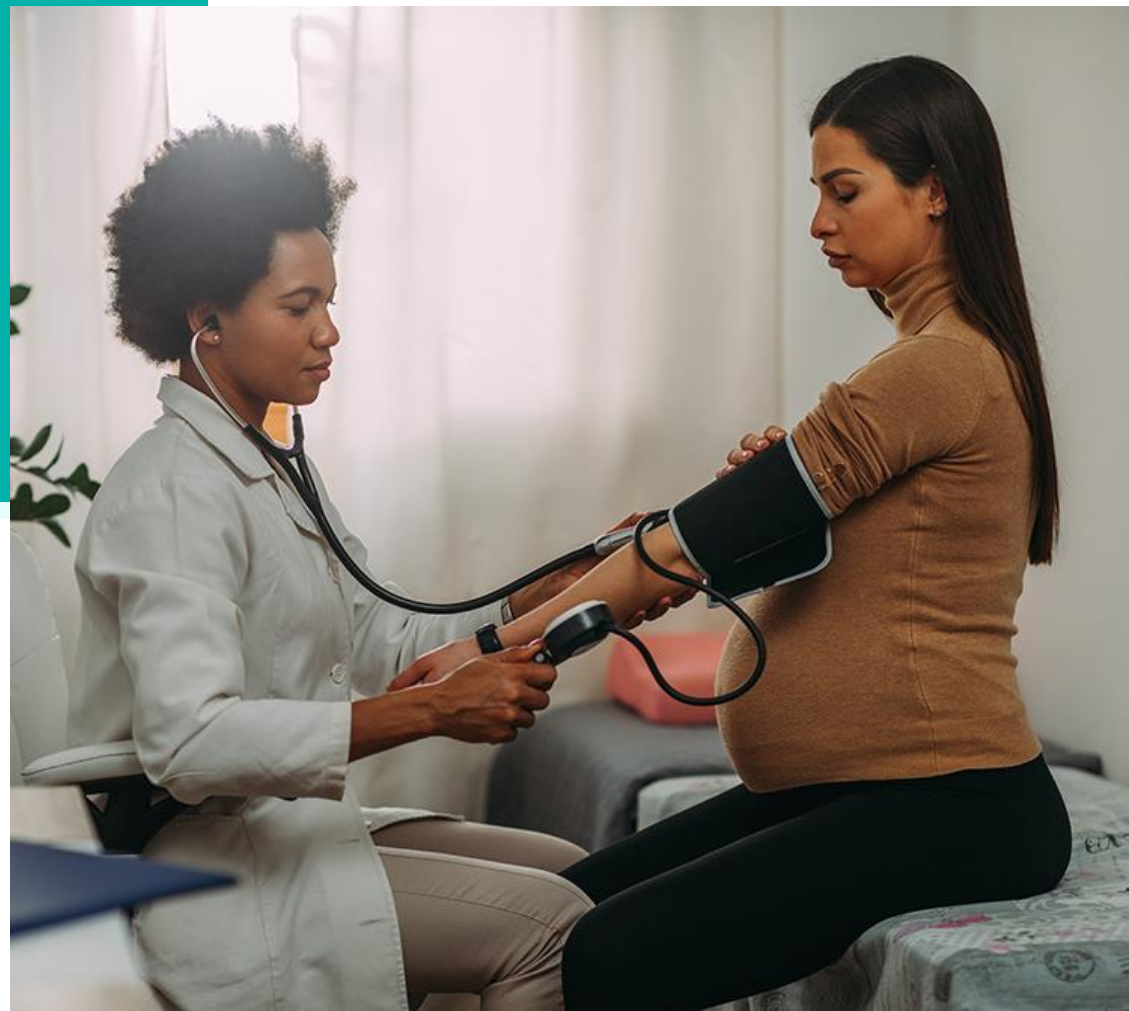
Prenatal Care Redesign:

Creating flexible maternity care models for the future

Alex Peahl MD MSc

Assistant Professor, Obstetrics and Gynecology

Chair, ACOG Redesigning Prenatal Care Initiative



ACOG
The American College of Obstetricians and Gynecologists

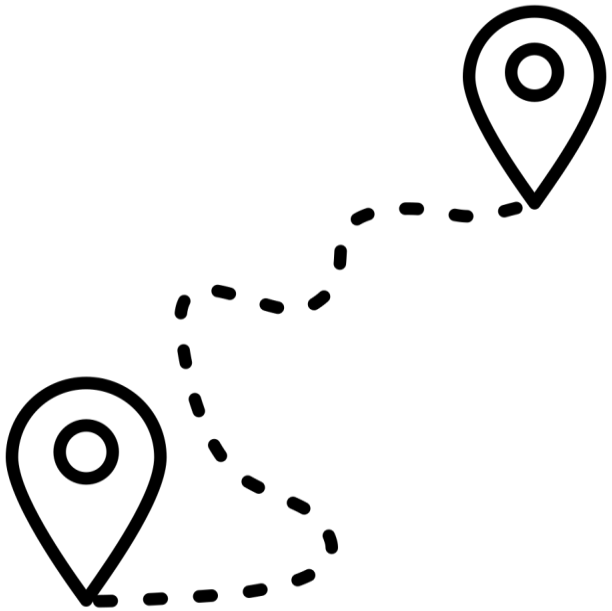
INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Disclosures

Dr. Peahl is a paid consultant for Maven Clinic.

Today's PATH:

1. A personal story
2. What vs. How
3. How to redesign (prenatal) care delivery
   - Gather evidence and knowledge
   - Develop guiding principles
   - Generate expert guidance
   - Incorporate public comment



A personal story

A personal story

ACOG

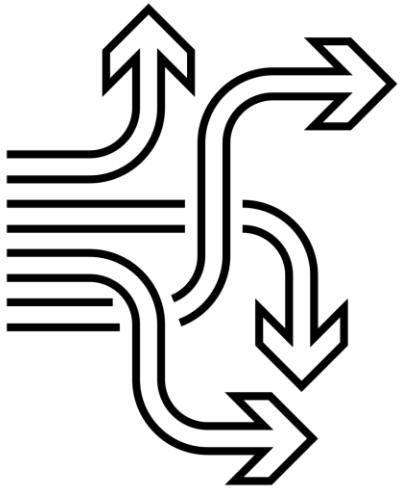
INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Health care is complicated…

Evidence-based standard of care

Tailored to individual people and their circumstances

Same, high-quality services for every patient, every time



Dynamic people, conditions, and situations

…especially in Women's Health, where physical conditions create a ripple of psychosocial effects.

Drastic Physical Changes	Loss of usual function	Increased health system contact
Change in identity	Significant educational Burden	Critical need for non-medical support

Health care can be separated into two key components:

"WHAT"

Health care services

The different elements of care provided to patients including screenings, management, and treatment

"HOW"

Health care delivery

The way healthcare is administered, including visit frequency, modality, and support services

Today's goal: inspire YOU to incorporate care delivery redesign in your practice

"WHAT"	"HOW"	
Prenatal Care	Postpartum Care	Contraception
Oncology	Incontinence	Abnormal Uterine Bleeding

WHAT vs. HOW

“WHAT”

“HOW”

“HOW”

Milkshake

Banana split

Ice cream truck

Home freezer

Ice cream vs. prenatal care delivery.

“WHAT”

“HOW”

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

“WHAT”


Rhogam
Home pregnancy tests
Vaccines
Ultrasound
Home monitoring
Aspirin
Anemia screening
PEC risk stratification

“HOW”

Sweden

8-9 in-person visits

United States

12-14 in-person visits

“HOW”

Group prenatal care

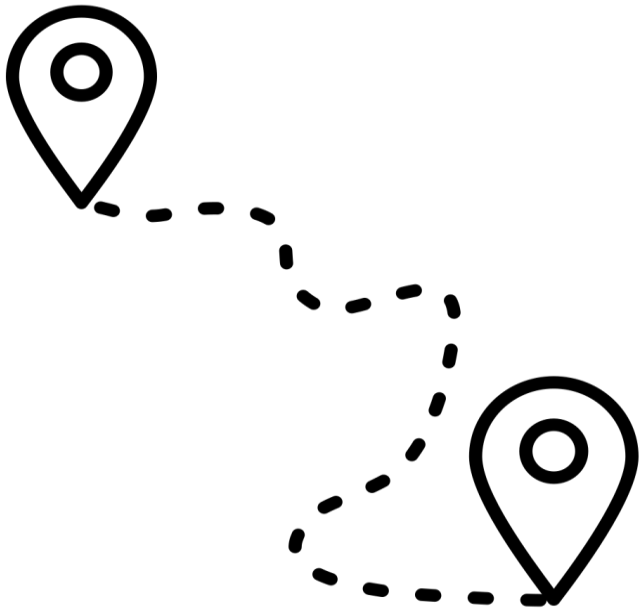
Care coordination

Local clinics and care delivery

Telemedicine and home monitoring


Ice Cream Bar
Chocolate Flakes
Publix
WHIPPED
lightcream
SWEETENED
GRADE A PASTEURIZED
Coconut
Granola
Pretzels
Candied Almonds
Strawberries
Mixed Berries
Bananas
Coffee
Salted Caramel
Mint Chocolate
Chocolate

Our roadmap for care redesign



1. Gather evidence and knowledge
2. Develop guiding principles
3. Generate expert guidance
4. Incorporate public comment

Gather evidence and knowledge

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

WHAT is prenatal care?

