**Peach State Health Plan**
**Perinatal Preventive Health Guidelines**

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| **PRECONCEPTION CARE:** consists of the identification of conditions that could affect a future pregnancy but may be ameliorated by early intervention | **Assessment and Counseling:**<br>• General physical exam including vital signs, height and weight<br>• Counseling regarding family planning and pregnancy spacing<br>• Family history<br>• Genetic history (both maternal and paternal)<br>• Medical, surgical, pulmonary, and neurologic history<br>• Substance use including tobacco, alcohol and illicit drugs<br>• Domestic abuse and violence<br>• Nutrition<br>• Environmental and occupational exposures<br>• Immunity and immunization status<br>• Risk factors for sexually transmitted diseases<br>• Obstetric history<br>• Gynecological history<br>• Assessment of socioeconomic, educational, and cultural context | **Potential Screening Tests:**<br>• Screening for sexually transmitted diseases, including HIV<br>• Testing to assess proven etiologies of recurrent pregnancy loss<br>• Testing for maternal diseases based on medical or reproductive history<br>• Mantoux skin test with purified protein derivative for tuberculosis<br>• Screening for genetic disorders based on racial and ethnic background:<br>-Sickle hemoglobinopathies (African Americans)<br>-β-thalassemia (Mediterraneans, Southeast Asians, and African Americans)<br>-α-thalassemia (African Americans and Asians, especially from Thailand)<br>-Tay-Sachs disease (Ashkenazi Jews, French Canadians, and Cajuns)<br>-Gaucher's, Canavan, and Niemann-Pick disease (Ashkenazi Jews)<br>-Cystic fibrosis (CF) (Caucasians of European and Ashkenazi Jewish Descent)<br>• Screening for other genetic disorders on the basis of family history (eg, CF, fragile X syndrome for family history of nonspecific predominantly male-affected, mental retardation; Duchenne muscular dystrophy) | **Additional Counseling:**<br>• Exercising<br>• Reducing weight before pregnancy, if obese<br>• Increasing weight before pregnancy, if underweight<br>• Avoiding food faddism<br>• Preventing HIV infection<br>• Determining the time of conception by an accurate menstrual history<br>• Abstaining from tobacco, alcohol, and illicit drug use before and during pregnancy<br>• Consuming folic acid, 0.4 mg per day, while attempting pregnancy and during the first trimester of pregnancy for prevention of neural tube defects (NTDs)<br>• Maintaining good control on any preexisting medical conditions (eg, diabetes, hypertension, systemic lupus erythematosus, asthma, seizures, thyroid disorders, inflammatory bowel disease<br>• Encourage Reproductive Life Plan (see below) |

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| **ROUTINE PRENATAL CARE VISITS:** should take into consideration the medical, nutritional, psychosocial, and educational needs of the patient and her family, and it should be periodically reevaluated and revised in accordance with the progress of the pregnancy. | **Initial Prenatal Care Visit:** During the gestational time period the **initial patient visit should include all content covered in the preconception visit as stated above**.<br>Additional evaluation should include:<br>• A patient questionnaire with personal health history, exposures affecting health, family history, psychosocial screening.<br>• Pelvic examination;<br>• Assessment of the cervix, uterus size, adnexa and clinical impression of the adequacy of the pelvis;<br>• Assessment of gestational age by LMP, clinical exam and/or ultrasound prior to 18-20 weeks.<br>• Papanicolaou smear and culture for gonorrhea and chlamydial infection;<br>• Blood studies including blood type, Rh and antibody screen, hemoglobin and hematocrit, and serologic tests for hepatitis B, rubella, syphilis, HIV (if patient consents).<br>• Urine for protein, glucose and culture for asymptomatic bacteriuria.<br>• Tests specific to patients ethnic background or family history as appropriate (e.g. hemoglobin electrophoresis to check for sickle cell or thalassemia trait, carrier testing for other inherited disorders such as Tay-Sachs and cystic fibrosis) if not done preconceptionally.<br>• Repeat risk assessment for obstetrical outcomes as pre-term birth, low birth weight and pre-ecclampsia.<br>• Review medication use and concurrent medical conditions. | **Follow Up Prenatal Care Visits:** The purpose of each visit is to assess maternal and fetal well-being. Recommended time periods, laboratory evaluations, and nutritional assessments are:<br>• Prenatal visits every 4 weeks until 28 weeks of pregnancy, then every 2 to 3 weeks until 36 weeks, then weekly until delivery (Note: this should be individualized and visit frequency is determined by the nature and severity of problems encountered);<br>• Patient weight, blood pressure, presence or absence of edema, urine dipstick to check protein and glucose levels should be done each visit;<br>• Height of the uterine fundus measured, fetal heart tone recorded, and patient asked about the perception of fetal movement. Usually the fetal heart rate can be auscultated by 12 weeks with a Doptone, and fetal movement is apparent by 20 weeks. After the patient reports quickening, she should be asked about fetal movement, contractions, leakage of fluid, or vaginal bleeding;<br>• At 15 weeks patients should be offered biochemical marker screening for risk assessment for trisomies and open neural tube defects.<br>• Between 27 weeks and 36 weeks' gestation (although may be given at any time during pregnancy), vaccinate with Tdap due to the dramatic and persistent increases in pertussis in infants in recent years<br>• At 28 weeks a glucose screen for gestational diabetes, assays for hemoglobin and hematocrit and blood antibody screening and repeat testing for syphilis are done if indicated. If the patient is Rh negative and unsensitized, she should receive Rh immunoglobulin (RhoGAM) at this time;<br>• At 35 to 37 weeks a vaginal and rectal culture can be obtained for group B Streptococcus; when using risk strategy, (and should be obtained for GC and Chlamydia when patients continue to be at risk.<br>• At 36 weeks VDRL should be repeated for patients at risk.<br>• Iron supplements and folic acid supplementation is advised. |

