



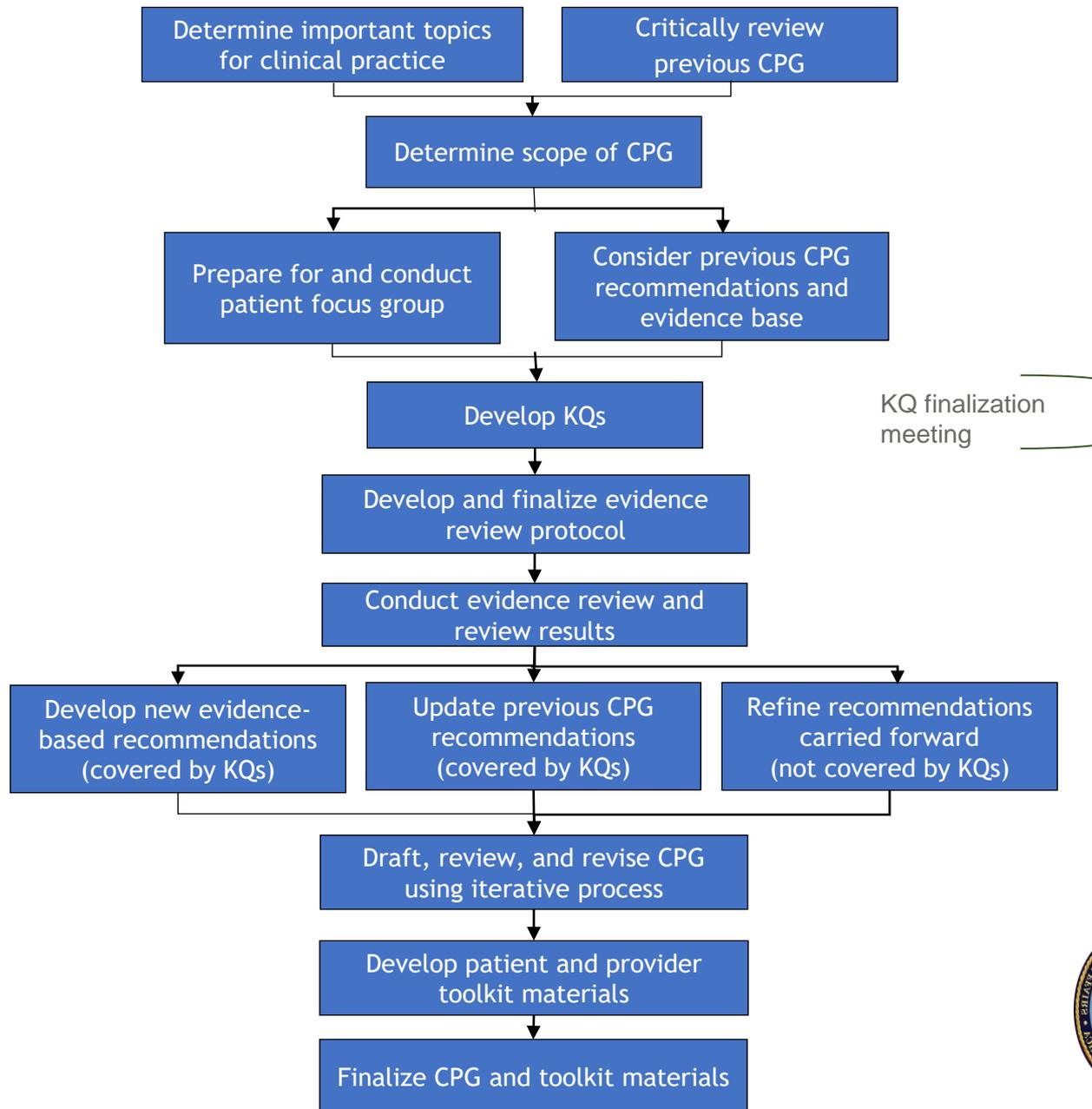
VA/DoD Clinical Practice Guideline for the Management of Pregnancy

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Overview of CPG Development Process



Grading Recommendations - GRADE

Evidence-based clinical practice recommendations were developed based on the:

- Evidence review, which was informed by 12 key questions
 - GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology and use of four decision domains to determine strength (*Strong* or *Weak*) and direction (*For* or *Against*) of each recommendation:
 - Confidence in the quality of evidence
 - Balance of desirable and undesirable outcomes
 - Patient values and preferences
 - Other implications (e.g., equity, resource use)
-

Strength of a Recommendation

Strength of a recommendation on a continuum:

- **Strong for** (or “*We recommend...*”)
 - **Weak for** (or “*We suggest...*”)
 - **Neither for nor against** (or “*There is insufficient evidence...*”)
 - **Weak against** (or “*We suggest against...*”)
 - **Strong against** (or “*We recommend against...*”)
-

Categorizing Recommendations

Recommendation Categories and Definitions^a

Evidence Reviewed	Recommendation Category	Definition
Reviewed ^b	New-added	New recommendation
	New-replaced	Recommendation from previous CPG was carried forward and revised
	Not changed	Recommendation from previous CPG was carried forward but not changed
	Amended	Recommendation from previous CPG was carried forward with a nominal change
	Deleted	Recommendation from previous CPG was deleted
Not reviewed ^c	Not changed	Recommendation from previous CPG was carried forward but not changed
	Amended	Recommendation from previous CPG was carried forward with a nominal change
	Deleted	Recommendation from previous CPG was deleted

^a Adapted from the NICE guideline manual (2012)¹ and Garcia et al. (2014).²

^b The topic of this recommendation was covered in the evidence review carried out as part of the development of the current CPG.

^c The topic of this recommendation was not covered in the evidence review carried out as part of the development of the current CPG.

¹National Institute for Health and Care Excellence: The guidelines manual. London: National Institute for Health and Care Excellence; 2012.

<https://www.nice.org.uk/process/pmg6/chapter/introduction>.

²Garcia LM, McFarlane E, Barnes S, et al. Updated recommendations: an assessment of NICE clinical guidelines. Implement Sci. Jun 2014;11;9:72.

