



PREVENTIVE CARE GUIDELINE

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Effective Date: 02/2010

Guideline Subject: Prenatal Care

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Pages: 1 of 1

Obsoletes: 4/99, 9/02, 10/05, 7/06, 7/07, 0708


Medical Management Committee Chair

1-14-10
Date

I. PURPOSE:

To define standards for prenatal care for eligible members of the Denver Health Medical Plan, Inc.

II. POPULATION:

Eligible DHMP members requiring prenatal, postpartum, and perinatal care

III. ATTACHMENT:

CLINICAL CARE STANDARD CCS-19.012

“DENVER COMMUNITY HEALTH SERVICES ROUTINE PRENATAL CARE”

NOTE:

This guideline is designed to assist providers by providing an analytical framework for the evaluation and treatment of patients, and is not intended either to replace a clinician's judgment or to establish a protocol for all patients with a

DENVER HEALTH	NO. CCS-19.012
CLINICAL CARE STANDARD	PAGE 1 of 8
Title of Clinical Care Standard: Denver Community Health Services Routine Prenatal Care	OBSOLETES: Sect. NEW Dated: NEW
APPROVED: Patricia A. Gabow, M.D., CEO and Medical Director	EFFECTIVE DATE: 08/14/08 REVIEW DATE: 07/14/11

I. Purpose:

Initiation of prenatal care:

Routine prenatal care should ideally begin before conception and include preventive care, counseling, and screening for risks to maternal and fetal health. All patient presenting with a possibility of pregnancy should be evaluated promptly, and early entry into prenatal care facilitated. The initial visits to complete the prenatal assessment should take place in the first trimester (before 14 weeks from the LMP). In the intake and OB PE, a detailed medical, obstetrical and social and family history and directed physical examination should be performed to detect conditions associated with increased maternal and perinatal morbidity and mortality, and to establish accurate dates. See the below grid for recommended screening tests that are due at different stages of pregnancy. The DH Antepartum record should be used for all pregnant patients, and started at the intake visit. Prenatal patients should be counseled on what screening tests are available, what they are for, possible risks to her and her fetus, the choices she will face once results are obtained.

II. Responsibility:

A. OB/GYN

B. Family Medicine

III. Procedure:

A. Ongoing prenatal care

Prenatal care should be provided with a single provider to the extent possible. After the initial visit, patients should be seen according to the following general schedule. Visits should be scheduled so as to include screening tests that need to be done at a given gestational age. For low risk women, reducing the number of prenatal visits does not lead to increased adverse outcomes for the mother or infant; however, women were less satisfied with the reduced-visit schedule

B. Low-risk patients should be seen a minimum of:

1. Every 6 weeks during the first 20 weeks with at least one visits at 14-16 weeks
2. Every 4 weeks between 21 and 30 weeks
3. Every 2-3 weeks between 30-35 weeks.
4. Weekly after 36 weeks until delivery

C. This schedule applies only to low-risk OB patients. More frequent visits may be scheduled at the caregiver's discretion.

VISIT	CHECK-IN	LABS	ENCOUNTER	COUNSELING
Pregnancy Verification	BP, Weight, Ht, pre-pregnant weight Baseline BMI	<ul style="list-style-type: none"> • Urine or serum pregnancy test. • Offer Triple Test if 15-21 weeks. • If >14 weeks, order ultrasound to be performed between 18 & 20 weeks.. 	<ol style="list-style-type: none"> 1. Use Pregnancy Verification Form 2. Document pregnancy by lab test, auscultation of FHTs or written verification of test from another clinic. 3. If >16 weeks, size the uterus and listen for FHTs. 4. Discuss alternatives, options of pregnancy. 5. If planning to deliver at DHMC. <ul style="list-style-type: none"> • Schedule OB intake • Draw prenatal labs (after seeing Enrollment Specialist) if > 2 weeks until intake, and plans to deliver at DHMC • Begin prenatal vitamins (and iron if indicated). Folic acid if cannot tolerate prenatal vitamins 6. If patient has significant pain or bleeding, need to rule out ectopic pregnancy-ultrasound, quant. HCG, OBGYN referral. 	<ol style="list-style-type: none"> 1. Encourage stopping tobacco, drug and EtOH use if applicable. 2. Refer to enrollment specialist and WIC
OB Intake	BP, Height Prepregnant Weight Initiate Weight gain grid	Urinalysis, Urine culture CBC Blood type & RH, antibody screening test	<ol style="list-style-type: none"> 1. Start Antepartum Record: medical, obstetrical, & family history, review of systems & weight gain grid, 	<ol style="list-style-type: none"> 1. Encourage prenatal vitamins and iron. 2. Teaching: <ul style="list-style-type: none"> • Clinic orientation, • Breastfeeding • Basic information

