Examples of Alternate or Reduced Prenatal Care Schedules

March 24, 2020

In response to the COVID-19 outbreak, various organizations and institutions have created suggested modified obstetric visit schedules to reduce the spread of disease while maintaining adequate levels of maternal and fetal care/safety. Modifying or reducing care is only appropriate because the risk of inadvertent exposure from receiving or delivering care can be high at this time; return to normal care approaches and schedules should resume when this risk subsides.

Examples of alternate or reduced prenatal care schedules are posted below as resources. These examples are shared with the express permission of their developers, and without identification when requested. These examples, along with relevant journal publications listed below, are for resource purposes only and should not be considered developed or endorsed by the American College of Obstetricians and Gynecologists. Adopted plans for modified care are best made at the local level with consideration of patient populations and available resources.

Additional Resources:

- Randomized comparison of a reduced-visit prenatal care model enhanced with remote monitoring (Tobah, et al., 2019)
- OB Nest: Reimagining Low-Risk Prenatal Care (Meylor de Mooij, et al., 2018)
- MFM Guidance for COVID-19 (Berghella, et al., 2020)

FACILITY 1

KEY RECOMMENDATIONS AND REVISED PRENATAL CARE SCHEDULE (FOR MEDICALLY LOW-RISK PATIENTS)

University of Michigan

Key recommendations for outpatient prenatal care for medically low-risk patients:

Phase 1 (active):

1. **Reduce in-person prenatal care** to essential services requiring in-person contact (initial prenatal visit, anatomy ultrasound, 28, 36, and 39 week)
2. **Conduct additional prenatal visits through telemedicine platforms** (allow for longer visit; e.g. 20 minute vs. 10 minutes for phone/video visits) as needed per schedule below.
3. We endorse for Phase 1 that most virtual care will not include blood pressure measurement and fetal heart tone auscultation; we will support patients' use of **home doppler devices, blood pressure cuffs, and scales** to be used in conjunction with virtual visits.

Phase 2 (1 week):

1. Collect information on streamlining services to specified centers
    a. Identify site capacity for NST/Ultrasound
2. Work to **secure home devices** for patients.
    a. Work with payors to reimburse patients for their device purchase
    b. Work with payors to reimburse the department for devices purchased for patients who are unable to purchase their own devices
    c. Create workflow for device distribution for 1000 secured through donors
2. Ensure **patients are prepared for device use**:
    a. Share U of M ambulatory blood pressure cuff and fetal doppler handouts
    b. Create student hotline for patients to answer questions on monitoring devices
3. Identify patient support need through online groups and educational platforms

Prenatal Care Revised Schedule:

Visit (week)	Location	Optional	History/ Exam	Labs	Imaging/ Injections	Education
Intake	Nurse Call		-Full history Depression/IPV screen -Review of symptoms			-Nutrition (Folate, Ca, Fish, pasteurized foods/cooked foods) -OTC medications in pregnancy -Weight gain -Work exposures/risks -Travel/Zika/COVID19 -Breastfeeding -Miscarriage precautions
8-12	**Provider Visit**		-Vitals (Height,	Prenatal labs UA/UCx	Dating US Influenza	-orientation to practice -doppler and BP cuff use

