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Antenatal and Postpartum Care Guideline

Clinical Care Guideline

PURPOSE

To provide routine prenatal and postpartum care in alignment with American Academy of Family Physicians (AAFP) best practices.

INCLUSION CRITERIA

Patient Population:

A. *Inclusion:* All patients presenting with a possibility of pregnancy should be evaluated promptly so early entry into prenatal care is facilitated.
B. *Exclusion:* Non pregnant patients

RESPONSIBILITY

Departments Include:

A. Department of Obstetrics and Gynecology
B. Department of Family Medicine
C. Community Health Services

GUIDELINE

A. The initial prenatal assessment should take place in the first trimester (before 14 weeks from the last menstrual period (LMP) whenever possible. When patients transfer later in pregnancy, request information from prior prenatal care providers so the OB chart can be updated.

1. The first prenatal visit or Obstetrical intake should be a combined visit between the Nurse and the OB Provider. The nurse reviews the patient's history, starts the problem list, and performs education aligned with the prenatal intake guidelines. The OB provider performs a physical exam, provides education and discussion of plan for presenting concerns with the patient. These visits may be a combination of virtual/telehealth and in person visits based on patient and provider preference.

    a. Please refer to Attachment A which outlines the standard elements of prenatal care recommended at each stage of pregnancy.

    b. Please refer to Attachment B (patient version) and C (provider version) which outlines the incorporation of virtual visits into a prenatal care schedule.

2. Confirmation of accurate dating can prevent unnecessary inductions and allow for appropriate diagnosis and treatment of preterm labor.

3. The OB Episode function in Epic should be used to document the OB intake history and then used as a reference for all pregnant patients during return OB visits. A problem list should be developed at the initial visit and updated throughout pregnancy. Maintaining an up-to-date problem list facilitates safe communication, especially when patient care is shared among providers.

4. Prenatal patients should be counseled on what screening tests are available during each trimester of care, and be aware of risks/benefits of testing vs not testing for the patient and the fetus.

5. Screen patients for their mental health as well as adequate access to financial resources and emotional support. Offer supportive counseling throughout prenatal care as needed for their circumstances.

B. Ongoing prenatal care:

1. Prenatal care should be provided with a single provider or care team to the extent possible.

2. The frequency of visits should be determined by the patient's individual needs and risk factors. Visits should be scheduled to include screening tests at the recommended gestational age. More, or less, frequent visits can be scheduled as needed to fit patient needs or if following up on higher risk conditions in pregnancy.

3. For low risk patients, reducing the number of prenatal visits does not lead to increased adverse outcomes for the patient or infant; however, patients were less satisfied with a reduced-visit schedule. The American Congress of Obstetricians and Gynecologists (ACOG) recognizes the

following schedule for low risk patients:

a. Ideally, the first visit should occur before 14 weeks when possible.

b. Every 4-6 weeks during the first 20 weeks, with at least one visit at 14-16 weeks.

c. Every 4 weeks between 21 and 30 weeks.

d. Every 2-3 weeks between 30 and 35 weeks.

e. Weekly after 36 weeks until delivery.

4. High risk patients should be seen more often and/or monitored for change in condition and status as indicated by their medical or obstetrical diagnoses.

C. Genetic Screening:

1. Offer genetic screening to all patients. BillionToOne offers Prenatal Genetic Testing--Unity which is non-invasive cell-free DNA sampling (blood test from a pregnant patient). This test evaluates fetal risk for recessive conditions, aneuploidies, and integrates a carrier screen as well.

a. Patients must be at least 10 weeks gestational age to collect the test; there is no upper limitation on gestational age for test collection.

b. This test includes all ACOG recommended testing for pregnant persons.

c. Testing may be done regardless of patient age/risk factors.

d. Testing is affordable and accessible to all patients; partner testing is not required.

e. The Unity test replaces the need to order first trimester screening (ultrasound plus integrated blood draws). Order dating ultrasounds as clinically indicated.

f. Higher risk patients (Advanced Maternal Age (AMA), prior history of a child affected by genetic condition) should still be offered referral to Genetics counselor through Women's Care clinic.

