OB RISK FACTORS & RECOMMENDED INTERVENTIONS

The following are common risk factors associated with High Risk Pregnancy-related complications that are addressed with the member:

- Comorbidity (e.g., diabetes, hypertension, asthma, depression) and non-adherence with the treatment plan for comorbid conditions
- Preelampsia or eclampsia
- History of preterm labor, incompetent cervix, placental abruption or placenta previa
- BMI < 18.5 kg/m^2 or $\geq$ 30 kg/m^2
- Anemia
- Current smoker
- Self-reported alcohol use
- Self-reported substance use
- History of second pregnancy within 12 months
- Age < 18 or > 35 years old
- Self-reported symptoms of depression
- Potential psychiatric risk per assessment
- Potential domestic conflict in the home
- Limited financial resources for health care or basic needs
- Ineffective psychosocial support systems
- Safety issues-potential unsafe home environment
- Pre-existing Type 1 or Type 2 diabetes
- Gestational diabetes
- A1C $\geq$ 7 %
- Frequent urinary track infections
- History of delivering a newborn > 9 lbs.
- Current STD
- HIV/AIDS
- Rh negative blood or Rh sensitization
- Pre-existing hypertension or new hypertension before 20 weeks gestation.

RECOMMENDED INTERVENTIONS*

The recommended intervention is: Early identification of potential pregnancy complications. Assess for history of genetic conditions, Rh Disease, previous pregnancy and history, existing comorbidity including sexually transmitted diseases and substance use. Anemia work-up, urinalysis and urine cultures, drug screen, A1C, Rh and genetic disease testing depending on history, age, and genetics. Prenatal vitamins use. Referral for genetic counseling, nutritional counseling and treatment with RhoGam if indicated.

The recommended intervention is: Early identification of pre-term labor (PTL) and prevention of pre-term delivery**.** Consider transvaginal ultrasound, pelvic exam and SalEst or fetal fibronectin assay; aminotomy if indicated. Treatment depends on gestational age and symptoms but can include hydration, bed rest, prohibition of sexual activity or strenuous exercise, medications (e.g., prenatal vitamins, antibiotics for specific infections identified, tocolytics), and cerclage. Evaluation of the fetus: biophysical profile, non-stress or stress tests, amniotic fluid volume index (AFI), ultrasound. Corticosteroid therapy for fetal maturation and fetal monitoring.

The recommended intervention is: Early identification and treatment of depression. Psychotherapy, using interpersonal psychotherapy or cognitive-behavioral techniques, is suggested for the initial treatment of mild-to-moderate symptoms of depression for pregnant patients who are not suicidal. The more severely ill patients with severe symptoms of depression should be managed by a psychiatrist, who can consult with the obstetrical care provider regarding appropriate use of medications in pregnancy. Consider antidepressant medication such as selective serotonin reuptake inhibitors (SSRIs) combined with cognitive behavioral therapy (CBT) with referral to an allied mental health care provider. Rule out medications as well as other medical conditions such as endocrine disorders as the source for the depression. Nutritional therapy; prenatal vitamins; referrals to dietitian and a social worker may also be indicated.

The recommended intervention is: Weight management: target BMI goal 18.5 to 24.9 kg/m2. When the BMI is < 19.8 kg/m2, the pregnancy weight gain goal is 28-40 lbs. When the BMI is between 19.8 and 25 kg/m2, the pregnancy weight gain goal is 25-35 lbs. When the BMI is above 26 the pregnancy weight gain goal is 15-25 lbs. For non-compliance, consider individualized diet therapy, a daily exercise program unless contraindicated, and behavioral therapies; referral to a dietitian and/or counselor; daily or weekly self-monitoring of weight.

The recommended intervention is: Control of hypertension. If late in pregnancy, bedrest and increased self blood pressure monitoring. If early in pregnancy, stress proper diet, exercise, stress reduction and, if necessary, medication. If preelcamptic, IV magnesium sulfate may be indicated. Consider early delivery. The goal BP for people with diabetes or kidney disease is < 130/80.

The recommended intervention is: Glycemic control, diet, exercise, and insulin if necessary when diabetic and pregnant. A1C is the primary target for glycemic control. The A1C target for people with diabetes in general is < 7% with A1C tests done every six months if target is met, every three months if results are equal to or greater than 7%. Referral to a dietitian is recommended during pregnancy to control A1C. Aggressive glycemic management with daily self-monitoring of blood glucose during pregnancy is strongly recommended. The American Diabetes Association recommends self-blood glucose monitoring upon awakening and one or two hours after meals in women with GDM.

The recommended intervention is: Smoking cessation: Medication and/or behavior modification programs should be strongly considered if the member is a smoker and is overweight. Discuss smoking cessation at every visit. Offer nicotine replacement aids if member cannot quit without them and counsel regarding potential side effects.

**Adapted from the guidelines and research by the National Institute of Child Health and Human Development (NICHHD) 2005, American College of Obstetricians and Gynecologists (ACOG) 2005, American Diabetes Association (ADA) 2009, Institute for Clinical Systems Improvement (ICSI) 2008 and the American Academy of Family Physicians (AAFP) 2005.*

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