



## Pregnancy and Post-Partum Care Guidelines

### OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based recommendations for the management of pregnancy and post-partum care. The CPG discusses the care and management of pregnancy and postpartum care including evidence based care, complications, modifiable risks, co-morbid conditions (e.g. smoking, depression, substance use disorder, cardiovascular conditions, hypertension, and diabetes) and the role of condition management, diet, physical activity and behavioral health management. Also, included is Postpartum care including evidence based care, complications and co-morbid conditions for the infant (e.g. jaundice, birth defects, developmental disabilities, breastfeeding issues and Sudden Infant Death Syndrome (SIDS)).

Early infancy is a critical time for the health of both baby and mother; continuity of care can help detect problems early and prevent complications. Compared to infants born after 37 weeks of gestation, infants born pre-term incur significantly higher hospitalization charges at birth. Infants born at low-birth weight are also significantly more likely to incur longer hospitalization stays than infants born at normal birth weight and are at increased risk for several health problems, including; neurodevelopment issues, congenital anomalies and respiratory illness.

The postpartum visit is a chance for a provider to converse with the mother to detect early problems with postpartum depression, parenting skills and to perform a pelvic, breast and postpartum depression screenings, among other tests. The postpartum visit also allows the provider to follow-up with any problems that occurred during pregnancy, such as maternal diabetes.<sup>1,2</sup>

### OVERVIEW

#### **Pregnancy**

Pregnancy which is confirmed by a blood test, ultrasound, detection of fetal heartbeat or an X-ray has a full-term duration of 40 weeks and is measured from the date of the woman's last menstrual period (LMP). Pregnancy is divided into three trimesters with each roughly three months in length. The progression of the pregnancy multiple physical and emotional changes for the pregnant woman.<sup>3</sup>

Early, effective **prenatal care** can identify mothers at risk of delivering a preterm or growth-retarded infant and provide an array of medical and educational interventions. Studies show a positive relationship between comprehensive prenatal care and a reduction in low birth weight and infant mortality; women who receive early and regular prenatal care are more likely to have healthier infants. Death rates related to complications from pregnancy are four times higher among women who received no prenatal care compared to women who received prenatal care.

For screening information related to Pregnancy and Post-Partum Care, visit the United States Preventive Services Task Force (USPSTF) website at <https://www.uspreventiveservicestaskforce.org>. In addition, refer to the following preventive CPGs: *Adult Preventive Health (HS-1019)* and *Adolescent Preventive Health (HS-1051)*.

#### **Postpartum**

The first six weeks after childbirth are considered postpartum or recovery period. A pregnancy, labor and delivery may

proceed smoothly and still experience bleeding, pain, exhaustion, engorged breasts, joint pain, backache, hair loss, or mood swings. Key postpartum complications include:<sup>4</sup>

- Postpartum Bleeding
- Deep Vein
- Endometritis
- Postpartum Depression
- Pulmonary Embolism
- Postpartum Urinary tract infections
- Vulva Hematoma
- Cervical or Vaginal Lacerations

### **High Risk Complications**

High-risk pregnancy is defined as one that threatens the health or life of the mother or fetus, requiring specialized care from specially trained providers. A woman may become high-risk as her pregnancy progresses while some are at-risk of complications due to predisposed factors. To support a health pregnancy and a delivery without complications, women should receive early and regular prenatal care.<sup>25</sup> Providers should educate the Member on the risk factors that predispose the pregnant woman to complicated or preterm delivery:<sup>3,25</sup>

- **Existing conditions** such as asthma, autoimmune disease, blood disorders (sickle cell), depression, diabetes, eating disorders, epilepsy, high blood pressure, HIV/AIDS, infertility, kidney disease, lupus, migraines, obesity, polycystic ovary syndrome (PCOS), sexually transmitted infections (STIs), thyroid disease (specifically hyperthyroidism), and uterine fibroids.<sup>23,24</sup>
- **Age** – specifically teen pregnancy or first-time pregnancy after age 35
- **Lifestyle Factors** such as alcohol use or cigarette smoking
- **Conditions of Pregnancy** such as multiples, gestational diabetes, preeclampsia, and eclampsia

### **Member Care Management**

Members are educated on risk management techniques to minimize the chance of complicated pregnancy including:<sup>31</sup>

- Avoiding alcohol and use of non-prescribed drugs and medications; discuss OTC use with Provider
- Taking medications as prescribed
- Seeing Provider(s) and specialists as scheduled and following the treatment plan
- Following activity restriction, as recommended by Provider
- Reporting new or worsening symptoms to Provider(s)

Members are also educated on basic pregnancy care including:<sup>31</sup>

- Proper weight gain and diet in pregnancy
- Proper hydration in pregnancy of 64 oz/day and significance to preventing preterm contractions
- Importance of regular dental care and how it can help prevent preterm labor and preeclampsia
- Monitoring kick counts (timing how long it takes to feel 10 kicks, flutters, swishes, or rolls; ideally, the mother should feel at least 10 movements within 2 hours – report any changes to the Provider)
- Fetal growth and development
- Vaginal infections in pregnancy and importance of partner treatment
- Signs and symptoms of preterm labor including causes, self-care measures, and when to contact the Provider
- Signs and symptoms of complications: abdominal pain, cramping, vaginal bleeding with or without pain, uncontrollable thirst, dizziness, confusion, blurred vision, chest pain, shortness of breath, gaining weight too fast
- Identifying barrier(s) to managing risk of complicated pregnancy

The following items are also discussed with Members with a behavioral health comorbidity:<sup>31</sup>