One of the **most common preventive care services** in the world that aims to **improve the health** of pregnant patients and their children each year through:

1. Medical screening & treatment

2. Anticipatory guidance

3. Psychosocial Support

Evidence supports aspects of both prenatal care services and care delivery

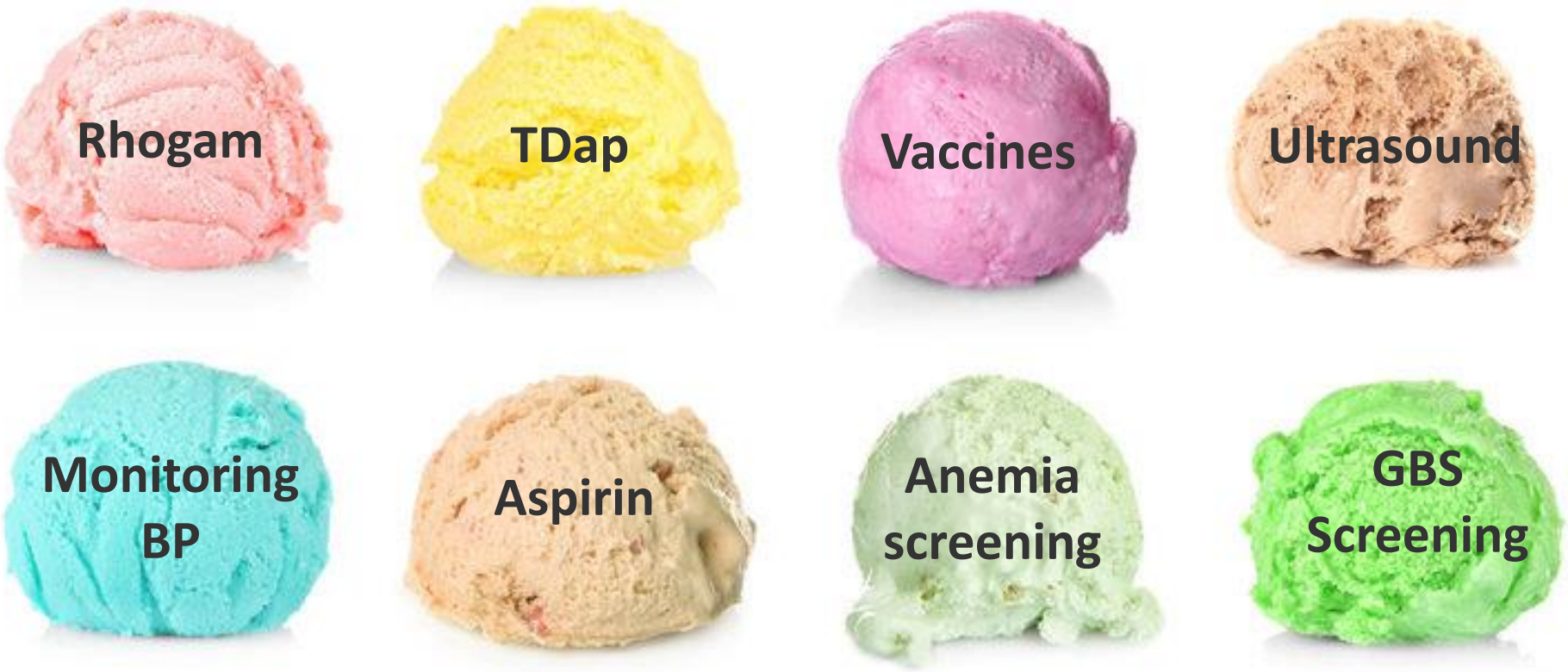
"WHAT" = Services

"HOW"= Delivery

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

“WHAT”


Rhogam
TDap
Vaccines
Ultrasound
Monitoring BP
Aspirin
Anemia screening
GBS Screening

Prenatal care delivery has remained largely unchanged over the past century (HOW)

1. Prenatal visit frequency
2. Prenatal visit modality (telemedicine)
3. Integration of non-medical care

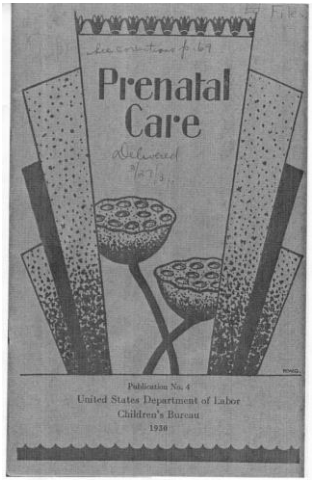
Evidence on prenatal care delivery is growing (HOW)

1. **Prenatal visit frequency**
2. Prenatal visit modality (telemedicine)
3. Integration of non-medical care

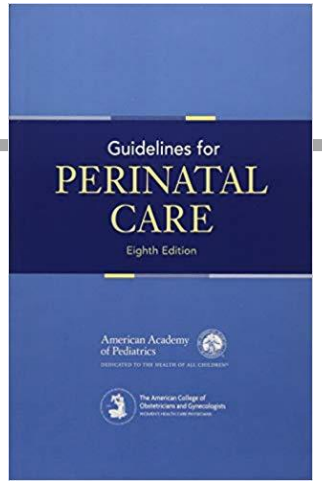
Kilpatrick *Guidelines for Perinatal Care* 2017

Prenatal care delivery guidelines in the United States have remained the same since 1930

1930:
Children's Bureau



2017:
ACOG's most recent guidelines



Frequency

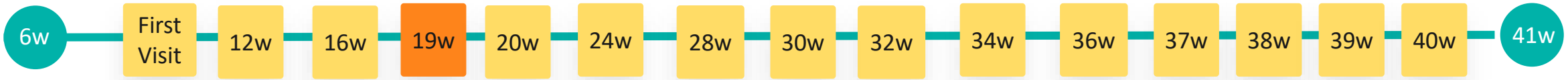
Typically, a woman with an uncomplicated first pregnancy is examined every 4 weeks for the first 28 weeks of gestation, every 2 weeks until 36 weeks of gestation, and weekly thereafter. Women with medical or obstetric

Peahl and Howell. Am Journal Obstet Gynecol 2021; 224(4): 339-347

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Traditional prenatal care delivery in the U.S. includes >40 hours of care for patients without risk-factors



First Visit
Physical Exam
Dating Ultrasound
Influenza Vaccine
Prenatal Labs
Cervical Cancer Screening

Week 19
Anatomy Ultrasound

Week 28
Diabetic Screen,
Complete Blood Count
Pertussis Vaccine
Rhogam as Indicated

Week 36
Group B Strep,
Assess for Presentation

Week 39
Cervical Exam

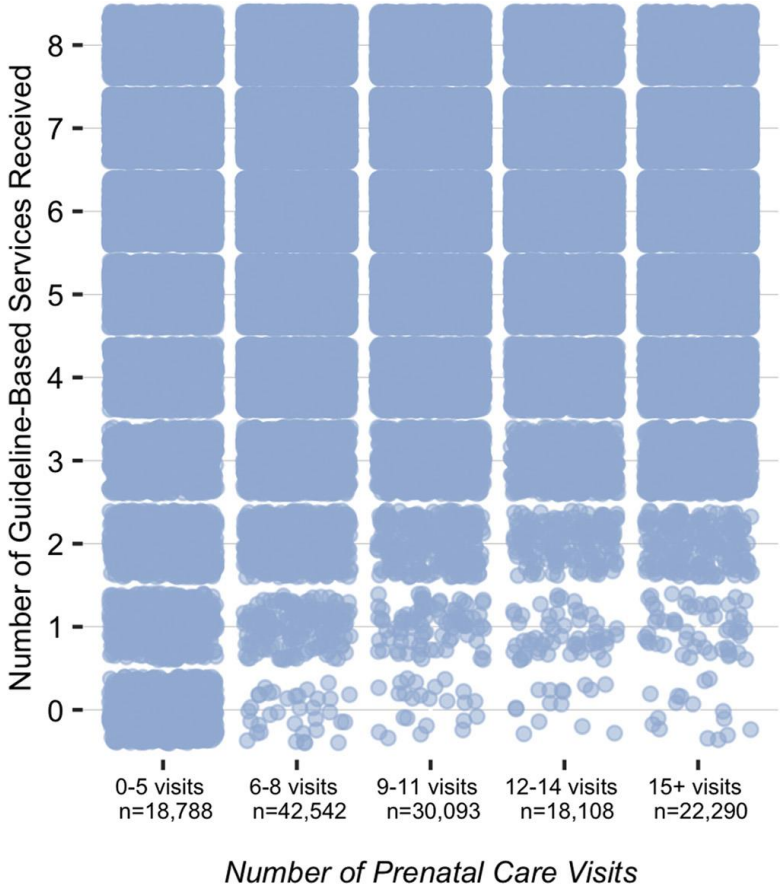
In-person visit
Ultrasound visit

Peahl et al. Am Journal Obstet Gynecol 2021; 223(3): 339-e1

ACOG
INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Quantity of prenatal care does not always reflect quality.

After a threshold of 5 visits, more prenatal visits were not associated with increased guideline-based services*.



*Testing for STI, OB laboratory panel, Urinalysis, Urine Culture, Anatomy US, Oral GTT, TDap, GBS

Gourevitch et al *AJOG* 2021

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

More visits may be associated with harms.

