

Proposed Changes to Existing Measure for HEDIS^{®1} 2020: Prenatal and Postpartum Care (PPC)

Proposed New Measures for HEDIS 2020: Prenatal Depression Screening and Follow-Up (PND) Postpartum Depression Screening and Follow-Up (PPD)

NCQA seeks comments on the following for the HEDIS 2020 health plan measure set:

- Proposed revisions to the *Prenatal and Postpartum Care* measure, following a recently released American College of Obstetricians and Gynecologists (ACOG) guideline recommending changes to the timing of postpartum care.
- Two proposed new measures, specified for the HEDIS Electronic Clinical Data Systems (ECDS) reporting method, assessing prenatal and postpartum depression screening and follow-up. ECDS includes data from administrative claims, electronic health records, case management systems and health information exchanges/clinical registries.

Summary of HEDIS Perinatal Measures for Public Comment

HEDIS perinatal measures assess whether pregnant and postpartum women receive recommended services that are associated with positive outcomes. Perinatal visits represent important opportunities to provide evidence-based care, and the *Prenatal and Postpartum Care* measure ensures that women are accessing health care in a timely way. NCQA seeks public comment on proposed revisions to the measure to bring it up-to-date for HEDIS 2020.

NCQA recently incorporated the ECDS reporting method into HEDIS, which was a foundational step toward developing measures that assess effectiveness of perinatal care. NCQA seeks public comment on two new perinatal depression measures for HEDIS 2020 that use the ECDS reporting method: *Prenatal Depression Screening and Follow-Up* and *Postpartum Depression Screening and Follow-Up*. These measures assess receipt of appropriate depression screening and care during critical periods, which is linked to the long-term health and well-being of both mothers and infants.

Prenatal and Postpartum Care Measure Recommendations

This measure uses the hybrid data collection method for commercial and Medicaid reporting. Receipt of a postpartum visit during 3 to 8 weeks after delivery is a rate within this measure (in addition to a prenatal visit rate). ACOG recently published an updated guideline for postpartum care and now recommends an initial postpartum visit within 3 weeks after birth to address acute issues, followed by ongoing care as needed and concluding with a visit from 4 to 12 weeks after birth. NCQA proposes replacing the current postpartum rate with three rates:

1. **Early postpartum visit:** percentage with a postpartum visit within 21 days after delivery.
2. **Later postpartum visit:** percentage with a postpartum visit during 22 and 84 days after delivery.
3. **Early and later postpartum visit:** percentage with both an early and a later postpartum visit (numerator compliant for both indicators).

The *Prenatal and Postpartum Care* measure also includes a rate assessing timeliness of prenatal care, with various decision rules for the timing of the prenatal visit depending on when women were enrolled in the plan during pregnancy. Currently, women who enroll in the plan after the first trimester must have a prenatal visit within 42 days of enrollment start. Based on stakeholder feedback, we propose allowing any first trimester visit to count in the measure, regardless of when women were enrolled in the plan, and aligning and simplifying the prenatal visit criteria across the different enrollment populations.

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Prenatal and Postpartum Depression Screening and Follow-Up Measure Recommendations

The U.S. Preventive Services Task Force and other major guideline developers recommend screening all pregnant and postpartum women for depression and establishing and maintaining regular follow-up for those diagnosed with depression. We propose two new ECDS measures for commercial and Medicaid plan reporting:

Prenatal Depression Screening and Follow-Up

1. **Depression screening:** The percentage of deliveries in which women were screened for clinical depression using a standardized tool during pregnancy.
2. **Follow-up on positive screen:** The percentage of deliveries in which pregnant women received follow-up care within 30 days of screening positive for depression.

Postpartum Depression Screening and Follow-Up

1. **Depression screening:** The percentage of deliveries in which women were screened for clinical depression using a standardized tool within 12 weeks (84 days) post-delivery.
2. **Follow-up on positive screen:** The percentage of deliveries in which postpartum women received follow-up care within 30 days of screening positive for depression.

Expert panel members supported two stand-alone measures because they correspond to how care is provided and would provide actionable information for health plans. We aligned these measures with other existing HEDIS measures where possible. The definition of depression screening and follow-up aligns with the existing depression measure; the prenatal depression measure denominator is the same as the existing prenatal immunization measure.

For the postpartum depression screening measure, we have specified the measure to allow depression screenings administered across different settings of care to count as numerator compliant in the measure. Thus, for example, depression screenings conducted by the health plan as part of case management programs, or screenings conducted by the woman's provider or the infant's pediatrician, would be acceptable screening methods. In addition to ACOG, the American Academy of Pediatrics recommends that pediatricians or family medicine providers screen mothers during well-baby visits.

Specific Requested Public Comment Feedback

Medicaid coverage and continuous enrollment: Women who qualify for Medicaid due to pregnancy alone lose coverage at 60 days post-delivery, yet ACOG recommends postpartum care through 12 weeks (84 days) after delivery. For the *Prenatal and Postpartum Care* and *Postpartum Depression Screening and Follow-Up* measures, we propose to specify continuous enrollment beyond the 60 days in order to align with the guidance that providers are receiving. The disadvantage to this approach is that women who lose Medicaid coverage at 60 days will not be captured in the measure's eligible population. However, we have received stakeholder feedback that fewer women may lose Medicaid coverage in states that have implemented Medicaid expansion programs (which currently includes 32 states and the District of Columbia, with an additional four states expected to implement Medicaid expansion in 2019). We seek public comment on the proposed specifications for continuous enrollment.

Telehealth: We seek public comment on our recommendation to allow prenatal and postpartum telehealth care to count for all of the perinatal measure rates.

Supporting documents include the draft measure specification, evidence workup and performance data.