			weight, BMI, BP) -Full physical exam (pelvic, GC/CT, PAP PRN) -pregnancy symptoms	Aneuploidy Screen		-genetic screening options *As appropriate:* -Obesity counseling -VBAC/TOLAC -Preeclampsia and preterm birth prophylaxis -Vaccinations
16-20	Virtual Visit		-BP, weight -FHR -pregnancy symptoms		17-OHP as appropriate	-Physical/emotional changes in pregnancy -Signs of complications (preeclampsia, preterm labor) -exercise -safe sex -managing work -seatbelt use
19-21w	FDC		-BP, weight		Anatomy US	
24-28	Virtual Visit		-BP, weight -FHR -pregnancy symptoms			-Childbirth classes/directions to birth center -Parenting/ breastfeeding classes -Trauma in pregnancy -diet/nutrition *As appropriate:* -VBAC/TOLAC
28-30	**Provider Visit**		-BP, weight -FHR, FH -pregnancy symptoms -Depression/ IPV screen	Diabetic screen CBC T&S if Rh negative	Tdap Rhogam PRN	-L&D anticipatory guidance -Newborn provider and car seat -Family planning
30-32	Virtual Visit	X	-BP, weight -FHR -pregnancy symptoms			
34-36*	**Provider Visit**		-BP, weight -FHR, FH -pregnancy symptoms	GBS screen	Presentation scan	-Signs of labor -Infant safety, infant care, parenting -Self-care postpartum -Confirm breastfeeding and family planning preferences *As appropriate:*

						Cesarean delivery education and consents
36-38**	Virtual Visit	X	-BP, weight -FHR, FH -pregnancy symptoms			
39	**Provider Visit**		-BP, weight -FHR -pregnancy symptoms -membrane sweep			Discuss patient preferences re: IOL, post-dates testing

*preferred at 36
**preferred at 38

HIGH-RISK PRENATAL CARE RECOMMENDATIONS:

- For high risk conditions, please place OB Care Coordination Note & plan for remaining prenatal visit frequency in problem list.
- Consult MFM if questions.

Preconception

Convert all to Virtual Care or Phone visit

[see Appendix A for full recommendations on preconception visits]

Antepartum

For the following isolated conditions, follow low-risk prenatal visit outpatient protocol.

1. Hypothyroidism on stable dose of levothyroxine.
2. Grave's disease on stable PTU or methimazole **and** with TSI in normal range. Consult MFM for transition from PTU to methimazole after 1st trimester.*
    a. Encourage home Doppler of FHR if available
    b. Check FH each visit
    c. Refer to MFM if concern for fetal tachycardia
3. Stable IBD (UC or Crohn's, oral meds only)*
4. Stable SLE (only requiring Plaquenil) with Rheumatology following closely*
5. Isolated obesity (BMI <50)*
6. Isolated structural fetal anomalies, e.g. cleft lip/palate, club feet, VSD, mild ventriculomegaly
    a. This excludes multiple anomalies, aneuploidy, gastroschisis, IUGR, major CHD, CPAM, CDH.
7. Recurrent early pregnancy loss with negative APLS workup
8. Alloimmunization with antibody titer <1:16 or confirmed negative paternal antigen status
    a. Exception: Titer 1:16 or greater, anti-Kell, or prior pregnancy affected by severe alloimmunization →refer to MFM
9. Well-controlled diabetes on oral or insulin therapy and reliably submits blood sugar data via patient portal*
10. Chronic hypertensions on no medication or on stable single anti-hypertensive agent. Must have home BP cuff*
11. Stable seizure disorder (no seizure >12 months, no recent medication changes)
12. Stable chronic Hepatitis B or C
13. ITP with stable platelets – combine CBC with PNV
14. Stable MS*
15. History of IUFD in prior pregnancy, without recurring etiology*
16. Uncomplicated dichorionic twins with concordant growth

*Check 3rd trimester EFW

*As recommended by MFM or based on antenatal testing guidelines, additional FDC US/testing may be scheduled but do **not** need to be combined with prenatal visits.

