Standardizing Prenatal and Postpartum Care at Whiteriver Indian Hospital

ITCA MATERNAL HEALTH WEBINAR

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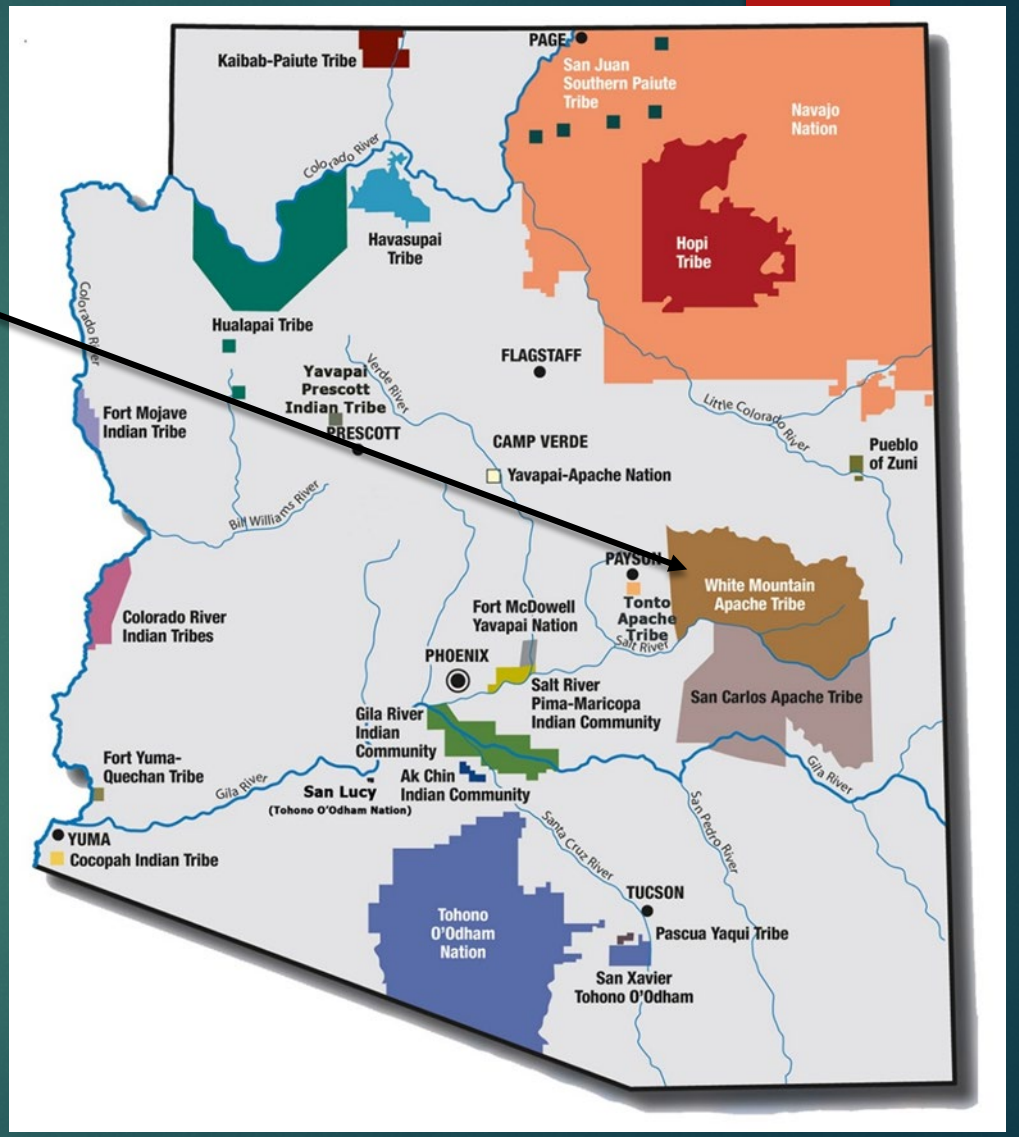
IHS Acknowledgement and Disclaimer

- This material is the result of work supported with resources and the use of facilities at the Whiteriver Service Unit, located in the Phoenix Area of the Indian Health Service.
- I acknowledge my employment as a family nurse practitioner at the Whiteriver Service Unit, located in Whiteriver, AZ.
- The contents of this presentation do not represent the views of the Indian Health Service or the United States Government.