NCQA acknowledges the contributions of the Pregnancy Health Measurement Advisory Panel, the Behavioral Health Measurement Advisory Panel and the Technical Measurement Advisory Panel

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO HEDIS 2020

- Added definitions.
- Revised the continuous enrollment criteria and the delivery timing for the eligible population to align with the new postpartum visit timings.
- Changed the timeliness of prenatal care indicator as follows:
 - Deleted the decision rules and standardized the prenatal care visit requirements.
 - Deleted the requirement to only include visits that occurred while the member was enrolled.
- Retired the postpartum care rate assessing a visit between 21 and 56 days after delivery and replaced it with the following:
 - Two rates assessing an early postpartum visit and a later postpartum visit.
 - An “early and later postpartum visit” rate assessing numerator compliance for both the early and later postpartum visit rates.
- Provided additional examples in the hybrid specification numerator criteria indicating that a postpartum visit occurred.

Description

The percentage of deliveries of live births on or between ~~November 6~~ **October 8** of the year prior to the measurement year and ~~November 5~~ **October 7** of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit ~~as a member of the organization~~ in the first trimester, on ~~or before~~ the enrollment start date or within 42 days of enrollment in the organization.
- ~~*Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.~~
- *Early Postpartum Visit.* The percentage of deliveries that had a postpartum visit on or between 1 and 21 days after delivery.
- *Later Postpartum Visit.* The percentage of deliveries that had a postpartum visit on or between 22 and 84 days after delivery.
- *Early and Later Postpartum Visit.* The percentage of deliveries that had both an Early Postpartum Visit and a Later Postpartum Visit.

Definitions

First trimester	280–176 days prior to delivery (or EDD).
Enrollment segment	A period of continuous enrollment with no gaps in enrollment.
Last enrollment segment	The enrollment segment during the pregnancy with the start date that is closest to the delivery date.

Eligible Population

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid (report each product line separately).
Age	None specified.
Continuous enrollment	43 days prior to delivery through 56 84 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	<p>Delivered a live birth on or between November 6 October 8 of the year prior to the measurement year and November 5 October 7 of the measurement year. Include women who delivered in any setting.</p> <p><i>Multiple births.</i> Women who had two separate deliveries (different dates of service) between November 6 October 8 of the year prior to the measurement year and November 5 October 7 of the measurement year count twice. Women who had multiple live births during one pregnancy count once.</p> <p>Follow the steps below to identify the eligible population, which is the denominator for both rates.</p> <p>Step 1 Identify deliveries. Identify all women with a delivery (<u>Deliveries Value Set</u>) on or between November 6 October 8 of the year prior to the measurement year and November 5 October 7 of the measurement year.</p> <p><i>Note: The intent is to identify the date of delivery (the date of the “procedure”). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.</i></p> <p>Step 2 Exclude non-live births (<u>Non-live Births Value Set</u>).</p> <p>Step 3 Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 56 84 days after delivery, with no gaps.</p>

Administrative Specification

Denominator The eligible population.

Numerator

~~**Timeliness of Prenatal Care** A prenatal visit in the first trimester, on the enrollment start date or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.~~

~~Include only visits that occur while the member was enrolled.~~

~~Follow the steps below to identify the numerator.~~

~~**Step 1** Determine enrollment status during the first trimester. For all women in the eligible population, identify those who were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, proceed to step 2.~~

~~For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to step 3.~~

~~**Step 2** Determine continuous enrollment for the first trimester. Identify women from step 1 who were continuously enrolled during the first trimester (176–280 days prior to delivery [or EDD]), with no gaps in enrollment. For these women, determine numerator compliance using the decision rules for *Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester*.~~

~~For women who were not continuously enrolled during the first trimester (e.g., had a gap between 176 and 280 days before delivery), proceed to step 3.~~

~~**Step 3** Determine the start date of the last enrollment segment (i.e., the enrollment segment during the pregnancy with the start date that is closest to the delivery date).~~

~~For women whose last enrollment started on or between 219 and 279 days before delivery, proceed to step 4.~~

~~For women whose last enrollment started less than 219 days before delivery, proceed to step 5.~~

~~**Step 4** Determine numerator compliance. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the instructions for *Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester* and find a visit on or between the last enrollment start date and 176 days before delivery.~~

~~**Step 5** Determine numerator compliance. If the last enrollment segment started less than 219 days before delivery (i.e., between 219 days before delivery and the day of delivery), determine numerator compliance using the instructions for *Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester* and find a visit on the enrollment start date or within 42 days after enrollment.~~

~~Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester~~

~~**Decision Rule 1** Either of the following during the first trimester, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP meets criteria:~~

- ~~• A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).~~
- ~~• A visit for prenatal care (Stand Alone Prenatal Visits Value Set).~~

~~**Decision Rule 2** A prenatal visit (Prenatal Visits Value Set) with an OB/GYN or other prenatal care practitioner and at least one of the following, all during the first trimester (on the same date of service as the prenatal visit or on different dates of service):~~

- ~~• An obstetric panel (Obstetric Panel Value Set).~~
- ~~• An ultrasound of the pregnant uterus (Prenatal Ultrasound Value Set).~~
- ~~• A pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) for the prenatal visit (codes must be from the same visit).~~
- ~~• All of the following on the same date of service or on different dates of service:
 - ~~— Toxoplasma (Toxoplasma Antibody Value Set).~~
 - ~~— Rubella (Rubella Antibody Value Set).~~
 - ~~— Cytomegalovirus (Cytomegalovirus Antibody Value Set).~~~~