For the following isolated conditions, follow a modified outpatient prenatal visit schedule:

1. History of spontaneous preterm birth
    a. Convert to 17OHP to home injections if possible or continue weekly RN-only visits
    b. 16, 18, 22 weeks – in-clinic provider TVCL, 20 weeks TVCL with anatomy survey
    c. Then move to monthly prenatal visits
2. All other high-risk conditions (eg poorly controlled diabetes, HIV, spinal cord injury/quadriplegic, complex maternal disease(s), chronic kidney disease, active substance use disorder and/or on MAT)
    a. at least monthly visits or
    b. as per consultation with MFM for individualized plan

The following conditions must be seen by MFM**

1. Uncontrolled thyroid disease

2. Diabetes requiring postpartum medication adjustment. Utilize portal as possible for remote adjustment
3. Substance use disorders
4. Thrombophilia or APLS, on anticoagulation
5. Maternal cardiac disease
6. Chronic kidney disease
7. Complex/multiple diseases

**Arrange postpartum hand-offs to PCPs or other specialists for management of certain medications, e.g. insulin, anticoagulation

Align FDC visits as much as possible with clinic visits. If clinic visit allows for performance of FDC services, consider combining scheduled clinic encounters with as many services as possible using this workflow:

1. In-clinic EFW, AFI, check fetal presentation
2. Print images
3. Scan to patient chart via Haiku or HITS
4. If billing for your ultrasound, ensure a result note within your clinic encounter

To limit unnecessary clinic visits for patients undergoing antenatal testing: check VS including BP for patients coming for NSTs.

ANTENATAL TESTING RECOMMENDATIONS:

Condition	Start testing at:	Frequency
Advanced maternal age (age 36 at EDD)	36 weeks	FKC if nl 3rd trimester EFW
Amniotic Fluid Volume		
Oligohydramnios (AFI<5 or MVP <2)	Time of Diagnosis	2x/week
Aneuploidy	32 weeks	1x/week
eg Trisomy 21, with trial of therapy planned (per MFM/NICU consult)		
Coagulopathies		
Thrombophilia on LMWH/UFH	32 weeks	FKC if nl 3rd trimester EFW
Antiphospholipid Antibody Syndrome	32 weeks	1x/week
Cholestasis		
Bile acids <40	32 weeks	FKC
Bile acids >40	32 weeks	1x/week with AFI
Diabetes		
Pregestational Diabetes	32 weeks	2x/week (AFI 1x/week)
Gestational Diabetes		
Diet-controlled	40 weeks	FKC
Oral Meds/Insulin- well controlled	32 weeks	1x/week with AFI
Any meds - poorly controlled	32 weeks	2x/week (AFI 1x/week)
Gastroschisis	32 weeks	2x/week (AFI 1x/week)
Hypertension		
Chronic Hypertension		
Not on meds	32 weeks	FKC if nl 3rd trimester EFW
On meds	32 weeks	1x/week with AFI if nl 3rd trimester EFW
Gestational Hypertension, mild Pre-Eclampsia with nl EFW/AFI	Time of Diagnosis	2x/week (AFI 1x/week)
IUGR		
EFW between 5-10%, nl Dopplers	Time of Diagnosis	1x/week
EFW </=5% or with abnormal Dopplers	Time of Diagnosis	2x/week
Maternal Conditions *requiring meds or flare or conditions*		
e.g. SLE, CKD, Grave's, IBD, Cyanotic Heart Disease, Hemoglobinopathy	32 weeks	2x/week (AFI 1x/week)
Obesity, BMI >40	36 weeks	FKC if nl 3rd trimester EFW
Post-Dates		
41-42 weeks	41 weeks	2x/week (AFI 1x/week)
42 weeks and beyond	42 weeks	Every other day
Previous IUFD	32 weeks or per MFM consult	1x/week with AFI if nl 3rd trimester EFW
PPROM	Time of diagnosis	1x/day
Substance Abuse (Active or on MAT)	32 weeks	1x/week with AFI if nl 3rd trimester EFW
Twins		
Di-Di, concordant growth	36 weeks	FKC if nl EFW in last 4 weeks
Di-Di, discordant growth	32 weeks	2x/week
Mo-Di, concordant growth	32 weeks	2x/week
Mo-Di, discordant growth	30 weeks	Per MFM consult
Mo-Mo	Timing TBD after MFM/Neo consults	3x/day (inpatient), 1x/day (outpatient)
Triplets	Per MFM consult	2x/week