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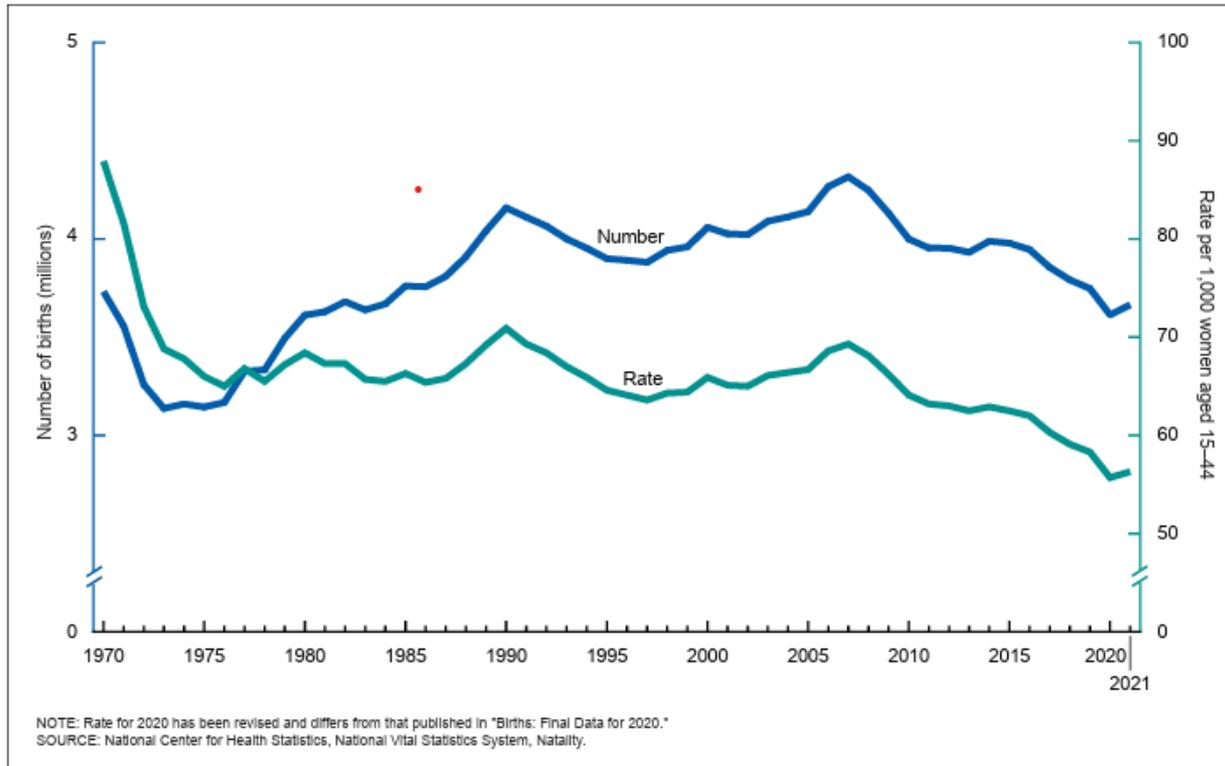
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Pregnancy trends in the United States

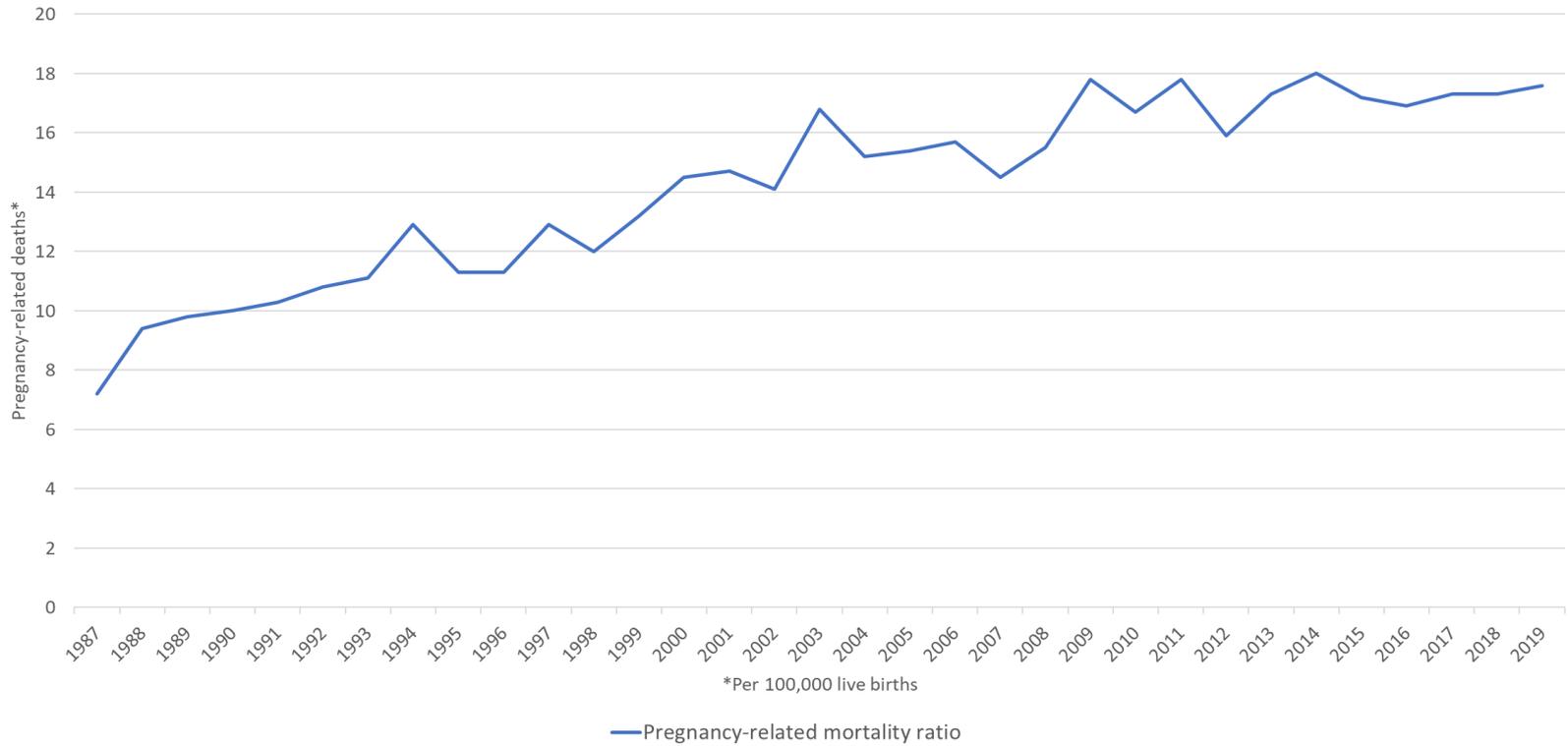
*Slides 8-22 drawn from slides developed by Sandra R. Schumacher PhD, WHNP - BC,
CNM and Sophia Hill-Smith MSN, RN*