- Encourage Member to discuss behavioral health concerns with prenatal care provider
- Refer to a therapist and/or psychiatrist specializing in managing behavioral health disorders in pregnant women as well as ensure collaboration with behavioral health providers and prenatal care provider
- Educate on recognizing psychotic symptoms (such as hallucinations and delusions) and reporting them to the prenatal care and behavioral health Providers. The Care Manager is to ensure that the psychiatrist and prenatal care provider are able to collaborate.
- Members with a Substance Use Disorder should be referred to treatment services including childcare,

transportation, reproductive health, nutrition and parenting

### Gestational Diabetes

Gestational diabetes is a type of diabetes that found in a pregnant woman who did not have diabetes before pregnancy. The condition is typically discovered mid-pregnancy; women who become pregnant again may develop gestational diabetes again. Complications related to gestational diabetes includes: <sup>26</sup>

- **An Extra Large Baby.** This results from the baby's blood sugar to be high and the baby is "overfed". Discomfort for the mother is common as well as problems during delivery for both the mother and the baby. Nerve damage is common for infants due to pressure on the shoulder during delivery.
- **C-Section (Cesarean Section).** Women with diabetes that is not well controlled has a higher chance of needing a C-section. This may prolong recovery time for the mother.
- **High Blood Pressure (Preeclampsia).** Caused by protein in urine, preeclampsia can lead to swelling in the fingers and toes. The condition can cause harm to both the woman and her unborn baby – a woman is at risk for pre-term delivery, seizures, or stroke during labor and delivery.
- **Low Blood Sugar (Hypoglycemia).** Women with diabetes who take insulin or other diabetes medications can develop blood sugar that is too low. This can be serious and even fatal when not treated quickly. Pregnant women should monitor their blood sugar closely. When uncontrolled, the baby can quickly develop low blood sugar after birth.

Pregnant women are undergo screening at 24 to 28 weeks gestation. There is a high prevalence of gestational diabetes, concomitant with the obesity epidemic. Providers should understand maternal and fetal risks related to the disorder as well as antepartum maternal and fetal assessment, use of obstetrical ultrasound to monitor fetal growth and well-being, decision-making about timing and route of delivery, intrapartum obstetric and glycemic management, and postpartum assessment and counseling. <sup>27</sup>

Short term complications of gestational diabetes include: <sup>27</sup>

- Large for gestational age infant and macrosomia
- Preeclampsia
- Polyhydramnios
- Stillbirth
- Neonatal morbidity

A long-term complication of gestational diabetes include an increased risk of infant developing obesity, impaired glucose tolerance, and metabolic syndrome. Gestational diabetes is also a strong marker for maternal development of type 2 diabetes, including diabetes-related vascular disease. <sup>27</sup>

Risk factors include the following – noted that one's risk increases when multiple factors are present: <sup>28</sup>

- Personal history of impaired glucose tolerance or gestational diabetes mellitus in a previous pregnancy
- Member of one of the following ethnic groups that have a high prevalence of type 2 diabetes: Hispanic American, African American, Native American, South or East Asian, Pacific Islander
- Family history of diabetes, especially in first-degree relatives
- Prepregnancy weight  $\geq 110$  percent of ideal body weight or BMI  $>30$  kg/m<sup>2</sup>, significant weight gain in early adulthood and between pregnancies [41], or excessive gestational weight gain during the first 18 to 24 weeks
- Maternal age  $>25$  years of age
- Previous unexplained perinatal loss or birth of a malformed infant
- Glycosuria at the first prenatal visit
- Medical condition/setting associated with development of diabetes, such as metabolic syndrome, polycystic ovary syndrome, current use of glucocorticoids, hypertension
- Multiple gestation

Women with gestational diabetes should be encouraged to eat healthy foods, exercise regularly, monitor blood sugar often, take insulin (if needed), and to be tested for diabetes 6 to 12 weeks post-partum.<sup>26</sup>

### Placenta-Related Complications

- **Placenta Previa.** Placenta previa is suspected in any pregnant woman beyond 20 weeks of gestation who presents with vaginal bleeding. Women who have not had a second-trimester ultrasound examination and also present with bleeding after 20 weeks of gestation should have immediate sonographic determination of placental location before digital vaginal examination is performed to avoid severe hemorrhage (due to palpitation). Risk factors include:<sup>29</sup>
  - Previous placenta previa which may occur in 4-8% of subsequent pregnancies
  - Previous cesarean delivery may increase risk by 47-60% (risk increases with an increasing number of cesarean deliveries).
  - Multiple gestation may increase the risk by up to 40% as compared to single births
  - Increasing parity
  - Increasing maternal age
  - Infertility treatment
  - Previous abortion
  - Previous uterine surgical procedure
  - Maternal smoking
  - Maternal cocaine use
  - Male fetus
  - Non-white race

A diagnosis of placenta previa should alert the Provider for the possibility of placenta previa-accreta/percreta, especially in women who have had a previous cesarean delivery.

### *Member Care Management*

Members are educated on the signs and symptoms of placenta previa, including instances when to seek emergency help. This includes painless vaginal bleeding during the second or third trimester. Upon request, Members receive educational materials on placenta previa. Members are also educated on management techniques of placenta previa. These include:<sup>31</sup>

- Not smoking as it highly increases one's risk of complications
  - Taking medications as prescribed
  - Seeing Provider(s) and specialists as scheduled and following the treatment plan
  - Diet and fluid intake, as recommended
  - Physical activity or bedrest, as recommended
  - Avoiding alcohol and use of non-prescribed drugs and medications
  - Avoiding sex as it may trigger bleeding
  - Reporting new or worsening symptoms to Provider(s) which may result in possible hospitalization for monitoring or specialized care
- **Placenta Abruptio.** Placental abruptio (or abruptio placentae) is bleeding at the decidual-placental interface that causes partial or complete placental detachment prior to delivery of the fetus. It is typically diagnosed in pregnancies over 20 weeks gestation and is found in 1% of pregnancies. Women with placental abruptio are at several-fold higher risk of abruptio in a subsequent pregnancy, especially when the abruptio was severe. Placenta abruptio is a cause of maternal and perinatal morbidity.<sup>30</sup>