- ~~Herpes simplex (Herpes Simplex Antibody Value Set).~~
- ~~A rubella antibody test (Rubella Antibody Value Set) and an ABO test (ABO Value Set) on the same date of service or on different dates of service.~~
- ~~A rubella antibody test (Rubella Antibody Value Set) and an Rh test (Rh Value Set) on the same date of service or on different dates of service.~~
- ~~A rubella antibody test (Rubella Antibody Value Set) and an ABO/Rh test (ABO and Rh Value Set) on the same date of service or on different dates of service.~~

Decision Rule 3

~~A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) (codes must be from the same visit) where the practitioner type is a PCP and at least one of the following, all during the first trimester (on the same date of service as the prenatal visit or on different dates of service):~~

- ~~An obstetric panel (Obstetric Panel Value Set).~~
- ~~An ultrasound of the pregnant uterus (Prenatal Ultrasound Value Set).~~
- ~~All of the following on the same date of service or on different dates of service:~~
 - ~~Toxoplasma (Toxoplasma Antibody Value Set).~~
 - ~~Rubella (Rubella Antibody Value Set).~~
 - ~~Cytomegalovirus (Cytomegalovirus Antibody Value Set).~~
 - ~~Herpes simplex (Herpes Simplex Antibody Value Set).~~
- ~~A rubella antibody test (Rubella Antibody Value Set) and an ABO test (ABO Value Set) on the same date of service or on different dates of service.~~
- ~~A rubella antibody test (Rubella Antibody Value Set) and an Rh test (Rh Value Set) on the same date of service or on different dates of service.~~
- ~~A rubella antibody test (Rubella Antibody Value Set) and an ABO/Rh test (ABO and Rh Value Set) on the same date of service or on different dates of service.~~

~~Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester~~

~~Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria:~~

- ~~• A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).~~
- ~~• A visit for prenatal care (Stand Alone Prenatal Visits Value Set).~~
- ~~• A prenatal visit (Prenatal Visits Value Set) **and** an ultrasound of the pregnant uterus (Prenatal Ultrasound Value Set) on the same date of service or on different dates of service.~~
- ~~• A prenatal visit (Prenatal Visits Value Set) **with** a principal pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).~~

Numerator

Timeliness of Prenatal Care A prenatal visit during the first trimester, on or before the enrollment start date or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.

Step 1 Identify women whose last enrollment segment started on or between 280 and 219 days before delivery (or EDD).

These women must have a prenatal visit during the first trimester.

Step 2 Identify women whose last enrollment segment started less than 219 days before delivery (or EDD).

These women must have a prenatal visit anytime during the period that begins 280 days prior to delivery and ends 42 days after enrollment start date.

Step 3 Identify prenatal visits that occurred during the required timeframe (the timeframe identified in step 1 or 2). Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
- A prenatal visit (Prenatal Visits Value Set) **with** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

Postpartum Care A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. Any of the following meet criteria:

- ~~• A postpartum visit (Postpartum Visits Value Set).~~
- ~~• Cervical cytology (Cervical Cytology Value Set).~~
- ~~• A bundled service (Postpartum Bundled Services Value Set) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).~~

Note: ~~The practitioner requirement only applies to the Hybrid Specification. The organization is not required to identify practitioner type in administrative data.~~

Early Postpartum Visit A postpartum visit for a pelvic exam or postpartum care on or between 1 and 21 days after delivery. Any of the following meet criteria:

- A postpartum visit ([Postpartum Visits Value Set](#)).
- Cervical cytology ([Cervical Cytology Value Set](#)).
- A bundled service ([Postpartum Bundled Services Value Set](#)) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

Exclude services provided in an acute inpatient setting ([Acute Inpatient Value Set](#); [Acute Inpatient POS Value Set](#)).

Later Postpartum Visit

A postpartum visit for a pelvic exam or postpartum care on or between 22 and 84 days after delivery. Any of the following meet criteria:

- A postpartum visit ([Postpartum Visits Value Set](#)).
- Cervical cytology ([Cervical Cytology Value Set](#)).
- A bundled service ([Postpartum Bundled Services Value Set](#)) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

Exclude services provided in an acute inpatient setting ([Acute Inpatient Value Set](#); [Acute Inpatient POS Value Set](#)).

Early and Later Postpartum Visit

Numerator compliant for both the early postpartum visit and later postpartum visit indicators.

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for each product line. ~~Because *Prenatal and Postpartum Care* has been significantly revised, sample size reduction is not allowed. Organizations may reduce the sample size using the current year's lowest product line-specific administrative rate of these two indicators and the >81% indicator from *Frequency of Ongoing Prenatal Care* or the prior year's lowest audited product line-specific rate for these two indicators and the >81% indicator from *Frequency of Ongoing Prenatal Care*.~~

Numerator

Timeliness of Prenatal Care

A prenatal visit in the first trimester, on **or before** the enrollment start date or within 42 days of enrollment, depending on the date of enrollment in the organization and gaps in enrollment during the pregnancy. ~~Include only visits that occurred while the member was enrolled.~~

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record

Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of *one* of the following.

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, **or** pelvic exam with obstetric observations, **or** measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
 - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B

- surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), **or**
- TORCH antibody panel alone, **or**
- A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, **or**
- Ultrasound of a pregnant uterus.
- Documentation of LMP, EDD or gestational age in conjunction with *either* of the following.
 - Prenatal risk assessment and counseling/education.
 - Complete obstetrical history.

Note: For women whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery) and women who had a gap during the first trimester, count documentation of a visit to an OB/GYN, family practitioner or other PCP with a diagnosis of pregnancy.