Birth rates in the United States 1970-2021

Figure 1. Live births and general fertility rates: United States, 1970–2021



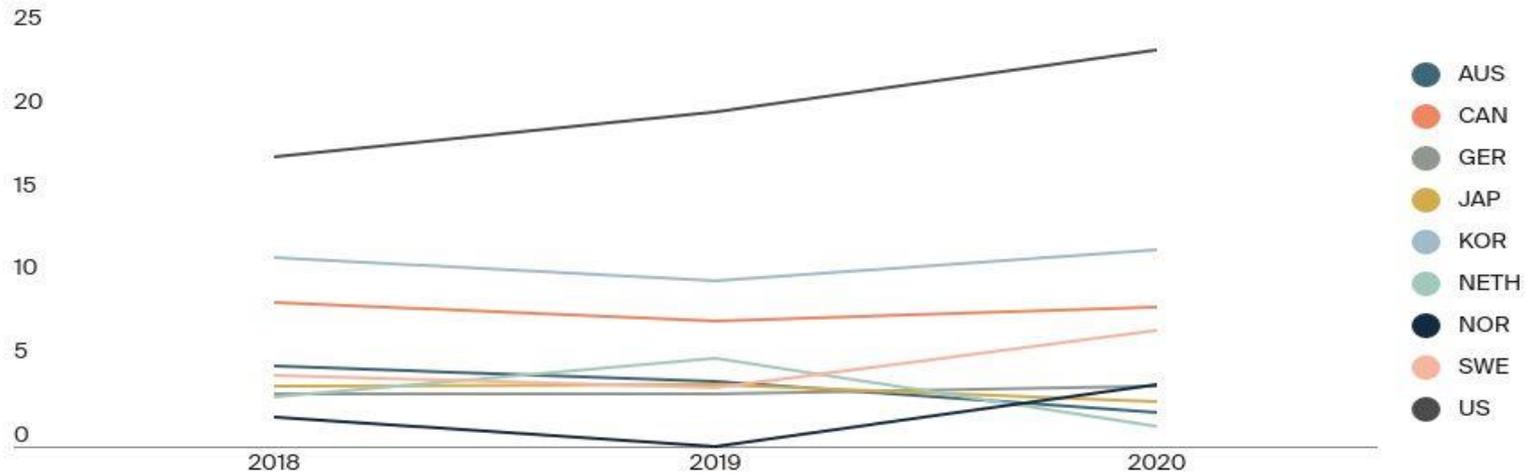
Trends in Pregnancy-Related Mortality in the United States: 1987-2019



Pregnancy Mortality Surveillance System | Maternal and Infant Health | CDC; Baeva S, Saxton DL, Ruggiero K, et al. Identifying maternal deaths in Texas using an enhanced method, 2012. *Obstet Gynecol.* 2018;131:762–769.

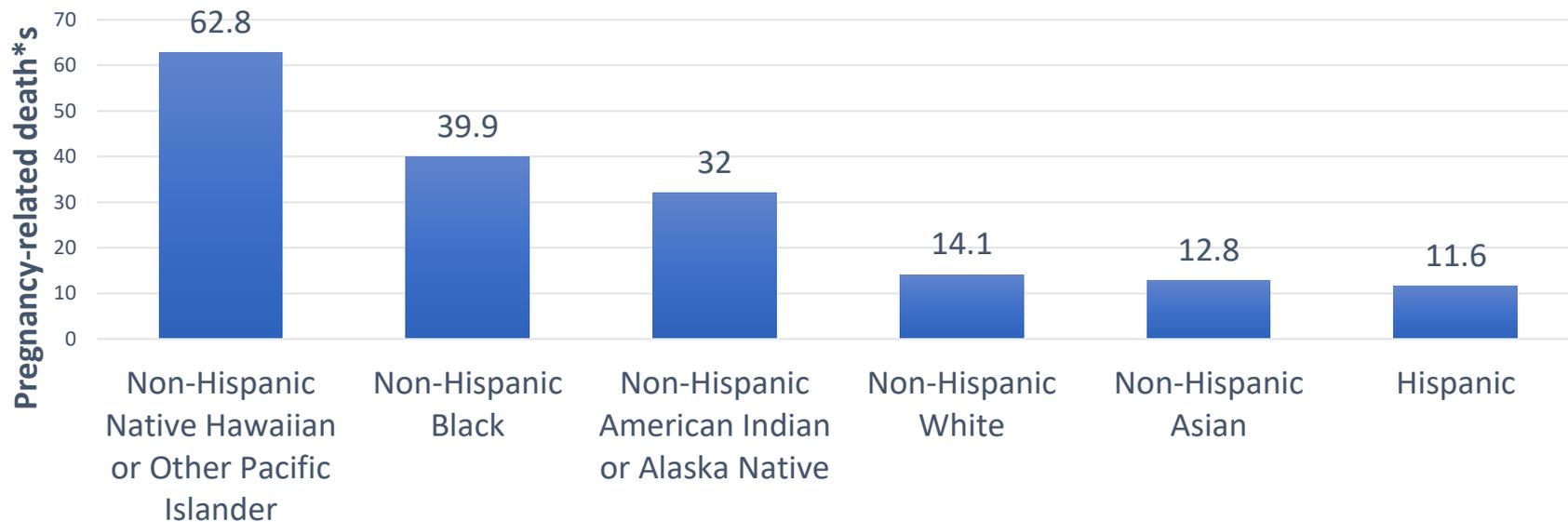
U.S. Maternal Mortality Rate Has Been Getting Worse over Time

Deaths per 100,000 live births



Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, "The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison," *To the Point (blog)*, Commonwealth Fund, Dec. 1, 2022. <https://doi.org/10.26099/8vem-fc65>; Data for all countries except US from OECD Health Statistics 2022. Data for US from Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2020* (National Center for Health Statistics, Feb. 2022).; [U.S. Maternal Mortality Crisis Continues to Worsen | Commonwealth Fund](#)

Pregnancy-Related Mortality Ratio by Race/Ethnicity: 2017-2019



*Per 100,000 live births
■ Pregnancy-related mortality...