In low-risk patients, >10 vs. <10 prenatal visits was associated with:

- **=** Equivalent neonatal outcomes
- **↑** Increased induction of labor
- **↑** Higher cesarean birth rates

Carter et al *J Perinatol* 2016

Three reviews show equivalent maternal & neonatal outcomes with reduced visit schedules

Dowswell 2015	Barrera 2021	AHRQ 2022
Systematic Review >5000 high-income patients 7 studies	**Rapid Review** >17,000 low-risk patients 8 studies	**Systematic Review,** > 14,000 low-risk patients 10 studies

Dowswell 2015, Barrera 2021, AHRQ

Evidence from 5 RCTs and 5 NRCTs suggests equivalent outcomes for reduced vs. traditional visit schedules

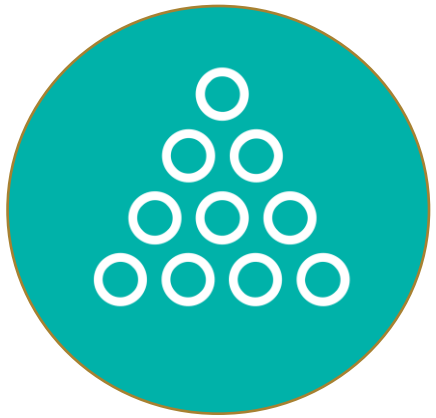
Moderate evidence	Low evidence	Qualitative evidence
= Gestational age at birth = Small for gestational age = Abnormal APGAR = NICU admission	= Maternal anxiety = Preterm birth = Low birth weight	Providers believe fewer visits may be more convenient for patients and scheduling Providers have concerns about “lesser care”

Dowswell 2015, Barrera 2021, AHRQ

AHRQ ACOG INSTITUTE FOR HEALTHCARE POLICY & INNOVATION UNIVERSITY OF MICHIGAN

To summarize: prenatal visit frequency

Less is more



Quantity does not equal quality

Exact number remains unknown?

Dowswell 2015, Barrera 2021, AHRQ

AHRQ ACOG INSTITUTE FOR HEALTHCARE POLICY & INNOVATION UNIVERSITY OF MICHIGAN

Evidence on prenatal care delivery is growing (HOW)

1. Prenatal visit frequency
2. **Prenatal visit modality (telemedicine)**
3. Integration of non-medical care

Kilpatrick *Guidelines for Perinatal Care* 2017

Telemedicine is an emerging pathway for care delivery.

Telemedicine visits

Allows care to be delivered more conveniently for the patient.

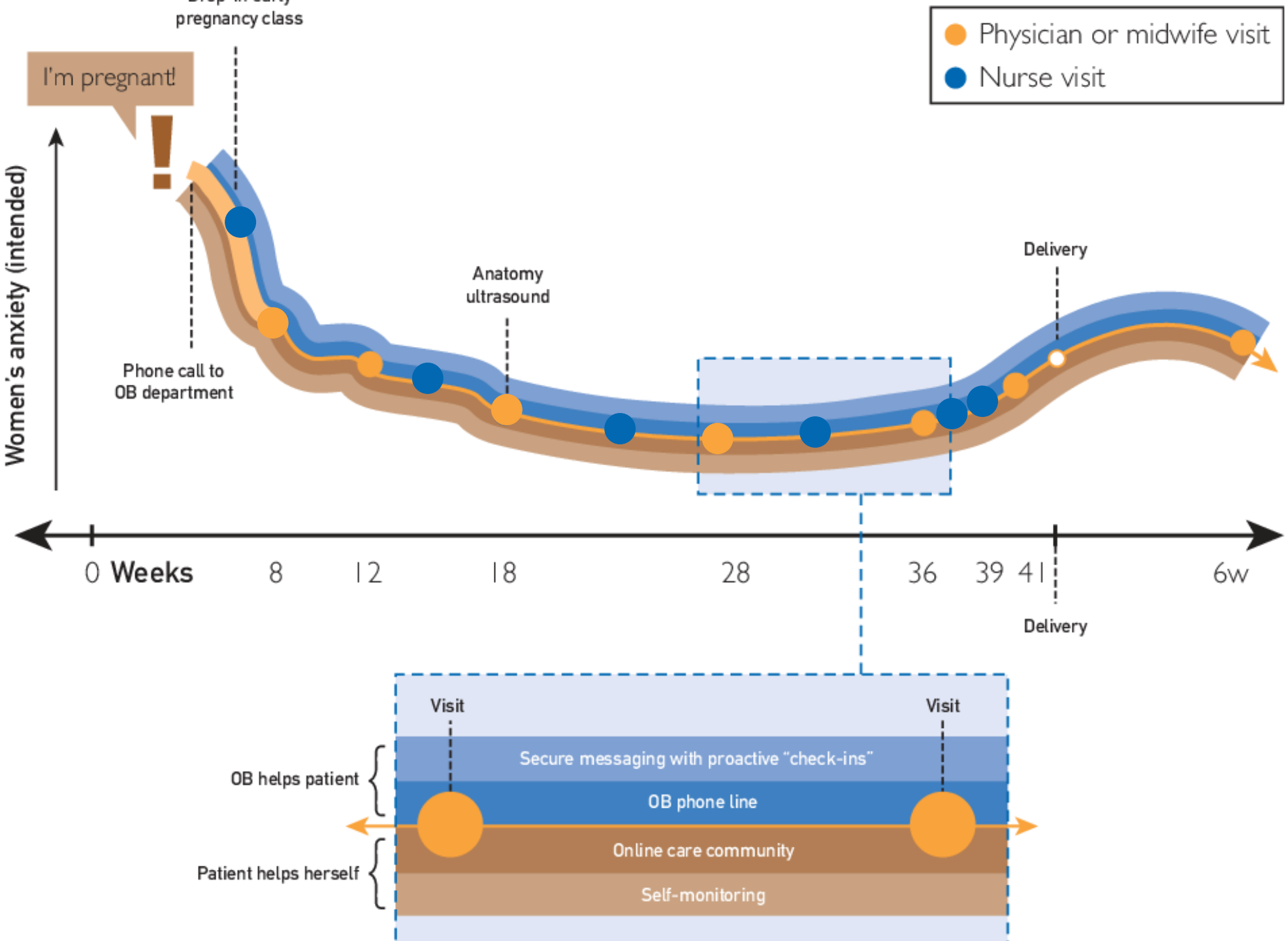
- Combination of in-person and telemedicine visits
- May include additional wraparound services with routine care

Remote Monitoring

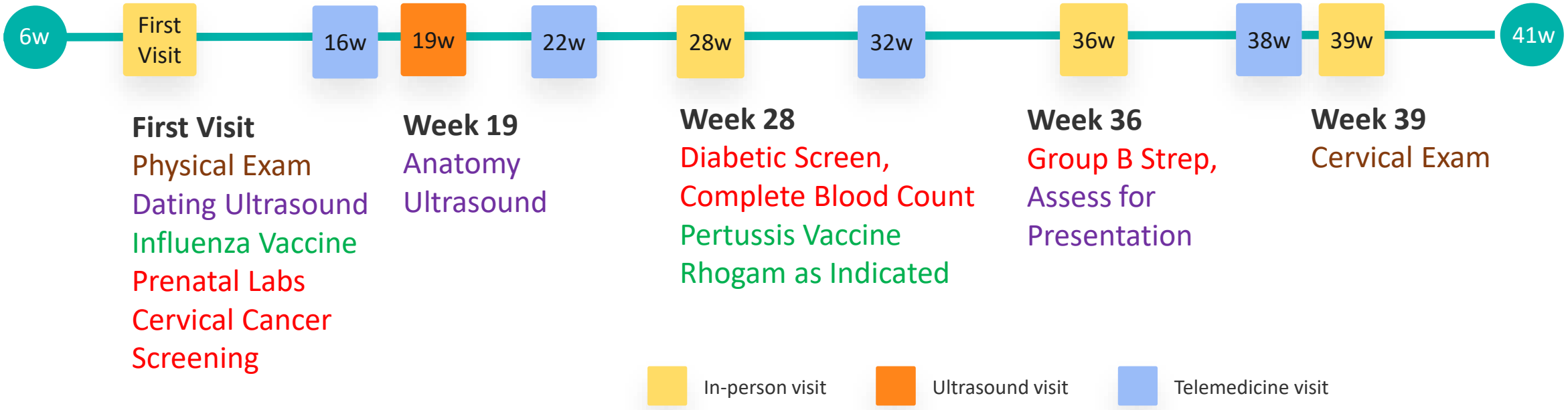
Allows for data collection outside of clinic with equal or increased frequency

- Blood pressure
- Fetal heart tones
- Weight
- Fundal height
- Blood sugar
- Symptoms
- Home ultrasound
- Non-Stress test

Kilpatrick *Guidelines for Perinatal Care* 2017


pregnancy class
I'm pregnant!
Physician or midwife visit
Nurse visit
Women's anxiety (intended)
Phone call to
OB department
Anatomy
ultrasound
Delivery
0 Weeks
8
12
18
28
36
39
41
6w
Delivery
Visit
Visit
OB helps patient
Secure messaging with proactive "check-ins"
OB phone line
Patient helps herself
Online care community
Self-monitoring

During the COVID-19 pandemic, many institutions implemented hybrid prenatal care models



Peahl et al. Am Journal Obstet Gynecol 2021; 223(3): 339-e1

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Key lessons from implementing hybrid prenatal care:

Quality must be the same across modality.

Patients and providers need preparation.

Patient preference is critical.

