2016
ACOG COUNCIL OF DISTRICT CHAIRS
SERVICE RECOGNITION AWARD
NOMINEES

*Winning Projects

*District I
Massachusetts Section – Massachusetts Child Psychiatry Access Project for Moms
(MCPAP for Moms)

District III
New Jersey Section – Maternal Health Awareness Day

District VI
Wisconsin Section – Wisconsin Perinatal Quality Collaborative (WisPQC)

District VIII
Colorado Section, Education Committee – “Success Through Change”

District IX
Quality Improvement Project to Promote Vaginal Birth and
Reduce Primary Cesarean Births

*District X
Navy Section – Patient Safety Bundle for Obstetric Hemorrhage

District XII
Smoking Cessation Initiative implemented by the
ACOG District XII Council of Residency Program Directors
November 29, 2016

ACOG Council of District Chairs
Department of District and Section Activities
The American College of Obstetricians and Gynecologists PO Box 70620
Washington, DC 20024-9998

Dear ACOG Council of District Chairs,

I am delighted to nominate the Massachusetts Child Psychiatry Access Project for Moms (MCPAP for Moms) for the 2017 Council of District Chairs Service Recognition Award. MCPAP for Moms is a first in nation, statewide program that helps first-line obstetric providers address perinatal depression. All Ob/Gyns in Massachusetts have access to the free MCPAP for Moms program by calling 1-855-Mom-MCPAP (855-666-6272) or through the website at www.mcpapformoms.org, and thus all pregnant and postpartum women in Massachusetts, regardless of insurance coverage, have access to mental health care.

While 1 in 7 women suffer from perinatal depression, the vast majority go untreated. Because pregnant and postpartum women have regular contact with health care professionals, each contact provides an opportunity to screen for depression and engage women in treatment. Recommendations and legislation supporting screening for perinatal depression are increasing. The ACOG now recommends screening at least once during the perinatal period. The United States Preventive Services Task Force also recently made a Grade B recommendation to screen pregnant and postpartum women for depression when supports are in place to assure accurate diagnosis, effective treatment and follow-up. To help pregnant and postpartum women enter mental health treatment, screening must be coupled with strategies to build patient, provider, and practice-level capacity to address depression. The Massachusetts Child Psychiatry Access Project (MCPAP) for Moms provides a solution.

The mission of MCPAP for Moms is to promote maternal mental health by helping front-line providers screen and manage depression in pregnant women and women within a year of their delivery. MCPAP for Moms addresses the public health crisis of under-diagnosed and under-treated depression, which can have profound negative effects on the mother, fetus, child and family. Pregnant and postpartum women with depression have regular contact with health care providers – as such, each visit provides an opportunity to screen for depression and engage women in treatment. With MCPAP for Moms, providers are supported with real-time access to perinatal psychiatric expert consultation as well as targeted mental health community-based supports to address the mental health needs of their patients. MCPAP for Moms supports are also available to fathers, adoptive parents, grandparents and other family members experiencing perinatal mental health concerns.

DEVELOPMENT OF MCPAP FOR MOMS
Launched in July 2014, MCPAP for Moms is the first program of its kind in the nation. MCPAP for Moms is funded by the Massachusetts Department of Mental Health, and is free to all Massachusetts providers serving perinatal women.

In July of 2013, MA passed legislation to develop and implement MCPAP for Moms. After a period of intensive lobbying by a diverse group of stakeholders including representation and support from MA ACOG, and women with lived experience, in July 2015, the legislative budget included a specific appropriation for the Program. The political will and funding for this Program is the result of long-term advocacy by several broad-based coalitions of consumer and professional stakeholders, including MA ACOG, working with public policy makers committed to finding solutions to address perinatal depression. MCPAP for Moms is funded though the MA Department of Mental Health and is available to providers caring for these women all pregnant and postpartum women, regardless of insurance. In 2014 the MA legislature added budgetary language stating that commercial insurers will be surcharged proportionately for their utilization of the MCPAP programs; 50% of women served by MCPAP for Moms in 2014-15 were commercially insured. MCPAP for Moms is administered by the Massachusetts Behavioral Health Partnership (MBHP), a Beacon Health Options company that provides managed behavioral health services in Massachusetts.

During development and early implementation, obstetric practices were engaged through presentations at regional medical conferences, grand rounds, practice level trainings and other personal and professional networks. MCPAP for Moms leadership developed relationships with individual stakeholders and professional societies to facilitate broad engagement. Two obstetric liaisons/ACOG members were contracted as consultants and designated to help develop and maintain relationships with professional societies, individual providers and leaders at birthing hospitals and practices throughout the state. MA ACOG was and continues to be instrumental to obstetric provider engagement in MCPAP for Moms. For example, MA ACOG leadership provided introductions to and information about MCPAP for Moms in their newsletters, email blasts, and other communications. MCPAP for Moms consulting psychiatrists proactively called individual practices, describing the program and offering to visit the practice to conduct trainings.

CORE COMPONENTS

- **Trainings and toolkits:** Provide evidence-based guidelines for providers and their staff on depression screening, triage and referral, risks and benefits of medications, and discussion of screening results and treatment options. All training and toolkit materials are open-source and available at [www.mcpapformoms.org](http://www.mcpapformoms.org) (or See Appendix p. 13-22).