POSTPARTUM CARE RECOMMENDATIONS:

Visit type:	Timing	In-person vs. virtual	Notes:
Vaginal delivery	4-8w	Virtual	
Cesarean delivery	4-8w	Virtual, video preferred	Incision check can be done through photo if video not available
Higher-order perineal laceration	2w 4-8w	In-person Virtual	
Depression	2w 4-8w	Virtual Virtual	
gHTN, PEC, cHTN, no meds	1-2w 4-8w	Call Virtual	Patient encouraged to check BP at newborn visit
gHTN, PEC, cHTN, on meds	**1w** **2w** **4-8w**	**Call** **Call** **Virtual**	**Meds to be titrated w/ on-call virtual MFM**
Desires PP LARC **Received PP IUD**	4-8w **4-8w**	In-person **In-person**	Per provider discretion **Per provider discretion**
Others	4-8w	Virtual preferred	Provider discretion

Providers should follow usual postpartum visit template.

EPDS should be completed verbally with patient until available to be pushed through portal

OB Actions→ Screenings→ EPDS

Appendix A: Recommendations for Preconception Care

-Review related medical records and document chief complaint (rationale for preconception referral)
-Review allergies, discuss medications including potential teratogens and advise PNV+folate as indicated
-Encourage remaining upt-to-date on immunizations
-Review family and genetic history – discuss carrier/ethnicity-based screening
-Review diet/exercise, wellness
-Discuss risk factor reduction: smoking, alcohol, substance use, environmental exposures and review fetal risks (eg optimal blood sugar control in diabetes)
-Avoid zika-exposure (https://wwwnc.cdc.gov/travel/page/zika-guide-for-travelers-infographic).
-Advise that we currently lack information on risk to pregnancies due to COVID-19. ASRM recommends not initiating IVF cycles until we know more, but we do not recommend termination of pregnancy if there has been COVID-19 exposure. Follow CDC guidelines on hand-washing, avoiding touching face, social distancing, avoid sick contacts, etc (https://www.cdc.gov/coronavirus/2019-ncov/prepare/pregnancy-breastfeeding.html)
-**Ensure timely access to contraception,** especially avoid an unplanned pregnancy in a high-risk individual (eg maternal cardiac disease, teratogenic medications) or if there is pertinent testing that is pending which will affect pregnancy (eg parental genetic testing).

APPENDIX B: DOCUMENTATION FOR PRENATAL CARE

Dot phrases for scheduling (can be searched under Peahl starting 3-23):
.COVIDPRENATALPLAN
To be used in message sent to Clinical Pools for rescheduling.

I have reviewed this patient's chart to assess for prenatal care needs during the COVID-19 Pandemic.

[Name] is a [AGE] year-old [Gravida, Para] at [gestational age] with pregnancy complicated by:
[Problem list]
Create/Convert her prenatal visits into the following revised prenatal care schedule:
*appointment length per ACU standard
16-20 weeks: virtual
19-21 weeks: anatomy scan
24-28 weeks: virtual
28-30 weeks: provider visit
30-32 weeks: virtual visit
34-36 weeks: provider visit
36-38 weeks: virtual visit
39 weeks: provider visit (only if not planning cesarean)
***modify if different schedule desired
She will need additional testing with:
NST [weekly/twice weekly] starting at [free text] week
Modified BPP [weekly/twice weekly] starting at [free text] week
BPP [weekly/twice weekly] starting at [free text] week
She will also need additional laboratory testing including: [free text] at [free text]

For prenatal care documentation:
1. **Please ensure the problem list is up to date**
2. **Use the pink sticky for social notes**
3. **Use care coordination plans for patients with complicated pregnancy/delivery needs**

Dot phrases for prenatal appointments:

