OBSTETRIC CARE BASKET OF CARE SUBCOMMITTEE

Report to:

Minnesota Department of Health

June 22, 2009

BASKET TOPIC DETERMINED BY BASKET OF CARE STEERING COMMITTEE:

Obstetric Care

BASKET TOPIC DETERMINED BY BASKET OF CARE SUBCOMMITTEE:

Prenatal Care

SCOPE STATEMENT: [1]

This basket of care is for prenatal services provided to women with a confirmed, singleton intrauterine pregnancy. The timeframe is from the confirmation of pregnancy until the onset of obstetrical labor. Services are provided by licensed healthcare professionals. Excluded are those patients with high-risk pregnancies such as HIV, insulin dependent diabetes, and multiple gestations.

Rationale for Scope Selection

The subcommittee discussed at length how much should be included in a basket of OB care. The limits of time to prepare the components of the basket was one factor for limiting it to the Prenatal phase of OB care. The subcommittee was also aware that some clinics only provide prenatal care and then the women are transitioned elsewhere for labor and delivery.

There is stronger and more evidence for Prenatal Care than recommendations for Labor, Delivery and Postnatal care. Therefore the subcommittee thought that for this first design of a basket of care, it made the most sense to limit the scope and components from the time of conception to the onset of obstetrical labor.

BASKET OF CARE COMPONENTS:

Basket components were identified based on current literature, existing guidelines, current standards of practice and in some cases evidence informed consensus.

Prenatal Assessments	**Frequency**
Preterm labor risk assessment	Every visit
Herpes Assessment	Initial and as needed
Varicella Assessment	Initial
Lead risk assessment	Initial
TB risk assessment	Initial
Screening Maneuvers	**Frequency**
Height/Weight/BMI [2]	BMI at initial visit Weight at every visit
Blood Pressure	Every visit
GC/Chlamydia	Initial; repeat as appropriate (Age and risk specific)
History/Physical exam	Initial
Rubella Antibody test	Initial
Syphilis Test	Initial
HIV	Initial and as appropriate
CBC/Hgb	Initial and as indicated
ABO/Rh/Ab	Initial Ab screen if Rh negative
Urinalysis/culture	Initial and as indicated
Hepatitis B Serum Antigen	Initial
Lead Screening	If appropriate
Herpes and Varicella testing	If appropriate
Pap test	If indicated
TB testing (Mantoux or chest x-ray)	If indicated
Ultrasound (limited) [3]	Limited to a specific indication
Cervical Assessment	As needed
Fetal heart tones	Each visit after 10 weeks
Gestational Diabetes Screening (1 and 3 hr test) Glucose Tolerance 3 hour	One As indicated
Fundal Height	Every visit after 20 wks
Confirm Fetal Position	Every visit after 36 wks
Group B Strep culture	Once; repeat as needed
Counseling / Education Topics and Interventions	**Frequency**
Review warning signs	Each trimester
Substance Use (tobacco, alcohol, drugs)	Initial and each trimester
Nutrition and weight, exercise	Initial and as needed
Nausea and Vomiting	Initial and as needed
Review medications, vitamins, herbal supplements	Update each trimester
Folic acid supplement (discuss need)	Initial
Domestic violence	Initial and each trimester

Depression	Initial/each trimester
Other Prenatal education (physiology of pregnancy, fetal growth, breast feeding, working, sexuality, etc.)	On-going
Discuss first and second trimester fetal aneuploidy [4] screening testing	Initial, second trimester
Awareness of fetal movement	On-going
Labor and Delivery concerns of the patient (e.g., episiotomy, when to call the provider, management of late pregnancy)	As needed
Post-Partum concerns (e.g., depression, contraception, pediatric care)	As needed
Vaginal Birth after Caesarean section (VBAC)	If indicated
Immunizations and Chemoprophylaxis (Provided)	**Frequency**
Tetanus booster	If needed
Hepatitis B vaccine	If at risk
Influenza	If indicated
RhoGAM	If indicated
Number of Prenatal Visits	**Typical range 10-14 visits**

Notes:

1. **Scope:**

   The subcommittee discussed and reached the decision by consensus that this basket of care would only include services provided during the prenatal phase of total OB care. Time was a factor. Also, there is more evidence supporting prenatal components than those of labor and delivery. However it is hoped that subsequent baskets containing components for the other phases of OB care will follow rapidly.