Symptoms include vaginal bleeding, abdominal pain, contractions, uterine rigidity and tenderness; non-reassuring fetal heart rate (FHR) pattern is also possible. Vaginal bleeding may not be seen in 10-20% of cases. Some abruptios are asymptomatic and the amount of bleeding may not correlate with the extent of maternal hemorrhage; this should not be used as a marker to gauge the severity of premature placental

separation. FHR abnormalities suggest clinically significant separation that could result in fetal death.<sup>30</sup>

Risk factors of placenta abruption include previous abruption (the strongest risk factor), maternal age, parity, having a male baby, being a smoker during pregnancy (which can result in an increase of fetal death by 40% per pack per day smoked), and having a diagnosis of hypertension. Risk factors with acute etiology include abdominal trauma/accidents; use of cocaine or other drug abuse; and polyhydramnios. Obstetrical and medical risk factors include:<sup>30</sup>

- Chronic hypertension
- Preeclampsia or pregnancy induced hypertension
- Eclampsia
- Premature rupture of membranes
- Chorioamnionitis
- Previous ischemic placental disease (preeclampsia, fetal growth retardation / small for gestation age infant, previous abruption)

#### *Member Care Management*

Members are educated on the signs and symptoms of placenta abruption, including instances when to seek emergency help. This includes painless vaginal bleeding, cramping, abdominal pain, and/or uterine tenderness. Upon request, Members receive educational materials on placenta abruption. Members are also educated on management techniques of placenta abruption. These include:<sup>31</sup>

- Not smoking as it highly increases one's risk of complications
  - Taking medications as prescribed
  - Seeing Provider(s) and specialists as scheduled and following the treatment plan
  - Diet and fluid intake, as recommended
  - Physical activity or bedrest, as recommended
  - Avoiding alcohol and use of non-prescribed drugs and medications
  - Avoiding sex as it may trigger bleeding
  - Reporting new or worsening symptoms to Provider(s) which may result in possible hospitalization for monitoring or specialized care
- **Placenta Accrete Spectrum (PAS).** This is a general term used to describe placenta accreta, increta, and percreta. The condition results from placental implantation at an area of defective decidualization typically caused by preexisting damage to the endometrial-myometrial interface.<sup>32</sup>

The biggest risk factors for development of a PAS is placenta previa after a prior cesarean delivery. The risk increases with the number of cesarean deliveries a woman has had. When placenta previa is not found, the frequency of a PAS in women undergoing cesarean delivery is significantly lower. Additional risk factors include: a history of uterine surgery, cesarean scar pregnancy, age of over 35 years, history of pelvic irradiation, manual removal of the placenta, postpartum endometritis, and infertility and/or infertility procedures such as in vitro fertilization.<sup>32</sup>

- **Retained Placenta.** The third stage of labor includes the expulsion of the placenta. Delayed separation and expulsion can threaten the life of the mother due to hemorrhage during the postpartum contraction of the uterus. Expulsion should occur within 30 minutes of delivery of the infant; for births in the second trimester and third stages of labor managed without oxytocin, the time range is 90 to 120 minutes. Risk factors for retained placenta include stillbirth, maternal age over 30 years, delivery at 240/7 to 276/7 weeks compared with  $\geq 34$  weeks, and delivery in a teaching hospital.<sup>33</sup>

#### Preeclampsia and Pregnancy-Induced Hypertension

Preeclampsia (or "toxemia") is a condition that starts after 20 weeks of pregnancy and results in high blood pressure as well as problems with the kidneys and other organs. Pregnancy induced hypertension is high blood pressure that starts

after 20 weeks of pregnancy and goes away after birth.

#### *Member Care Management*

Members are educated on the signs and symptoms of pregnancy induced hypertension and preeclampsia, including instances when to seek emergency help. This includes headache, dizziness (vertigo), nausea, extreme anxiety, vision problems (blurred vision), swelling of hands and face, chest pain, shortness of breath, uncontrollable nose bleed, and stomach pain. Upon request, Members receive educational materials on high blood pressure and preeclampsia. Members are also educated on management techniques, including:<sup>31</sup>

- Basic treatment plan activities that help manage signs / symptoms
- Not smoking as it highly increases one's risk of complications
- Taking medications as prescribed
- Seeing Provider(s) and specialists as scheduled and following the treatment plan
- Diet and fluid intake, as recommended
- Physical activity or bedrest, as recommended
- Avoiding alcohol and use of non-prescribed drugs and medications
- Avoiding sex as it may trigger bleeding
- Reporting new or worsening symptoms to Provider(s) which may result in possible hospitalization for monitoring or specialized care
- Taking blood pressure readings as directed by the Provider and maintaining a log of readings for review
- Maintaining blood pressure within normal range
- Maintaining a healthy BMI (body mass index)
- Managing stress
- Tobacco cessation and second-hand smoke exposure

#### Pre-Term Labor

Additional information regarding scheduled early inductions and Cesarean delivery can be found in the addendum. The Care Manager will educate the Member on preterm labor risk management techniques such as:<sup>31</sup>

- Importance of taking prescribed medications as directed
- Importance of attending all appointments as scheduled
- Importance of following activity restrictions as prescribed by doctor
- Importance of reporting new or worsening symptoms to Primary Doctor/Specialist
- Importance of following doctor's recommended treatment plan
- Care manager will send educational materials to member/caregiver on preterm labor
- Care manager will assist member/caregiver with addressing identified barrier(s) to managing risk of preterm labor, specifically [selections]
- Member/caregiver will report worsening symptoms to Primary Doctor/specialist timely
- Member/caregiver will follow recommended treatment plan ordered by Primary Doctor/Specialist.

## Hierarchy of Support

### GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the American Congress of Obstetricians and Gynecologists (ACOG), American Diabetes Association (ADA), and World Health Organization (WHO). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to post-partum care, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for

- Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Providers, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites.

NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with ACOG, ADA, and WHO on the topic of pregnancy and post-partum care. The following are highlights from their recommendations, committee opinions, and guidelines.

### AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG)

The American Congress of Obstetricians and Gynecologists offers the following recommendations to assist clinicians with evaluation, and treatment on the following topics:

- [Screening for Perinatal Depression](#)<sup>5</sup>
  - Screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool.
  - Screen women with current depression or anxiety, a history of perinatal mood disorders, or risk factors for perinatal mood disorders as this may warrant particularly close monitoring, evaluation, and assessment.
  - Screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.
  - Systems should be in place to ensure follow-up for diagnosis and treatment
- [HIV Screening](#)<sup>6</sup>
  - Screen all pregnant women for HIV infection as early as possible during each pregnancy using the opt-out approach where allowed.
  - Repeat HIV testing in the third trimester is recommended for women in areas with high HIV incidence or prevalence and women known to be at risk of acquiring HIV infection.
  - Women who were not tested earlier in pregnancy or whose HIV status is otherwise undocumented should be offered rapid screening on labor and delivery using the opt-out approach where allowed.
  - If a rapid HIV test result in labor is reactive, antiretroviral prophylaxis should be immediately initiated while waiting for supplemental test results.
  - If the diagnosis of HIV infection is established, the woman should be linked into ongoing care with a specialist in HIV care for co-management
- [Documentation Standards and Physician Measurement & Assessment](#)<sup>7</sup>

WellCare recommends the use of ACOG format for documenting patients' pregnancies identified and linked above. The following items are requested to be completed to ensure compliance with guidelines:

  - Adequate documentation of physical examination at each obstetric visit;
  - Documentation of prenatal and postpartum depression screening utilizing the Patient Health Questionnaire-2 (PHQ2) Depression Screening tool or the Edinburgh Depression Scale tool;
  - Documentation of family planning counseling and services for all pregnant women and mothers; and

Information related to ACOG recommendation on scheduled early inductions and cesarean delivery can be found in the Addendum at the end of this CPG.

### AMERICAN DIABETES ASSOCIATION (ADA)

WellCare aligns with the American Diabetes Association (ADA) on the topic of gestational diabetes. For additional information, please access the *2017 Standards of Medical Care in Diabetes* [here](#).<sup>8</sup>

**WORLD HEALTH ORGANIZATION (WHO)**

WellCare aligns with the World Health Organization (WHO) on the topic of substance use and substance use disorders. For additional information, click [here](#) to access the *Guidelines for Identification and Management of Substance Use and Substance Use Disorders in Pregnancy*.<sup>9</sup> Additional information on Substance Use Disorders can be found below under *Other Considerations*.

**Evidence Based Practice**

**MEASUREMENT OF COMPLIANCE**

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare’s Clinical Policy Guiding Document titled *Quality Improvement*.

NOTE: To access Clinical Policy Guiding Documents visit [www.wellcare.com](http://www.wellcare.com) – select the Provider tab, then “Tools” and “Clinical Guidelines”.

**MARKET SPECIFIC CRITERIA**

**Illinois Related Requirements**

Postpartum depression screening during the one year period after delivery to identify high risk mothers who have an acute or long term history of depression, using an HFS-approved screening tool. After delivery and discharge, the Enrollee will have a mechanism to readily communicate with her health team and not be limited to a single “six week” postpartum visit. WellCare will also provide or arrange for inter-conception care management services for high risk women for 24 months following delivery.

WellCare will also provide evidence based care including immediate and subsequent postpartum visits, in accordance with the Department’s approved schedule, to assess and provide education on areas such as: perineum care, breastfeeding and feeding practices; nutrition; exercise and physical activity; immunization; sexual activity and effective family planning (including pregnancy intervals); SIDS; and the importance of ongoing well woman care. In addition, referrals will be given to parenting classes, text4baby, and WIC Food and Nutrition Service.

**New Jersey Pregnancy Related Requirements**

WellCare complies with the New Jersey requirements to ensure the provision of pregnancy related services include, at a minimum, the program components listed below. For pregnant members the following required OB preventive screenings are assessed:

- Physical assessment that includes weight, blood pressure, fundal height and fetal heart tones
- Nutritional assessment and counseling
- Blood typing and anti-body screening
- Rubella anti-titer
- Urinalysis
- Pap smear
- STD testing
- Hemoglobin and hematocrit tests
- HIV counseling and HIV testing
- HBsAG testing at the initial prenatal visit
- Depression screening
- Pre-term delivery risk assessment
- Alpha Fetal Protein screening
- Diabetes screening
- Group B Strep screening
- Post-partum exam

**Care Management**

The goals for Care Management is to support the member’s ability to self-manage their pregnancy and the postpartum period, minimize risk factors and remove manageable barriers to assist the member with achieving a healthy pregnancy and birth outcome. Educate the member to identify and address risk factors that predispose the pregnancy to complications such as:

- Previous Preterm Birth
- Multiple Pregnancy
- Cardiovascular Conditions
- Hypertension

- Diabetes
- Smoking
- Uterine Shape Disorder
- Kidney Disease
- Thyroid Disorder
- Age (teen or  $\geq$  age 35)
- Obesity
- Substance Use Disorder
- Polycystic Ovary Disorder
- Autoimmune Disorder
- HIV/AIDS
- Preeclampsia/Eclampsia

Educate the member on the primary symptoms she should recognize and report to the healthcare team. Some signs and symptoms indicating potential complications are:

- Contractions (tighten and relaxing across the abdomen) once every 10 minutes or more
- Vaginal discharge (leaking fluid or bleeding from vagina)
- Pelvic pressure (feeling like a bowling ball in pressing down on pelvic area)
- Contractions (tighten and relaxing across the abdomen) once every 10 minutes or more
- Low, dull backache that does not resolve
- Cramps like during a menstrual period
- Abdominal cramps with or without diarrhea
- Sudden or severe swelling in the face, hands, or fingers
- Severe or long-lasting headaches

Integrated Pregnancy and Postpartum care management includes identification of significant risk factors:

- Comprehensive pregnancy and previous health condition management for cardio, hypertension or diabetes
- Consideration of age risk factors
- Reference to ethnicity of African-American, Hispanic, or American-Indian
- History of smoking, alcohol use or misuse of prescriptive or street drugs
- Multiples pregnancy, Gestational diabetes or Preeclampsia or Eclampsia

Please reference the Addendum of this CPG regarding additional items that can be discussed with Members. This includes what to expect during prenatal visits (e.g., examinations; education; diagnostic and genetic screenings) as well as information on complications including gestational diabetes.