		<p>Rubella titer, RPR, Glucose screen if at risk¹ or >26 weeks, Hepatitis B antigen, HIV antibody (with patient consent), Offer Triple test (15 0/7 thru 21 6/7 weeks.) PPD skin test Genetic Screening in high risk groups³</p>	<ol style="list-style-type: none"> 2. Risk assessment as per AP record to include Infection Hx, Genetic screening and preterm birth risk, substance use, environmental exposures. 3. Psychosocial evaluation: Family, job, school, financial, living conditions, domestic abuse screening, support system, acceptance of pregnancy, etc. Refer to social service prn 4. Size uterus and document FHT's as appropriate. 5. Order routine ultrasound between 18-20 weeks gestation.(see OB ultra sound guidelines) 6. Nutrition review. Special attention to nausea and vomiting, weight loss and diet to help morning sickness. 7. Refer to genetic counseling if 35 yrs or older at term or positive for other factors, and interested in genetic testing 8. Td booster if not up to date 	<p>on pregnancy,</p> <ul style="list-style-type: none"> • Nutrition and weight • Warning signs and where to seek emergency care • Substance and tobacco use, <ol style="list-style-type: none"> 3. Institute Maternal Teaching Summary. Hand out trimester packets. 4. Give information on prenatal classes, teen-parent program (e.g., TPEN, TAP Aware), food supplements, WIC, Medicaid and other programs as appropriate.
<p>OB Physical</p>	<p><i>BP,</i> <i>Weight</i></p>	<p>UA dipstick, UCX if abnormal or</p>	<ol style="list-style-type: none"> 1. Review AP record, symptoms, interval history 	<ol style="list-style-type: none"> 1. Breastfeeding 2. If patient has had a prior c-section, request

		symptoms, Pap Smear, if > 6 months since last normal GC culture, & Chlamydia test if > 6 mos since last negative (except teens) Glucose screens if high risk or > 24 wks Offer Triple test (15-21) weeks	<ol style="list-style-type: none"> 2. Complete PE. Special attention to uterine size, dates, weight gain. 3. Risk assessment (initiate OB check list as indicated) 4. Schedule routine US for 18-20 weeks (see OB ultrasound guidelines) 5. (note routine screening for bacterial vaginosis is not recommended by the USPSTF. Symptomatic women should be evaluated and treated) 	operative report & counsel about repeat section vs. VBAC.
16-24 Weeks	<i>BP, Weight</i>	UA dipstick, Repeat CBC if initial HCT< 35% Glucose screen if high risk Triple test by 21 weeks if not done	<ol style="list-style-type: none"> 1. Routine prenatal care (interval history, FHTs, fundal height, update risk assessment) 2. Schedule routine US if not already done (see OB ultrasound guidelines) 3. Gestational diabetes screen if high risk and not previously done (1-hour post 50 gm Glucola non-fasting) 	<ol style="list-style-type: none"> 1. Discuss symptoms & signs of preterm labor (PTL) 2. Discuss prenatal classes.
25-31 Weeks	BP Weight	UA dipstick, Glucose screen Rh-negative: .Repeat antibody screen and give Rhogam	<ol style="list-style-type: none"> 1. Routine prenatal care. 2. Routine diabetes screen @ 24-28 weeks (1-hour post 50 gm Glucola non-fasting) 3. Give Rhogam at 28-30 weeks to unsensitized RH-negative patients. 	<ol style="list-style-type: none"> 1. PTL signs 2. Discuss fetal movement counts 3. Contraception. Discuss all appropriate forms of contraception and give handout (see Pulse) 4. If patient desires postpartum BTL have her sign Medicaid

				papers between 26 & 32 weeks.
32-35 Weeks	BP Weight	UA dipstick, CBC Repeat if <35% at prior screening, HCT if initial CBC normal Repeat glucose if + screen and normal 3 hr GTT at 24-28 weeks. GBS culture GC culture &/or Chlamydia test if + during pregnancy.	1. Routine prenatal care.	1. Contraception. 2. If desires Postpartum BTL sign Medicaid papers.
36-39 Weeks	BP Weight	UA dipstick, GBS if not done	1. Routine prenatal care 2. Check presenting part; if breech, refer to OBSR at 37 weeks to confirm position and arrange version 3. Cervical exam and membrane sweeping may decrease need for induction. 4. Schedule OB HR visit at 36-38 weeks if repeat c-section indicated by calling 303-602-9036.	1. Discuss PTL signs, ruptured membranes, adequacy of fetal movements. 2. Labor analgesia. Give patient a handout on pain management in labor. . 3. Breast-feeding. 4. Infant Care 5. Review need for postpartum care, discuss postpartum depression
40-42 Weeks	BP Weight	UA dipstick	1. Schedule NST and AFI between 40 ⁴ + 41 ³ weeks, with goal to induce by 41 ³ weeks. (See post dates guidelines) 2. Continue weekly clinic	