Dowswell 2015, Barrera 2021, AHRQ

Evidence from 6 studies suggests equivalent outcomes for hybrid (telemedicine) vs. in-person only visits

Low evidence	Qualitative evidence
= Preterm births = NICU admissions ↑ satisfaction with hybrid visits	Patients and providers are open to hybrid models of care Patients and providers expressed concerns about quality of care

Dowswell 2015, Barrera 2021, AHRQ

AHRQ ACOG INSTITUTE FOR HEALTHCARE POLICY & INNOVATION UNIVERSITY OF MICHIGAN

To date, telemedicine for high-risk patients has been limited to monitoring and consultation

Blood Glucose Monitoring

Blood Pressure Monitoring

High-risk consultations

- Feasible
- Accurate
- Reduced clinic utilization
- Improved outcomes in select patients

Barrera 2021

To date, telemedicine for high-risk patients has been limited

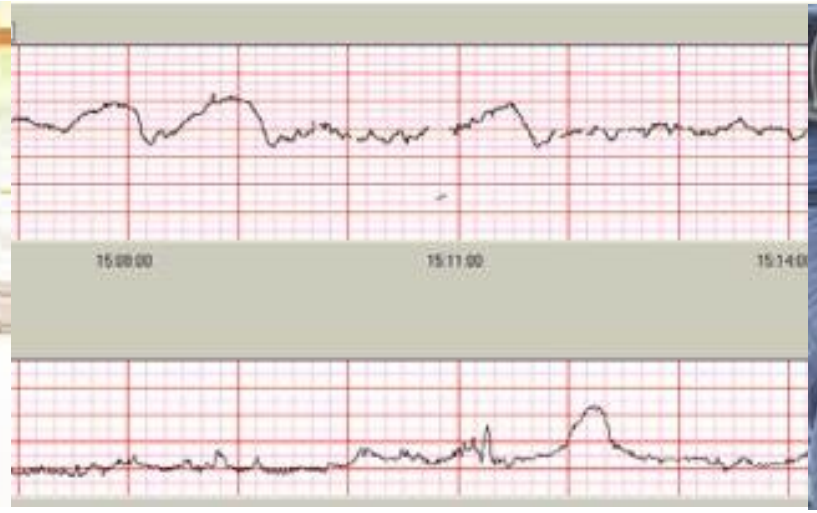
Limited uptake of hybrid prenatal care models

- Home NST
- Home AFI
- Concern about patient complexity

Dowswell 2015, Barrera 2021, AHRQ

New innovations may make hybrid prenatal care models more available for high-risk patients

Connected devices for vitals.



Home cardiotocography.

Home guided ultrasound.

To summarize: hybrid prenatal care

Emerging supporting data in low-risk patients.

Patient preference and selection is key.

New technologies are promising for high-risk patients

Dowswell 2015, Barrera 2021, AHRQ

Evidence on prenatal care delivery is growing (HOW)

1. Prenatal visit frequency
2. Prenatal visit modality (telemedicine)
3. **Integration of non-medical care**

Kilpatrick *Guidelines for Perinatal Care* 2017

Medical care is just one part of prenatal care delivery

1. Medical screening & treatment

2. Anticipatory guidance

3. Psychosocial Support

>40% of health outcomes are attributable to **non-medical factors**, like education, socioeconomic status.

Traditionally, we consider medical risk in pregnancy.

Low Medical Risk	High Medical Risk

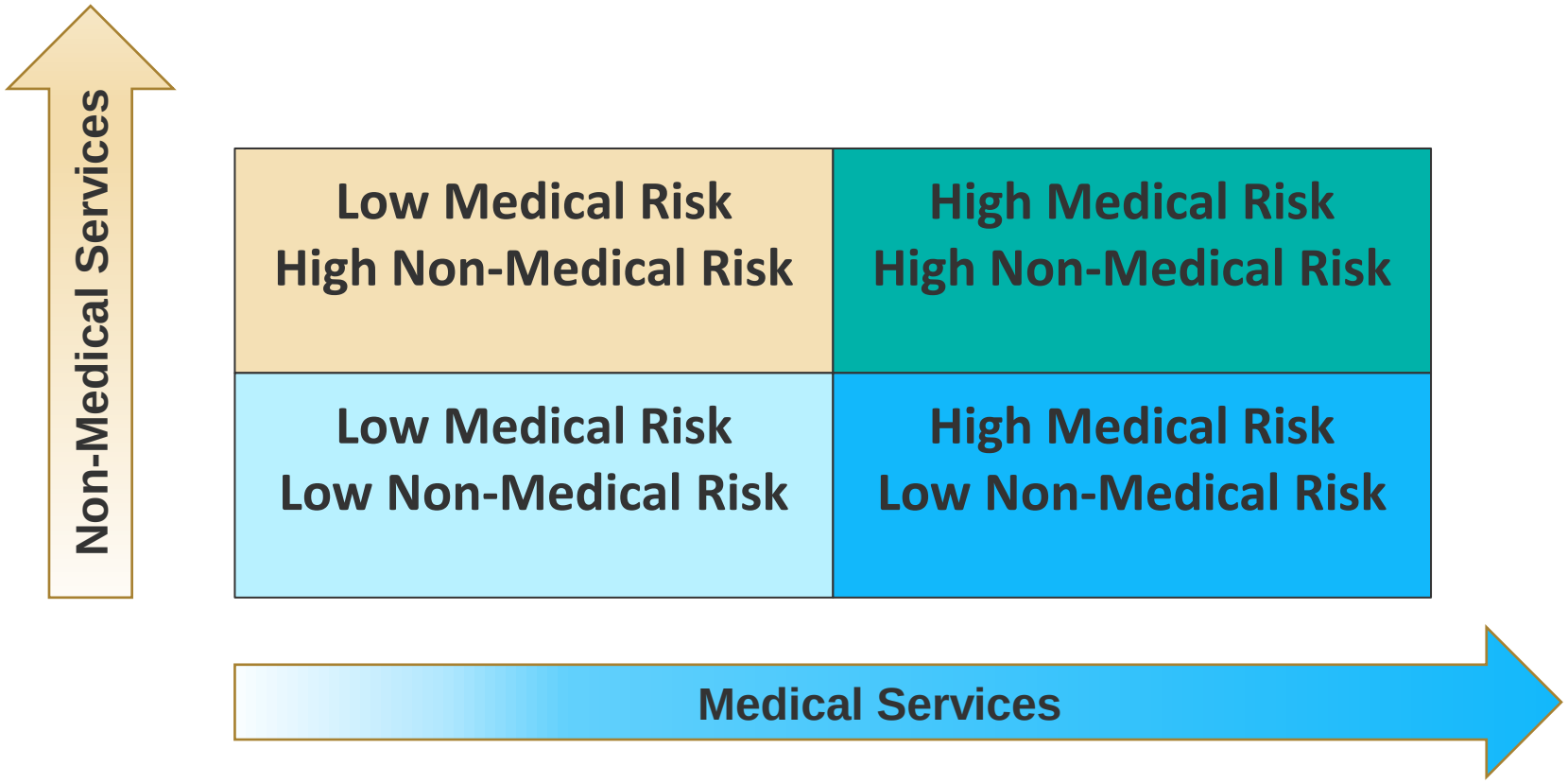
But non-medical risk factors play a critical role in patients' access to care and health outcomes.

Low Non-Medical Risk	High Non-Medical Risk

Four patient basic patient types emerge

Low Medical Risk High Non-Medical Risk	High Medical Risk High Non-Medical Risk
Low Medical Risk Low Non-Medical Risk	High Medical Risk Low Non-Medical Risk

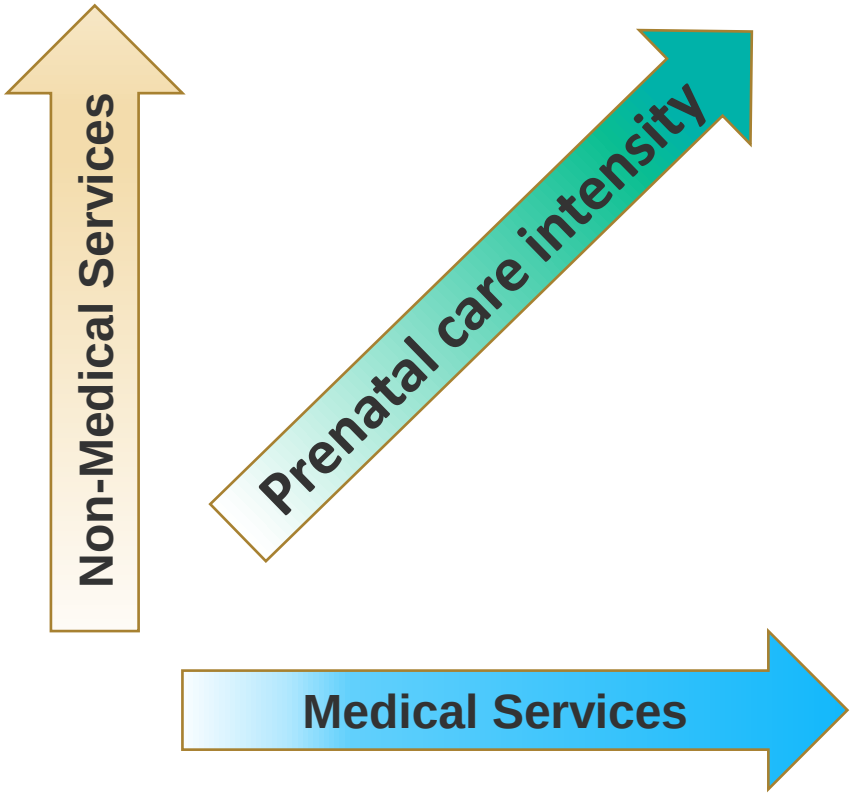
Ideally, the intensity of care delivery can match patients' needs.



ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Patient needs should guide recommended services

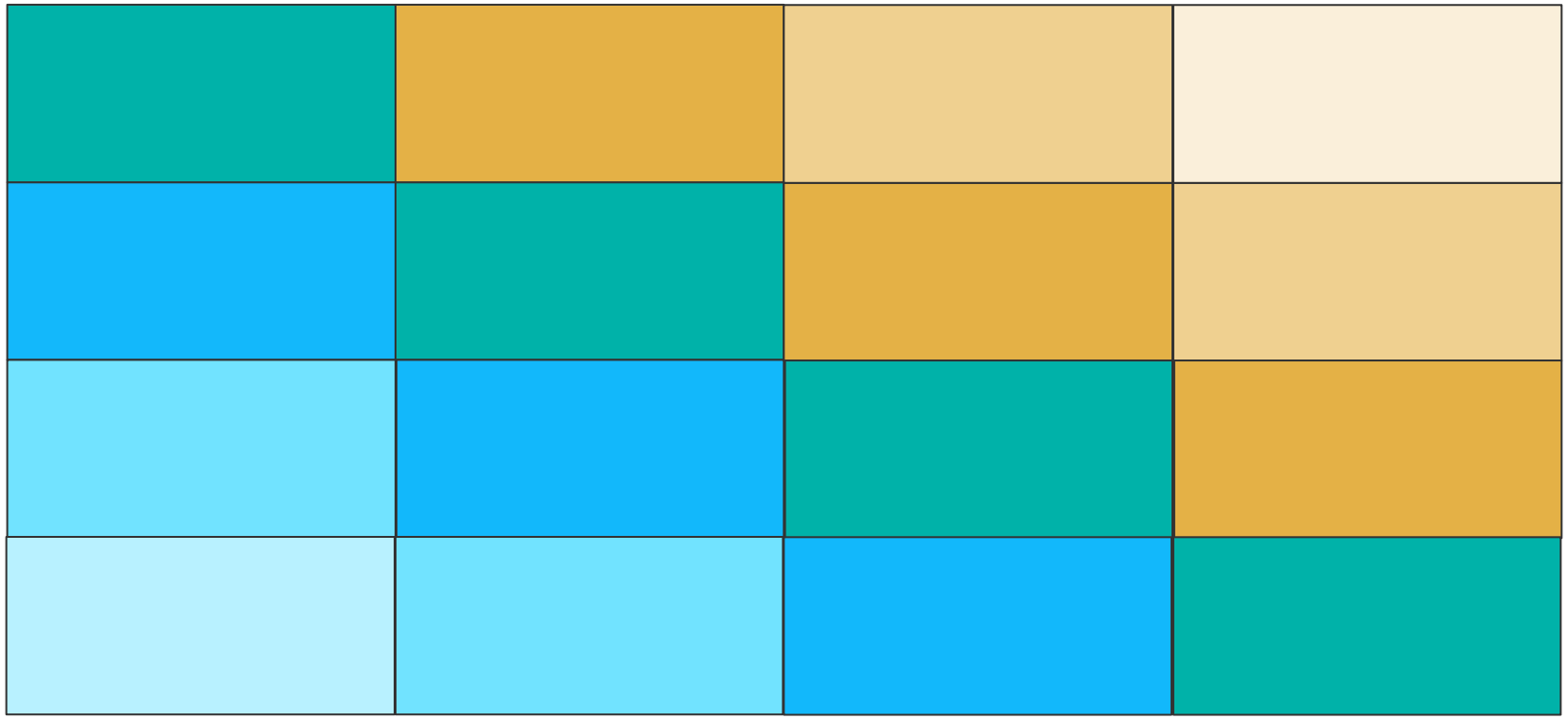


Peahl et al. Obstet Gynecol 2020; 135.5: 1027-1037

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

In reality, this is much more complicated.



Variety of needs to be addressed:

Medical
Social Support
Material Needs
Education

Non-medical needs can be met with supplemental services…

- Apps
- Peer support
- Social workers

…or novel care delivery models.

- Group prenatal care
- Home visiting
- Community-based clinics

The possibilities are endless

Connected care apps

Care coordination

Local libraries as care centers

Community Health Workers

Interventions have mixed data on pregnancy outcomes, patient experience, and health system costs.

Develop guiding principles

3 key principles emerge from existing knowledge of prenatal care delivery.

1

Essential Services

Let services guide prenatal care delivery frequency and modality

2

Non-medical needs

Ensure patients' social determinants of health are addressed

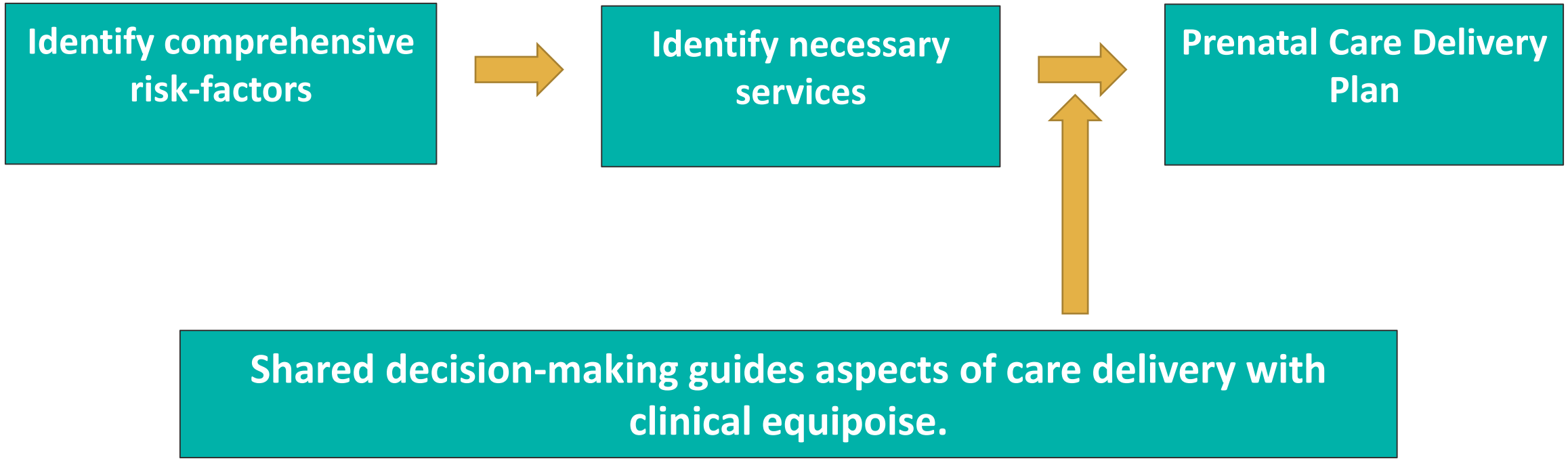
3

Clinical Equipoise

In areas of insufficient evidence, shared decision-making drives delivery.

Peahl et al. Am Journal Obstet Gynecol 2020; 223(3): 389-e1

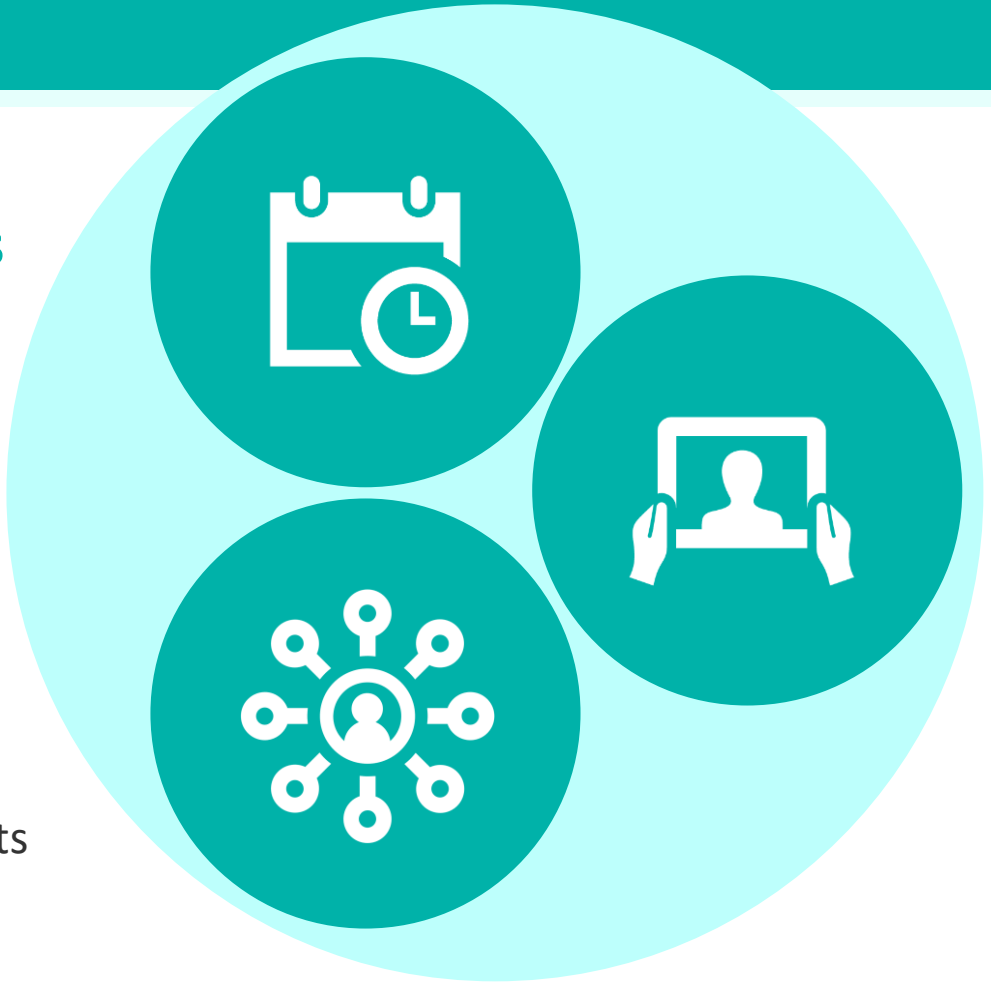
Ideal prenatal care plans account for complex factors, including patient preference.



