Routine Prenatal Care

**Purpose**
To identify and promote the most important contributors to improved clinical outcomes for pregnant women and their newborns.

**Major Recommendations**
- Provide each patient with visit-specific screening, education and immunizations.
- Counsel appropriate patients regarding the different screening options and the limitations and benefits of each.
- Inform patients who have had a previous Cesarean delivery about the risks and benefits associated with vaginal birth after Cesarean (VBAC).
- Conduct a comprehensive risk assessment and provide appropriate treatment to all patients as it relates to risks for preterm labor, relevant infectious diseases and genetic disorders.
- Conduct a postpartum visit or a phone call within 2 weeks after delivery. Conduct a postpartum visit 4-6 weeks after delivery.
- All pregnant women should get one dose of Tdap during the third trimester or late second trimester (after 20 weeks gestation). If not administered during pregnancy, Tdap should be administered immediately postpartum. Family and friends who will be in contact with the baby should be education on receiving a Tdap vaccination.
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**Preconception**
- Risk profile
- Ht/Wt. (BMI)
- Blood pressure
- Breast exam
- Pelvic exam
- Family/OB hx
- Psychosocial hx
- Prescription drugs, herbal supplements, vitamins
- Exposure to lead/other environmental/occupational hazards
- Domestic violence
- Depression*
- Substance abuse
- Zika virus risk

**Initial Visit**
- Risk profile
- Ht/Wt. (BMI)
- Blood pressure
- Pelvic exam
- Exposure to lead, environmental/occupational hazards
- Breast exam
- Family/OB hx
- Estimated date of delivery
- Psychosocial hx
- Language/cultural issues
- Domestic violence
- Depression*
- Substance abuse
- Oral health and refer as needed
- Unstable housing

**Subsequent visits 0-28 wks. (visits should occur every 4 wks.)**
- Risk profile
- Weight
- Blood pressure
- Fundal height
- Fetal heart rate/tones

**29-36 wks. (visits should occur every 2-3 wks.)**
- Risk profile
- Weight
- Blood pressure
- Fundal height
- Fetal heart rate/tones

**37 + wks. (visits should occur wkly)**
- Risk profile
- Weight
- Blood pressure
- Fundal height
- Fetal heart rate/tones

**Immediate Post-Partum**
- Confirm fetal position/presentation
- Check cervix

**Post-Partum visits (3-8 wks. after delivery)**
- Uterine involution
- Delivery history
- Weight
- Blood pressure
- Pelvic exam
- Breast exam
- Medical, dental, psychosocial needs
- Postpartum depression*

### History and Physical

#### Preconception
- Initial Visit
- Subsequent visits
- Immediate Post-Partum

#### Diagnostic Procedures
- Pap smear
- Screening for:
  - Rubella
  - Varicella
  - PPD
  - Hepatitis B & C if indicated

#### Genetic Screening
- Cystic Fibrosis
- Ashkenazi Jewish population
- SMA
- Sickle Cell

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*Guidelines approved March 2022. Next scheduled review by March 2024.*
Measures Commonly Used by National Organizations

- Prenatal care: Screening for HIV- Percentage of Patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit. *(CMS Meaningful Use)*
- Prenatal care: Anti-D Immune Globulin - Percentage of D (Rh) negative non-sensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation. *(CMS Meaningful Use)*
- Educate patients whose previous child was delivered by Caesarean section of risks and benefits of VBAC. *(ICSI)* Current guidelines do not utilize race in the decision to have VBAC.
- Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. *(NCQA)*
- Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. *(NCQA)*


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High Risk Populations/Disparities

- In 2018, the rate of severe maternal morbidity for Black women delivering was 447 per 10,000 deliveries — 2.3 times higher than among white women, for whom the rate was 191 per 10,000 deliveries. The rate for Hispanic women was approximately 1.7 times the rate for white women; the rate for Asian women was approximately 1.5 times higher than the rate for white women.\(^2\)

- With established links between historical redlining practices and racial disparities in outcomes for Black patients seeking obstetric care, preterm births occurred in higher percentages in zip codes labeled “hazardous” – 12.38% of total preterm births – versus the lower percentage in “best” or “still desirable” zip codes (7.55%) in comparing 9 counties in the Finger Lakes region from 2005 to 2018.\(^3,4,5\)

- Across the Finger Lakes region, infant mortality rates for African-Americans and Latinos are consistently much higher than the rate for White infants. For the 3 years ending 2017, the African-American rate – 14.8 per 1000 live births - was nearly 3 times the White rate of 5.3 per 1000 live births.\(^6\)

- Adding a doula to a patient’s care team can improve outcomes, especially since doulas can play critical roles in advocating for the birth parent’s care and autonomy and helping to combat racism and discrimination that Black parents experience during pre- and post-natal care. (HealthConnect One and HBN.)

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\(^3\) Healthy Start Centers, Healthy Baby Network. Available from: [https://www.healthy-baby.net/resources/directory/3017/healthy-start-center-3/](https://www.healthy-baby.net/resources/directory/3017/healthy-start-center-3/)


Resources for Physicians

American College of Obstetrics and Gynecology
- Professional resources online bookstore

New York State Perinatal Quality Collaborative
An initiative of the New York State Department of Health that aims to provide the best and safest care for women and infants by preventing and minimizing harm through the use of evidence-based practice interventions.

Healthy Baby Network (formerly known as Perinatal Network of Monroe County)
- Information and resources for physicians and their patients.
- Includes information about the Black Doula Collaborative.

Project TEACH

Online Vaginal Birth After Cesarean (VBAC) calculator.
- The VBAC has recently eliminated “race” in the algorithm.

Resources for Patients

American College of Obstetrics and Gynecology
- Frequently Asked Questions
- Tips for Moms and Moms 2 Be - Free text messages every week to help during pregnancy.

Centers for Disease Control
- Maternal Health

Healthy Baby Network (formerly known as Perinatal Network of Monroe County)
- Healthy Babies Roc – Resources for health insurance and support services

Monroe County Health Department
- Women, Infants and Children’s Program (WIC) – The WIC Program is a supplemental food and nutrition education program that serves pregnant, breastfeeding, postpartum women. (To be eligible, the applicant must be a resident of New York State and have a household income of less than 185% of the poverty level.)

The Black Doula Collaborative,
- Doulas can provide multifaceted support to patients both during and after pregnancy and are effective care team members whose interventions have been effective in improvements in Black maternal mortality and morbidity.

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References


The American College of Obstetricians and Gynecologists. Immunizations for Women http://www.immunizationforwomen.org/


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Western NY Collaborative Prenatal Care Risk Screening & Referral Form
https://www.independenthealth.com/Portals/0/PDFs/ProvidersPublic/ToolsResources/RoutinePrenatalCare.pdf