Pregnancy Mortality Surveillance System | Maternal and Infant Health | CDC; Petersen EE, Davis NL, Goodman D, et al. Racial/ethnic disparities in pregnancy-related deaths— United States, 2007–2016. MMWR Morb Mortal Wkly Rep. 2019;68:762–765; Petersen EE, Davis NL, Goodman D, Cox S, Mayes N, Johnston E, Syverson C, Seed K, Shapiro-Mendoza CK, Callaghan WM, Barfield W. Vital signs: Pregnancy-related deaths, United States, 2011–2015, and strategies for prevention, 13 states, 2013–2017. MMWR Morb Mortal Wkly Rep. 2019;68:423–429.

Rurality and Access to Care

- Rural residents have a 9 percent greater probability of severe maternal morbidity and mortality, compared with urban residents
- Variability in the risk of death by geographic location groups might reflect chronic health conditions and access to care (e.g., rural residents may face challenges such as distance from and lack of access to obstetric services and providers) including risk-appropriate care
- Over the past decade, the U.S. has seen an increase in obstetric unit closures in hospitals, leaving over 55% of rural counties without hospital-based maternity services
- The loss is most prominent in rural communities with a high proportion of Black residents

Kozhimannil, K. B., Interrante, J. D., Henning-Smith, C., & Admon, L. K. (2019). Rural-urban differences in severe maternal morbidity and mortality in the US, 2007-15. *Health Affairs (Project Hope)*, 38(12), 2077-2; Kozhimannil KB, Interrante JD, Tuttle MKS, Henning-Smith C. Changes in Hospital-Based Obstetric Services in Rural US Counties, 2014-2018. *JAMA*. 2020;324(2):197–199. doi:10.1001/jama.2020.5662085. doi:http://dx.doi.org/10.1377/hlthaff.2019.0080; Taylor, J., Novoa, C., Hamm, K., & Phadke, S. (2019). (rep.). *Eliminating Racial Disparities in Maternal and Infant Mortality* (p. 1). Center for American Progress; Interrante JD, Admon LK, Tuttle MS, Ibrahim BB, Kozhimannil KB. Rural and Urban Hospital Characteristics by Obstetric Service Provision Status, 2010-2018.; 2021:8. <https://rhrc.umn.edu/publication/rural-and-urban-hospital-characteristics-by-obstetric-service-provision-status-2010-2018>; *Maternal & Child Health | HRSA Data Warehouse*

Key Points

- Pregnancy-related deaths are increasing in the United States
- Uncertain reasons . . .
- People at increased risk for pregnancy-related death include:
 - Older maternal age at delivery
 - Live in a rural area
 - Existing medical conditions (e.g., hypertension, chronic cardiovascular disease)
 - Race/ethnicity (e.g., Black, Native American) due to structural racism
 - COVID-19

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Pregnancy in the DOD population

Pregnancy Statistics in DOD (2015-2021)

- Active Duty Service members – 95,534 live births
 - Highest in 2020 – 13,854
 - Lowest in 2021 – 12,841
 - 67.6% (63,906) – delivered in an MTF
- Dependents – 562,318 live births
 - 89,326 in 2015 to 71,900 in 2021
 - 20% decrease in live births for dependents
 - 32.9% (185,000) – delivered in an MTF

Source: Department of Defense Birth and Infant Health Research (BIHR) program: Select reproductive health outcomes, 2015-2021; BIHR response to data request, December 9, 2022.