D. Vaccination

1. All pregnant patients should be offered vaccination for influenza (in season) and for Covid-19 regardless of gestational age. There is no evidence that vaccination in the first trimester is unsafe.

2. Tetanus-Diphtheria-Pertussis (TDap) should be given to each pregnant patient in each pregnancy regardless of time elapsed from last Tetanus (Td) or TDap vaccine. Vaccine should ideally be administered between 27-36 weeks.

3. Patients noted to be Rubella non-immune or equivocal on prenatal labs will be offered vaccination in the immediate postpartum interval while in hospital.

E. Postpartum Care

1. Please refer to Attachment A which outlines the recommended elements of care in the 6-week postpartum period.

2. Patients are encouraged to attend up to 3 visits in the six-week postpartum period:

    a. Patients following up in the Family Medicine CHS clinics are scheduled for a dyad (parent/newborn) RN visit at 2-3 days post discharge.

    b. One visit scheduled around 2-3 weeks (often with new infant for dyad care) and the final visit around 6-8 weeks postpartum.

        i. Other postpartum visits may be scheduled as indicated to follow up on high risk or other medical conditions.

        ii. Example: surgical post-operative visits, blood pressure checks for hypertensive patients, mood checks, birth control counseling visits.

3. Patients undecided on birth control method at hospital discharge should be offered a two-week clinic visit with provider to discuss available methods and determine follow up plan as indicated.

    a. Note: Nexplanon may be inserted at any time in the 6-week postpartum period as long as the patient does not have risk of unprotected intercourse.

    b. Pelvic rest is encouraged in the first 6 weeks after delivery.

4. Ongoing lactation support should be offered to all patients.

5. Patients with medical conditions transferring from the High-Risk Obstetric Clinic at Women's Care Clinic to primary care in clinics will need appropriate follow up plans discussed and referral to specialty care as indicated.

    a. Example: All gestational diabetic patients need a 2-hour glucose tolerance test ideally at 6 weeks postpartum (though up to 3 months is acceptable) to screen for overt diabetes mellitus type 2. If not able to do the 2-hour test, a hemoglobin A1c test is acceptable.

6. Review need for repeat pap testing as indicated per pap protocol.

7. Screen patients for postpartum depression symptoms as well as adequate access to financial resources and emotional support.

EXTERNAL REFERENCES

A. AAFP. Maternity Care: Clinical Recommendations and Guidelines. Maternity Care | AAFP. Site accessed 3/4/2024.

B. AAFP. Prenatal Care. AAFP by Topic: Editors' Choice of Best Available Content. Topic | AAFP Site accessed 3/4/2024.

C. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 8th ed. Elk Grove Village, Ill.: American Academy of Pediatrics, and Washington, D.C.: American College of Obstetricians and Gynecologists, 2017.

D. Screening for Fetal Chromosomal Abnormalities: ACOG Practice Bulletin, Number 226. Obstet Gynecol. 2020 Oct;136(4): e48-e69.

E. Paladine HL, Blenning CE, Strangas Y. Postpartum Care: An approach to the fourth trimester. Am Fam Physician. 2019;100(8):485-491.

F. Pregnancy and whooping cough—Vaccinating pregnant Patients. https://www.cdc.gov/pertussis/pregnant/hcp/pregnant-patients.html Site accessed 3/4/2024.

DHMP/DHHA RELATED DOCUMENTS

None

This Clinical Care Guideline is intended to assist care providers in the provision of patient care. This document serves as a guide, and is not a substitute for independent medical decision-making.

Attachments

ATTACHMENT A Low Risk Schedule for Antenatal and Postpartum Care.pdf

ATTACHMENT B_Who needs Zika blood testing flowchart.pdf

Attachment C-Prenatal Care Incorporation of Telehealth-Provider version 2_29_24.pdf.pdf

Approval Signatures

Step Description	Approver	Date
Final Signatory	Christine Seals-Messersmith: Medical Director Managed Care	12/2024
Formatting	Candy Gibbons: Executive Assistant [SG]	11/2024
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Applicability

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