~~**Postpartum Care** A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery, as documented through either administrative data or medical record review.~~

~~**Administrative** Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.~~

~~**Medical record** Postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following.~~

- ~~Notation of postpartum care, including, but not limited to:
 - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
 - A preprinted “Postpartum Care” form in which information was documented during the visit.~~
- ~~Pelvic exam.~~
- ~~Evaluation of weight, BP, breasts and abdomen.
Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component.~~

~~**Early Postpartum Visit** A postpartum visit for a pelvic exam or postpartum care on or between 1 and 21 days after delivery, as documented through either administrative data or medical record review.~~

~~**Administrative** Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.~~

~~**Medical record** Postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 1 and 21 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred. Examples of medical record documentation indicating that a postpartum visit occurred include:~~

- ~~Notation of postpartum care, including, but not limited to:
 - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
 - A preprinted “Postpartum Care” form in which information was documented during the visit.~~
- ~~Mood and emotional well-being: screening for depression and anxiety, tobacco use, substance use disorder, preexisting mental health disorders.~~
- ~~Assessment of comfort and confidence with infant care and breastfeeding.~~

- Guidance on sexuality, birth spacing and provision of contraception.
- Sleep and fatigue: discussion of coping options and engaging family and friends in assisting with care responsibilities.
- Physical recovery from birth: assessment of cesarean or perineal wound infection, pain, urinary and fecal incontinence, resumption of physical activity and attainment of healthy weight.
- Chronic disease management: discussion of pregnancy complications (e.g., hypertension, ASCVD) and implications for future childbearing and long-term maternal health, glucose screening for women with gestational diabetes mellitus, review of medication selection and dose outside of pregnancy.
- Health maintenance: review of vaccination history and administration of indicated immunizations; well-woman screening, including PAP test and pelvic examination as indicated.

Do not include postpartum care provided in an acute inpatient setting (e.g., that occurs in the hospital after delivery but prior to discharge).

Later Postpartum Visit

A postpartum visit for a pelvic exam or postpartum care on or between 22 and 84 days after delivery, as documented through either administrative data or medical record review.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical Record

Postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 22 and 84 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred. Examples of medical record documentation indicating that a postpartum visit occurred include:

- Notation of postpartum care, including, but not limited to:
 - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
 - A preprinted “Postpartum Care” form in which information was documented during the visit.
- Mood and emotional well-being: screening for depression and anxiety, tobacco use, substance use disorder, preexisting mental health disorders.
- Assessment of comfort and confidence with infant care and breastfeeding.
- Guidance on sexuality, birth spacing and provision of contraception.
- Sleep and fatigue: discussion of coping options and engaging family and friends in assisting with care responsibilities.
- Physical recovery from birth: assessment of cesarean or perineal wound infection, pain, urinary and fecal incontinence, resumption of physical activity and attainment of healthy weight.
- Chronic disease management: discussion of pregnancy complications (e.g., hypertension, ASCVD) and implications for future childbearing and long-term maternal health, glucose screening for women with gestational diabetes mellitus, review of medication selection and dose outside of pregnancy.
- Health maintenance: review of vaccination history and administration of indicated immunizations; well-woman screening, including PAP test and pelvic examination as indicated.

Do not include postpartum care provided in an acute inpatient setting (e.g., that occurs in the hospital after delivery but prior to discharge).

Note

- For women continuously enrolled during the first trimester (280–176 days before delivery with no gaps), the organization has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental.
- Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.
 - For women whose last enrollment segment started on or between 279 and 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.
 - For women whose last enrollment segment started less than 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.
- Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.
- For each member, the organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between ~~November 6~~ **October 8** of the year prior to the measurement year and ~~November 5~~ **October 7** of the measurement year, the member is excluded as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester.
- The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.
- A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.
- The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.
- The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.
- Refer to Appendix 3 for the definition of PCP and OB/GYN and other prenatal practitioners.

Prenatal and Postpartum Care (PPC) **Measure Workup**

Topic Overview

Importance and Prevalence

Each year, about 4 million women in the United States give birth, and 1 million have one or more complications during pregnancy, labor and delivery or the postpartum period. Studies indicate that as many as 60% of all deaths from pregnancy complications could be prevented if women had better access to health care, received better quality of care and changed their health and lifestyle habits (Centers for Disease Control & Prevention [CDC], 2018).

Pregnancy represents a period of increased risk for various health conditions and complications, which can be acute or have long-term effects for both mother and child (VA/DOD 2018). Pregnancy complications can be initiated by the pregnancy or be existing conditions that are aggravated by pregnancy. Common pregnancy complications include maternal obesity, gestational diabetes mellitus, anemia, pregnancy-induced hypertension or pre-eclampsia, as well as mental health conditions such as depression and anxiety (VA/DOD, 2018). In 2014, the CDC estimated that there were 18 pregnancy-related deaths per 100,000 births (CDC Reproductive Health, 2018).

Ensuring early initiation of prenatal care is an important component of safe-motherhood programs that aim to improve maternal and infant health outcomes. Women who have inadequate prenatal care are at greater risk of having adverse birth outcomes, potentially because their health care provider has fewer opportunities to identify and manage conditions that can negatively impact the mother or infant. The goal of prenatal contact is to exchange information and identify existing risk factors that may impact the pregnancy. According to the National Institutes of Health (NIH), women who utilize prenatal care can minimize their risk for pregnancy complications and negative birth outcomes (NIH 2012).

Lack of prenatal care is often considered a high-risk factor for neonatal complications and post neonatal death. In one study, researchers found greater rates of morbidity among neonates with no prenatal care than among those with adequate or intermediate prenatal care (Okoroh, et al., 2012). In a separate study, infants of mothers who began prenatal care after the first trimester or received no prenatal care had an infant mortality rate of 9 deaths per 1,000 births, compared to an infant mortality rate of 6.2 deaths per 1,000 births when prenatal care was initiated in the first trimester (Matthews et al., 2004). Studies have also found that inadequate prenatal care is associated with preterm birth (Debiec et al. 2010). Children born prematurely are more likely to suffer a variety of motor, cognitive, academic and behavioral problems, as well as physical health problems in adulthood, such as increased rates of coronary heart disease, stroke, hypertension and non-insulin dependent diabetes (CDC, 2017).