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| **PRENATAL LABS AND TESTING** | **FIRST TRIMESTER/INITIAL LAB TESTING:**<br>• Blood type, D (Rh) Type<br>• Antibody Screening<br>• Hct/Hgb<br>• Rubella<br>• VDRL<br>• Urine culture/screen<br>• HBsAg<br>• HIV Counseling/Testing<br>• Hgb Electrophoresis (optional)<br>• PPD (optional)<br>• Chlamydia (optional)<br>• Gonorrhea (optional)<br>• Genetic Screening Tests (optional) | **SECOND TRIMESTER TESTING:**<br>**8 – 18 weeks (when indicated/elected)**<br>• Ultrasound<br>• MSAFP/Multiple Markers (ideally at 16-18 wks)<br>• Amniocentesis<br>• Chorionic Villus Sampling (CVS)<br>• Karotype<br>• Amniotic Fluid (AFP | **THIRD TRIMESTER TESTING:**<br>**24 – 28 weeks (when indicated)**<br>• Hct/Hgb<br>• Diabetes Screening (1-hr GTT)<br>• 4-hr GTT if screening abnormal<br>• D (Rh) Antibody Screen, as indicated<br>• Anti-D Immune Globulin (RhIG) Given (28 wks), as indicated<br>**32 – 36 weeks (when indicated)**<br>• Hct/Hgb (recommended)<br>• Ultrasound<br>• VDRL<br>• Gonorrhea, Chlamydia<br>• Group B Strep (35-37 wks) |

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| **PRENATAL PLANS/ EDUCATION** | **FIRST TRIMESTER:**<br>• HIV and other routine prenatal tests<br>• Risk factors based on prenatal history<br>• Anticipated course of prenatal care<br>• Nutritional weight counseling<br>• Toxoplasmosis precautions<br>• Sexual activity<br>• Exercise<br>• Environmental work hazards<br>• Travel<br>• Tobacco (ask, advise, assess, assist, and arrange)<br>• Alcohol<br>• Illicit drugs<br>• Use of any over the counter medication (including supplements, vitamins, and herbs)<br>• Indications for ultrasound<br>• Domestic violence<br>• Seat belt use<br>• Child birth classes/hospital facilities<br>• Depression screen (Edinburgh Scale) | **SECOND TRIMESTER:**<br>• Signs and symptoms of pre-term labor<br>• Abnormal laboratory values<br>• Influenza vaccine<br>• Selecting a pediatrician<br>• Postpartum family planning / sterilization | **THIRD TRIMESTER:**<br>• Anesthesia/analgesia in labor<br>• Fetal movement monitoring<br>• Labor signs<br>• VBAC counseling<br>• Signs and symptoms pre-ecclampsia<br>• Circumcision<br>• Post term counseling<br>• Breast or bottle feeding<br>• Depression screening using the Edinburgh Depression Scale<br>• Car seats for newborn<br>• Family Medical Leave Act/Disability<br>• Tubal Sterilization Consent |
| **PRENATAL RECORD AND DOCUMENTATION** | The content of the preconceptional assessment, prenatal care assessments and follow-up assessments must be documented in a well organized prenatal record. The Antepartum Record of the American College of Obstetrics and Gynecologists provides the template for documentation and the patients' medical history questionnaire. All above described content can be documented in an appropriate format. Utilization of this nationally recognized record or an equivalent version is required unless the obstetrical provider can provide evidence of an alternative record that captures all required information and education content. Practitioners should encourage patients to consider a reproductive life plan and educate patients about how their reproductive life plan impacts contraceptive and medical decision-making. The Centers for Disease Control and Prevention's reproductive life plan template is available at http://www.cdc.gov/preconception/rlptool.html | | |

Source: Guidelines for Perinatal Care. Sixth Edition. 2007. American Academy of Pediatrics. The American College of Obstetricians and Gynecologists