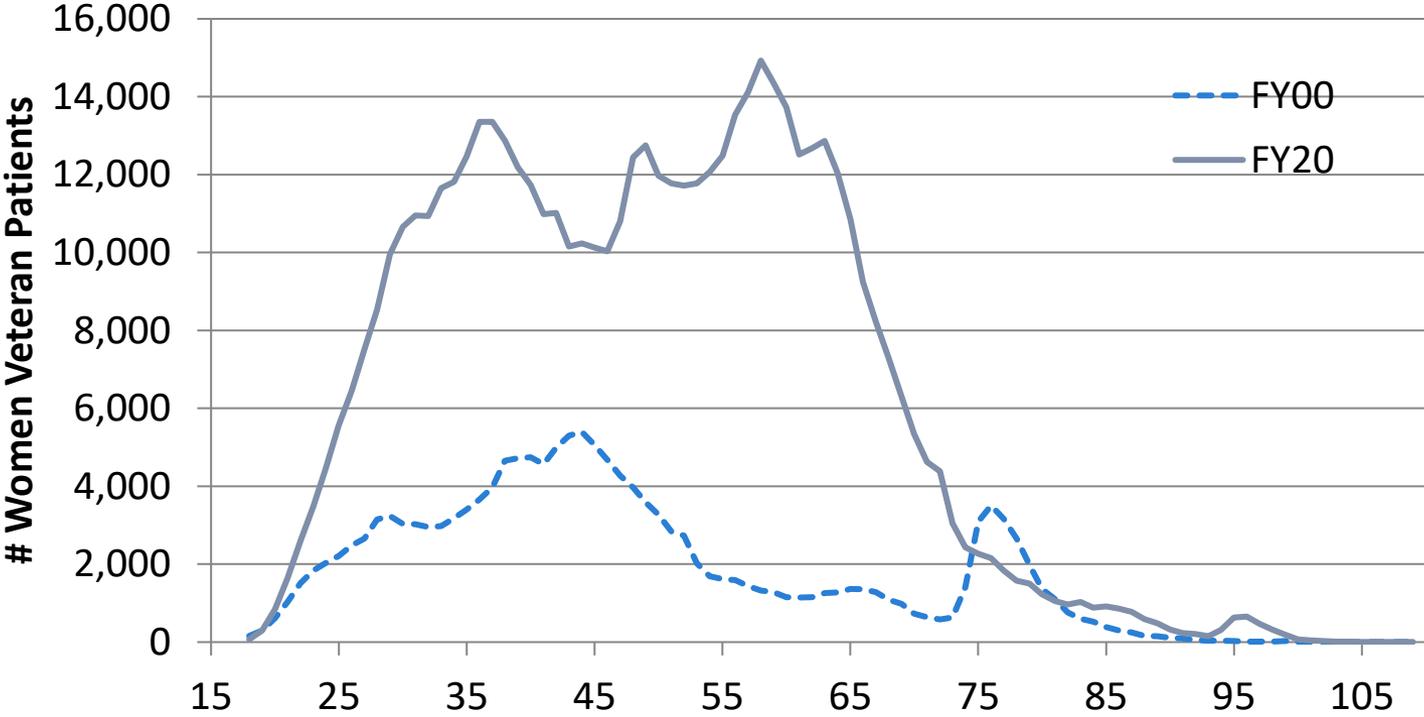
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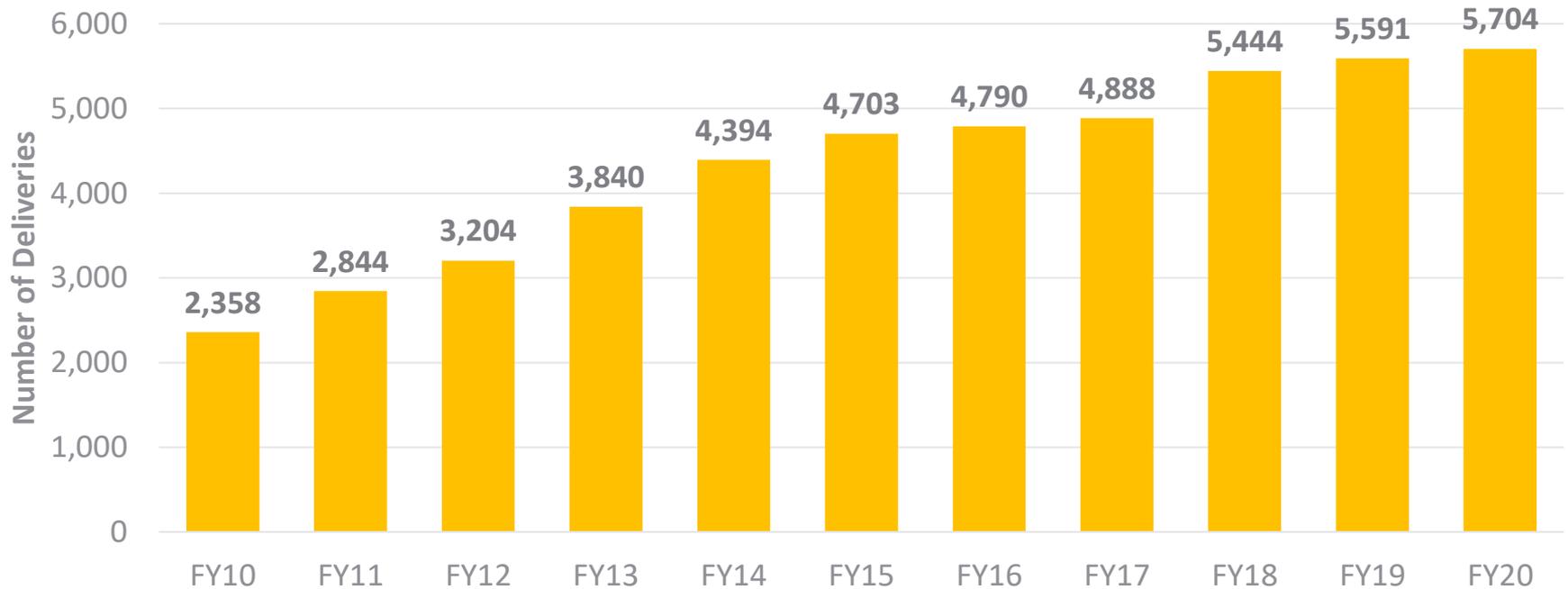
Pregnancy in the Veteran Population

Age Distribution Among Female Veteran VHA Patients, FY00 and FY20



Cohort: Women Veteran VHA patients with non-missing ages 18-110 years (inclusive) in FY00 and FY20. Women in FY00: N=159,553; FY20: N=557,967.
Source: WHEI Master Database, FY00-FY20

VHA-Covered Obstetric Deliveries among Female Veteran VHA Patients, FY2010-2020



Source: Phibbs, Frayne, Esmaeili, et al, WHEI, 2.26.2022

VHA Maternity Care Data

- Data for VHA Maternity Care has been challenging to capture

	FY21	FY22
New Pregnancies by VHA Users	11,412	12,583
VHA Covered Deliveries	5,904	6,327

- People at increased risk for pregnancy-related death include:
 - Older maternal age at delivery
 - Live in a rural area
 - Existing medical conditions (e.g., hypertension, chronic cardiovascular disease)
 - Race/ethnicity (e.g., Black, American Indian/Alaskan Native)

Veteran Maternal Health

- Veteran population has characteristics that put them at higher risk of severe maternal morbidity and mortality
- A higher proportion of female Veterans are Black (31%) than in the general population
- Characteristics of Veterans who use VA for maternity care:
 - Mental health comorbidities
 - Advanced maternal age
 - Hypertension



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2023 Pregnancy CPG Overview

2023 Pregnancy CPG Overview

- Update of the previous version of the CPG published in 2018
- Evidence used in the update published through June 1, 2022
- 28 evidence-based recommendations categorized into the following key areas

Routine Care

- Aneuploidy Screening
- Lactation
- Pelvic Floor Health
- Selected Conditions

Complicated Obstetrics

- Preterm Delivery
- Hypertensive Disorders
- Bariatric Surgery

Mental Health

- Screening for comorbidities
- Treatment

- Algorithm provides recommended interventions by weeks of gestation
 - Additional sections include Referral indications, Emerging Topics, and Research priorities
-

Scope of the Guideline

- Audience
 - VA and DoD providers and other providers involved in the care of pregnant patients
 - Community-based providers involved in the care of pregnant Service members, beneficiaries, or Veterans
 - Population
 - Pregnant patients who are eligible for care in the VA or DoD health care delivery systems and those who receive care from community-based clinicians
 - This includes Veterans, Service members, and their dependents
-

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Routine Obstetric Recommendations

Pelvic Floor Question

- In pregnant and postpartum patients, what is the effectiveness and comparative effectiveness of pelvic muscle physical therapy/training in patients during the pregnancy and postpartum period?

