



Body System: Reproductive-Female		
Session Topic: Obstetric Care Update		
Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. <u>Please describe your interest and plan for teaching a PBL on your proposal form.</u>
ACGME Core Competencies Addressed (select all that apply)		
X	Medical Knowledge	Patient Care
	Interpersonal and Communication Skills	Practice-Based Learning and Improvement
	Professionalism	Systems-Based Practice
Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
<ul style="list-style-type: none"> Counsel patients on healthy diet and lifestyle modifications to improve pregnancy outcomes. Family physicians should be familiar with antenatal screening using serum markers and ultrasound. Family physicians should be familiar with schedule and components of routine prenatal care, and be familiar with potential complications that can occur during pregnancy. Family physicians should be able to assess patients at risk for complications during pregnancy and understand how to manage complications and when to refer for specialty care. 	<ol style="list-style-type: none"> Develop collaborative care plans with patients regarding healthy diet and lifestyle modifications to improve pregnancy outcomes. Perform routine prenatal visits to determine when pregnancy complications may arise due to family history and risk factors. Evaluate high-risk women for complications as necessary throughout pregnancy into the third trimester and whether to perform antenatal screening using serum markers and ultrasound. Evaluate current scientific literature on obstetric care, for relevant practice application. 	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.
Faculty Instructional Goals		
Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality,		



innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
 - Visit <http://www.aafp.org/journals> for additional resources
 - Visit <http://familydoctor.org> for patient education and resources
- Provide specific strategies and resources for developing collaborative care plans with patients regarding healthy diet and lifestyle modifications to improve pregnancy outcomes
- Provide specific evidence-based recommendations and guidelines for routine prenatal visits, emphasizing the evaluation of high-risk women for complications as necessary throughout pregnancy into the third trimester and whether to perform antenatal screening using serum markers and ultrasound
- Provide specific case-based examples illustrating evidence-based recommendations and guidelines for providing optimal care and prenatal screenings
- Provide recommendations regarding guidelines for Medicare reimbursement.
- Provide recommendations to maximize office efficiency and guideline adherence.
- Provide an overview of newly available treatments, including efficacy, safety, contraindications, and cost/benefit relative to existing treatments.
- Provide instructions regarding the incorporation and use of the PCMH/ACO/Primary Care Core Measure Set into practice.

Needs Assessment

* Note – per feedback from FMX attendees, the focus of this topic should be placed on recent (2015-2016) updates regarding obstetric care, along with recommendations for adherence to evidence-based clinical guidelines.

Trends in the provision of obstetric care by family physicians have been declining over the past 20 years; even so, family physicians and general practitioners have provided more than 2 million prenatal visits per year.¹⁻³ While American Academy of Family Physicians (AAFP) practice profile data shows that 82 percent of family physicians choose not to provide maternity care as part of their practice, family physicians are still often the first to perform pregnancy tests and initial evaluations and provide wellness tips and guidance before the patient is referred to a specialist.⁴ Family physicians are also often asked to advise patients on everything from



conception to fertility, so it is imperative they possess the tools and resources to maximize reproductive health outcomes. The CDC also considers every woman a candidate for preconception care due to unintended pregnancies and poor health, which can contribute to poor birth outcomes.⁵

The 2012 AAFP CME Needs Assessment Survey indicates that family physicians have gaps in knowledge and skills required to provide optimal obstetric care for patients.⁶ Access to maternity care is a public health concern in many rural areas; therefore, family physicians may want to consider sharing care among physicians and other care providers.⁷ CME outcomes data from the 2012-2015 AAFP FMX (formerly Assembly): *Obstetric Care* sessions indicate that physicians have knowledge and practice gaps with regard to providing optimal prenatal care; appropriate use of noninvasive prenatal testing (NIPT); following evidence-based immunization recommendations; evidence-based recommendations for progesterone; strategies and resources to provide lifestyle modification of unhealthy behaviors during pregnancy; and adherence to updated evidence-based guidelines for obstetric care.⁸⁻¹¹

The scope of practice for family physicians in maternity/child care may range from only managing medical problems during pregnancy, prenatal care only, or comprehensive care of low-risk pregnancy to comprehensive care of high-risk pregnancy, including performing cesarean deliveries. The AAFP advocates that maternal/child care is a core discipline of the specialty of Family Medicine, and further advocates that all Family Medicine residents receive basic maternal/child care training and that those residents who plan to practice the full scope of maternal/child care receive advanced training to include management of complications and surgical intervention.¹² However, the 2012 AAFP CME Needs Assessment Survey indicates a statistically significant and meaningful difference in medical skill to provide prenatal care between those members with seven or fewer years out of residency (4.92 out of 7.00), compared to those members with more than seven years out of residency (3.71 out of 7.00).⁶