Visit	Visit Type	Available Documentation
Intake	Nurse Call	.PNCPRENATALINTAKE*
8-12	**Provider Visit**	**.**INITIALOB*
16-20	Virtual Visit	.PNCVIRTUALOB16-20
19-21w	FDC	
24-28	Virtual Visit	.PNCVIRTUALOB24-28
28-30	**Provider Visit**	.PNCVISITOB28-30
30-32	Virtual Visit	.PNCVIRTUALOB30-32
34-36	**Provider Visit**	.PNCVISITOB34-36
36-38	Virtual Visit	.PNCVIRTUALOB36-38
39	**Provider Visit**	.PNCVISITOB39

*please use existing templates for these prenatal visits.
-BP, weight, and FHR to be documented in prenatal visit tab
-contractions, fetal movement, vaginal bleeding, loss of fluid to be documented in prenatal visit tab

.PNCVIRTUALOB16-20
[Name] is a [AGE] year-old [Gravida, Para] at [gestational age] with pregnancy complicated by:
[Problem list]
Seen today via: virtual visit (Phone/Skype/Video Visit)

BP/FHT/Weight obtained via patient device and recorded in prenatal tab, all questions answered on device use
Anatomy scan scheduled for: [Date]
Education provided on:
-Physical/emotional changes in pregnancy
-Signs of complications (preeclampsia, preterm labor)
-Exercise
-Safe sex
-Managing work
-Seatbelt use
Next appointment: virtual, 24-28 weeks

.PNCVIRTUALOB24-28
[Name] is a [AGE] year-old [Gravida, Para] at [gestational age] with pregnancy complicated by:
[Problem list]
Seen today via: virtual visit (Phone/Skype/Video Visit)
Prenatal Care:
-BP/FHT/Weight obtained via patient device and recorded in prenatal tab, all questions answered on device use
-Anatomy scan reviewed: [no concerns/reviewed abnormal findings]
Education provided on:
-Childbirth classes/directions to birth center
-Parenting/ breastfeeding classes
-Trauma in pregnancy
-diet/nutrition
-need for Diabetic Screen, CBC [Type and Screen if Rh negative] with next appointment
-BLTL consents
As appropriate:
-VBAC/TOLAC

.**PNCVISITOB28-30**
[Name] is a [AGE] year-old [Gravida, Para] at [gestational age] with pregnancy complicated by:
[Problem list]
Seen today via in-person visit
Prenatal Care:
-BP/FHT/Weight obtained in clinic, all questions answered on device use and patient instruction provided
-Diabetic screen, CBC completed [Type and Screen if Rh negative] completed today
-Tdap administered [Rhogam administered if Rh negative]
Education provided on:
-L&D anticipatory guidance
-Newborn provider and car seat
-Family planning

.PNCVIRTUALOB30-32
[Name] is a [AGE] year-old [Gravida, Para] at [gestational age] with pregnancy complicated by:
[Problem list]
Seen today via: virtual visit (Phone/Skype/Video Visit)
Prenatal Care:
-BP/FHT/Weight obtained via patient device and recorded in prenatal tab, all questions answered on device use
-Diabetic Screen reviewed: [no concerns/reviewed abnormal findings and referral]
-CBC reviewed: [no concerns/reviewed abnormal findings and need for Fe]
Education provided on:
-any patient questions

.PNCVISITOB34-36

[Name] is a [AGE] year-old [Gravida, Para] at [gestational age] with pregnancy complicated by:
[Problem list]

Seen today via in-person visit

Prenatal Care:

-BP/FHT/Weight obtained in clinic, all questions answered on device use and patient instruction provided
-GBS swab collected
-Presentation scan completed, [vertex/breech] by US ***if breech, offered ECV/scheduled CD

Education provided on:

-Signs of labor
-Infant safety, infant care, parenting
-Self-care postpartum
-Confirm breastfeeding and family planning preferences
As appropriate:
Cesarean delivery education and consents