2. **Height, Weight and BMI**

   Must be measured height, not self-report. Self-reported heights can be very inaccurate.

3. **OB Ultrasound**

   Ultrasonography is a commonly used imaging tool in pregnancy and should be performed only when there is valid medical indication for this examination. There is no evidence to support ultrasounds in the first trimester. A **limited** ultrasound should be performed **only** if indicated. This type of examination is for specific and limited clinical concerns.

4. **Fetal Aneuploidy discussion**

   First trimester aneuploidy screening should be discussed with the patient. However, at this time the cost and access of these tests may be prohibitive. Second trimester aneuploidy screening should also be discussed and offered. The cost of the testing is not included in the basket.

Components considered but not included:

- See rationale for scope above.
- Interpreter services: The subcommittee agreed that interpreter services are a need that is crucial in the delivery of care. Although there are certainly regional variations, even in rural practice, the need for interpreter services continues to increase steadily. However, rather than it being a component in this basket, the recommendation is that in a new healthcare delivery system, qualified interpreters would be available and covered as a benefit for all.

Components in initial basket that were modified for final draft:

- Aneuploidy screening: The American College of Obstetricians and Gynecologists recommends that all pregnant women be counseled regarding testing for chromosomal abnormalities. The option of testing is important, what testing to include is a problem. Clearly the first trimester screen is the better test but not yet widely available. Requiring inclusion of it would be difficult for many clinics at this time. However, requiring that patients be educated about screening options is the best answer currently.
- OB Ultrasound: Ultrasonography is a commonly used imaging tool in pregnancy. And should be performed only when there is valid medical indication for this examination. However, it has become standard of care to offer it and it is a patient expectation. There is no evidence to support ultrasounds in the first trimester. We have determined that one standard ultrasound be offered and included. A standard ultrasound is an evaluation of fetal biometry and anatomic survey. It is most often used in determining dates of pregnancy. A limited ultrasound should be performed only if indicated. This type of examination is for specific and limited clinical concerns.

OPPORTUNITIES FOR INNOVATION INCLUDE:

- The subcommittee discussed whether to include the number of visits or not in the basket. It is recommended that the number of visits needed for comprehensive prenatal care should be discussed and agreed upon by the patient and provider. The typical range is from 10-14 visits.
- Visits may be clinic-based, e-visit, group visits, etc.
- The subcommittee feels that the frequency of the components is well-defined as initial, each visit, as appropriate, once etc. However, the model was meant to be flexible to accommodate different care systems and innovation.

ADDITIONAL CONSIDERATIONS:

- Visits may be clinic-based, e-visit, group visits, etc.
- Number of visits for comprehensive prenatal care should be determined between the patient and provider. However 24-hour access to a licensed professional is required.
- We recognize that interpreter services are an important part of the administration of all baskets of care. This is a service that should be covered universally.
- There is great ambivalence among the subcommittee members about this process. It is hard to imagine how this basket will be used, how it will be offered and paid for and how will providers be held accountable for its delivery?

JUNE 4, 2009 STEERING COMMITTEE REVIEW AND COMMENT:

- Discussed concern of including ultrasound (without clinical indication or evidence) as well as absence of labor and delivery component. Steering Committee recommended removal of standard 18-20 week ultrasound.
- Questioned if it would be difficult to implement this basket without labor and delivery services; Steering Committee recommended review around claims and billing for this by Administrative / Operations work group to help answer this question.

SUPPORTING REFERENCES

These care components are supported by the following evidence and guidelines:

American College of Obstetrics and Gynecology 1994-2007

Guidelines for Prenatal Care—American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, 6th Edition 2007

Institute for Clinical Systems Improvement—Prenatal Guideline 2008

Centers for Disease Control and Prevention—Sexually Transmitted Diseases, 2006