Physicians should be familiar with recent scientific literature in the field of obstetrics, including but not limited to the following:

- A recent large trial did not observe a benefit for vaginal progesterone¹³
- The World Health Organization (WHO) has updated its guidelines on the use of antiretroviral agents to manage and prevent HIV infection¹⁴
- Consistent with USPSTF and ACOG guidelines, studies comparing usual care with a program for depression screening during pregnancy (one trial) or postpartum (four trials), found that screening reduced the prevalence of depression at three- to five-month follow-up.^{15,16}
- The FDA has implemented new labeling for medications used during pregnancy and lactation¹⁷
- New research for treating nausea and vomiting in early pregnancy¹⁸
- New recommendations regarding reducing and managing obstetric hemorrhage^{19,20}
- Women with a hypertensive disorder of pregnancy were also at increased risk for cardiomyopathy >5 months after delivery compared with women without this history, although the absolute risk of cardiomyopathy was small²¹
- The Antenatal Late Preterm Steroids (ALPS) Trial offers new considerations for antenatal steroids at 34 to 37 weeks for pregnancies at high risk of preterm birth²²



- Data from the Metformin in Obese Nondiabetic Pregnant Women randomized trial suggests that the use of metformin in pregnancy should be limited to management of hyperglycemia²³

Family physicians should be knowledgeable about current practice recommendations and guidelines related to providing prenatal care, and be able to devise evidence-based, shared decision making management strategies.²⁴ Family physicians should be knowledgeable about appropriate prenatal screening; and be prepared to counsel patients regarding screening results, proper supplemental nutrition, and the avoidance of exposure to environmental risks to the health of the mother and the developing fetus.^{25,26} Adherence to medical recommendation by women with high risk pregnancies is dependent upon the patient's perception of their medical risk; therefore these patients require counseling to encourage early initiation of prenatal care.^{25,27}

Family physicians should be able to apply the following AAFP Recommendations for Clinical Preventive Services:²⁸

- The AAFP *recommends* screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
- The AAFP *recommends* screening for hepatitis B virus (HBV) in pregnant women at their first prenatal visit.
- The AAFP *recommends* that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors); see clinical consideration for further discussion of risk factors.
- The AAFP *concludes there is insufficient evidence to recommend for or against* screening for gonorrhea infection in pregnant women who are not at increased risk for infection; see clinical consideration for further discussion of risk factors.
- The AAFP *recommends* that clinicians screen all pregnant women for HIV.
- The AAFP *concludes that the current evidence is insufficient* to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use.
- The AAFP *recommends* routine screening for iron deficiency anemia in asymptomatic pregnant women.
- The AAFP *recommends against* routine screening for elevated blood levels in asymptomatic pregnant women.
- The AAFP *strongly recommends* Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
- The AAFP *recommends* repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation.
- The AAFP *recommends* that clinicians screen all pregnant women for syphilis infection.
- The AAFP *strongly recommends* that clinicians screen all pregnant women for tobacco use and provide 5-15 minutes of smoking cessation counseling using messages and self-help materials tailored for pregnant smokers.
- The AAFP *recommends* screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
- The AAFP *recommends against* screening for bacterial vaginosis in asymptomatic pregnant women at low risk for preterm delivery.



- The AAFP *recommends* screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.
- The AAFP *recommends against* routinely providing screening for chlamydial infection for women aged 25 and older whether or not they are pregnant, if they are not at increased risk.
- The AAFP *recommends against* routine serological screening for herpes simplex virus (HSV) in asymptomatic pregnant women at any time during pregnancy to prevent neonatal HSV infection.

Additionally, physicians may improve their care of pregnant patients by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:²⁹⁻³¹

- All women should be screened for depression during pregnancy and the postpartum period.
- Women with peripartum depression should be evaluated for bipolar disorder, postpartum psychosis, and suicide risk and referred for emergent psychiatric evaluation when appropriate.
- There is insufficient evidence to recommend selective serotonin reuptake inhibitors, estrogen, or docosahexaenoic acid for the prevention of peripartum depression.
- There is insufficient evidence to recommend one selective serotonin reuptake inhibitor over another in the treatment of moderate to severe postpartum depression.
- Women with gestational hypertension or preeclampsia without severe features should have planned delivery at 37 weeks' gestation.
- Magnesium sulfate is the treatment of choice to prevent eclamptic seizures (NNT = 100) and placental abruption (NNT = 100) in women who have preeclampsia with severe features.
- Magnesium sulfate is more effective than diazepam (Valium) or phenytoin (Dilantin) for preventing recurrent eclamptic seizures and decreasing maternal mortality.
- Intravenous labetalol or hydralazine or oral nifedipine may be used to treat severe hypertension during pregnancy.
- For women who have preeclampsia with severe features between 24 and 34 weeks' gestation, expectant management with close monitoring of the mother and fetus reduces neonatal complications and days in the intensive care unit.
- Low-dose aspirin has small to moderate benefits in the prevention of preeclampsia among at-risk women (NNT = 72). The NNT falls to 19 among those at greatest risk.
- Calcium supplementation may decrease the incidence of hypertension, preeclampsia, and mortality among high-risk women with low calcium intake. However, women in the United States or other developed countries are unlikely to benefit.
- Promote walking and upright positions (kneeling, squatting, or standing) for the mother in the first stage of labor.
- Provide continuous support during labor and delivery.
- Do not discontinue an epidural late in labor in an attempt to avoid assisted vaginal delivery.
- Allow women to deliver in the position they prefer. Women without an epidural who deliver in upright positions have a significantly reduced risk of assisted vaginal delivery