.PNCVIRTUALOB36-38

[Name] is a [AGE] year-old [Gravida, Para] at [gestational age] with pregnancy complicated by:
[Problem list]

Seen today via: virtual visit (Phone/Skype/Video Visit)

Prenatal Care:

-BP/FHT/Weight obtained via patient device and recorded in prenatal tab, all questions answered on device use
-GBS Screen reviewed: [no concerns/reviewed need for antibiotics in labor]

Education provided on:

-any patient questions

.PNCVISITOB39 (only for patients not planning cesarean delivery)

[Name] is a [AGE] year-old [Gravida, Para] at [gestational age] with pregnancy complicated by:
[Problem list]

Seen today via in-person visit

Prenatal Care:

-BP/FHT/Weight obtained in clinic, all questions answered on device use and patient instruction provided
-cervical check performed, ***membrane sweep completed

Education provided on:

-patient preferences regarding IOL & post-dates testing
-Patient to call if not delivered by 40’6 for post-dates testing

We have developed strategies to deliver safe prenatal care for pregnant patients during the COVID-19 pandemic

Reduce in-person visits to 5:

Initial OB
28 weeks
Anatomy Scan
36 weeks
39 weeks

By clustering care around:

Exams

Labs & Injections

Imaging

Maximize support using telemedicine:

Video visits where possible

Phone visits as an alternative

Supported by remote monitoring:

1. Blood Pressure
2. Fetal Heart Tones
3. Weight

Use strict precautions when in-person contact is necessary

Wait in the car

Reduce contact with symptomatic patients

See CDC guidelines!

Alex Friedman Peahl, MD

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

FACILITY 2

COVID-19 LOW-RISK PRENATAL CARE VISIT GUIDELINES

COVID-19 Low risk Prenatal Care Visit Guidelines

In an effort to adhere to practices of social distancing while balancing maternal and fetal safety during the COVID-19 outbreak, we have assembled this suggested obstetric visit schedule. Below is a brief description of who this may or may not apply to regarding patient co-morbidities. As always, provider discretion should apply as well.

Gestational Age	Proposed visit	Tests	Explanation
8-10 weeks	Viability ultrasound New to nurse visit New OB provider visit		
12-13 weeks		*First trimester screen *Genetic counseling	
18-20 weeks	Return OB provider visit	Anatomy ultrasound	
24-26 weeks	Return OB provider visit [a]		Schedule 6 weeks from prior visit
28-30 weeks	Return OB provider visit	3rd trimester labs, TDAP vaccine	
32-34 weeks	Return OB provider visit [a]		Schedule 4 weeks from prior visit
36 weeks	Return OB provider visit	GBS screen	
≥37 until delivery	Weekly Return OB provider visits		
Postpartum	1 week mood check [a, b]		

*as desired/indicated

[a] Consider doing as telehealth if available

[b] Telephone visit appropriate

Acceptable to use this schedule

- No medical complications
- Hypothyroidism
- Tobacco, THC use
- Prior cesarean
- Advance maternal age less than 40
- Pregnancy result of assisted reproductive techniques
- Anxiety / depression (with increased phone checks)
- Obesity BMI between less than 40

Consider using above MD visit schedule – but use usual ultrasound schedules

- Twins
- Marginal or velamentous cord insertion
- Obesity with BMI>40

FACILITY 3

TEMPORARY PROTOCOL FOR OUTPATIENT OB VISITS DURING THE COVID-19 OUTBREAK

Massachusetts General Hospital

Temporary Protocol for Outpatient OB Visits During the COVID-19 Outbreak (V2.4, March 18, 2020)

Low Risk Patients
Definition: all patients that do not fit into intermediate or high risk category

Essential Visits:

- Initial Visit-ideally around 11-12 weeks gestation with genetic screening US labs if desired
- 20 weeks with fetal anatomic survey (*For health center patients, consider a telemedicine visit rather than having them come to both the US and the health center if appropriate)
- 26 weeks with GLT and /3\ labs, TDAP
- 32 weeks
- 35 weeks
- 37 weeks with GBS
- 39 weeks, and weekly from that time

