



Clinical Practice Guidelines for Perinatal Care

Source: Guidelines for Perinatal Care, Fifth Edition, copyright © October, 2002 by the American Academy of Pediatrics and The American College of Obstetricians and Gynecologists and supported in part by March of Dimes and the Health Plan Employer Data and Information Set (HEDIS) Standards for Access and Availability, © 2007 by the National Committee for Quality Assurance.

DEFINITION:

Early, effective prenatal care can identify mothers at risk of delivering a preterm or growth-retarded infant and provide an array of medical and educational interventions. Early infancy is a critical time for the health of both baby and mother. Continuity of care can help detect problems early and prevent complications.¹

Studies show a positive relationship between comprehensive prenatal care and a reduction in low birth weight and infant mortality.² Women who receive early and regular prenatal care are more likely to have healthier infants.³

ASSESSMENT/EDUCATION:

The following table shows a high level summary of services that should be provided to each member with an uncomplicated pregnancy. During every visit, the health care practitioner should evaluate the woman's blood pressure, weight, urine protein and glucose levels, uterine size for progressive growth and consistency with the estimated date of delivery, and fetal heart rate. After the patient reports quickening (and at each subsequent visit), she should be asked about fetal movement, contractions, leakages of fluid, or vaginal bleeding. Ultrasound before 20 weeks of gestation may be indicated for the purpose of dating if there is a size-date discrepancy or if menstrual dates are uncertain.

Visit Schedule	History / Physical Exam	Diagnostic Testing / Screening	Education / Counseling
Initial Prenatal Care Visit	<ul style="list-style-type: none"> • Complete medical, surgical, obstetrical, and gynecological assessment • History including genetic history of parents • Physical exam 	<ul style="list-style-type: none"> • Hemoglobin / Hematocrit • U/A, microscopy and infection screening • Blood typing and Rh D and Antibody screen • Rubella titer • Hepatitis B surface antigen screen • VDRL • HIV testing • Tb skin test • STD testing 	<ul style="list-style-type: none"> • Overall care plan • Expected course of pregnancy • Signs/symptoms that should be reported • Nutrition including individualized vitamin and mineral supplementation as needed • General health • Psychosocial aspects of pregnancy • HIV counseling

¹ Prenatal and Postpartum Care, The State of Health Care Quality 2005, National Committee for Quality Assurance

² Safe Motherhood: Promoting Health for Women Before, During, and After Pregnancy 2004, Centers for Disease Control and Prevention.

³ Guidelines for Perinatal Care, Fifth Edition, copyright © October, 2002 by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists (ACOG)

Visit Schedule	History / Physical Exam	Diagnostic Testing / Screening	Education / Counseling
	<ul style="list-style-type: none"> Risk assessment Estimated Date of Delivery calculation 	<ul style="list-style-type: none"> OB Ultrasound Urine culture Lead level Genetic counseling Depression 	<ul style="list-style-type: none"> Smoking cessation Avoidance of alcohol and other substance abuse
<p>Subsequent Visits: 0-28 Weeks (visits should occur every 4 weeks)</p> <p>29-36 Weeks (visits should occur every 2-3 weeks)</p> <p>37+ Weeks (visits should occur weekly)</p>	<ul style="list-style-type: none"> Physical assessment including weight and blood pressure, uterine growth, fetal heart rate, fetal movement and presentation (when applicable) Follow-up risk assessments 	<ul style="list-style-type: none"> Urine protein, glucose OB Ultrasound at 16 -18 weeks, 32-36 weeks as needed Karyotype at 8-18 weeks when indicated/elected Maternal Serum Alpha Fetoprotein at 16-18 weeks Diabetes screening at 24-28 weeks with GTT as needed Repeat hemoglobin or hematocrit at 24-28 weeks and again at 32-36 weeks STD tests Rh-D and Antibody screen at 24-28 weeks Rh/G Immune Globulin at 28 weeks Group B Strep screen at 26-28 weeks Amniocentesis Depression 	<ul style="list-style-type: none"> Nutrition including individualized vitamin and mineral supplementation as needed Desired weight gain Activity / Exercise Labor and Delivery process to expect Signs of labor Smoking cessation if applicable Avoidance of alcohol and other substance abuse Childbirth education classes Infant feeding Psychosocial needs Discussion of VBAC
<p>Postpartum Visit 4-6 Weeks Following Delivery</p>	<ul style="list-style-type: none"> Interval history Physical exam including weight, blood pressure, breasts, abdomen and pelvic exams 	<ul style="list-style-type: none"> Pap test Postpartum visit may occur within 21-56 days (4-6 weeks) after delivery Depression 	<ul style="list-style-type: none"> Nutrition including individualized vitamin and mineral supplementation as needed Breast feeding Psychosocial needs Family planning

PATIENT EDUCATION:

• Vaccinations:

- All women at risk for or susceptible to rubella, varicella, and hepatitis B should be offered vaccination.
- All women who will be in the second or third trimester of pregnancy during the influenza season should be offered vaccination. Women with medical conditions that put them at higher risk for influenza complications should be offered vaccination regardless of the stage of their pregnancy.