Generate expert guidance

COVID-19 forced rapid changes in prenatal care delivery overnight

Reduced visit schedules
Focused on needed services

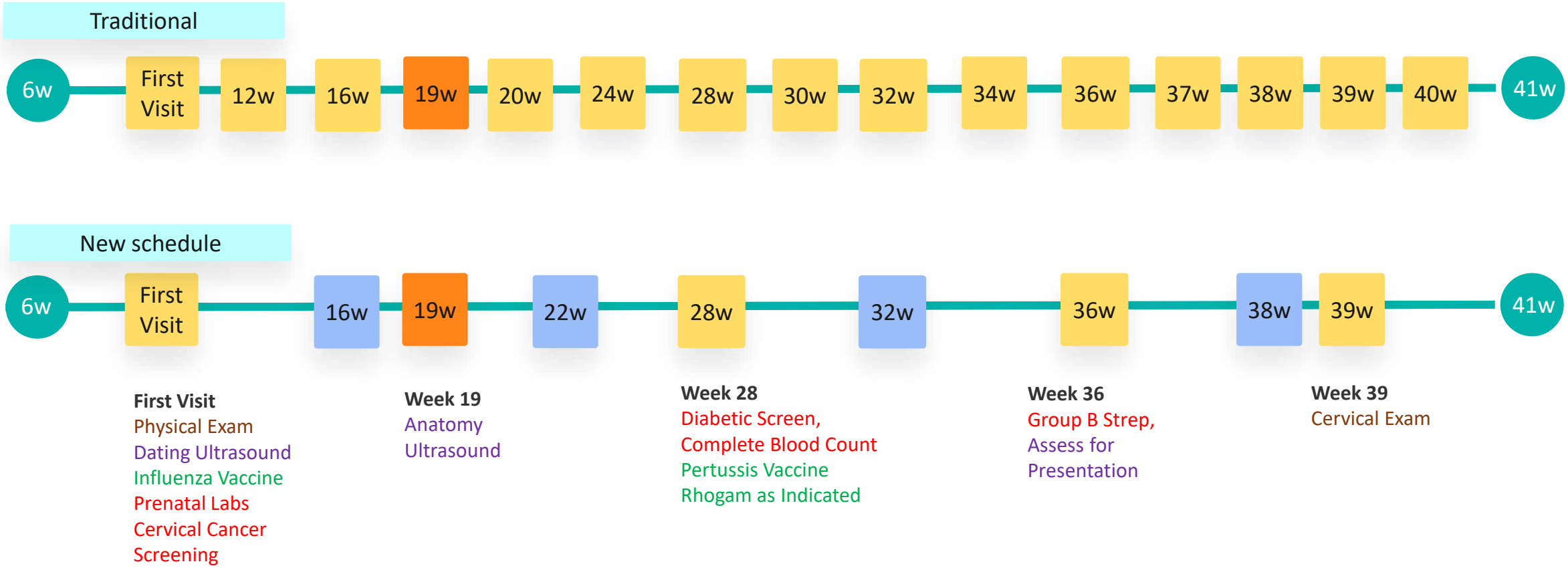


Telemedicine
Video visits and use of home monitoring devices

Awareness of gaps in non-medical services
Poor attention to anticipatory guidance and social determinants

Peahl et al. Am Journal Obstet Gynecol 2021; 223(3): 339-e1

New care delivery models recommend the same prenatal services, just organized differently



Peahl 2021

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

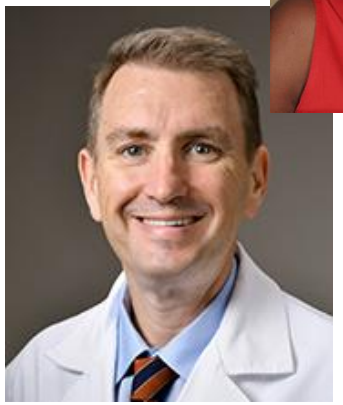
The Plan for Appropriate Tailored Healthcare in pregnancy panel (PATH) was convened to rethink prenatal care

Goal: develop prenatal care delivery guidance for average-risk pregnant patients

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

The panel was led by a group of maternity care leaders and experts in consensus methodology.

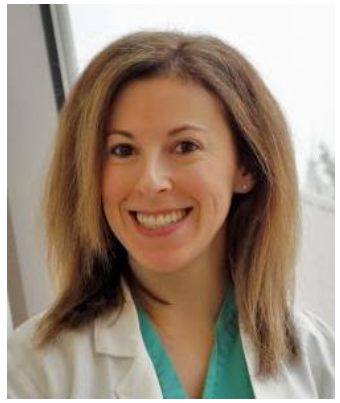


Sean Blackwell, MD

Wanda Barfield, MD

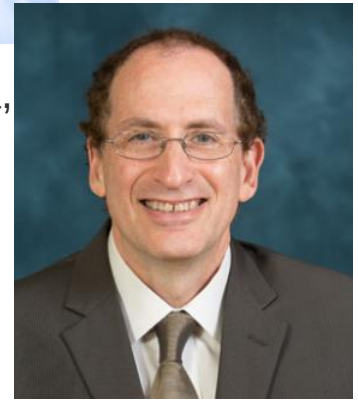
Chris Zahn, MD

Mark Turrentine, MD



Alex Peahl, MD MSC

Vineet Chopra, MD



Steven Bernstein, MD

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

The panel included 19 national maternity care and public health leaders and 2 patient representatives.

Jeffrey Bacon, DO

Tiffani Buck, MPH, MS, ARNP-BC, RN

Yvonne Butler Tobah, MD

Beth Choby, MD

Joia Creer-Perry, MD

Lauren Desmothenes, MD

Christina Han, MD

Susan Hintz, MD, MD, Epi

Patient Reps: Jamie Bardwell, Lauren Keenan Devlin PhD MPH

Camille Hoffman, MD MSc

Sue Kendig, JD WHNP-BC, FAANP

Tekoa King, CNM MPH

Milton Kotelchuck, PhD MPH

Monica Lutgendorf, MD, CDR, MC, USN

Tiffany Moore Simas, MD, MPH

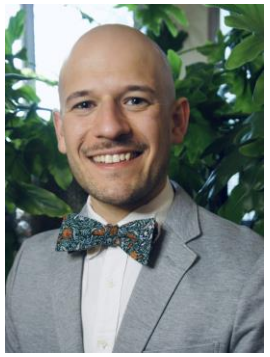
Sindu Srinivas, MD MSCE

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION UNIVERSITY OF MICHIGAN

The panel was also supported by a dedicated team of undergraduate, medical, and PhD students and fellows

Chloe Barrera, MPH

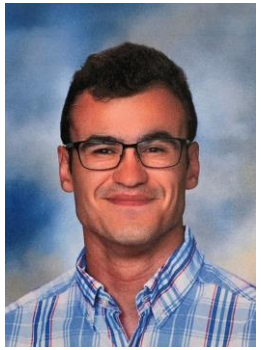


Yoni Siden, MPP

Allison Powell, MD MSE

Suni Jo Roberts

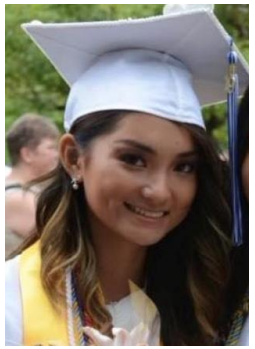
Chloe Ramirez Biermann, MD



Bradley Hartmann

Amara Khalid

Emma Lawrence, MD MSc



Buu-Haac Nguyen

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

The RAND/UCLA Appropriateness Method was selected for developing new recommendations

Evidence-based, modified Delphi approach for deciding the *appropriateness* of care interventions, even when evidence is limited.

Appropriate: the expected health benefit (e.g. increased life expectancy, relief of pain, reduction in anxiety, improved functional capacity) exceeds the expected negative consequences (e.g. mortality, morbidity, anxiety, pain, time lost from work) by a sufficiently wide margin that the procedure is worth doing, regardless of cost.

Does not require consensus, but rather, focuses on minimizing disagreement.

Fitch et al *RAND/UCLA Appropriateness Method* 2001

The RAND/UCLA Appropriateness Method is helpful for areas of clinical care with incomplete evidence.

RAM has been used for guidelines for diverse indications: cesarean delivery, intravenous catheters, hip replacement, and others

Fitch et al *RAND/UCLA Appropriateness Method* 2001

The PATH panel was completed virtually from November to December 2021

Panel Kick-Off
Introduction to process and materials

1st Round
Rated 1230 individual scenarios

Panel Meeting
Discussion using feedback from Round 1

2nd Round
Rated 883 individual scenarios

Final results
Tabulation of findings

Each scenario received a final rating of appropriate, inappropriate, or uncertain.