Intermediate Risk Patients (same as low risk for the time being):
Definition: HTN not on meds, GDM or Pregestational Diabetes not on meds, AMA >40, BMI > 30, routine di/di twin pregnancies

- Initial Visit-ideally around 11-12 weeks gestation with genetic screening US labs if desired
- 20 weeks with fetal anatomic survey
- 26 weeks with GLT and /3\ labs, TDAP
- 32 weeks
- 35 weeks
- 37 weeks with GBS
- 39 weeks, and weekly from that time

High Risk Patients:
Definition: HTN on meds, Preeclampsia or gestational HTN, Pregestational Diabetes or GDM on meds, monochorionic twins and higher level multiples, other complex maternal or fetal comorbidities, patients that we recommend weekly testing (see modified antenatal testing guidelines below)
At the discretion of the provider. Consult MFM for any questions.
Consider this as a potential guide:

- Initial Visit-ideally around 11-12 weeks gestation with genetic screening US labs if desired
- 20 weeks with fetal anatomic survey
- 26 weeks with GLT and /3\ labs, TDAP
- 32 weeks
- 34 weeks
- 36 weeks with GBS
- And then weekly

Other Visit Types:

- Lactation: assess on a case by case basis and move to virtual for appropriate visits once available. Can also increase referrals to community providers/Zipmilk as possible
- Nutrition: phone visits
- MFM preconception consults: will be moved to telemedicine, virtual when possible
- MFM consults for pregnant patients: Please utilize MFM e consults as much as possible, will do phone if appropriate and will move to virtual once we have capabilities
- Genetic counseling: Phone as of 3/19, will be virtual when possible
- Routine Postpartum Visits: Patients delivering now will be deferred until 8-10 weeks postpartum at a minimum, can consider deferring indefinitely for the time being
- Incision Checks: still considered essential to see in person visit
- Moods Checks: can be a telephone check in vs. virtual visit once available but in some cases in person may be essential to see in person
- BP Checks: still considered essential to see in person at this point- can work to provide BP cuffs at discharge and try to move these to virtual visits

Other Important Points:

- Please encourage patients to do kick counts
- Antenatal testing guidelines- to be updated as below- discuss with MFM if you have questions.
- Problem visits are of course considered essential but triaging these calls appropriately over the phone will be of utmost importance

Change to US indications:

- Try to schedule US to coincide with another visit.
- Limit dating/viability scans to those who have not had a prior scan, with bleeding, other risk factors, or truly uncertain dates.
- 1st trimester scan in the setting of cfDNA: Ideally will be scheduled with an OB appointment and blood draw at between 11 and 13 weeks to minimize visits.
- Schedule Anatomy US at 20 weeks.
- For US for EFW, for most low and intermediate risk patients can start at 32 weeks.
- TVUS for cervical length at the time of the fetal anatomic survey only unless prior preterm birth less than 32 weeks.

Antenatal testing guidelines – please note that both gestational age and frequency may have been modified.