### **MEASURABLE HEALTH OUTCOMES**

Targeted Health Outcomes (Extended Program Goals) result from successful member self-management (see Case Management Objectives).

1. The Member experiences no symptoms requiring acute medical care and intervention during pregnancy. Case Management monitors for ED and inpatient utilization related to pre-existing or pregnancy induced conditions including (but not limited to) hypertension, diabetes, clotting factor disorder, eclampsia, substance use, preterm labor.
2. The Member delivers near or at full term pregnancy (37 weeks or greater), without long-term complications to mother or baby. Case Management monitors inpatient utilization related delivery, postpartum complications, and birth complications including but not limited to eclampsia, post-partum hemorrhage, postpartum depression, fetal alcohol spectrum disorder, neonatal abstinence syndrome, and failure to thrive.

### **CASE MANAGEMENT GOALS**

Case Goals should target specific care gaps and/or adherence issues, and measure the member's progress towards self-management and adherence which will lead to the targeted health outcomes above. Examples:

1. The Member will attend first prenatal visit within the first trimester and at least 80% of prenatal care visits after first prenatal visit as follows: every 4 weeks through the first 28 weeks of pregnancy, every 2 to 3 weeks for the next 7 weeks, weekly thereafter until delivery.
2. The Member will attend postpartum care visit within 21 to 56 days after delivery.
3. The Member is adherent to routine labs and diagnostics (such as urine, blood & ultrasound screening for complications of pregnancy, including gestational diabetes) as prescribed by the physician (verified by claims)

- or member/provider narrative) throughout pregnancy.
- The Member will achieve healthy weight gain during pregnancy per CDC guidelines based on Member's pre-pregnant BMI, or per the specific guidance of the Member's provider.<sup>12</sup>
  - The Member describes daily/weekly routine that demonstrates adherence to a healthy balanced diet supplemented with prenatal vitamins and mild to moderate physical exercise as approved by physician.
  - Specific for Members requiring hospitalization: The Member participates in provider follow-up visit within 7 days of hospital discharge.

Also refer to the *Pediatric Preventive Health CPG (HS-1019)* for resources with which to educate new mothers related to care for their newborns, and related compliance measures, targeted health outcomes, and case goals.

### CASE MANAGEMENT OBJECTIVES

Case Management Objectives should focus on improving the member's self-management skills including:<sup>13</sup>

#### **Perinatal**

- Applying healthy pregnancy habits such as diet, exercise, and stress management per OB Provider's guidance;
- Attending prenatal and postpartum visits scheduled by the OB Provider (Pregnancy Weeks 1-28, visits every 4 weeks); (Pregnancy Weeks 29-36, visits every 2-3 weeks); (Pregnancy Weeks 37 & beyond, visits weekly). Note if high risk conditions – attend visits as requested, weekly or more;
- Completing pregnancy testing as prescribed by OB Provider including:
  - OB Lab Panel at first visit,
  - Glucose Tolerance Testing at mid-point of pregnancy,
  - Ultrasound as indicated and additional lab and
  - Ultrasounds as requested by OB Provider to screen for high risk conditions for mom and baby;
- Sharing list of all over the counter, prescribed on non-prescribed medications taken prior to pregnancy and currently used with CM and OB Provider;
- Discussing with CM and OB Provider current stressors and anxiety / depression experiences, and strategies for coping and managing during pregnancy
- Discussing cessation of smoking of cigarettes or marijuana with provider and understanding importance of reducing or discontinuation during pregnancy;
- Understanding the importance of avoiding second hand smoke during pregnancy and upon delivery and bringing baby home to smoke free environment;
- Identifying signs and symptoms of preterm labor and other pregnancy complications (see list above);
- Calling OB Provider and follow their guidance to go to hospital as needed if these warning signs occur;
- Sharing with OB Provider any previous preterm delivery, so OB Provider can consider use of 17P or Makena;
- Understanding significance of cervical length measurement;
- Following OB Provider's treatment plan including 17P, vaginal progesterone, and bedrest;
- Preparing for Labor and Delivery including attending childbirth educational classes;
- Understanding risks of rushing your baby's birth day and importance of doing what is possible to stay pregnant for at least 39 weeks.<sup>14</sup>

#### **Post-Partum**

- Knowing where and how to get breastfeeding support
- Adhering to newborn screening for baby
- Watching for and reporting signs and symptoms of postpartum depression, infection after delivery
- Planning for and ensuring there is support for being able to get plenty of rest and recovery
- Caring for baby regarding jaundice, feeding schedules, car seat safety, well child checkups, and immunizations
- Watching for baby's signs and symptoms of infection
- Understanding and managing SIDS risk factors

The care team should also conduct risk screening anxiety and depression, if applicable. Use the Edinburgh Postnatal Depression Scale for screening for depression postpartum. See *Behavioral Health Considerations* below.

