Behavioral Health Conditions in High Risk Pregnancy

BACKGROUND

Prematurity is a birth that occurs before 37 weeks of completed gestation.
- Late pre-term birth is between 34 and 37 weeks of gestation
- Very pre-term birth is between 29 and 33 weeks of gestation
- Extremely per-term birth is at or below 28 weeks of gestation

Premature Infants are defined by birth weight as follows:
- Low birth weight - less than 2500 g
- Very low birth weight - less than 1500 g
- Extremely low birth weight - less than 1000 g

Two serious conditions of pregnancy include **placenta previa** (when the placenta lies near or over the cervix) and **placenta abruption** (when the placenta separates from the uterus). Placenta previa can cause varying degrees of vaginal bleeding and deprive the baby of oxygen and nutrients. In some cases, early delivery is needed. Placental abruption can cause varying degrees of vaginal bleeding and deprive the baby of oxygen and nutrients. In some cases, early delivery is needed. Risk factors for preterm labor and delivery include:
- No prenatal care
- Extremes of pre-pregnancy weights and BMI including obesity and low pre-pregnancy weight
- Having diabetes which increases the risk of iatrogenic preterm birth resulting from medical complications
- Smoking (dose-dependent effect)
- Substance abuse (cocaine, alcohol, opiates)

Screening and Testing by Trimester

First Trimester
- Red cell antibodies
- Current or past infection
- Inherited disorders
- Fetal aneuploidy (e.g. trisomy 21)
- Thyroid disease
- Lead
- Neural tube defects (at 15-24 weeks)

Second and Third Trimesters. The standard of care for prenatal care is every 4 weeks until 28 weeks, then every 2 weeks from 28 to 36 weeks, then weekly until delivery—for uncomplicated, low-risk pregnancies. High-risk pregnancies may necessitate a higher frequency of visits. Visits are used to measure:

- Maternal blood pressure and weight
- Screening for gestational diabetes
- Measure uterine size and fundal height
- Document fetal heartbeat

Maternal Body Mass Index and the Risk of Fetal Death, Stillbirth, and Infant Death

A study published on maternal body mass index and the risk of fetal death, stillbirth and infant death reviewed 38 studies that included 10,147 fetal deaths; 16,274 stillbirths; 4,311 perinatal deaths; and 11,294 neonatal deaths. Findings were discussed for women with BMIs at 20, 25, and 30. The study demonstrates that even modest increases in maternal BMI are associated with increased risk of all four complications. Weight management guidelines for women who plan pregnancies should take these findings into consideration to reduce the burden of fetal death, stillbirth, and infant death.[1]

Neonatal Complications in Very Low Birth Weight (VLBW)

The following complications may be found in infants with VLBW:

- Respiratory distress (93%)
- Retinopathy of prematurity (59%)
- Patent ductus arteriosus (46%)
- Bronchopulmonary dysplasia (42%)
- Late-onset sepsis (36%)
- Necrotizing enterocolitis (11%)
- Intraventricular hemorrhage (8%)

Risks of Taking / Risks of Not Taking Psychiatric Medication During Pregnancy

Psychiatric Medications and Pregnancy

- The first trimester of the pregnancy is considered the highest risk for malformations as this is the period when organ development occurs.
- Although most psychiatric medications are safe during pregnancy, there is an abundance of caution when using them during gestation.
- Before using them, the prescriber should have a thoughtful discussion with the patient to explain potential risks versus benefits of the medication.

Depression During Pregnancy

- Unintended or unwanted pregnancy increases the risk for depression.
- Treatment can include cognitive-behavioral therapy and at times antidepressant medications.
- While depression rates are slightly higher in pregnant women, suicidal behaviors and risks are much lower than depressed women who are not pregnant.
- Women with depression during pregnancy are at higher risk for post-partum depression.

Bipolar Disorder During Pregnancy

- Management of bipolar disorder during pregnancy is very complicated and all pregnant women with bipolar disorder should be considered high risk.
- Discontinuing maintenance medications runs a very high rate of manic relapse.
- Continuing maintenance medications runs a high rate of fetal malformations.
- Psychiatric management throughout the pregnancy is critical.

Psychosis During Pregnancy

- Similar to bipolar disorder, management of psychosis during pregnancy is very complicated and all pregnant women with bipolar disorder should be considered high risk.
- Psychotic women are at risk for poor self-care and prenatal care.
- Discontinuing maintenance medications runs a very high rate of manic relapse.
- Continuing maintenance medications runs a high rate of fetal malformations.
- Psychiatric management throughout the pregnancy is critical.

Anxiety During Pregnancy

Similar to depression, unintended or unwanted pregnancy increases the risk for anxiety or panic attacks. Treatment can include cognitive-behavioral therapy and at times antidepressant medications.

Psychiatric Medications and Breastfeeding

Breast milk confers certain health benefits to the infant and may yield psychological benefits to the mother and infant including emotional bonding. There are other considerations as all psychiatric medications will be present in breast milk of the mother however the concentration of the medications is quite variable. Peak levels in breast milk occur 6-8 hours after dosing. Conversely, lowest drug levels occur right before dosing. This may be the best time to breast feed however infants usually feed every 2-4 hours, making this cycle impractical.

Most bipolar medications can be toxic to newborns, so alternatives to breast-feeding should be explored. Also, bipolar mothers who breast-feed are at higher risk for relapse due to sleep disruptions. Women on psychiatric medications should discuss with their prescribing clinician the pros and cons of breast-feeding while on psychiatric medications.

Postpartum Behavioral Disorders

The “baby blues” are a period of anxiety, sudden weepiness, and trouble sleeping that can impair maternal-child bonding. This common among mothers (50-80%) and is a transient phenomenon. Persistent depression during the weeks after delivery occurs in about 10-15% of women. Those at highest risk for postpartum depression include mothers with a prior history of postpartum depression, bipolar disorder, and/or major depressive disorder

Management of Psychiatric Conditions in Pregnancy

The co-occurrence of a psychiatric condition increases the risks associated with pregnancy and the post-partum period. Psychiatric consultation is important to assess the member’s needs for continued use of prescribed medications while minimizing risks of fetal toxicity. Members with psychotic disorders or bipolar disorders are at greatest risk for psychiatric relapse during pregnancy and in the post-partum period.

HEDIS AND STAR MEASURES

CMS has not published any measures for this topic.

NCQA has published the following measures for this topic:

Follow-Up After Hospitalization for Mental Illness. Members who are hospitalized due to a mental health diagnosis should follow up with a mental health practitioner:

- 7-Day Follow-Up should include an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge.

- 30 Day Follow-Up should include an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge.

RELATED CLINICAL PRACTICE GUIDELINES

In addition to the information contained in this document, please reference the following CPGs:

- Substance Use Disorders in Pregnancy : HS 1041

REFERENCES

1. Aune D, Saugstad O, Henriksen T, Tonstad S. Maternal Body Mass Index and the Risk of Fetal Death, Stillbirth, and Infant Death: A Systematic Review and Meta-analysis. JAMA. 2014;311(15):1536-1546. doi:10.1001/jama.2014.2269.

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MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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