Recommendation		Strength ^a	Category ^b
Routine Care			
Selected Conditions			
Pelvic Floor Health			
5.	We suggest all patients have an early prenatal evaluation of pelvic floor muscle function and receive pelvic floor muscle exercise instruction during pregnancy for the prevention of urinary incontinence in late pregnancy and up to 6 months postpartum.	Weak for	Reviewed, New-added
6.	We suggest referral to pelvic health rehabilitation for patients with reported urinary incontinence in the postpartum period.	Weak for	Reviewed, New-added

Pelvic Floor Discussion

- Moderate evidence suggested that PFMT exercise initiated during early pregnancy (mixed prevention and treatment) reduced the prevalence of urinary incontinence for all patients in late pregnancy and up to 6 months postpartum
 - The Work Group's confidence in the quality of the evidence was low due to limitations.
 - Evidence indicated no significant reported harms or adverse outcomes associated with PFMT exercises in the reviewed studies.
 - The patient focus group findings cited desires for enhanced consideration of co-occurring health conditions and improved access to rehabilitation resources in the postpartum period. The benefits of supervised pelvic muscle training by a rehabilitation provider improved rates of urinary incontinence and QoL measure scores that outweighed the potential harms (no reported significant adverse outcomes) or burdens (increased health care use rates).
-

Lactation Questions

- In pregnant and postpartum patients, what factors impact initiating and continuing breastfeeding or lactation?
- In pregnant and postpartum patients, what is the effectiveness or comparative effectiveness of interventions that impact the probability of initiating and continuing breastfeeding or lactation?
 - Do outcomes differ for the following subpopulations: racial/ethnic minorities, rural, economically disadvantaged, Military/ Veterans?

Recommendation		Strength ^a	Category ^b
Routine Care			
Lactation			
3.	We suggest assessing all patients for risk factors that impact initiation and continuation of lactation, including obesity, depression, inappropriate gestational weight gain, and gestational diabetes mellitus.	Weak for	Reviewed, New-added
4.	We suggest individual or group lactation education delivered via in-person, telemedicine, or multimedia modalities be provided for all pregnant and postpartum patients to improve the probability of initiating and continuing lactation.	Weak for	Reviewed, New-replaced

Discussion of Risk Factors that Impact Lactation

- The evidence identified risk factors, such as obesity and overweight, depression and anxiety, metabolic dysfunction (GDM), and inappropriate gestational weight gain.
 - The work group's confidence in the quality of this evidence to be low to fair; however, the findings carry substantial weight and are very important to mention.
 - Providers should be aware of risk factors suspected to impact lactation. Bringing awareness to these risk factors enables the provider to help patients meet their individual goals.
 - Patients who present with these risk factors and desire to breastfeed might need additional support or referral to ensure lactation success.
-

Discussion of Lactation Interventions

- The evidence suggested that individual or group lactation education delivered via in-person, telehealth, or multimedia modalities increased the probability that pregnant and postpartum patients would initiate and continue lactation
 - Lactation education is provided and offered to patients in various ways. Lactation education differs immensely across clinical settings.
 - Lactation education should be tailored to the needs of the individual patient and the resources available in the community.
 - Overall, the benefits of individual and group lactation education on the probability of initiating and continuing lactation outweighed the potential harms.
-

Routine Obstetric Recommendations

- What is the impact of prenatal and postpartum care delivered through telemedicine on maternal and neonatal outcomes?
 - Do outcomes differ for the following subpopulations: racial/ethnic minorities, rural, economically disadvantaged, Military/ Veterans?
- What is the effectiveness of strategies to reduce healthcare/racial disparities in pregnancy and childbirth?

Recommendation		Strength ^a	Category ^b
Routine Care			
Selected Conditions			
9.	We suggest offering telemedicine as a complement to usual perinatal care.	Weak for	Reviewed, New-added
10.	There is insufficient evidence to recommend for or against specific interventions that would diminish disparities in perinatal care access and maternal and childbirth outcomes.	Neither for nor against	Reviewed, New-added

Telemedicine Discussion

- U.S. Department of Health and Human Services' definition of telemedicine, which broadly defines telemedicine as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care.
 - The workgroups quality of the evidence was low
 - The evidence suggested no difference between telemedicine and treatment as usual.
 - The patient focus group findings highlighted preferences for continuity of care and feelings that telemedicine might help provide continuity when FTF visits are difficult or impossible.
 - No Harms were reported
-

Routine Obstetric Recommendations

- Not Reviewed

Recommendation		Strength ^a	Category ^b
Routine Care			
Selected Conditions			
7.	We recommend offering scheduled delivery to patients who reach 41 weeks and 0/7 days undelivered. Antepartum fetal testing should begin at 41 weeks and 0/7 days if not delivered.	Strong for	Not reviewed, Amended
8.	We suggest that patients with uncomplicated pregnancies may continue a standard work schedule throughout their pregnancy.	Weak for	Not reviewed, Amended

Discussion on Selected Conditions

- Scheduled Delivery 41 weeks and antepartum testing
 - Although not part of the previous systematic evidence review from the 2018 VA/DoD Pregnancy CPG, subsequent studies continued to support the findings that induction of labor at 41 weeks is associated with a reduction in perinatal mortality and a reduction in rates of cesarean section.
 - Work Schedule for uncomplicated pregnancies
 - The benefits of this recommendation slightly outweighed the potential harms for patients with uncomplicated pregnancies. Patient values and preferences varied somewhat because some patients might need to work, although others might prefer to lessen work burden.
-

Routine Obstetric Recommendations

What is the comparative accuracy and safety of screening methods (including NIPT) used to screen for aneuploidy in pregnant patients?

Recommendation		Strength ^a	Category ^b
Routine Care			
Aneuploidy Screening			
1.	We recommend offering non-invasive prenatal testing as the prenatal screening test of choice for all patients with singleton pregnancies who choose aneuploidy screening.	Strong for	Reviewed, New-added
2.	We suggest non-invasive prenatal testing for patients with twin pregnancies who choose aneuploidy screening.	Weak for	Reviewed, New-added

^a See Determining Recommendation Strength and Direction section of the Pregnancy CPG for additional information.

^b See Recommendation Categorization section of the Pregnancy CPG for additional information.

Discussion of aneuploidy screening

- Evidence suggests that NIPT, with cell-free fetal deoxyribonucleic acid screening for aneuploidy, is a superior screening test for aneuploidy.
 - For patients who choose aneuploidy prenatal screening, the benefits of NIPT far outweigh the potential risks.
 - The Work Group's confidence in the quality of the evidence was moderate to low.
 - The benefits of NIPT for aneuploidy screening in singleton and, to a lesser extent, twin gestation because of superior test performance parameters outweighed the potential harm of anxiety associated with false positive testing.
 - Patient values and preferences varied somewhat because of differing preferences surrounding genetic testing.
-

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Knowledge Check

Audience Poll Question

Case Study: Emily



- 27 years old, G2 P1 at 13w4d
 - Relevant Health History:
 - Elevated blood pressure towards the end of first pregnancy
 - Preterm delivery at 34 weeks in her first pregnancy due to preterm labor
 - Anxiety, no medications
 - Thinks she may have had postpartum depression last pregnancy, but never sought help from her clinicians
 - Struggled with lactation in her first pregnancy, motivated to try again this time
-

Audience poll question

Based on our recommendations for lactation, which intervention would you suggest?

- A. Cognitive processing therapy
 - B. Individual group or lactation education and support
 - C. Interpersonal psychotherapy
 - D. Peer support
-

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Complicated Obstetrics

Clinical Practice Recommendations

Recommendation		Strength ^a	Category ^b
Complicated Obstetrics			
Preterm Delivery			
11.	We recommend considering fetal fibronectin testing as a part of the evaluation strategy in patients between 24 0/7 and 34 6/7 weeks' gestation with signs and symptoms of preterm labor, particularly in facilities where the result might affect management of delivery.	Strong for	Not reviewed, Amended
12.	We suggest vaginal progesterone or cerclage for singleton pregnancy with short cervix, history of spontaneous preterm birth, or both depending on patient characteristics and preferences.	Weak for	Reviewed, New-added
13.	There is insufficient evidence to recommend for or against the use of aspirin to reduce recurrent spontaneous preterm birth.	Neither for nor against	Reviewed, New-added

^a See Determining Recommendation Strength and Direction section of the Pregnancy CPG for additional information.

^b See Recommendation Categorization section of the Pregnancy CPG for additional information.

Preterm Delivery Recommendations Discussion

- Preterm birth history can be complex and the resulting counseling and management options are nuanced
- The removal of IM Progesterone from the US market results in 2 potential interventions – vaginal progesterone and cerclage – tailored to patient history, examination findings, and preferences
- Patients with a history of spontaneous preterm birth warrant consultation with an Obstetrician and/or Maternal Fetal Medicine Specialist
- Fetal fibronectin can be used as part of the evaluation of preterm labor symptoms
- There is no evidence to support the use of aspirin for spontaneous preterm birth prevention alone



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Knowledge Check

Audience Poll Question

Audience poll question

Recall that Emily has a history of spontaneous preterm birth at 33 weeks in a prior pregnancy.

Which of the following is the best plan of care based on Emily's history?

- A. Refer her to consultation with a high risk obstetric provider to discuss her history and the options of vaginal progesterone, cerclage, or both
 - B. Prescribe her aspirin solely based on her history of preterm birth
 - C. No special attention is needed to this history – routine care, unless she has preterm labor symptoms
 - D. Provide a follow-up appointment weekly
-

Clinical Practice Recommendations

Recommendation		Strength ^a	Category ^b
Complicated Obstetrics			
Hypertensive Disorders			
14.	We recommend initiating aspirin therapy at or before 16 weeks' gestation in patients at risk of developing preeclampsia.	Strong for	Reviewed, New-replaced
15.	We suggest low-dose aspirin of 100–150 mg daily for patients at risk of preeclampsia.	Weak for	Reviewed, New-replaced
16.	We suggest patients with cardiometabolic disorders (e.g., gestational diabetes mellitus, hypertension, and obesity) be counseled on the benefits of following the Dietary Approaches to Stop Hypertension diet.	Weak for	Reviewed, New-added
17.	There is insufficient evidence to recommend for or against self-monitoring for blood pressure during pregnancy and the postpartum period.	Neither for nor against	Reviewed, New-added

^a See Determining Recommendation Strength and Direction section of the Pregnancy CPG for additional information.

^b See Recommendation Categorization section of the Pregnancy CPG for additional information.

Hypertensive Disorders of Pregnancy Discussion

- Prenatal aspirin is an evidence based intervention to reduce risk of developing preeclampsia in patients with risk factors
- Initiation before 16 weeks has proven to have the greatest efficacy
- Common dose in the US is 81 mg (baby ASA)
 - Doses >100 mg seem to be more effective in preventing preeclampsia without an increase in the number of adverse events
- Evidence base is limited regarding the optimal use of home blood pressure cuffs – this does not mean home blood pressure cuffs are not useful
- Following the DASH diet was also effective in reducing the risk of developing preeclampsia in patients with other cardiometabolic disorders



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Knowledge Check

Audience Poll Question

Audience poll question

Recall that Emily has a history of gestational hypertension in her prior pregnancy.

Which of the following is the best plan of care based on Emily's history?

- A. Provide Emily with a blood pressure cuff for home measurements
 - B. Prescribe her aspirin starting at 12 weeks
 - C. No additional interventions beyond routine blood pressure monitoring at her prenatal visits
 - D. Provide an office follow-up appointment weekly
-

Clinical Practice Recommendations

Recommendation		Strength ^a	Category ^b
Complicated Obstetrics			
Bariatric Surgery			
18.	We suggest patients who have undergone bariatric surgery be evaluated for nutritional deficiencies and the need for nutritional supplementation where indicated (e.g., vitamin B12, folate, iron, calcium).	Weak for	Not reviewed, Amended
19.	There is insufficient evidence to recommend for or against the routine supplementation of vitamins A, D, E, or K for pregnant patients who have undergone bariatric surgery.	Neither for nor against	Not reviewed, Amended

^a See Determining Recommendation Strength and Direction section of the Pregnancy CPG for additional information.