## OTHER CONSIDERATIONS

**Behavioral Health Considerations.** The rapid changes in the levels of reproductive hormones that occur after delivery are thought to be biological factors in the development of postpartum depression. Additionally, stress in pregnancy and the care of the newborn may be a factor. While traditionally the pregnant state is assumed to be “protective” for mood disorders, in actuality between 14 to 23% of pregnant women will experience depression. Furthermore, about half of all postpartum depression begins during pregnancy. Therefore, screening for depression is critical throughout a woman’s pregnancy to ensure the safety of both the mother and the developing fetus. Psychotherapy is the first line treatment for a pregnant woman with depression, however, in serious cases psychotropic medications are considered.<sup>15,16,17</sup>

Women who have known mental illness should remain under the care of their psychiatrist throughout the duration of their pregnancy. Close coordination between the woman’s psychiatrist and obstetrician is critical to ensure optimal maternal health throughout the pregnancy. Up to 80% of new mothers will experience the “Baby Blues” after their first delivery. Baby Blues occurs within a few days of the baby’s birth and lasts for up to 2 weeks. Symptoms include tearfulness, exhaustion, anxiety and difficulty sleeping. Symptoms usually resolve without professional help, but these mothers require support and monitoring to ensure that postpartum depression does not develop. In contrast, postpartum depression is a serious, sometimes life-threatening condition which typically starts within 4 to 6 weeks after delivery but may be recognized anytime during the first year. Symptoms include extreme sadness, anxiety, poor sleep, poor self-care, social withdrawal, poor appetite and crying spells. The Edinburgh Postnatal Depression Scale is a self-report screen instrument that should be administered to help obstetricians (and even pediatricians) identify women who may require further assessment. A referral to a mental health professional should be made if a new mom scores 10 or higher on the PDS or if she has a plan to harm herself, her child or others.<sup>15,18</sup>

**Substance Use Disorder in Pregnancy.** Nationally, up to 25 percent of expectant mothers use illicit drugs. Healthcare providers should ask all pregnant women about their use of alcohol and other substances (past and present) as early as possible in the pregnancy and at every antenatal visit. Women dependent on alcohol or drugs should be advised to cease their alcohol or drug use and be offered detoxification services under medical supervision where necessary and applicable. When a pregnant woman is addicted to drugs or alcohol, her baby is also addicted. Various pilot programs exist to medically stabilize the expectant mother and her baby. Replacement therapy and/or complete detoxification may be recommended depending on the clinical situation and staff at the pilot programs may assist with making that determination. For pregnant or postpartum women identified with substance use disorder, refer to the *Substance Use Disorder in High Risk Pregnancy CPG (HS-1041)* for additional guidance.

## MEMBER EDUCATIONAL RESOURCES

WellCare contracts with Krames/StayWell for Member educational materials utilized by Case Managers. Items are available to review with Members to address knowledge gaps. Case Managers verbally educate Members on the topics below related to asthma. (Titles may also be sent to the member).

- How Smoking Effects Pregnancy
- Influenza (Flu) and Pregnancy
- How Birth Control Works
- Understanding Conception
- Tubal Sterilization Surgery
- Preventing Zika During Pregnancy
- Severe Morning Sickness
- What is Gestational Diabetes?
- What is Group B Strep?
- What is Prenatal Care?
- Treating Group B Strep
- Understanding Cerclage
- Understanding Fetal Alcohol Syndrome
- Understanding Preeclampsia
- Birth Control Choices
- Amniocentesis
- Vaginal Infection: Understanding the Vaginal Environment
- Comfort Tips During Pregnancy
- Back pain during pregnancy
- Quit Smoking During Pregnancy with Less Stress
- Healthy Eating Habits During Pregnancy
- After a Cesarean
- Anesthesia Options for Labor
- Cesarean Birth
- Kick Counts
- Labor and Childbirth: Active Labor
- Labor Induction
- Understanding Preterm Labor
- Understanding Miscarriage: Recovery
- Understanding Postpartum Depression
- Postpartum Care After a Vaginal birth
- Breast Care After Birth

- CVS (Chorionic Villi Sampling)
- Blood Glucose Screening During Pregnancy
- Breast Health: Breast Self-Awareness
- Incision Care After Vaginal Birth
- What are Sexually Transmitted Diseases (STDs)
- Understanding STDs

Providers may wish to research the titles above related to pneumonia that Case Managers utilize with Members.

### Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPGs: *Preconception and Inter-Pregnancy (HS-1028)* and *Substance Use Disorder in High Risk Pregnancy (HS-1041)*. Information related to resources with which to educate new mothers on care for their newborns, refer to *Pediatric Preventive Health (HS-1019)*. Additional information from the United States Preventive Services Task Force (USPSTF) can be found in the following age-specific Preventive Health CPGs: *Adolescent (HS-1051)* and *Adult (HS-1018)*.

NOTE: Clinical Policies can be accessed by going to [www.wellcare.com](http://www.wellcare.com) – select the Provider tab, then “Tools” and “Clinical Guidelines”.