SPECIALIZED ASSESSMENT:**Issues to Discuss Before Delivery**

- Anticipating Labor (i.e. what to do in the event of regular contractions, membrane rupture, or vaginal bleeding)
- Working / Occupation
- Non-routine Travel
- Breech presentation
- Umbilical Cord Blood Banking
- Circumcision
- Postpartum Tubal Ligation
- Discharge planning
- Perinatal psychosocial issues

Depression

Utilize the Patient Health Questionnaire-2 (PHQ2) Depression Screening questions regarding the frequency of depression or anhedonia over the past two weeks:

- “Over the last 2 weeks, how often have you been bothered by little interest or pleasure in doing things?”
- “Over the last 2 weeks, how often have you been feeling down, depressed or hopeless?”

Domestic Violence

Research indicates that the majority of abused women continue to be victimized during pregnancy and this may affect both maternal and fetal well-being. Some of the obstetrical presentations of abused women include:

- Unwanted pregnancy
- Late entry into prenatal care, missed appointments
- Substance abuse or use
- Poor weight gain and nutrition
- Multiple, repeated somatic complaints

If a patient confides that she is being abused, the physician should record verbatim accounts in the medical record, inquire about her immediate safety and the safety of her children, and refer to appropriate local resources for counseling, legal, and social services.

SPECIALIZED COUNSELING:

- Moderate exercise 30 minutes or more per day on most if not all days of the week within limitations and with physician guidance (avoid supine positions, potential abdominal trauma, new strenuous sports taken up during pregnancy, etc.)
- Tobacco, alcohol, and substance abuse use should be strongly discouraged. Assessment of and counseling on the perinatal implications of substance abuse during pregnancy, referral to appropriate drug treatment programs if needed
- Appropriate weight gain during pregnancy (25-35 lbs for average weight women, 15-25 lbs for significantly overweight women, 28-40 lbs for underweight women). Patients economically unable to meet nutritional needs should be referred to federal food and nutrition programs such as the Special Supplemental Food Program for Women, Infants, and Children.

GENETIC RISK ASSESSMENT/COUNSELING

Teratogens counseling and serum screening
Trisomy 21 screening
Neural Tube Defects screening

DOCUMENTATION STANDARDS

WellCare recommends the use of the American College of Obstetricians and Gynecologists (ACOG) format for documenting patients' pregnancies. The format is available as Appendix A, "ACOG Antepartum Record and Discharge/Postpartum Form", in Guidelines for Perinatal Care, Fifth Edition, which can be purchased online at www.acog.org.

PHYSICIAN MEASUREMENT AND ASSESSMENT OF COMPLIANCE WITH GUIDELINES:

- Adequate documentation of physical examination at each obstetric visit
- Documentation of prenatal and postpartum depression screening utilizing the Patient Health Questionnaire-2 (PHQ2) Depression Screening tool described above or the Edinburgh Depression Scale tool.⁴
- Documentation of family planning counseling and services for all pregnant women and mothers.
- *Postpartum Care.* The percentage of deliveries in the denominator* that had a postpartum visit on or between 21 and 56 days after delivery.⁵ [*"Denominator" of live births as defined by HEDIS*]

ADDITIONAL RESOURCES:

- Educational materials available from ACOG (www.acog.org), the US Public Health Service (www.os.dhhs.gov/phs), and the March of Dimes Birth Defects Foundation (www.modimes.org).

Legal Disclaimer:

These clinical practice guidelines were developed to assist practitioners in making decisions about appropriate health care for specific clinical circumstances. These guidelines are not fixed protocols that must be followed, but are intended for health care professionals and providers to consider. While they identify and describe generally recommended courses of intervention, they are not presented as a substitute for the advice of the physician or other knowledgeable health care professional or provider service provider treating the patient. Individual patients may require different treatments from those specified in a given guideline. Guidelines are not entirely inclusive or exclusive of all methods of reasonable care that can obtain/produce the same results. While guidelines can be written that take into account variations in clinical settings, resources, or common patient characteristics, they cannot address the unique needs of each patient nor the combination of resources available to a particular community or health care professional or provider. Deviations from clinical practice guidelines may be justified by individual circumstances. Thus, these guidelines must be applied based on individual patient needs and are not a substitute for the professional medical judgment of the provider of care.

⁴ L. Murray and J. L. Cox 1990, a.k.a. The Edinburgh Postnatal Depression Scale (EPDS), J L Cox, J M. Holden, R Sagovsky – 1987

⁵ Health Plan Employer Data Information Set (© HEDIS) 2007, Volume 2: Technical Specifications, © 2006 by the National Committee for Quality Assurance