Indication	When to Start	Frequency/Type of Test	Notes
Preeclampsia	When diagnosed	2X/Wk: NST, BPP	
Fetal Growth Restriction	When diagnosed	2X/Wk: NST, BPP, Wkly Doppler	Weekly testing if < 32 weeks
Twin Gestation (mono/di)	32 weeks	Weekly BPP if reassuring, concordant growth, normal fluid. 2x weekly if does not meet any of those criteria	Q2 wk u/s TTTS 18-28 weeks
Diabetes (on meds, well controlled)	32 weeks	Weekly BPP	No need to test diet controlled. T1DM or control may consider increased frequency
Autoimmune Disease	36 weeks	Weekly BPP	Earlier depending on disease, disease control, and end organ involvement
Cholestasis	When diagnosed	Weekly BPP to 34 weeks, 2x weekly testing at 34 weeks	
Chronic Abruption	When diagnosed	Weekly BPP if no active bleeding	
Twin Gestation (di/di)	36 weeks	Weekly BPP	Consider earlier/more frequent if complicated discordant growth
Prior Stillbirth	36 weeks or 2 weeks before the GA of the stillbirth, whichever is earlier	Weekly BPP	Can be modified for very early stillbirth (i.e. prior to 28 weeks do not need to start at 26 weeks) depending on particular patient circumstances and comorbidities
Chronic HTN on Meds	32 weeks	Weekly BPP	provided fluid and growth is normal
Post Dates	41 0/7 to 42	Weekly BPP	Scheduling may dictate earlier
BMI over 40	36 weeks	Weekly BPP	Starting BMI
AMA over 40	36 weeks	Weekly BPP	
Low Serum Analytes			
PAPP-A < 5th %'ile			Ultrasound for EFW at 32-34 wks
HCG < 1st %'ile			Ultrasound for EFW at 32-34 wks
PAPP-A < 1st %'ile	36 weeks if normally	Weekly BPP	U/S at 32, 36 weeks for growth

	grown		
Elevated MSAFP	36 weeks if normally grown	Weekly BPP	U/S at 32, 36 weeks for growth

FACILITY 4

SUGGESTED TIMELINE FOR ROUTINE PRENATAL CARE DURING THE COVID-19 PANDEMIC

Suggested Timeline for Routine Prenatal Care During the COVID-19 Pandemic*

Gestational Age	Visit Type	Care Provided	
1-10 weeks	Telehealth Visit	Introduction to practice / care model ROS (labs, imaging, Rx as needed) Individualized pregnancy education and counseling When applicable, discussion of influenza vaccination → referral to local pharmacy for administration	
11-13 weeks	In-person Visit	Viability / Dating / NT scan ROS + Physical exam Discussion of aneuploidy screening vs diagnostic testing Intake labs Individualized education and counseling	
13-18 weeks	Telehealth Visit or MD/RN call	Lab review	
18-22 weeks	In-person Visit	ROS, BP, Weight, +/- exam Anatomy scan with cervical length Individualized education and counseling	
26-29 weeks	In-person Visit	ROS, BP, Weight, +/- exam Growth scan (+ F/U anatomy if not done prior) 3rd tri labs TDaP Rhogam (if indicated) Mid-pregnancy education + individualized education and counseling	
32-34 weeks	In-person Visit (MULTIPLES ONLY)	ROS, BP, Weight, +/- exam Growth scan Late-pregnancy education + individualized education and counseling	*May do US-only if patient can home BP monitor*
35-36 weeks	In-person Visit	ROS, BP, Weight, +/- exam Growth scan GBS Term-preg education + individualized education and counseling	
37 weeks	In-person Visit	Weekly visits with ROS, BP, Weight, +/- exam Term-preg education Individualized education and counseling	*May be every other week and / or telehealth visit if patient*
38 weeks	In-person Visit		
39 weeks	In-person Visit		

40 weeks	In-person Visit	*nas home BP monitor*
41+ weeks	In-person Visit	Twice-weekly visit for ROS, BP, Weight, +/- exam Antenatal testing
1-2 weeks PP	Telehealth visit	May be scheduled at the discretion of the provider (ie depression screen, incision check, BP review)
6-8 weeks PP	Telehealth visit	ROS Lab requisition as needed Individualized education and counseling re: PP care and future pregnancy

Prenatal Consult (Initial or F/U / Co-Mgt)	TBD	Need for in-person vs telehealth visit TBD by consulting MFM
Preconception	Telehealth visit	

* This schedule is presented as a suggested approach to providing outpatient prenatal care; is not meant to be restrictive and providers may schedule additional visits (in person or telehealth) and / or increase testing at their discretion based on individual scenarios.