### References

1. USPSTF recommendations. U.S. Preventive Services Task Force Web site. <http://www.uspreventiveservicestaskforce.org>. Accessed April 19, 2018.
2. Obstetric hemorrhage resources. American Congress of Obstetricians and Gynecologists Web site. <http://www.acog.org/About-ACOG/ACOG-Districts/District-II/SMI-OB-Hemorrhage>. Updated September 1, 2017. Accessed April 19, 2018.
3. What are the factors that put a pregnancy at risk? Eunice Kennedy Shriver National Institute of Child Health and Human Development Web site. <https://www.nichd.nih.gov/health/topics/high-risk/conditioninfo/pages/factors.aspx>. Accessed April 19, 2018.
4. Warning signs after birth. March of Dimes Web site. <http://www.marchofdimes.org/pregnancy/warning-signs-after-birth.aspx>. Accessed April 19, 2018.
5. Screening for perinatal depression (no. 630). American Congress of Obstetricians and Gynecologists Web site. <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression>. Published May 2015. Accessed April 19, 2018.
6. Committee Opinion No. 635: Prenatal and perinatal human immunodeficiency virus testing: expanded recommendations. *Obstet Gynecol.* 2015;125(6):1544–1547.
7. The obstetric patient record: antepartum and postpartum forms. American Congress of Obstetricians and Gynecologists Web site. <http://www.acog.org/About-ACOG/ACOG-Departments/Patient-Records>. Accessed April 19, 2018.
8. American Diabetes Association Web site. [http://professional.diabetes.org/sites/professional.diabetes.org/files/media/dc\\_40\\_s1\\_final.pdf](http://professional.diabetes.org/sites/professional.diabetes.org/files/media/dc_40_s1_final.pdf). Accessed January 6, 2017.
9. Guidelines for identification and management of substance use and substance use disorders in pregnancy. World Health Organization Web site. Accessed April 19, 2018.
10. Antidepressant treatment of depression during pregnancy and the postpartum period. Content last reviewed July 2014. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/research/findings/evidence-based-reports/er216-abstract.html>. Accessed April 19, 2018.
11. Internet Citation: Smoking Cessation Interventions in Pregnancy and Postpartum Care. Content last reviewed February 2014. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/research/findings/evidence-based-reports/smi-pregtp.html>. Accessed April 19, 2018.
12. Weight gain during pregnancy. Centers for Disease Control and Prevention Web site. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-weight-gain.htm>. Published October 14, 2016. Accessed April 19, 2018.
13. Preterm labor and premature birth. March of Dimes Web site. <http://www.marchofdimes.org/complications/preterm-labor-and-premature-baby.aspx>. Accessed April 19, 2018.
14. Don't rush your baby's birthday. March of Dimes Web site. <http://www.marchofdimes.org/pregnancy/pregnancy-39weeks.aspx>. Accessed April 19, 2018.
15. Depression and pregnancy. American Pregnancy Association Web site. <http://americanpregnancy.org/pregnancy-health/depression-during-pregnancy/>. Accessed April 19, 2018.
16. Gaynes BN, Gavin N, Meltzer-Brody S, Lohr KN, Swinson T, Gartlehner G, et al. Perinatal depression: prevalence, screening accuracy, and screening outcomes. *Evid Rep/Technol Assess (Summ)* 2005:1-8. <https://www.ncbi.nlm.nih.gov/pubmed/15760246>. Accessed April 19, 2018
17. O'Keane V and Marsh M. Depression during pregnancy. *BMJ*, 2007;334:1003-1005. <https://doi.org/10.1136/bmj.39189.662581.55>.
18. Pregnancy and birth: Depression after childbirth – What can help? United States National Library of Medicine Web site. <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0072762/>. Published September 21, 2016. Accessed April 19, 2018.
19. Medically indicated late-preterm and early-term deliveries. American Congress of Obstetricians and Gynecologists Web site. <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Medically-Indicated-Late-Preterm-and-Early-Term-Deliveries>. Published April 2013. Accessed April 19, 2018.
20. Elimination of non-medically indicated (elective) deliveries before 39 weeks gestational age. American Congress of Obstetricians and Gynecologists Web site. <http://www.acog.org/About-ACOG/ACOG-Districts/District-III/Less-Than-39-Weeks-Deliveries> (subscription). Accessed April 19, 2018.
21. Induction of labor (no. 107). American Congress of Obstetricians and Gynecologists Web site. <http://www.acog.org/Resources-And-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Obstetrics/Induction-of-Labor>. Published August 2009. Accessed April 19, 2018.
22. Elective induction versus spontaneous labour in Latin America. World Health Organization Web site. <http://www.who.int/bulletin/volumes/89/9/08-061226/en/>. Published 2011. Accessed April 19, 2018.
23. Pregnancy Complications. United States Department of Health and Human Services Office on Women's Health Web site. <https://www.womenshealth.gov/pregnancy/youre-pregnant-now-what/pregnancy-complications>. Updated February 9, 2018. Accessed April 19, 2018.
24. Salkic S, Batic-Mujanovic O, Ljuca F, Brkic S. Clinical Presentation of Hypertensive Crises in Emergency Medical Services. *Materia Socio-Medica*. 2014;26(1):12-16. doi:10.5455/msm.2014.26.12-16. Accessed April 19, 2018.
25. What is a high-risk pregnancy? Eunice Kennedy Shriver National Institute of Child Health and Human Development (NIH) Web site. <https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/high-risk>. Updated January 31, 2017. Accessed April 19, 2018.
26. Gestational Diabetes and Pregnancy. Centers for Disease Control and Prevention Web site. <https://www.cdc.gov/pregnancy/diabetes-gestational.html>. Updated September 29, 2017. Accessed April 19, 2018.
27. Caughey AB. Gestational diabetes mellitus: Obstetrical issues and management. [https://www.uptodate.com/contents/gestational-diabetes-mellitus-obstetrical-issues-and-management?search=gestational%20diabetes&source=search\\_result&selectedTitle=2-88&usage\\_type=default&display\\_rank=2](https://www.uptodate.com/contents/gestational-diabetes-mellitus-obstetrical-issues-and-management?search=gestational%20diabetes&source=search_result&selectedTitle=2-88&usage_type=default&display_rank=2). (Subscription). Updated February 16, 2018. Accessed April 19, 2018.
28. Durnwald C. Gestational diabetes mellitus: Diabetes mellitus in pregnancy: Screening and diagnosis. [https://www.uptodate.com/contents/diabetes-mellitus-in-pregnancy-screening-and-diagnosis?search=gestational%20diabetes&source=search\\_result&selectedTitle=3-88&usage\\_type=default&display\\_rank=3](https://www.uptodate.com/contents/diabetes-mellitus-in-pregnancy-screening-and-diagnosis?search=gestational%20diabetes&source=search_result&selectedTitle=3-88&usage_type=default&display_rank=3).