^b See Recommendation Categorization section of the Pregnancy CPG for additional information.

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Mental Health

Scope of Mental Health Recommendations

- To avoid overlap with other VA/DoD CPGs, evidence for and use of psychotropic medications during pregnancy and postpartum were not included in this CPG.
 - Examples of other CPGs that include recommendations and/or discussion about psychotropic use in pregnancy
 - [Management of Bipolar Disorder \(BD\) \(2023\) - VA/DoD Clinical Practice Guidelines](#)
 - [Management of Major Depressive Disorder \(MDD\) \(2022\) - VA/DoD Clinical Practice Guidelines](#)
 - [Management of Substance Use Disorder \(SUD\) \(2021\) - VA/DoD Clinical Practice Guidelines](#)
-

Mental Health (MH) Interventions: Strong Recommendations

In pregnant and postpartum patients, what is the effectiveness of interventions to promote and support maternal mental health?

Recommendation		Strength ^a	Category ^b
Mental Health			
Treatment			
23.	We recommend offering individual or group Interpersonal Psychotherapy or cognitive behavioral therapy for pregnant patients at risk of perinatal depression.	Strong for	Reviewed, New-added
24.	We recommend offering Interpersonal Psychotherapy for treating depression during pregnancy or postpartum.	Strong for	Reviewed, New-added

^a See Determining Recommendation Strength and Direction section of the Pregnancy CPG for additional information.

^b See Recommendation Categorization section of the Pregnancy CPG for additional information.

Discussion of Strong MH Interventions

- Strong evidence suggests that
 - Interpersonal Psychotherapy (IPT) and Cognitive Behavioral Therapy (CBT) are effective *preventive interventions* for postpartum depression.
 - IPT is an effective *treatment* for perinatal depression.
 - For either of these psychotherapies, benefits outweigh risks.
 - The Work Group's confidence in the quality of the evidence was high for prevention, moderate for treatment.
 - Patient values and preferences may vary somewhat. Some patients may prefer pharmacotherapy and/or find the treatment burden of psychotherapy challenging.
-

MH Interventions: Weak Recommendations

In pregnant and postpartum patients, what is the effectiveness of interventions to promote and support maternal mental health?

Recommendation		Strength ^a	Category ^b
Mental Health			
Treatment			
25.	We suggest offering cognitive behavioral therapy for treating depression during pregnancy or postpartum.	Weak for	Reviewed, New-added
26.	We suggest offering peer support for people with perinatal depression or risk of perinatal depression to improve depressive symptoms.	Weak for	Reviewed, New-added
27.	We suggest exercise, mindfulness, yoga, or any combination of these interventions for depressive symptoms in perinatal patients.	Weak for	Reviewed, New-added

^a See Determining Recommendation Strength and Direction section of the Pregnancy CPG for additional information.

^b See Recommendation Categorization section of the Pregnancy CPG for additional information.

Discussion of Weak MH Interventions

- Among psychotherapies, weaker evidence suggests that CBT is an effective treatment for perinatal depression.
 - Evidence also suggests that several other interventions (peer support, exercise, mindfulness, yoga) can reduce depressive symptoms.
 - For these interventions, benefits outweigh risks.
 - The Work Group's confidence in the quality of the evidence was low.
 - Patient values and preferences may vary somewhat. Time commitment is a barrier for some interventions.
-

Recommendations Related to Anxiety and Trauma

What is the effect of anxiety, trauma (including interpersonal), and distress on perinatal outcomes?

Recommendation		Strength ^a	Category ^b
Mental Health			
Treatment			
22	We suggest screening patients with posttraumatic stress disorder (PTSD) for active PTSD and offering PTSD treatment. See VA/DoD PTSD CPG.	Weak for	Reviewed, New-added
28.	We suggest offering psychotherapies (e.g., cognitive behavioral therapy, Interpersonal Psychotherapy) or yoga or both for anxiety symptoms during and after pregnancy.	Weak for	Reviewed, New-added

^a See Determining Recommendation Strength and Direction section of the Pregnancy CPG for additional information.

^b See Recommendation Categorization section of the Pregnancy CPG for additional information.

Discussion of Anxiety/Trauma Recommendations

- PTSD screening
 - Evidence suggests that active PTSD during pregnancy is associated with increased pregnancy complications in Veteran populations, warranting screening for active symptoms among those with PTSD diagnoses and offering treatment when indicated.
 - Treatment of anxiety symptoms
 - Evidence suggests efficacy for two types of psychotherapy (CBT, IPT) and yoga for reducing anxiety symptoms during pregnancy or postpartum.
 - Both
 - The Work Group's confidence in the quality of the evidence was low.
 - For these interventions, benefits outweigh risks.
 - Patient preferences may vary.
-

Other Mental Health Screening Recommendations

Recommendation		Strength ^a	Category ^b
Mental Health			
Screening			
20.	We recommend screening for use of tobacco and nicotine products, alcohol, cannabis , illicit drugs, and inappropriate use of prescription medication. See VA/DoD Substance Use Disorders CPG.	Strong for	Not reviewed, Amended
21.	We recommend screening for depression periodically using a standardized tool, such as the Edinburgh Postnatal Depression Scale or the 9-item Patient Health Questionnaire, during pregnancy and postpartum.	Strong for	Not reviewed, Not changed

- These were carried forward from prior CPG
- Cannabis added since no longer consistently included in “illicit drugs”

^a See Determining Recommendation Strength and Direction section of the Pregnancy CPG for additional information.

^b See Recommendation Categorization section of the Pregnancy CPG for additional information.

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Knowledge Check

Audience Poll Question

Case Study

Remember Emily?



- 27 years old, G2 P1 at 13w4d
- Relevant Health History:
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 - Anxiety, no medications
 - Thinks she may have had postpartum depression last pregnancy, but never sought help from her clinicians
 - Struggled with lactation in her first pregnancy, motivated to try again this time

Audience poll question

Emily wants to reduce her anxiety and prevent postpartum depression from recurring. She prefers nonpharmacologic interventions. Which of the following interventions has the strongest evidence for efficacy for those goals?

- A. Cognitive processing therapy
 - B. Mindfulness-based interventions
 - C. Interpersonal psychotherapy
 - D. Peer support
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Audience Q&A



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