Whiteriver Service Unit (WRSU)

- Indian Health Service
- Located in the White Mountains
- Home to the White Mountain Apache Tribe
- 5500 ft elevation
- Land mass: 1.67 million acres, 2,600 mi^2 (slightly smaller than the state of Delaware)
- Population: 18,000 people



Whiteriver Service Unit

- Hospital that includes an inpatient unit, emergency department, outpatient clinics, operating room, and birthing center.
- Physical therapy, occupational therapy, speech therapy, dental and optometry are on campus as well.
- Some providers work in specific department, some work in different settings across the hospital.

Our Birthing Center

Whiteriver Birthing Center

Standardized Prenatal Care

- General outline of visits
  - Every 4 weeks in first and second trimester
  - Every 2 weeks from 28-36 weeks
  - Weekly from 36 weeks to delivery
- Labs
  - First trimester labs (?genetic screening)
  - Late second trimester / early third trimester gestational diabetes screening
  - Third trimester labs
  - Group B step swab
- Imaging:
  - Dating ultrasound
  - Anatomy ultrasound
- Immunizations (and explain why!)
  - Flu – when due during flu season
  - Covid – when due
  - Tdap – beginning of third trimester

Positive Pregnancy Test

- Can happen through the Birthing center, the ED, or regular clinic visit
  - Review possible dates, LMP, update GsPs
- First trimester order set
  - First trimester lab panel
  - Dating ultrasound
  - Nutrition consult
  - Prenatal medications: prenatal multivitamin, calcium/vitamin D, ? Ferrous sulfate
- Scheduling of first prenatal visit
  - Collaboration and communication with clinic staff

First Prenatal Visit

- Nurse / Medical assistant education
  - Health history and prenatal education
  - Prenatal packets / handouts
- Provider
  - Health history
  - Education
  - Physical exam
- Nutrition consult
  - With follow-up as needed

Provider aspect of first prenatal visit

- Health history
  - Overall PMH, surgeries, allergies
  - Review first trimester labs
  - OB history: GsPs, past deliveries and issues in prior pregnancy
    - Example: hx of preterm delivery at 34 weeks for preeclampsia with severe features
  - Medications
  - Bothersome symptoms
- Education:
  - Roadmap for typical prenatal course
  - Toxoplasmosis
  - Diet / exercise recommendations
  - OTC medications
- Physical exam

Low dose aspirin for pre-eclampsia prevention

- Recommended by ACOG, SMFM, USPSTF to prevent or delay the onset of preeclampsia
- 81mg po daily
- Initiate at 12-16 weeks gestation (optimal benefit)
  - Can be initiated up to 28 weeks gestation
- Continue through reminder of pregnancy
- Screen everyone at the first prenatal visit with aspirin checklist

Guidelines for Initiation of Aspirin for Prevention of Preeclampsia

Criteria for initiation of low-dose aspirin prophylaxis for women at risk of preeclampsia:

One of more high risk factor:
[ ] History of preeclampsia, especially when accompanied by an adverse outcome
[ ] Multifetal gestation
[ ] Chronic hypertension
[ ] Pregestational type 1 or 2 diabetes
[ ] Kidney disease
[ ] Autoimmune disease (ie, systemic lupus erythematous, antiphospholipid syndrome)

Two or more moderate risk factors:
[ ] Nulliparity
[ ] Obesity (BMI > 30)
[ ] Family history of preeclampsia (ie, mother or sister)
[ ] Black persons (due to social, rather than biological, factors)
[ ] Low income
[ ] Age 35 years or older
[ ] Personal history factors (eg, low birth weight or small for gestational age, previous adverse pregnancy outcome, > 10-year pregnancy interval)
[ ] In vitro conception

Can consider if patient has one or more of these moderate-risk factors:
[ ] Black person (as a proxy for underlying racism)
[ ] Low income

Determination:
[ ] Meets criteria for aspirin prophylaxis
[ ] Does not meet criteria of aspirin prophylaxis

Dosing/initiation:
Aspirin 81mg po daily, initiated at 12-16 weeks gestation (up to 28 weeks, but considered optimal if before 16 weeks). Continue daily until delivery.