Similarly, comprehensive postpartum care is critical for setting the stage for the long-term health and well-being of new mothers and their infants (ACOG, 2018). Common issues for mothers after birth include lack of sleep, fatigue, pain, stress, breastfeeding difficulties, mental health disorders and preexisting health and social concerns (ACOG, 2018). In addition, more than half of maternal deaths occur after birth (Kassebaum et al., 2014).

Financial importance and cost-effectiveness

Excessive maternity costs are primarily driven by preterm births (defined as births before the 37th gestational week). Preterm births cost the U.S. an estimated \$26.2 billion each year. These costs are primarily related to care for the infant, but also encompass \$1.9 billion in care provided during labor and delivery for the mother (March of Dimes, 2013). For every dollar spent on prenatal care, an estimated \$3.38 is saved in medical costs for low birthweight babies (Pennsylvania Health Care Cost Containment Council, 2003). These cost savings are largely based on reduced rates of neonatal intensive care unit admissions of babies born to mothers who receive prenatal care. Additionally, there is a large cost savings associated with ensuring adequate prenatal and postpartum care. Every dollar spent on preconception care generates \$1.60–\$5.16 in savings for hospitalization costs for mothers and infants (Gross et al., 2006). Moreover, intensive prenatal care for pregnant women who have high-risk pregnancies results in \$1.37 savings for every \$1 spent on augmented prenatal care (Sakett et al., 2004). Adequate and timely prenatal care not only improves the likelihood of a healthy birth, but also provides a higher probability of a prosperous future for the infant.

High costs associated with poor birth outcomes extend beyond the early years of life and into adulthood. The cost of lost work and pay for persons born prematurely is estimated to be \$5.6 billion. This amount represents the long-term effects of preterm birth on a person's education and work capabilities (March of Dimes, 2013).

Supporting Evidence: *Prenatal Care*

Frequency of visits and routine evaluations

Joint guidelines published by American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists ACOG recommend that the frequency of prenatal visits be determined on an individual basis, according to the needs of every woman. They recommend a prenatal visit in the first trimester for all women. Women with an uncomplicated first pregnancy should be examined every 4 weeks, up to 28 weeks of gestation, every 2 weeks until 36 weeks of gestation and weekly thereafter. Women with complications should be surveilled more closely (AAP/ACOG, 2017).

Similarly, the Department of Defense, Veteran's Administration (DoD/VA) clinical practice guidelines for the management of pregnancy recommend that women have their first provider visit at 10–12 gestational weeks, a visit every 4 weeks thereafter until 38 weeks of gestation and a weekly visit beginning at 38 weeks (DoD/VA 2018). Routine prenatal evaluations include blood pressure, weight, and fetal heartbeat, growth and movement (DoD/VA, 2018).

Determining gestational age

AAP/ACOG guidelines emphasize that an accurately assigned estimated due date (EDD) is among the most important evaluation early in prenatal care. The guidelines note that EDD is vital for timing appropriate obstetric care, determining fetal growth and intervening to prevent preterm and post-term births and related morbidities. The gestational age and the EDD should be determined, discussed with the patient and documented clearly in the medical record as soon as data from the first accurate ultrasound or the last menstrual period, or both, is obtained. They also recommend that gestational age at delivery represents the best obstetric estimate for the purpose of clinical care and should be recorded on the birth certificate (AAP/ACOG, 2017). The DoD/VA clinical practice guidelines recommend conducting a first trimester ultrasound to establish or confirm gestational age and state that women who present after the first trimester should have an ultrasound prior to 22 weeks if possible (DoD/VA, 2018).

Genetic screening and diagnostic testing	AAP/ACOG guidelines recommend offering screening and invasive diagnostic testing for aneuploidy to all women who seek prenatal care before 20 weeks of gestation, regardless of their age, and that the optimal timing for a single ultrasound exam in absence of specific conditions for first trimester exams is 18–20 weeks gestation (AAP/ACOG, 2017). The DoD/VA guidelines recommend that pregnant women receive education for prenatal screening from 6–8 weeks and have a screening test for aneuploidy and other common genetic disorders from 16–20 weeks (DoD/VA, 2018).
Health and risk assessments	AAP/ACOG, DoD/VA and the US Preventive Services Task Force (USPSTF) recommend various health and risk screenings early in pregnancy. These assessments include lab tests to establish ABO and Rh(D) blood type, screenings for sexually transmitted infections, depression, smoking, alcohol and substance use, intimate partner violence and others, which are summarized in Table 1 below. The three sets of guidelines recommend screening for gestational diabetes between 24–28 gestational weeks and administering anti-D prophylaxis for Rh-negative women at 28 gestational weeks. Both the AAP/ACOG and DoD/VA guidelines recommend Group B streptococcal screening at around 36 gestational weeks.
Prenatal patient education	Prenatal care involves substantial patient education and health promotion. AAP/ACOG, DoD/VA and the USPSTF recommend counseling and support for breastfeeding throughout pregnancy, or during the second and third trimester at a minimum. AAP/ACOG and DoD/VA guidelines recommend promoting exercise throughout pregnancy and providing education about preterm labor later in pregnancy. AAP/ACOG also recommend prenatal education on other topics, such as dental care, nausea and vomiting, vitamin and mineral toxicity, teratogens, air travel, and preparing for baby after delivery.

Supporting Evidence: *Postpartum Care*

The DoD/VA clinical practice guidelines recommend a postpartum visit within 6 weeks, and no later than 8 weeks, after delivery (DoD/VA, 2018). In May 2018, ACOG published a committee opinion proposing a new paradigm for postpartum care that reinforces the concept of a fourth trimester, rather than a single 6-week postpartum visit. Specifically, ACOG now recommends that all women who have experienced a miscarriage, stillbirth or neonatal death should have an initial assessment with a maternal care provider, either in person or by phone, within 21 days after birth to address acute postpartum issues. The initial assessment should be followed by ongoing care as needed and conclude with a comprehensive well woman visit by the start of the 12th week (77 days) after birth. The comprehensive visit should address mood and emotional well-being, infant care and feeding, contraception and birth spacing, sleep and fatigue, physical recovery from birth, chronic disease management and overall health maintenance (ACOG, 2018). ACOG acknowledges that these changes will require changes to reimbursement policies.

Gaps in care	A key step to a healthy pregnancy and optimal birth outcomes is the prompt initiation of prenatal care. Early establishment of prenatal care is important to identifying potential birth risks, initiating appropriate behavioral interventions and reducing the burden of maternal and newborn morbidity and mortality (Lassi et al. 2014). Health plan members who enroll and are engaged in their care have an improved likelihood of obtaining prenatal care. Data from the Adequacy of Prenatal Care Utilization (APNCU) Index indicate that approximately 77% of women who gave birth in 2016 initiated prenatal care during their first trimester of pregnancy, 5% initiated prenatal care in the third trimester and less than 2% received no prenatal care (Osterman & Martin, 2018). APNCU data also shows that 15% of women receive inadequate prenatal care (Osterman & Martin, 2018).
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There is limited data on utilization of postpartum care; however, ACOG estimates that as many as 40% of women do not have a postpartum visit with their provider (ACOG, 2017). Another study found that 66% of women who did not obtain prenatal care accessed postpartum care. Similarly, 60% of women whose infants did not have a newborn checkup accessed postpartum care (DiBari et al., 2014).

Health care disparities

Improving rates of timely and adequate prenatal care is a challenge for the general population, and more so for vulnerable populations. Low-income women are disproportionately at risk of not initiating prenatal care due to late enrollment in a health plan during their pregnancy, which can result in limited access to prenatal screenings and other resources (Lassi et al. 2014).

There are also racial disparities in initiation of prenatal care. In 2016, 10% of Black women, 13% of American Indian or Alaskan Native women and 19% of Native Hawaiian or Other Pacific Islander women reported having late or no prenatal care, compared to 4% for non-Hispanic White women (Martin et al. 2018). Moreover, approximately 82% of White women began care during their first trimester, compared to 67% of Black women and 72% of Hispanic women (Osterman & Martin, 2018).

Women 19 years of age and under also have a decreased likelihood of initiating prenatal care than older women (Lassi et al. 2014). Data from the APNCU Index show that nearly 37% of mothers under 15 do not receive prenatal care during the first trimester and 26% of mothers in this age category receive late or no care (Osterman & Martin, 2018).

There are also disparities in birth and neonatal outcomes that may result from a number of racial, age, economic or social factors of the mother and her environment. Data from the National Vital Statistics Report found that in 2016, 14% of non-Hispanic Black women delivered babies with low birth weights, while low birth weight rates for non-Hispanic White women and Hispanic women were 7% (Martin et al. 2018). Low birthweight infants will experience greater health and social challenges over the course of their lifetime and non-Hispanic Black infants face the challenge of poorer outcomes than infants of other racial backgrounds (March of Dimes, 2015).

Similarly, the percentage of women who do not access postpartum care is greater for certain subgroups, including low income women, Medicaid insurance holders and those with inadequate prenatal care (DiBari et al., 2014). Another study with California's Medicaid population found that Black women were 25% less likely to attend a postpartum visit than White women (Bocanegra et al., 2017).

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Specific Guideline Recommendations

Table 1: Clinical Guideline Recommendations for Prenatal Care

	American Academy of Pediatrics (AAP) & American College of Obstetrics and Gynecology (ACOG), 2017 <i>Evidence-informed expert consensus</i>	Department of Veteran’s Affairs / Department of Defense, 2018 <i>Recommendation grade in parentheses</i>	US Preventive Services Task Force, years vary <i>Recommendation grade in parentheses</i>
Frequency of prenatal visits	First visit in the first trimester	First prenatal visit 6-8 weeks	
	Frequency of follow-up visits should be individualized: <ul style="list-style-type: none"> • Women with uncomplicated first pregnancy: examined every 4 weeks for the first 28 weeks of gestation, every 2 weeks until 36 weeks of gestation, and weekly thereafter. • Women at higher-risk for complications: should be seen as early as possible and have closer surveillance. • Women with prior normal pregnancy outcomes and problems during the current pregnancy: can be seen less frequently as long as visits are available on an as-needed basis. 	Follow-up visits: <ul style="list-style-type: none"> • First provider visit (10-12 weeks) • Visit at 16-20 weeks • Visit at 24 weeks • Visit at 28 weeks • Visit at 32 weeks • Visit at 36 weeks • Weekly visits at 38-41 weeks 	
	Routine evaluations at each visit: <ul style="list-style-type: none"> • Blood pressure • Weight • Uterine size for progressive fetal growth • Presence of fetal heart activity at appropriate gestational ages • Fetal movement (after quickening), contractions, leakage of fluid or vaginal bleeding 	Routine evaluations at each visit: <ul style="list-style-type: none"> • Blood pressure (B) • Weight • Fetal heart tones (C) • Fetal growth (B) • Fetal movement (B) 	