and abnormal fetal heart rate pattern, but an increased risk of second-degree perineal laceration and an estimated blood loss of more than 500 mL.

- Offer warm perineal compresses during labor.
- Do not perform routine episiotomy.
- Delay cord clamping for one to three minutes after birth or until cord pulsation has ceased, unless urgent resuscitation is indicated.
- Actively manage the third stage of labor with oxytocin (Pitocin).
- Repair second-degree perineal lacerations with a continuous technique using absorbable synthetic sutures.

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Family physicians should be familiar with current AAFP immunization schedules, and be prepared to counsel pregnant women regarding the safety and efficacy of remaining up to date on immunizations during pregnancy.³² Physicians should receive continuing education to help them utilize ACOG/NCQA/AMA-PCPI quality measures to improve the care for women during pregnancy, delivery, and postpartum.³³ Continuing medical education, illustrating the application of evidence-based recommendations and guidelines for prenatal care and lifestyle coaching, should be provided to family physicians to help them optimize care delivered to their pregnant patients.

The American Academy of Family Physicians Academy has participated in the Core Measures Collaborative (the Collaborative) convened by America's Health Insurance Plans (AHIP) since August 2014. The Collaborative is a multi-stakeholder effort working to define core measure sets of various specialties promoting alignment and harmonization of measure use and collection across both public and private payers.

Participants in the Collaborative included Centers for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF), private payers, provider organizations, employers, and patient and consumer groups. This effort exists to decrease physician burden by reducing variability in measure selection, specifications and implementation—making quality measurement more useful and meaningful for consumers, employers, as well as public and private clinicians.

With significant AAFP input, a PCMH/ACO/Primary Care Core Measure Set has been developed for primary care. The goal of this set is to decrease burden and allow for more congruence between payer reporting programs.³⁴



Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Evidence-Based Prenatal Care: Part I. General Prenatal Care and Counseling Issues²⁴
- Evidence-Based Prenatal Care: Part II. Third-Trimester Care and Prevention of Infectious Diseases³⁵
- AAFP Recommendations for Clinical Preventive Services²⁸
- FDA Implements New Labeling for Medications Used During Pregnancy and Lactation¹⁷
- Nausea and Vomiting in Early Pregnancy¹⁸
- Hypertensive Disorders of Pregnancy²⁹
- Identification and Management of Peripartum Depression³⁰
- Reducing Obstetric Hemorrhage: Recommendations from the National Partnership for Maternal Safety¹⁹
- Institute for Clinical Systems Improvement (ICSI). Routine prenatal care³⁶
- Breastfeeding support: prenatal care through the first year, second edition. Evidence-based clinical practice guideline³⁷
- Michigan Quality Improvement Consortium. Routine prenatal and postnatal care³⁸
- Academy of Breastfeeding Medicine Protocol Committee. Clinical protocol number #19: breastfeeding promotion in the prenatal setting³⁹
- VA/DoD clinical practice guideline for management of pregnancy⁴⁰
- Repeat doses of prenatal corticosteroids for women at risk of preterm birth for improving neonatal health outcomes⁴¹
- Magnesium Sulfate and Other Anticonvulsants for Women with Preeclampsia⁴²
- ACOG Guidelines on Pregnancy After Bariatric Surgery⁴³
- Prevention of Perinatal Group B Streptococcal Disease: Updated CDC Guideline⁴⁴
- USPSTF Recommendations (specific to pregnancy)⁴⁵
- Engaging Patients in Collaborative Care Plans⁴⁶
- Health Coaching: Teaching Patients to Fish⁴⁷
- Encouraging patients to change unhealthy behaviors with motivational interviewing⁴⁸
- Vaccine administration: making the process more efficient in your practice⁴⁹
- Sharing maternity care⁷
- FamilyDoctor.org. Pregnancy & Newborns: Your Body (patient resource)⁵⁰

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