Health Net Inc
2010 Prenatal/Perinatal Health Guidelines

INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS	36+ WEEKS
The first prenatal visit should be within the first 12 weeks of pregnancy	Visits should be every four weeks *	Visits should be every two to three weeks*	Visits should be weekly *
Complete physical exam, including review of systems	Visit should include: • Blood pressure • Weight • Urine for presence of protein and glucose • Uterine size for progressive growth and consistency with estimated date of delivery (EDC) • Fetal heart rate • Fetal movement assessment	Visit should include: • Blood pressure • Weight • Urine for presence of protein and glucose • Uterine size for progressive growth and consistency with estimated date of delivery (EDC) • Fetal heart rate • Fetal movement assessment	Visit should include: • Blood pressure • Weight • Urine for presence of protein and glucose • Uterine size for progressive growth and consistency with estimated date of delivery (EDC) • Fetal heart rate • Fetal movement assessment • Fetal presentation
Complete medical history of expectant mother including menstrual history and previous pregnancies	Assessed at the first visit	Assessed at the first visit	Assessed at the first visit
Genetic screening/counseling of expectant mother and father and any pertinent family history	Assessed at the first visit	Assessed at the first visit	Assessed at the first visit
Lab tests: • Blood group and RH type • Antibody screen • Hematocrit & hemoglobin • Varicella • Rubella • VDRL • Urinalysis	Lab tests (when indicated) • Repeat antibody tests in unsensitized, D-negative patient at 28-29 weeks and prophylactic anti-D immune globulin should be administered. • Screen for gestational diabetes mellitus at 24-28 wks • Repeat hematocrit & hemoglobin	Lab tests: • Hct/Hgb • Screen at 35-37 wks for Group B strep Additional Lab tests (when indicated): • Ultrasound • VDRL • Gonorrhea	

Health Net Inc
2010 Prenatal/Perinatal Health Guidelines

INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS	36+ WEEKS
• Urine culture & sensitivity • Chlamydia Screen • Hepatitis B surface antigen • Cervical cytology (as needed) • Human immunodefiency virus (HIV) counseling/ testing (offered)		• Chlamydia (Women younger than 25yrs or at high risk) • HIV (Women at high risk for HIV)	
Optional lab test offered or recommended based on history: (May not be all inclusive) • Hemoglobin Electophoresis • PPD • Gonorrhea • Screen for Cystic Fibrosis • Tay-Sachs Genetic screening tests • Ultrasound at 8-10 weeks (when indicated) • Prenatal genetic diagnosis	Second and third trimester ultrasound examinations (i.e., standard, limited and specialized) should be performed only when there is a valid medical indication for the exam.	Second and third trimester ultrasound examinations (i.e., standard, limited and specialized) should be performed only when there is a valid medical indication for the exam.	Second and third trimester ultrasound examinations (i.e., standard, limited and specialized) should be performed only when there is a valid medical indication for the exam.
• 1st trimester aneuploidy risk assessment • MSAFP/multiple markers** **All women presenting for prenatal care before 20 weeks of gestation should be offered screening for aneuploidy. All women, regardless of age, should have the option of	Integrated screening or sequential screening should be offered to women who seek prenatal care in the first trimester. Integrated screening uses both the first-trimester and second-trimester markers. Results are reported only after both first- and second-trimester screening tests are completed. In sequential screening, the patient is informed of the first-trimester screening result. Those at highest risk		

INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS	36+ WEEKS
invasive prenatal diagnosis (ie, CVS or amniocentesis) for fetal aneuploidy.	might opt for an early diagnostic procedure and those at lower risk can still take advantage of the higher detection rate achieved with additional second-trimester screening. • First-trimester combined serum screening (pregnancy associated plasma protein-A and free B-hCG) with nuchal translucency measurement (10-13 weeks of gestation) • Second-trimester triple (alpha-fetoprotein (AFP), estriol, B-hCG) or Quadruple (AFP,estriol, B-hCG, inhibin-A) marker serum screening (15- 20 weeks of gestation) • The options for women who are first seen during the second trimester are limited to quadruple (or "quad") screening and ultrasound examination. • First trimester nuchal translucency testing alone for multiple gestations (Serum screening tests are not as sensitive in multiple gestations) • If nuchal translucency measurement is not available or cannot be obtained in an individual patient, a reasonable approach is to offer serum integrated screening to patients who present early and second-trimester screening to those who present later. • Women found to be at increased risk		

Health Net Inc
2010 Prenatal/Perinatal Health Guidelines

INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS	36+ WEEKS
	of aneuploidy with first-trimester screening should be offered genetic counseling and option of CVS or second trimester amniocentesis.		
Counsel regarding: • Prenatal Vitamins and folic acid • HIV and other prenatal tests • Risk factors identified by history • Anticipated course of prenatal care • Nutrition and weight gain • Toxoplasmosis precautions • Sexual Activity • Exercise • Seasonal Influenza vaccine • CDC recommends one dose of the injectable 2009 H1N1 monovalent vaccine for all pregnant woman • Smoking counseling • Environmental/work hazards • Travel • Tobacco use • Alcohol use • Illicit/recreational drugs • Use of any medications (supplements, OTC etc) • Indications for ultrasound • Domestic violence • Seat belt use • Childbirth classes and choosing newborn care provider • Air travel during pregnancy	Counsel regarding: • Signs & symptoms of preterm labor • Abnormal lab values • Injectable Influenza vaccine (for all pregnant women at high risk or women who will be pregnant during the influenza season) • Selection of pediatrician • Smoking counseling • Postpartum family planning/tubal sterilization	Counsel regarding: • Anesthesia/analgesia plans • Fetal movement monitoring • Labor signs • VBAC counseling (if indicated) • Signs & symptoms of pregnancy induced hypertension • Post term counseling • Circumcision • Breast or bottle feeding • Postpartum depression • Influenza vaccine • Smoking counseling • Domestic Violence • Newborn education • Family medical leave	