Medically and Socially Low-Risk Patient

First Prenatal Contact

4w	5w	6w	7w	8w	9w	10w	11w	12w	13w	14w
US	US	US	US	US	US	US	US	US	US	US
PNV	PNV	PNV	PNV	PNV	PNV	PNV	PNV	PNV	PNV	PNV

Prenatal Visit Schedule

≤ 13’6w	14’0 to 27’6	28’0 to 35’6	≥ 36’0
6w=Services*	6w*	6w	6w
4w*	4w*	4w=Services*	4w
2w	2w	2w*	2w*
1w	1w	1w	1w*
Services*	Services*	Services*	Services*

Red = inappropriate

Yellow = uncertain

Green = appropriate

Qualitative findings from panel discussions were also summarized.

PATH recommends a nuanced, tailored approach to prenatal care to meet individuals' needs & preferences

Start

Patient presents for care

Screen for medical & social determinants

Determine a Tailored Prenatal Care Plan

Visit Frequency & Monitoring Schedule

Determine intensity based on medical & social needs

More frequent contact for patients with pregnancy complications and chronic conditions

Telemedicine

Deliver recommended services through 4 in-person visits (1st visit, 28w, 36w, 39w)

Determine visit modality (in-person vs. telemedicine) for additional visits with the patient

Most monitoring can be completed remotely

Support for Social & Structural Determinants

Provide additional support based on community/health system resources and patient needs.

Solicit and incorporate patient preferences

Finalized Plan!

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

A comprehensive prenatal needs assessment should be performed as early as possible.

1. Goal to identify risks early to optimize pregnancy: 6-7 weeks or when patient presents for care
2. Assessment can be completed in-person or virtually with any trained member of care team
3. Assessments should include medical, social and structural determinants of health

Panelists affirmed a baseline visit schedule guided by evidence-based prenatal services.

Service	Weeks																	
	8	10	12	14	16	18	20	22	24	26	28	30	32	34	36	38	39	40
Schedule Based on Services																		
History and Physical Exam		*																
Labs		*																
Imaging		*																
Injections		*																
Health Screening		*																
Screening for Social and Structural Determinants of Health		*																
Anticipatory Guidance		*																

Routine in-person prenatal care | Additional routine services | Services not requiring in-person delivery | * Initial OB appointment

Peahl et al. Obstet Gynecol 2021; 138.4: 593-602

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Telemedicine is appropriate for all visits aside from 4 key in-person contacts requiring in-person services

1

1st Prenatal Visit

- History, exam, vaccinations
- First trimester laboratory testing
- Genetic screening

2

28 weeks

Third trimester laboratory testing

- Tdap vaccination
- Rho(D) Immunoglobulin*

3

36 weeks

- Group B Strep Testing
- Assessment for fetal presentation

4

39 weeks

- Birth planning

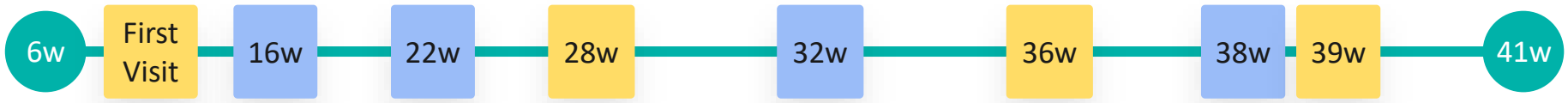
Intensity of prenatal care delivery should be guided by patients' determinants of health

Medical and Pregnancy Conditions	Social and Structural Determinants
Used to determine the baseline prenatal visit pathway including initiation of care, visit frequency and frequency of monitoring.	Used to shape connection to other services within the health system/community and adapt care as needed.

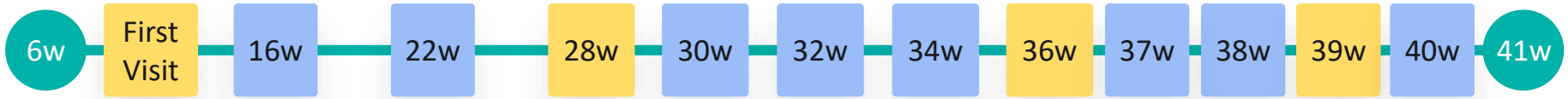
The panel emphasized the need to tailor prenatal care delivery to each patients' needs: not use a one-size-fits-all approach.

Medical and pregnancy conditions shape care delivery pathways

Patients without medical conditions or pregnancy complications can select a **less intense** visit schedule.



Patients with medical conditions or pregnancy complications should have a **more intense** visit schedule.



Shared decision making should guide the recommended visit and monitoring frequency, as well as visit modality.

Recommended in-person visit

In-person or Telemedicine visit (based on shared decision making)

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Low-risk patients can have flexible visit schedules.

Condition	≤13'6 weeks	14 0/7 to 27 6/7 weeks	28 0/7 to 35 6/7 weeks	≥36 0/7 weeks
Current Guidelines	4 weeks	4 weeks	2 weeks	1 week
Low-risk	4*-6* weeks (services)	4*-6* weeks (services)	2-4* weeks (services)	1*-2* weeks (services)
Chronic Hypertension	4* weeks	4* weeks	2* weeks	1* weeks
Preexisting Diabetes	4* weeks	4* weeks	2* weeks	1* weeks
Hx Pregnancy Loss (Early)	4* weeks	4* weeks		
Gestational Hypertension			2* weeks	1* week
Gestational Diabetes			2* weeks	1* week

*=some visits appropriate for telemedicine

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Patients with medical and pregnancy conditions can follow the traditional visit schedule

Condition	≤13'6 weeks	14 0/7 to 27 6/7 weeks	28 0/7 to 35 6/7 weeks	≥36 0/7 weeks
Current Guidelines	4 weeks	4 weeks	2 weeks	1 week
Low-risk	4*-6* weeks (services)	4*-6* weeks (services)	2-4* weeks (services)	1*-2* weeks (services)
Chronic Hypertension	4* weeks	4* weeks	2* weeks	1* weeks
Preexisting Diabetes	4* weeks	4* weeks	2* weeks	1* weeks
Hx Pregnancy Loss (Early)	4* weeks	4* weeks		
Gestational Hypertension			2* weeks	1* week
Gestational Diabetes			2* weeks	1* week

*=some visits appropriate for telemedicine

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Monitoring of routine pregnancy parameters mirrors visit frequency and can be completed remotely.

Blood Pressure

Weight

Fetal Heart Tones

Fundal Height

Patients with chronic conditions (e.g., hypertension) may need more frequent monitoring than the recommended visit schedule.

Condition	≤13'6 weeks				14 0/7 to 27 6/7 weeks				28 0/7 to 35 6/7 weeks				≥36 0/7 weeks			
	BP	FHT	Wt	FH	BP	FHT	Wt	FH	BP	FHT	Wt	FH	BP	FHT	Wt	FH
Current Guidelines	**4 weeks**				**4 weeks**				**2 weeks**				**1 week**			
	4	4	4	-	4	4	4	4	2	2	2	2	1	1	1	1
Low-risk	**4*-6* weeks (services)**				**4*-6* weeks (services)**				**2-4* weeks (services)**				**1*-2* weeks (services)**			
	4-6	4-6	4-6	-	4-6	4-6	4-6	4-6	2	2-4	2	2-4	1-2	1-2	1-2	1-2
Chronic Hypertension	**4* weeks**				**4* weeks**				**2* weeks**				**1* weeks**			
	4	4-6	4-6	-	1-2	4	4-6	4-6	1-2	2-4	2	2	1	1-2	1-2	1-2
Preexisting Diabetes	**4* weeks**				**4* weeks**				**2* weeks**				**1* weeks**			
	4	4-6	4-6	-	4	4	4-6	4	1-2	2	2	2	1	1-2	1-2	1-2
Hx Pregnancy Loss (Early)	**4* weeks**				**4* weeks**											
	4-6	4	4-6	-	4-6	4	4-6	4-6								
Gestational Hypertension									**2* weeks**				**1* week**			
									1-2	1-2	2	2	1	1-2	1-2	1-2
Gestational Diabetes									**2* weeks**				**1* week**			
									2	2	2	2	1-2	1-2	1-2	1-2

*=some visits appropriate for telemedicine

PATH recommends a nuanced, tailored approach to prenatal care to meet individuals' needs & preferences

Start

Patient presents for care

Screen for medical & social determinants

Determine a Tailored Prenatal Care Plan

Visit Frequency & Monitoring Schedule

Determine intensity based on medical & social needs

More frequent contact for patients with pregnancy complications and chronic conditions

Telemedicine

Deliver recommended services through 4 in-person visits (1st visit, 28w, 36w, 39w)

Determine visit modality (in-person vs. telemedicine) for additional visits with the patient

Most monitoring can be completed remotely

Support for Social & Structural Determinants

Provide additional support based on community/health system resources and patient needs.

Solicit and incorporate patient preferences

Finalized Plan!

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Ideally, social needs should be met by health system and community resources

If participants' needs can be met through available resources

Maternity care professionals may not be the best team member to address needs.