	American Academy of Pediatrics (AAP) & American College of Obstetrics and Gynecology (ACOG), 2017 <i>Evidence-informed expert consensus</i>	Department of Veteran's Affairs / Department of Defense, 2018 <i>Recommendation grade in parentheses</i>	US Preventive Services Task Force, years vary <i>Recommendation grade in parentheses</i>
Determining gestational Age	<ul style="list-style-type: none"> Accurately assigned estimated due date (EDD) is vital for timing appropriate care, determining fetal growth and designing interventions to prevent preterm/post-term births and related morbidities. Ultrasound measurement in the first trimester is the most accurate method. As soon as data from ultrasound or last menstrual period (LMP), or both, are obtained, the gestational age and the EDD should be determined, discussed with the patient, and documented clearly in the medical record. Assisted reproductive technology-derived gestational age should be used to assign the EDD where relevant. Gestational age at delivery represents the best obstetric estimate for the purpose of clinical care and should be recorded on the birth certificate. 	<ul style="list-style-type: none"> Accurate gestational age dating essential for timing tests Conduct a first-trimester ultrasound to establish or confirm the gestational age and estimated birth date, identify multiple pregnancies, and confirm the presence of cardiac activity. For pregnant women who present after the first trimester, a dating and anatomical ultrasound should be performed at the earliest opportunity, preferably prior to 22 weeks. 	
Genetic Screening and Diagnostic Testing	<ul style="list-style-type: none"> Obstetric providers provide genetic screening or have established referral sources. Pretest counseling should be provided to couples who will be offered screening. Screening and invasive diagnostic testing for aneuploidy should be offered to all women who seek prenatal care before 20 weeks of gestation regardless of maternal age. Optimal timing for a single ultrasound exam in absence of specific indications for first trimester exams is 18-20 weeks. 	<ul style="list-style-type: none"> Education for prenatal screening (6-8 weeks) Should be offered prenatal screening test for most common clinically significant fetal anomalies (B) Obstetric ultrasound (16-20 weeks) (C) 	
Prenatal Health and Risk Assessments	First Trimester		
	ABO Blood Type	ABO Blood Type (B)	
	D(Rh) type	D(Rh) type (B)	D(Rh) type (A)
	Antibody screen		Antibody screen (B)
	HIV screening	HIV screening (A)	HIV screening (A)
	Hepatitis B screening	Hepatitis B screening (A)	Hepatitis B screening (A)
	Syphilis screening	Syphilis screening (B)	Syphilis screening (A)
Chlamydia screening	Chlamydia screening (B)	Chlamydia screening (A)	

	American Academy of Pediatrics (AAP) & American College of Obstetrics and Gynecology (ACOG), 2017 <i>Evidence-informed expert consensus</i>	Department of Veteran's Affairs / Department of Defense, 2018 <i>Recommendation grade in parentheses</i>	US Preventive Services Task Force, years vary <i>Recommendation grade in parentheses</i>
	Gonorrhea screening	Gonorrhea screening (B)	Gonorrhea screening (A)
		Varicella screening (B)	Varicella, if unsure (A)
	Sickle cell disease screening, high-risk only	Sickle cell disease screening, high-risk only (B)	
		Asymptomatic bacteriuria (A)	
		Rubella screening (B)	
		Herpes simplex virus screening, high-risk only (B)	
		Periodontal disease (C)	
	Tuberculosis, high-risk only	Tuberculosis, high-risk only (C)	
	Substance use screening	Substance use screening (C)	
	Tobacco screening	Tobacco screening (A)	
	Alcohol screening	Alcohol screening (B)	
	Depression screening	Depression screening (B)	Depression screening (B)
	Intimate partner violence screening	Intimate partner violence screening (B)	
	Desire for pregnancy		
	Second/Third Trimester		
Gestational diabetes screening: 24-28 gestational weeks	Gestational diabetes screening: 28 gestational weeks (B)	Gestational diabetes screening: 24-28 gestational weeks (B)	
Anti-D prophylaxis for Rh-negative women: 28-29 gestational weeks	Anti-D prophylaxis for Rh-negative women: 28 gestational weeks (B)	Anti-D prophylaxis for Rh-negative women: 24-28 gestational weeks (B)	
Group B streptococcal disease screening: 35-37 gestational weeks	Group B streptococcal disease screening: 36 gestational weeks (B)		
Prenatal Patient Education	First Trimester		
		Breastfeeding (B)	Breastfeeding (B)
	Nutrition, exercise, weight gain	Exercise (A)	
	Dental care		

	American Academy of Pediatrics (AAP) & American College of Obstetrics and Gynecology (ACOG), 2017 <i>Evidence-informed expert consensus</i>	Department of Veteran's Affairs / Department of Defense, 2018 <i>Recommendation grade in parentheses</i>	US Preventive Services Task Force, years vary <i>Recommendation grade in parentheses</i>
	Nausea and vomiting		
	Vitamin and mineral toxicity		
	Teratogens		
	Air travel		
Second/Third Trimester			
	Breast feeding	Breastfeeding (B)	Breastfeeding (B)
	Pre-term labor	Pre-term labor: 24, 28, 32 gestational weeks (B)	
	Trial of labor	Trial of labor: 24 gestational weeks (B)	
	Childbirth classes		
	Elective delivery, cesarean delivery on maternal request		
	Breech presentation at term		
	Working		
	Choosing a newborn care provider		
	Umbilical cord banking, prep for discharge and neonatal interventions		
		Exercise (A)	
	Reproductive choices	Family planning counseling: 32 weeks (C)	

Table 2: Clinical Guideline Recommendations for Postpartum Care

	ACOG Committee Opinion on Optimizing Postpartum Care, 2018 <i>Evidence-informed expert consensus</i>	Department of Veteran’s Affairs / Department of Defense, 2018 <i>Recommendation grade in parentheses</i>	US Preventive Services Task Force, years vary <i>Recommendation grade in parentheses</i>
Postpartum Care	<ul style="list-style-type: none"> • All women who have experienced a miscarriage, stillbirth or neonatal death should have an initial assessment with a maternal care provider, either in person or by phone, within 21 days after birth to address acute postpartum issues. Acute issues can include hypertension disorders, depression, cesarean or perineal wound infection, lactation difficulties, heavy bleeding, pain, exhaustion and urinary incontinence. • The initial assessment should then be followed by ongoing care as needed. • Ongoing care concludes with a comprehensive well woman visit by the start of the 12th week (77 days) after birth. The comprehensive visit should address: <ul style="list-style-type: none"> – Mood and emotional well-being: screen for depression and anxiety, tobacco use, substance use disorder, preexisting mental health disorders – Infant care and feeding – Sexuality, contraception, and birth spacing – Sleep and fatigue: discuss coping options, engaging family and friends in assisting with care responsibilities 	<ul style="list-style-type: none"> • Postpartum visit within 6 weeks and no later than 8 after delivery • Pelvic and breast exams (B) • Cervical smear should be completed as indicated by cervical cancer screening guidelines (A) • Initiate or continue the HPV vaccine series for women age < 26 years (B) • Screen for postpartum depression (B) • Screen for domestic violence (B) • Diabetes testing for patients with pregnancies complicated by gestational diabetes (B) • Education about contraception, infant feeding method, sexual activity, weight, exercise and the woman’s assessment of her adaptation to motherhood (I) • Pre-existing or chronic medical conditions should be addressed with referral for appropriate follow-up as indicated (I) • Administer Rh immune globulin to Rh negative mothers with Rh positive babies 	<ul style="list-style-type: none"> • Recommends providing interventions during pregnancy and after birth to support breastfeeding (B) • Recommends screening for depression in the general population, including pregnant and postpartum women (B).
	ACOG Committee Opinion on Optimizing Postpartum Care, 2018 <i>Evidence-informed expert consensus</i>	Department of Veteran’s Affairs / Department of Defense, 2018 <i>Recommendation grade in parentheses</i>	US Preventive Services Task Force, years vary <i>Recommendation grade in parentheses</i>
Postpartum Care	<ul style="list-style-type: none"> – Physical recovery from birth: assess pain, urinary and fecal incontinence, resumption of physical activity and attainment of healthy weight – Chronic disease management: discuss pregnancy complications and implications for future childbearing and long-term maternal health, glucose screening for women with GDM, review meds – Health maintenance: review vaccination history and provide indicated immunizations, perform well-woman screening, including PAP test and pelvic examination as indicated 		

Grading System Key

Department of Veteran’s Affairs/Department of Defense, 2018

Strength of Recommendations Rating System	
A	A strong recommendation that the clinicians provide the intervention to eligible patients. Good evidence was found that the intervention improves important health outcomes and concludes that benefits substantially outweigh harm.
B	A recommendation that clinicians provide (the service) to eligible patients. At least fair evidence was found that the intervention improves health outcomes and concludes that benefits outweigh harm.
C	No recommendation for or against the routine provision of the intervention is made. At least fair evidence was found that the intervention can improve health outcomes, but concludes that the balance of benefits and harms is too close to justify a general recommendation.
D	Recommendation is made against routinely providing the intervention to asymptomatic patients. At least fair evidence was found that the intervention is ineffective or that harms outweigh benefits.
I	The conclusion is that the evidence is insufficient to recommend for or against routinely providing the intervention. Evidence that the intervention is effective is lacking, or poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

US Preventive Services Task Force: What the Grade Means and Suggestions for Practice

Grade	Definition	Suggestions for Practice
A	USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
D	USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

References (Guidelines)

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HEDIS Health Plan Performance Rates: Prenatal and Postpartum Care (PPC)

Table 1. Timeliness of Prenatal Care—Medicaid Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2017*	275	253 (92)	81.1	8.8	69.8	76.9	83.2	87.1	90.8
2016	282	256 (91)	81.7	10.1	70.9	77.7	83.6	88.6	91.7
2015	278	253 (91)	80.0	10.4	66.9	74.2	82.3	87.6	91.0

*For 2017 the average denominator across plans was 379 live birth deliveries, with a standard deviation of 106.

Table 2. Timeliness of Prenatal Care—Commercial Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2017*	406	387 (95)	80.6	14.7	59.7	77.4	84.9	89.8	93.7
2016	420	399 (95)	80.6	14.7	57.5	76.0	85.0	90.0	95.0
2015	428	398 (93)	79.4	15.9	55.3	75.1	84.0	89.9	94.4

*For 2017 the average denominator across plans was 422 live birth deliveries, with a standard deviation of 933.

Table 3. Postpartum Care Measure Performance—Medicaid Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2017*	275	253 (92)	64.4	8.4	53.5	59.6	62.2	69.3	74.0
2016	282	256 (91)	63.8	8.9	51.7	59.6	64.4	69.4	73.7
2015	278	253 (91)	60.9	10.1	48.9	55.5	61.0	67.5	73.6

*For 2017 the average denominator across plans was 380 live birth deliveries, with a standard deviation of 106.

Table 4. Postpartum Care Measure Performance—Commercial Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2017*	406	387 (95)	80.6	14.7	59.7	77.4	84.9	89.8	93.7
2016	420	401 (96)	80.6	14.7	57.5	76.0	85.0	90.0	95.0
2015	428	401 (94)	79.4	15.9	55.3	75.1	84.0	89.9	94.4

*For 2017 the average denominator across plans was 441 live birth deliveries, with a standard deviation of 956.