Health Net Inc
2010 Prenatal/Perinatal Health Guidelines

INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS	36+ WEEKS
• Umbilical cord blood banking • Breastfeeding • Circumcision • Vaginal Birth after Cesarean delivery (VBAC) • Newborn screening • Dental care in pregnancy			

*The frequency of follow up visits is determined by the individual needs of the woman and assessment of her risk. Women with medical or obstetric problems may require closer surveillance

Postpartum Visit:

4-6 weeks after delivery but may be modified according to the needs of the patient. A visit within 7-14 days after delivery may be advised for cesarean delivery or complicated gestation.

Postpartum review should include:

- Interval history
- Physical exam
- Pap smear if indicated
- Review of family planning/birth control/preconceptional care
- Screen for depression
- Review of immunization status and recommendations as necessary

Preconception Care:

Consists of the identification of those conditions that could affect a future pregnancy or fetus and that maybe amenable to intervention. Counseling to optimize pregnancy outcomes should include:

- Family planning and pregnancy spacing
- Family HX
- Genetic history (both maternal and paternal)
- Medical, surgical, pulmonary and neurologic hx
- Current medication (prescription and non prescription)
- Substance use, including alcohol, tobacco and illicit drugs
- Domestic abuse and violence
- Nutrition
- Environmental and occupational exposures

- Immunity and immunization status and offer vaccine if indicated (rubella, varicella, and hepatitis B). Avoiding pregnancy within 1 month of receiving a live attenuated viral vaccine (e.g.rubella) is recommended.
- Risk factors for sexually transmitted diseases
- Obstetric history
- Gynecologic history
- General physical exam
- Assessment of socioeconomic, educational and cultural context
- Testing for specific diseases can be performed when indicated such as with genetic disorders.

Patients should be counseled regarding exercise, weight, nutrition, prevention of HIV infection, abstaining from alcohol, tobacco and illicit drugs use before and during pregnancy, determining the time of conception by accurate menstrual history, folic acid 0.4mg daily while attempting pregnancy and during first trimester of pregnancy for prevention of neural tube defects and maintaining good control of any preexisting conditions. Based on racial and ethnic background, screening for genetic disorders may be performed. Vaccination(s) should be offered to women found to be at risk for or susceptible to rubella, varicella, and hepatitis B.

References:

1. ACOG Practice Bulletin. Clinical Management Guidelines for Obstetrician-Gynecologists. Screening for Fetal Chromosomal Abnormalities. Number 77, January 2007
2. The U.S. Preventive Services Task Force (USPSTF) Obstetric and Gynecologic Conditions. Available at: http://www.ahrq.gov/clinic/cps3dix.htm#obstetric
3. American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 5th edition.
4. Kirkham C, Harris S, Grzybowski S. Evidence-Based Prenatal Care: Part I. General Prenatal Care and Counseling Issues. American Family Physician. 2005 Apr 1;71(7):1307-16. Available at: http://www.aafp.org/afp/20050401/1307.html
5. Kirkham C, Harris S, Grzybowski S. Evidence-based prenatal care: part II. Third-trimester care and prevention of infectious diseases. Am Fam Physician. 2005 Apr 15; 71(8): 1555-60 Available at: http://www.aafp.org/afp/20050415/1555.html
6. Centers for Disease Control and Prevention. (CDC) Sexually Transmitted Diseases Treatment Guidelines, 2006. August 4, 2006 / 55(RR11);1-94. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5511a1.htm
7. American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 6th edition
8. ACOG Practice Bulletin. Clinical Management Guidelines for Obstetrician-Gynecologists. Invasive Prenatal Testing for Aneuploidy. Number 88, December 2007
9. Centers for Disease Control and Prevention. 2009 H1N1 Influenza Vaccine and Pregnant Women: Information for Healthcare Providers. Jan 2010. Available at: http://www.cdc.gov/h1n1flu/vaccination/providers_qa.htm

Health Net Inc
2010 Prenatal/Perinatal Health Guidelines

Important Note

Health Net's Prenatal/Perinatal Health Guidelines provide recommendations are for the general population, based on the best available medical evidence at the time of release. A Health Net member's medical history and physical examination may indicate that further medical tests are needed. Guidelines may also differ from state to state based on state regulations and requirements. As always, the judgment of the treating physician is the final determinant of member care. Your benefit plan may or may not cover all the services listed here. Please refer to your certificate of coverage for complete details or contact the customer service number listed on your ID card.

Review History: February 2007, February 2008, March 2009, February 2010