- (Subscription). Updated February 27, 2018. Accessed April 19, 2018.
29. Lockwood CJ, Russo-Stieglitz K. Placenta previa: epidemiology, clinical features, diagnosis, morbidity and mortality. UpToDate Web site (subscription). [https://www.uptodate.com/contents/placenta-previa-epidemiology-clinical-features-diagnosis-morbidity-and-mortality?search=placenta&source=search\\_result&selectedTitle=3~150&usage\\_type=default&display\\_rank=3](https://www.uptodate.com/contents/placenta-previa-epidemiology-clinical-features-diagnosis-morbidity-and-mortality?search=placenta&source=search_result&selectedTitle=3~150&usage_type=default&display_rank=3). Updated August 4, 2017. Accessed April 19, 2018.
  30. Ananth CV, Kinzler WL. Placental abruption: Clinical features and diagnosis. UpToDate Web site (subscription). [https://www.uptodate.com/contents/placental-abruption-clinical-features-and-diagnosis?search=placenta%20abruption&source=search\\_result&selectedTitle=1~150&usage\\_type=default&display\\_rank=1](https://www.uptodate.com/contents/placental-abruption-clinical-features-and-diagnosis?search=placenta%20abruption&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1). Updated December 19, 2017. Accessed April 19, 2018.
  31. WellCare internal document. Care Management: Pregnancy Complications. Accessed April 20, 2018.
  32. Resnik R, Silver RM. Clinical features and diagnosis of placenta accreta spectrum (placenta accreta, increta, and percreta). UpToDate Web site (subscription). [https://www.uptodate.com/contents/clinical-features-and-diagnosis-of-placenta-accreta-spectrum-placenta-accreta-increta-and-percreta?search=placenta&source=search\\_result&selectedTitle=8~150&usage\\_type=default&display\\_rank=8](https://www.uptodate.com/contents/clinical-features-and-diagnosis-of-placenta-accreta-spectrum-placenta-accreta-increta-and-percreta?search=placenta&source=search_result&selectedTitle=8~150&usage_type=default&display_rank=8). Updated March 14, 2018. Accessed April 19, 2018.
  33. Weeks A. Retained placenta after vaginal birth. UpToDate Web site (subscription). [https://www.uptodate.com/contents/retained-placenta-after-vaginal-birth?search=placenta&source=search\\_result&selectedTitle=4~150&usage\\_type=default&display\\_rank=4](https://www.uptodate.com/contents/retained-placenta-after-vaginal-birth?search=placenta&source=search_result&selectedTitle=4~150&usage_type=default&display_rank=4). Updated August 4, 2017. Accessed April 19, 2018.

## Disclaimer

Clinical Practice Guidelines (CPGs) made available by WellCare are informational in nature and are not a substitute for the professional medical judgment of treating physicians or other health care practitioners. CPGs are based on information available at the time and may not be updated with the most current information available at subsequent times. Individuals should consult with their physician(s) regarding the appropriateness of care or treatment options to meet their specific needs or medical condition. Disclosure of a CPG is not a guarantee of coverage and is not intended to be used for Utilization Management Decisions or for claims. Members of WellCare Health Plans should consult their individual coverage documents for information regarding covered benefits. WellCare does not offer medical advice or provide medical care, and therefore cannot guarantee any results or outcomes. WellCare does not warrant or guarantee, and shall not be liable for any deficiencies in the information contained herein or for any inaccuracies or recommendations made by independent third parties from whom any of the information contained herein was obtained. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on [www.wellcare.com](http://www.wellcare.com). Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

*Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ 'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona  
OneCare (Care 1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ WellCare Prescription Insurance ~ WellCare Texan Plus (Medicare – Dallas and Houston markets)  
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)*

## Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
5/3/2018	<ul style="list-style-type: none"> <li>• Approved by MPC. Inclusion of serious pregnancy complications.</li> </ul>
4/6/2017	<ul style="list-style-type: none"> <li>• Approved by MPC. Enhanced Care Management and Measures of Compliance sections. Revised with CM, DM, QI, UM, BH and the Chief Medical Directors.</li> </ul>
4/20/2016	<ul style="list-style-type: none"> <li>• Approved by MPC. Inclusion of items from USPSTF and ACOG.</li> </ul>
6/17/2014	<ul style="list-style-type: none"> <li>• Approved by MPC. Inclusion of WHO recommendations for substance use during pregnancy.</li> </ul>
6/7/2013	<ul style="list-style-type: none"> <li>• Approved by MPC. New CPG.</li> </ul>

## Addendum

### INDUCTION OF LABOR / ELECTIVE DELIVERIES

The American College of Obstetricians and Gynecologists (ACOG) established clinical management guidelines for induction of labor. Indications for induction of labor include:<sup>19,20,21</sup>

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

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

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

Induction of labor is contraindicated for the following reasons:

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

Risks of non-medically indicated elective deliveries between 37 and 39 weeks gestation include:

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

#### *Elective Cesarean Sections*

ACOG states evidence suggests that non-medically indicated obstetrical procedures such as elective inductions performed prior to 39 weeks have risen sharply in the U.S. over the past 20 years, with associated increases in C-sections and late preterm births. The reported rate of labor induction in the United States has more than doubled since 1990, from 9.5% to 22.5% in 2006. Based on the evidence of ACOG, it is recommended that elective cesarean sections not be performed prior to 39 weeks unless the health of mother and/or baby is jeopardized. In addition, ACOG states that elective cesarean section should only be performed prior to 39 weeks unless the health of mother and/or baby is jeopardized.<sup>20</sup> In addition, complications can include: infection; blood loss; blood clots in the legs, pelvic organs or lungs; injury to the bowel or bladder; and/or reaction to medications or to the anesthesia that is used. For additional information, please visit the WHO website [here](#).<sup>22</sup>