Population specific issues

- What are you seeing a lot of?
- How can you adjust your standards of care to address these needs?
  - Example – pregestational and gestational diabetes
    - Standard first trimester screening with A1c and random glucose
    - Early GTT based on risk factors (BMI > 30, hx GDM, A1c in preDM range)
    - Continuous glucose monitor – offered for anyone with pregestational or gestational DM to limit frequent finger sticks
      - Scan the meter and record their fasting and postprandial values

Integration of cultural practices

- Tour of birthing center during pregnancy to get a feel for the space – meet the staff, view the layout / style
- Natural deliveries with nitrous oxide as indicated
  - Spinning babies – used by nursing staff in late pregnancy to help promote maternal comfort and get mom and baby ready for labor
- Baby Friendly hospital designation – rooming in, lactation support (hospital-wide lactation education)
- We are a Birthing Center, which necessitates transfer of some patients with medical needs
  - Many of our prenatal patients meet criteria for high risk pregnancies and as such, deliver elsewhere
  - We maintain connections, facilitate transfers and ensure follow-up at every opportunity
- Postpartum practices – support practices across traditions – ask questions
  - Traditional ceremonies
  - Ex. Cradleboards and the "back to sleep" campaign

Team approach to care

- Necessitates agreement on how the team will address clinical concerns
  - Reinforcing similar education for patients
  - Standardizing care approach for things such as GDM, hx of preE, cHTN
- Consistency in charting – especially the assessment and plan

Prenatal assessment and plan

- Age of patient / Gravida & Para / Estimated gestational age / EDD _____ by _____. Pregnancy complicated by: _____
- 36yo G4P2012 at 24 3/7 EGA today with EDD 6/18/23 by sure LMP c/w 8w6d u/s. Pregnancy complicated by AMA, hx postpartum depression, hx genital HSV, hx c-section x 1, obesity.
  - AMA
    - Level II anatomy u/s 2/28/23 with normal anatomy
    - Normal genetic screening 12/16/22 via cell-free DNA
  - Hx postpartum depression
    - Mood stable today, evaluate each visit
    - At risk for postpartum depression following this pregnancy
  - Hx genital HSV
    - No active lesions this pregnancy
    - Start Valtrex prophylaxis at 36 weeks
  - Hx c-section x 1
    - G2: 5/11/18 due to breech presentation, successful vbac in G3: 6/19/20, interested in repeat VBAC
    - Low risk for vaginal birth on TOLAC risk assessment tool, has obgyn consult visit scheduled late April
  - Obesity
    - Pre-pregnancy BMI 37
    - Normal GTT / no GDM this pregnancy
    - Weekly NSTs at 37 weeks
  - Routine PNC
    - Continue prenatal care, ca/vit d
    - No anemia on first trimester labs, hgb 12.8, not on ferrous sulfate
    - Continue asa 81mg daily for preE prevention
    - It's a boy!
    - Plans to breastfeed
  - RTC 4 weeks, at f/u visit: third trimester labs, tdap, discuss circumcision

Follow-up appointments and flexible visits

- Patients always leave a prenatal visit with their next follow-up appointment in hand
  - With contact information to reschedule as needed
- Flexibility with patient appointments
  - Our patients often have difficulty with transportation, childcare, etc – we honor them and their pregnancy with seeing them during clinic hours whenever possible
  - Prenatal clinics across most days of the week
  - Birthing Center – always open

Educational topics by trimester

- Prompting the provider
- First trimester
- Second trimester
  - Anatomy ultrasound
  - GDM screening
  - MFM consult as needed
- Third trimester
  - Postpartum contraception
  - Newborn circumcision
  - Plans for breast and/or bottle feeding
  - Delivery planning (where, signs of labor)
  - Postpartum course

Lost to follow-up

- Call to check in, reschedule as needed
- Check with local community hospital
- Consult with community health resource
- Consult with department of preventative medicine outreach branch
  - Home visits to check on patient

Standardized Postpartum Care

- Postpartum care starts during prenatal care!
- Anticipatory guidance
  - Infant feeding / breastfeeding education and resources
  - Contraception counseling
  - Circumcision
  - Preeclampsia warning signs
  - Tour of the birthing center
  - Offering child birth education

Routine Postpartum Appointments

- 2-3 day postpartum check – Birthing Center
  - Lactation support
  - Postpartum depression screening
  - Acute concerns
- 2 week postpartum check – Prenatal clinic
  - Postpartum depression screening
  - Highlight resources for support
- 6 week postpartum check – Prenatal or PCP clinic
  - Postpartum depression screening
  - Follow-up on issues in pregnancy
  - Contraception
- Couplet care when possible
- "Discharge" back to primary care

Early motherhood is hard…physically, mentally, emotionally

- “The baby is the candy, the mom is the wrapper. Once the candy is out of the wrapper, the wrapper is cast aside.” - Alison Steube, MD University of North Carolina at Chapel Hill
- We are here to support mom’s through it

Postpartum Depression Screening

- Postpartum depression is the most common complication of childbearing
  - Onset occurs before or during pregnancy in roughly half of the cases
  - Postpartum onset most often within the first few months after delivery, but can begin up to 12mo after delivery
- Risk factors
  - **Past history of perinatal or nonperinatal depression**
  - Stressful life, poor social and financial support, young age, single marital status, multiparity, intimate partner violence
- Baby blues / postpartum depression / postpartum psychosis
- Treatment as indicated: counseling, medications, psychiatry services, close follow-up

The Edinburgh Postnatal Depression Scale

Check the answer that comes closest to how you have felt in the **past 7 days**, not just how you feel today.

1. I have been able to laugh and see the funny side of things □ As much as I always could □ Not quite so much now □ Definitely not so much now □ Not at all	6. * Things have been getting on top of me □ Yes, most of the time I haven't been able to cope at all □ Yes, sometimes I haven't been coping as well as usual □ No, most of the time I have coped quite well □ No, I have been coping as well as ever
2. I have looked forward with enjoyment to things □ As much as I ever did □ Rather less than I used to □ Definitely less than I used to □ Hardly at all	7. * I have been so unhappy that I have had difficulty sleeping □ Yes, most of the time □ Yes, sometimes □ Not very often □ No, not at all
3. * I have blamed myself unnecessarily when things went wrong □ Yes, most of the time □ Yes, some of the time □ Not very often □ No, never	8. * I have felt sad or miserable □ Yes, most of the time □ Yes, quite often □ Not very often □ No, not at all
4. I have been anxious or worried for no good reason □ No, not at all □ Hardly ever □ Yes, sometimes □ Yes, very often	9. * I have been so unhappy that I have been crying □ Yes, most of the time □ Yes, quite often □ Only occasionally □ No, never
5. I have felt scared or panicky for no very good reason □ Yes, quite a lot □ Yes, sometimes □ No, not much □ No, not at all	10. * The thought of harming myself has occurred to me □ Yes, quite often □ Sometimes □ Hardly ever □ Never

“Standardized care”

- Not synonymous with “one size fits all”
  - Individualize care to promote the autonomy of each new mom
- Normalize common postpartum issues
  - And break myths
- Link with resources in the hospital and community
  - Psychiatry
  - Physical therapy
  - Social services

Postpartum outreach initiative

- Home visits through the first year of life to screen for postpartum depression and link back to clinic and psych services as needed
- Administration of Edinburgh screen and Ages and Stages Questionnaire (ASQ) at home – provide resources for mom and baby
- Can call and connect to clinic staff from the patient's home in real time as needed for acute concerns
  - Work with the patient on when she can come in

Take-home message

- Pregnant patients are individual women who need personalized care, however guides / frameworks can help ensure that pertinent topics aren't missed
- Many women meet criteria for aspirin use in pregnancy!
- Care does not end once the baby is delivered: embrace the 4th trimester
- Postpartum depression is common – address and treat it!
- Anticipatory guidance is key – talk through possible issues each trimester to help manage anxiety and normalize uncomfortable topics
- Provide each woman the information necessary so she can have the autonomy to own her pregnancy and decisions

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