form of sitz bath to reduce discomfort and promote healing.
Care of the bladder:	Void as soon as possible. Check frequently during the first 24 hours after delivery. Single catheriza- tion may be necessary. With continued voiding difficulties, use of a single indwelling catheter is preferable to repeated catherization.
Care of the breasts	The decision about breast-feeding determines the appropriate care of the breasts.
Temperature elevation	Postpartum patients with elevated temperature (> or = 100.4 on two occasions, six hours apart) should be evaluated.

Immunization: Immune Globulin and Rubella	An unsensitized, D-negative woman who delivers a D-positive or D^u neonate should receive 300 ug of anti-D immune globulin postpartum, ideally within 72 hours, even when anti-D immune globulin has been administered in the antepartum period.

Post-Partum Maternal Considerations

Approximately 4-6 weeks after delivery, the mother should visit her provider for a postpartum review and examination. A visit within 7-14 days of delivery may be advisable after a cesarean delivery or a complicated gestation.

Review at Postpartum Visit

Obtain an interval history	Blood pressure
Perform a physical exam	Breasts
Specific inquiries about breast-feeding should be made.	Abdomen
Birth control review	Pelvic exam
Emotional evaluation	Episiotomy repair
Pap test if needed	Uterine involution
An evaluation of weight	Lochia
Review immunizations, including rubella	Encourage return for subsequent periodic examinations
Physical activity and nutrition counseling	

Neonatal Considerations

The frequency of follow-up visits should be consistent with the American Academy of Pediatrics and Passport Health Plan's EPSDT guidelines.

Passport Health Plan Provider Forms and Documents

PASSPORT HEALTH PLAN

MommySteps

5100 Commerce Crossings Drive | Louisville, KY 40229
Phone: 502-585-7900 | FAX: 502-585-7970

PREGNANCY NOTIFICATION FORM

NOTE: All fields must be filled out;
Please fax completed form to Mommy Steps @ 502-585-7970

Member Name: _____ Passport ID #: _____

Date of Birth: ____ / ____ / ____ Current Address: _____

Bldg. #: _____ Apt./Unit/Lot #: _____ City: _____ State: _____ Zip: _____

Race/Ethnicity*: _____ Preferred Language: _____

Current Phone #: _____ Alternative #: _____

Pregnancy Risk Level: ❑ Routine ❑ High Risk Date of First Visit: ___ / ___ / ___

Preferred Spoken Language: _____ EDC: ___ / ___ / ___

PRE-EXISTING MEDICAL CONDITIONS

- ❑ Pre-term Labor or Delivery < 37 weeks
- ❑ Premature Rupture of Membranes (PROM)
- ❑ Incompetent Cervix
- ❑ Pregnancy Induced Hypertension (PIH; aka GHTN) / Toxemia / Preeclampsia / Eclampsia / HELLP Syndrome
- ❑ Chronic Hypertension (CHTN)
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ Chronic Renal Disease
- ❑ Pulmonary Disease (Asthma or other chronic pulmonary disease)
- ❑ Epilepsy
- ❑ Other chronic maternal medical conditions
- ❑ 2nd or 3rd Trimester Loss (miscarriage/abortion after 15 weeks or still born)
- ❑ Other complications: _____

_____

- ❑ No complications

INDICATE OBSTETRICAL/COMPLICATION IN LAST/LATEST/OR CURRENT PREGNANCY:

- ❑ Emotional, Physical, or Sexual Abuse
- ❑ Homelessness
- ❑ Lack of Transportation
- ❑ Lack of Utilities
- ❑ Language or Other Communication Barrier
- ❑ Mental Health Issues (Specify): _____
- ❑ Smoking

INDICATE OBSTETRICAL/COMPLICATION IN CURRENT PREGNANCY:

- ❑ Multi-fetal Pregnancy
- ❑ Substance Abuse
- ❑ Teen Pregnancy (ages 15-19) and Pre-teen Pregnancy (ages 10-14)
- ❑ Advance Maternal Age (35 years and older)
- ❑ Pyelonephritis (if hospitalized for this during current pregnancy)
- ❑ Domestic Violence
- ❑ Homelessness
- ❑ Other Complications: _____

_____

- ❑ No Complications

PROVIDER INFORMATION:

Name: _____

ID #: _____

Phone #: _____

Fax #: _____

ONLY FOR NON-PAR PROVIDERS

Authorization #: _____
(FOR PASSPORT USE ONLY)

NOTE: Authorizations for Non-Par Providers will be faxed within 2 business days of the original fax date

Stratification Tool

PASSPORT HEALTH PLAN
MommySteps

High Risk
ANY Pregnancy: • Pre-term Labor or Delivery < 37 weeks • Premature Rupture of Membranes (PROM) • Incompetent Cervix • Pregnancy Induced Hypertension (PIH; aka GHTN) / Toxemia / Preeclampsia / Eclampsia / HELLP Syndrome • Chronic Hypertension (CHTN) • Diabetes • Thyroid Disease • Chronic Renal Disease • Pulmonary Disease (Asthma or other chronic pulmonary disease) • Epilepsy • Other chronic maternal medical conditions • 2nd or 3rd Trimester Loss (miscarriage/abortion after 15 weeks or still born)
Last / Latest or Current Pregnancy: • Intrauterine Growth Restriction (IUGR)
Current Pregnancy: • Multi-fetal Pregnancy • Substance Abuse • Teen Pregnancy (ages 15-19) and Pre-teen Pregnancy (ages 10-14) • Advance Maternal Age (35 years and older) • Pyelonephritis (if hospitalized for this during current pregnancy) • Domestic Violence • Homelessness

Postpartum Phase of Program is from date of delivery to 90 days postpartum

Updated: 10/12/15

Provider Manual
Section 13.0
Obstetrical

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13.0 Obstetrical

13.1 Overview

Passport Health Plan recognizes that access to effective prenatal and postpartum care provides a strong foundation for the health of women, as well as improving birth outcomes. As a result, Passport's Mommy Steps Program (a dedicated team of perinatal nurses and support staff) work with obstetrical clinicians, local health departments, home health agencies, and others to identify the psychosocial, nutritional and educational needs of pregnant members. Once these needs are identified, Mommy Steps staff provides coordination of these services for our members. Passport's specialized maternal and newborn nurses work to support the physician's plan of care, which may include additional health education, referrals to WIC (Women, Infant & Children), Smoking Cessation Programs, Substance Abuse Treatment Referrals, or Behavioral Health Counseling Referrals.

Our goal is to empower pregnant women to become more educated and responsible for their health and the decisions that impact their overall well-being. By partnering with providers and educating members, we can decrease the rate of prematurity, infant mortality, low birth weight and very low birth weight babies.

13.2 Mommy Steps Program

Mommy Steps nurses are available to assist members and obstetrical providers with questions. They can be reached at (877) 903-0082 or via fax at (502) 585-7970 Monday through Friday, 8:00

a.m. to 6:00 p.m. EST (excluding business approved holidays).

In addition, each newly identified pregnant member will receive a welcome packet to the program that includes: education materials about prenatal care (including coverage for classes conducted by certified prenatal educators), community resources, domestic violence support, dental and vision services, legal assistance contacts, and transportation service contact information. High risk pregnant members receive additional education and guidance from one of our Perinatal Nurse Case Managers.

Participation in the Mommy Steps Program, as with all Case Management Programs, is voluntary, and the member has the right to decline any or all parts of the program.

13.3 Member Access and/or Authorization Requirements

All components of obstetrical care are directly accessible by members including testing and prenatal care. Appointment standards must be provided for prenatal care as follows:

- 1st Trimester-within 14 business days of request.
- 2nd Trimester-within 7 business days of request.
- 3rd Trimester-within 3 business days of request.
- High-risk pregnancies-within 1 business day of the identification of a high-risk condition or immediately if an emergency exists.

In addition, authorizations for referrals to Maternal Fetal Medicine specialists, geneticists, and endocrinologists are not required for high risk conditions evaluation and treatment during pregnancy.

Maternity observation stays do not require authorizations. These are defined as a hospital stay of 23 hours or less for the observation of members with medical conditions related to pregnancy. Only 23-hours of observation is covered at a single encounter. For additional lengths of stay (over 23 hours) to be covered, inpatient stays must be authorized.

13.4 Responsibility of Providers

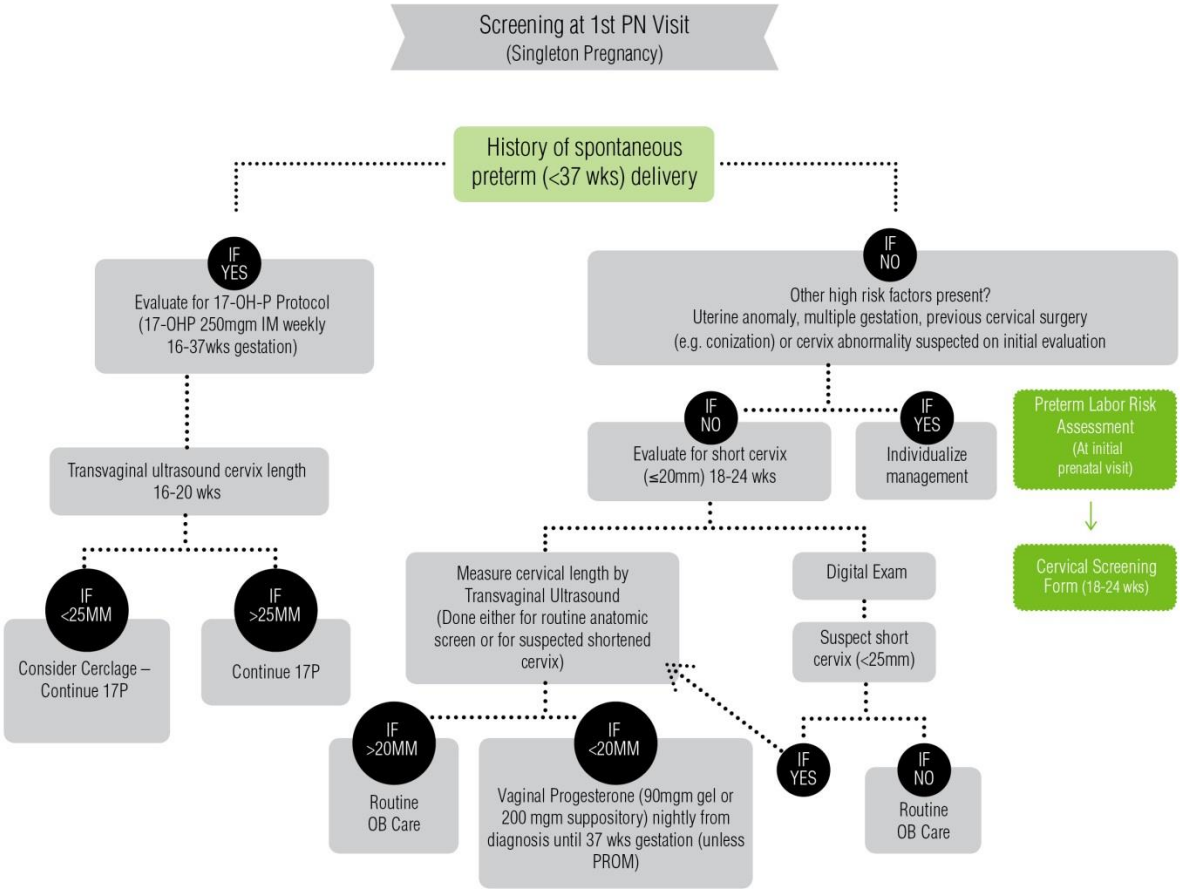
Follow the Passport Health Plan Clinical Practice Guideline for Perinatal Care which was adopted from the American College of Obstetricians and Gynecologists (ACOG).
OB providers should:

- Please fax the Pregnancy Notification Form to Mommy Steps at (502) 585-7970 within seven (7) business days of the initial prenatal visit (or determination of Passport membership/eligibility, whichever is later.)
- Submit the initial prenatal risk assessment/medical and obstetrical history within one week of the initial prenatal visit. An ACOG (or ACOG like) form containing this information should be faxed to the Passport Mommy Steps Program at (502) 585-7970. It is the responsibility of the provider to confirm that the ACOG (or ACOG-like) form has been received by Mommy Steps, if they assume the care of a member from another provider. This should be received by Passport Mommy Steps Program within 7 business days of the initial evaluation (or determination of Passport membership/eligibility, whichever is later.)
- Submit the Universal Cervical Length Screening Form (performed between 16-24 weeks

gestation.) via fax to (502) 585-7970. Universal Cervical Length Screening can be completed via physical exam or transvaginal ultrasound. For reimbursement of cervical length screening, providers should submit a claim. The claim should be filed as soon as possible following the screening evaluation. Please see Cervical Length Coding Procedures for assistance.

- Birth statistics should be reported for each delivery within 7 business days of delivery. This information should include: member name, member Passport ID #, facility, date of birth, delivery route, gestational age, birth weight, gender, 1 minute Apgar and 5 minute Apgar, living status: alive/fetal demise, delivering clinician name, delivering clinician NPI#, any complications of pregnancy, delivery, or the postpartum period.
- Schedule a postpartum visit for the period of 21-56 days post-delivery. Ideally, scheduling should be done no later than discharge from the hospital following delivery. In addition, for patients who are at risk for complications or are post-operative from Cesarean Section, an additional visit should be scheduled for the member to be seen 7 to 14 days post-operatively. Submit documentation of the postpartum visit including the member's choice of contraceptive. If the member elects to have a tubal ligation, the surgical permit must be signed 30 days prior to the procedure.
- Contact the Mommy Steps Program if the member's risk status or condition changes in any way during pregnancy, labor and delivery, or postpartum.
- Direct members to their PCP for the evaluation and treatment of conditions not related to pregnancy.
- Coordinate care with the member's PCP or other treatment clinicians as appropriate.
- Notify the Mommy Step's Program via fax within two business days of all missed prenatal appointments. Passport must receive the initial prenatal risk assessment/medical and obstetrical history on file prior to the missed appointment in order for payment to be made to the physician for the No Show. This process is outlined in the fee schedule for No Show visits.

PRETERM BIRTH PREVENTION ALGORITHM



References:

1. The Guidelines for Perinatal Care, Seventh Edition developed through the cooperative efforts of the American Academy of Pediatrics (AAP) Committee on Fetus and Newborn and the American College of Obstetricians and Gynecologists (ACOG) Committee on Obstetric Practice. Link: http://www.acog.org/About-ACOG/ACOG-Departments/Deliveries-Before-39-Weeks/ACOG-Clinical-Guidelines

2. Center for Disease Control (CDC) Immunization recommendations: Link: www.cdc.gov http://www.cdc.gov/vaccines/adults/rec-vac/pregnant.html http://www.cdc.gov/vaccines/pubs/downloads/f_preg_chart.pdf

3. ACOG Committee Opinion April 2015- **Clinical Guidelines and Standardization of Practice to Improve Outcomes** http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/Clinical-Guidelines-and-Standardization-of-Practice-to-Improve-Outcomes

4. The ACOG Committee Opinion, May 2015, Screening for Perinatal Depression. Link: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression

5. Screening Tools for Perinatal Depression: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression

6. Passport Health Plan MommySteps Stratification Tool

7. Institute of Clinical Systems Improvement, Fifteenth Edition July 2012, Healthcare Guideline: Routine Prenatal Care. Link: https://www.icsi.org/_asset/13n9y4/Prenatal.pdf

8. USPSTF / US Preventative Services Task Force Recommendations - Screenings in Pregnant Women: Bacterial Vaginosis, Hep B, Iron Deficiency Anemia (screening and supplementation), Lead Levels, Low Dose Aspirin Use for Prevention of Morbidity and Mortality from Pre-eclampsia, Pre-eclampsia Screening, Screening for Syphilis Infection link: http://www.uspreventiveservicestaskforce.org/BrowseRec/Index

ACOG Bulletins for further references for Practitioners:

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