Additional prenatal visits may create more patient burden & unlikely to address non-medical needs

New recommendations unchanged for all considered groups except:

Less intense visit schedule:

- Low-health literacy
- Pregnancy associated anxiety
- Intimate partner violence

Telemedicine

- Intimate partner violence (privacy)

Overarching qualitative panel findings and priorities for future research and policy

Continuum of Care	Importance of **pre-pregnancy and postpartum care** across the lifespan
National Variation	**Need for adaptation for the variety** of professionals, settings, & practices
Team-based Care	Call to **better integrate** other health care, public health, and community
Equity	Need to meet the needs of patients facing **greatest barriers to care**
Telemedicine	**Access** to internet, home devices, and payment for telemedicine

PATH recommends a nuanced, tailored approach to prenatal care to meet individuals' needs & preferences

Start

Patient presents for care

Screen for medical & social determinants

Determine a Tailored Prenatal Care Plan

Visit Frequency & Monitoring Schedule

Determine intensity based on medical & social needs

More frequent contact for patients with pregnancy complications and chronic conditions

Telemedicine

Deliver recommended services through 4 in-person visits (1st visit, 28w, 36w, 39w)

Determine visit modality (in-person vs. telemedicine) for additional visits with the patient

Most monitoring can be completed remotely

Support for Social & Structural Determinants

Provide additional support based on community/health system resources and patient needs.

Solicit and incorporate patient preferences

Finalized Plan!

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Incorporate public comment

The panel recognized the importance of quickly developing interim guidance, and used available data

Experience
with innovation during the COVID-19 pandemic

Evidence
from the literature where available

Expert opinion
from national maternity care leaders

Stakeholder Input
from diverse populations

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

The panel is now incorporating stakeholder input following initial recommendations

Experience
with innovation during the COVID-19 pandemic

Evidence
From the literature where available

Expert opinion
from national maternity care leaders

Stakeholder Input
from diverse populations

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Diverse stakeholders will inform revisions to the new care recommendations

Patients and Advocates

Providers and Researchers

Public health leaders

Policymakers

Payers

New prenatal care recommendations will be finalized in 2024, with stakeholder input and emerging evidence

2021:
PATH publication

2022:
Listening Tour Kickoff

2021-2022:
AHRQ Review

2022-2023:
Stakeholder feedback

2022-2023:
Emerging Evidence

2023-2024:
Updated guidance

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

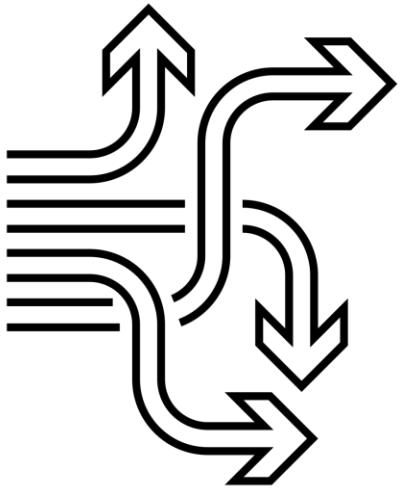
To summarize

Health care is complicated…

Evidence-based standard of care

Tailored to individual people and their circumstances

Same, high-quality services for every patient, every time



Dynamic people, conditions, and situations

High-quality care requires careful attention to both care services and delivery.

"WHAT"

"HOW"

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Yet, prenatal care delivery has remained largely unchanged over the past century

1. Prenatal visit frequency
2. Prenatal visit modality (telemedicine)
3. Integration of non-medical care

Kilpatrick *Guidelines for Perinatal Care* 2017

3 key principles emerge from existing knowledge of prenatal care delivery.

1

Essential Services

Let services guide prenatal care delivery frequency and modality

2

Non-medical needs

Ensure patients' social determinants of health are addressed

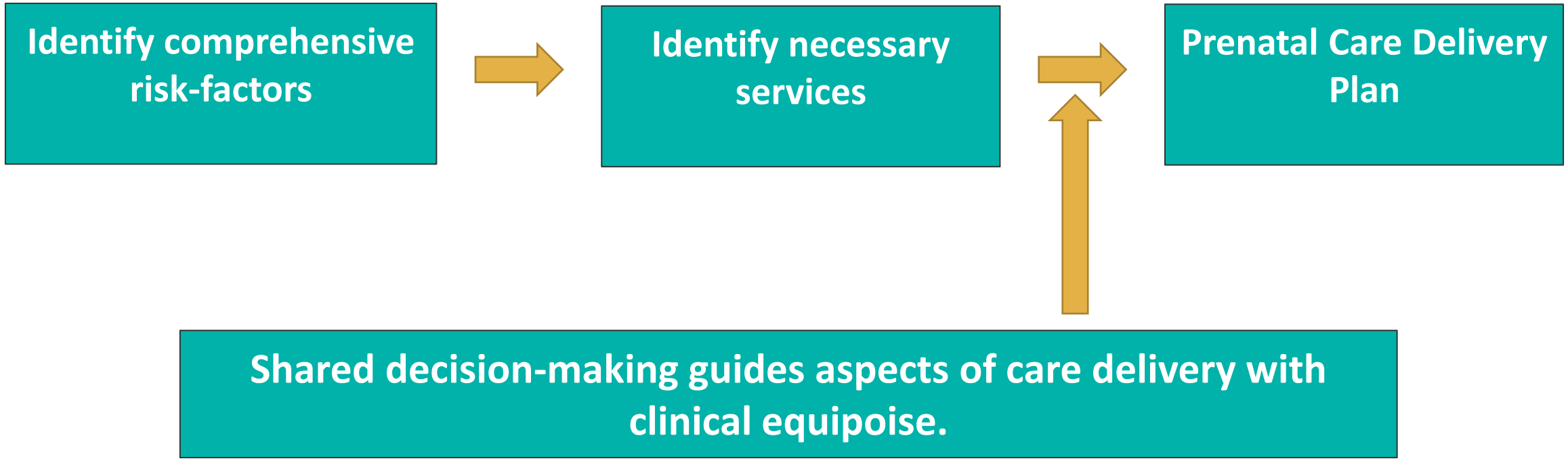
3

Clinical Equipoise

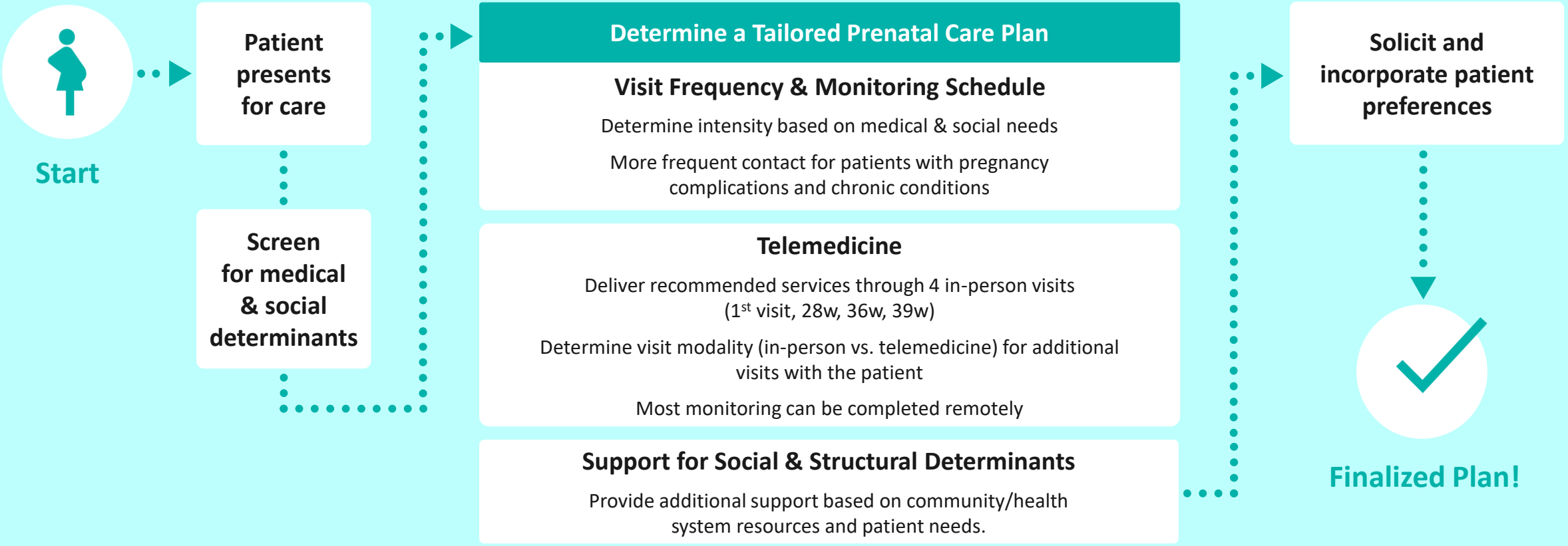
In areas of insufficient evidence, shared decision-making drives delivery.

Peahl et al. Am Journal Obstet Gynecol 2020; 223(3): 389-e1

Ideal prenatal care plans account for complex factors, including patient preference.



New consensus guidelines recommend a more nuanced, tailored approach to prenatal care.



ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

Incorporating diverse stakeholder feedback is critical.

Patients and Advocates

Providers and Researchers

Public health leaders

Policymakers

Payers


Ice Cream Bar
Chocolate Flakes
Publix
WHIPPED
lightcream
SWEETENED
GRADE A PASTEURIZED
Coconut
Granola
Pretzels
Candied Almonds
Strawberries
Mixed Berries
Bananas
Coffee
Salted Caramel
Mint Chocolate
Chocolate

Thank you!

I look forward to your questions.

@AFriedmanPeahl alexfrie@med.umich.edu

ACOG

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN