

Healthier Pregnancy: Tools and Techniques to Best Provide ACA-Covered Preventive Services
Provider Fact Sheet

Preventive Service: Screening for and Management of Obesity in Prenatal Patients											
<p><u>U.S. Preventive Services Task Force (USPSTF) Recommendation:</u> “Screening for and Management of Obesity in Adults” – Screen all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30kg/m² or higher to intensive, multi-component behavioral interventions.¹</p> <p>*NOTE: The USPSTF recommendation is <u>not</u> for or specific-to pregnant women. This fact sheet is designed for providers addressing obesity in prenatal patients; however, the information presented is not reflective of the USPSTF Recommendation for obesity screening and management.</p>											
Why is this important?	<p>More than one-half of pregnant women in the U.S. are overweight or obese, and 8% of reproductive-aged women are extremely obese.²</p> <p>During pregnancy, obesity increases the risk of early and late miscarriage, gestational diabetes, preeclampsia, and complications during labor and delivery.³ Obesity affects 1 in 5 pregnancies and remains largely untreated.⁴</p> <p>Obesity during pregnancy is associated with increased use of health care and longer hospital stays for delivery.⁵</p>										
How frequently is this preventive service being provided?	<p>Studies found that the percentage of all obese patients who received weight loss counseling from their primary care provider (PCP) varies from 20% to 40%.⁶ Most recent estimates suggest that only 18% of obese patients receive counseling for weight reduction, 25% for dietary change, and 21% on exercise.⁷ Rates of weight loss counseling among obese patients have not increased since the USPSTF guidelines were first released in 2003.⁸</p> <p>A survey of 900 obstetrician-gynecologists, conducted in 2005 by The American College of Obstetricians and Gynecologists (ACOG), showed that more than 85% counseled patients about pregnancy weight gain, and 64% used the patients’ prepregnancy BMI to modify their recommendations. However, only 35% believe that such prenatal care is an opportunity to modify behaviors that will lessen the likelihood of maternal obesity.⁹</p>										
What are the best screening practices identified in the literature?	<p>USPSTF recommends clinicians use age-and gender-specific Body Mass Index (BMI) to screen for obesity.¹⁰</p> <p>BMI is a number calculated from a person's weight and height and is used as a screening tool to identify possible weight problems for adults. However, BMI is not a diagnostic tool.</p> <table border="1" data-bbox="716 1661 1122 1906"> <thead> <tr> <th>BMI</th> <th>Weight Status</th> </tr> </thead> <tbody> <tr> <td>Below 18.5</td> <td>Underweight</td> </tr> <tr> <td>18.5 – 24.9</td> <td>Normal</td> </tr> <tr> <td>25.0 – 29.9</td> <td>Overweight</td> </tr> <tr> <td>30.0 and Above</td> <td>Obese</td> </tr> </tbody> </table>	BMI	Weight Status	Below 18.5	Underweight	18.5 – 24.9	Normal	25.0 – 29.9	Overweight	30.0 and Above	Obese
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For all women, American Congress of Obstetricians and Gynecologists (ACOG), encourages *preconception* assessment and counseling regarding maternal and fetal risks of obesity during pregnancy. **Initial prenatal visits for all patients should include a height and weight assessment and weight gain recommendations, accompanied with exercise counseling and nutritional consultation for all overweight and obese women.**¹¹

The table below demonstrates the Institute of Medicines (IOM) and ACOG recommended amount of gestational weight gain for women of different weight categories at the onset of pregnancy.¹²

2009 IOM Recommendations
Total and Rate of Weight Gain During Pregnancy, by Pre pregnancy BMI¹³

Pre pregnancy BMI	BMI+ (kg/m ²) (WHO)	Total Weight Gain Range (lbs)	Rates of Weight Gain* 2nd and 3rd Trimester (Mean Range in lbs/wk)
Underweight	Below 18.5	28–40	1 (1–1.3)
Normal weight	18.5-24.9	25–35	1 (0.8–1)
Overweight	25.0-29.9	15–25	0.6 (0.5–0.7)
Obese (includes all classes)	30.0 and Above	11–20	0.5 (0.4–0.6)

What are the best interventions identified in the literature?

A systematic review of interventions found that dietary interventions during pregnancy are effective in reducing gestational weight gain and risks of pre-eclampsia, gestational hypertension, and shoulder dystocia. There is no evidence of harm as a result of the dietary and physical activity-based interventions in pregnancy.¹⁴

Eating a healthy diet and engaging in regular physical activity are important to limiting gestational weight gain.

Physical Activity

The health benefits of physical activity are well recognized and recommended for most pregnant women. It is recommended that healthy women get at least 150 minutes per week of moderate-intensity aerobic activity during and after pregnancy; preferably activity should be spread throughout the week.¹⁵ Healthy women who already engage in vigorous-intensity activity, such as running, can continue doing so during and after pregnancy provided they stay healthy and discuss with their health care providers how and when activity should be adjusted over time.

Pregnant women with morbid obesity, diabetes, chronic hypertension, or a history of extreme sedentary lifestyle should be evaluated and have an individualized exercise prescription. Epidemiologic data suggest that exercise may be beneficial in the primary prevention of gestational diabetes, particularly in morbidly obese women (BMI > 33).¹⁶

ACOG provides [warning signs](#) that clinicians can use to counsel women about for terminating exercise while pregnant.¹⁷

	<p><u>Nutrition</u></p> <p>Nutrition consultation should be offered to all women to promote gestational weight gain within guidelines (noted in the table above). Among overweight and obese women, nutrition and exercise counseling should continue postpartum and before attempting another pregnancy.¹⁸</p> <p>Obstetricians should discuss the medical risks associated with obesity with their patients and avoid blaming patients for their increased weight. If physicians lack the resources necessary for the safe and effective care of an obese patient, consultation or referral or both are appropriate.</p>
<p>What barriers exist for providers?</p>	<ul style="list-style-type: none"> • Limited evidence base around how to address weight management, for overweight and obese patients in pregnancy • Limited or inadequate training • Low self-efficacy in addressing gestational weight gain¹⁹ • Personal bias based on the physician’s own body mass index status or cultural perspectives on weight^{20,21}
<p>What are some ideas to address these barriers?</p>	<p>Recent policy changes including the Affordable Care Act (ACA) Marketplace coverage of obesity screening and management and Medicare coverage obesity counseling visits may reduce concern about lack of reimbursement and time. Additionally, the rise of new models of care delivery and reimbursement, such as patient-centered medical homes or Accountable Care Organizations, may also facilitate referrals to ancillary providers like registered dietitians or multi-component weight loss programs.²²</p> <p>Other ideas include:</p> <ul style="list-style-type: none"> • increasing the number of dietitians and nutritionists in hospitals • providing professional and organizational support and training • offering financial incentives²³ • promoting diet and exercise for mother and family in all postnatal and well-child pediatric appointments <p>It is also recommended that obesity education focused on the specific medical, cultural, and social issues of the obese woman should be incorporated into physician education at all levels.</p>
<p>What does the Affordable Care Act cover?</p>	<p>All Marketplace plans and many other plans must cover obesity screening and counseling for all adults without charging a copayment or coinsurance. This is true even if the patient has not met their yearly deductible. This applies only when these services are delivered by a network provider. ACA also covers diet counseling for adults at higher risk for chronic disease.²⁴</p> <p>Additionally, the ACA covers well-woman visits, which include a full checkup, separate from any other visit for sickness or injury. These visits focus on preventive care for women and have three goals: 1. Documenting your health habits and history (includes covering topic of eating habits and physical activity); 2. Getting a physical exam (includes calculating BMI); 3. Setting health goals (like losing weight).²⁵</p> <p>The Centers for Medicare and Medicaid Services (CMS) also provides information about the Coverage of Preventive Services.</p> <p>HealthCare.gov provides lists of preventive care benefits for all adults and those specific to women.</p>

What does Medicaid cover?	Each state has its own plan for Medicaid coverage. To find out more about Medicaid and CHIP eligibility and coverage in your state, please visit Medicaid.gov .

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For more information

PROVIDER IMPLEMENTATION TOOLS

Centers for Disease Control and Prevention (CDC) [Body Mass Index website](#) includes general information about BMI and a calculator tool to easily determine BMI.

Institute of Medicine (IOM) [Weight Gain During Pregnancy: Reexamining the Guidelines](#) (2009)  examines weight gain during pregnancy from the perspective that factors that affect pregnancy begin before conception and continue through the first year after delivery. The guidelines are based Body Mass Index (BMI) categories and include a recommendation for obese women.

The American Congress of Obstetricians and Gynecologists (ACOG) [Obesity in Pregnancy Committee Opinion Report](#) (2013)  reflects emerging clinical and scientific advances and is subject to change; information should not be construed as dictating an exclusive course of treatment or procedure to be followed. It describes potential complications, counseling practices, and recommendations for care.

The American Congress of Obstetricians and Gynecologists (ACOG) [Weight Gain During Pregnancy Committee Opinion Report](#) (2013)  reflects emerging clinical and scientific advances and is subject to change; information should not be construed as dictating an exclusive course of treatment or procedure to be followed. It describes potential complications, counseling practices, and recommendations for care.

United Kingdom Department of Health [National Institute for Health and Clinical Excellence \(NICE\) Guidelines](#) (2010)  provides public health guidance on dietary and physical activity interventions for weight management before, during and after pregnancy; recommendation 2 is specific to pregnant women and recommendation 3 for perinatal patients.

UK Royal College of Obstetricians and Gynaecologists (RCOG) [Joint Guidelines](#) (2010)  for management of women with obesity in pregnancy; the recommendations cover interventions prior to conception, during and after pregnancy

OTHER RESOURCES

The American Congress of Obstetricians and Gynecologists (ACOG) [Exercise During Pregnancy and the Postpartum Period Committee Opinion Report](#) (2009)  reflects emerging clinical and scientific advances and is subject to change; information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

IOM [Healthy Weight Gain During Pregnancy](#)  is a comprehensive guide including interactive tools and resources for providers and consumers.

USDA [Health & Nutrition Information for Pregnant & Breastfeeding Women](#) provides interactive and informational website for consumers.

The **CDC [Overweight and Obesity website](#)** provides a variety of information including strategies to combat obesity for individuals, families, and communities, data and statistics, state and community programs, and other healthy living topics.