			appointments until delivered or referred for induction.	
Postpartum 2 Weeks See Note *	BP Weight	UA dipstick	<p>* (Family planning RN visit if Birth control method is uncertain at discharge)</p> <ol style="list-style-type: none"> 1. Use postpartum Form 2. Review method of contraception and give supplies to patient 3. Document that medical history is OK for BC pills and that routine pill information packet is given and discussed. 4. If BCPs are used, start pills on the Sunday after the 2-weeks visit 5. If breast feeding, may start minipill or combined OCs 2-6 weeks PP. 6. Use condoms with <u>any</u> intercourse for first month after starting OCP's. 7. Reinforce pelvic rest for 4-6 wks postpartum. 8. If breast-feeding, discuss any concerns. 9. Schedule 6-week visit. For interval tubal ligation, please have pt sign Medicaid papers if not already done, and refer to WCC at Davis Pavilion at 3-4 wks postpartum, if not 	

			already scheduled. . 10. Arrange follow-up for medical and other long-term problems.	
Postpartum 6-10 Weeks	BP Weight	<i>HCT if low (<35) during pregnancy or after delivery. Pap Smear: per PAP guidelines</i>	1. Social history review: Plans for job or school, FOC involvement, etc. 2. Review L&D and antepartum history, arrange follow-up of relevant problems. 3. PE-breasts, pelvic exam. 4. If abnormal Pap during pregnancy, testing as per Abnormal Pap Algorithm. 5. If breast-feeding, discuss concerns.	

1. See Gestational diabetes guidelines.
2. PPD Should be done on all high risk patients: Immigrants from countries with high TB prevalence, persons with HIV, close contacts of persons with known or suspected TB, Health care workers if not up to date in screening, alcoholics, IVDU and residents of long term care facilities, DOC patients. (See also DH TB screening guidelines)
3. Genetic screening:
 - a. Women at increased risk of aneuploidy (those who will be older than 35 years at delivery and have a singleton pregnancy or older than 32 years with a multiple pregnancy;
 - b. fetal structural anomalies or ultrasound markers of aneuploidy;
 - c. history of a previously affected pregnancy; couples with a known translocation, chromosome inversion, or aneuploidy;
 - d. and women with a positive maternal serum screen) should be offered prenatal diagnosis by amniocentesis or CVS.
4. Other tests should be offered to women of specific ethnic backgrounds include:
 - a. Cystic Fibrosis: Ashkenazi Jews, Caucasians
 - b. Tay-Sachs disease Ashkenazi Jews, Cajuns French Canadians in Eastern Quebec
 - c. A and b-thalassemia: Africans East Indians Hispanics Mediterranean's Middle Easterners Southeast Asians (If MCV is less than 80, order Hemoglobin electrophoresis, ferritin and Red cell morphology)
 - d. Sickle cell anemia Africans or African descent (Sickledex)
5. Flu vaccine
 - a. Influenza vaccination generally is recommended in women who will be in the second or third trimester of pregnancy during flu season.

- b. Pregnant women with medical conditions that increase their risk of complications from influenza should be immunized regardless of gestational age.
- c. There is no evidence that vaccination in the first trimester of pregnancy is unsafe.
- 6. Please also refer to the following
 - a. Ultrasound guideline
 - b. Antepartum testing
 - c. Gestational diabetes
 - d. GBS screening
 - e. HIV in pregnancy
 - f. Postpartum family planning
 - g. Infections in pregnancy
 - h. Obstetrical Consultation and referral guidelines between family medicine and Obstetrics and Gynecology.
 - i. Evaluation and diagnosis of women with anemia during pregnancy.

IV. References:

1. Kirkham C, Harris S, Grzybowski S. Evidence-based prenatal care: part I. General prenatal care and counseling issues. *Am Fam Physician* 2005;71:1307-16,1321-2. . .
2. Kirkham C, Harris S, Grzybowski S. Evidence-based prenatal care: part I Third-trimester care and prevention of infectious diseases. *Am Fam Physician* April 2005.
3. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 5th ed. Elk Grove Village, Ill.: American Academy of Pediatrics, and Washington, D.C.: American College of Obstetricians and Gynecologists, 2002
4. Institute for Clinical Systems Improvement. Knowledge resources. Routine prenatal care. Accessed online January 17, 2005, at:
<http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=191>