- **Real-time psychiatric consultation and care coordination:** Provides consultation with a perinatal psychiatrist, and subsequent care coordination.
- **Linkages with community-based resources:** Includes mental health care, support groups and other resources to support the wellness and mental health of pregnant and postpartum women.

**HOW MCPAP FOR MOMS WORKS**

Providers in Massachusetts can call MCPAP for Moms at 855-Mom-MCPAP (855-666-6272), Monday-Friday, 9am-5pm, and speak with a Care Coordinator who will work with the provider to determine their needs for assisting their patients - i.e., consultation regarding psychiatric care, community care coordination, or both.

- **Psychiatric consultation:** The MCPAP for Moms perinatal psychiatrist provides real-time consultation via the telephone to medical providers. The consultation may involve diagnostic support, guidance in regards to medication treatment (when indicated) or concerns regarding preconception, pregnancy and lactation, psychotherapy and community support needs, and treatment planning. The MCPAP for Moms psychiatrist works with the provider to assist him/her in addressing their patient's mental health concerns. The MCPAP for Moms psychiatrist is also available to see patients for face-to-face consultations, after which they will send a detailed written assessment that will include treatment recommendations to the provider.

- **Care coordination:** The Care Coordinator works with providers to assist them in arranging ongoing mental health support for patients including, but not limited to, psychotherapy groups, mental health treatment (including prescribers), and family based treatments. Community supports are specifically matched for each patient to ensure that they are geographically convenient and work with a patient’s insurance. In some cases the Care Coordinator can call the patient/family and provider to ensure that patients have access to follow-up mental health care.

**WHO CAN CALL**

- **Obstetrical providers:** This includes obstetricians/gynecologists, midwives, labor and delivery nurses, and family medicine providers practicing obstetrics. MCPAP for Moms builds the capacity of obstetric providers to detect and manage depression and other mental health concerns that may arise among perinatal women in their practices via screening, direct care management, and assistance with care coordination for ongoing mental health care and supports. MCPAP for Moms engages and enrolls obstetrical practices on a rolling basis.

- **Pediatric providers:** This includes pediatricians, family physicians, and nurse practitioners who provide well-child care in the first year of life. MCPAP for Moms helps pediatric providers detect and refer depression and other mental health issues that may arise among postpartum women seen in pediatric settings.
• **Adult psychiatric providers:** MCPAP for Moms builds the capacity of adult psychiatric providers to manage their patients who are planning to or who become pregnant during treatment via expert consultation with a perinatal psychiatrist to facilitate careful and thoughtful decisions regarding medication management before, during and after a pregnancy.

• **Adult Primary Care Providers:** This includes both internal and family medicine providers who practice general adult medicine. MCPAP for Moms assists PCPs in providing ongoing care for their patients during the postpartum period.

**HOW MCPAP FOR MOMS HELP PROVIDERS**
MCPAP for Moms has created an obstetric toolkit to assist front-line perinatal care providers in prevention, identification, and treatment of depression. This toolkit contains assessment tools, screening tools and algorithms, and guides on what to do when treatment with antidepressants is indicated (see Toolkit in Appendix p. 13-22 or online at [www.mcpapformoms.org](http://www.mcpapformoms.org)). The obstetric toolkit includes:

- Depression Screening Algorithm for Obstetric Providers
- Assessment of Depression Severity and Treatment Options
- Recommended Steps before Beginning Antidepressant Medication Algorithm
- Bipolar Disorder Screen
- Antidepressant Treatment Algorithm
- Key Clinical Considerations when Assessing the Mental Health of Pregnant and Postpartum Women
- Summary of Emotional Complications during Pregnancy and the Postpartum Period

**HOW MCPAP FOR MOMS PREGNANT AND POSTPARTUM WOMEN AND THEIR FAMILIES**
MCPAP for Moms has developed resources to support the mental health of perinatal women and their families. These resources, available at [www.mcpapformoms.org](http://www.mcpapformoms.org), include:

- Tips sheets for [How to Find a Primary Care Practitioner](http://www.mcpapformoms.org) and [How to Talk to Your Health Care Provider](http://www.mcpapformoms.org).
- A searchable database of regional [support groups](http://www.mcpapformoms.org) for pregnant and new mothers.
- Web-based and social media supports and resources for pregnant and postpartum women, fathers, perinatal loss, and crisis services.

**FACTS AND FIGURES**
Since Inception, MCPAP for Moms has:

- Served 2,091 unique patients
- Taken over 1,569 phone calls from providers
- Provided 2,585 care coordination activities
• Conducted over 130 trainings for front-line perinatal health care providers
• Enrolled 60% of all obstetric practices in Massachusetts

FEEDBACK
We have received excellent feedback from providers and patients. Providers note that they feel comfortable screening for, assessing and treating perinatal depression because they can call MCPAP for Moms for consultation and care coordination. As one Ob/Gyn Provider noted (see Appendix p. 7 for more testimonials):

“...it’s always been hard to know how to deal with patients who you feel are depressed or blue. There was no organized way to approach the problem and talk and if you did there was nowhere to refer these people to so it would be... I hate to say, almost kind of threw them under the rug a little bit. This has created such a great avenue to identify them and to get them help so I want to thank you for that.”

We have received positive feedback from patients who have been served by MCPAP for Moms. Patients’ have noted how critical their OB/Gyn provider was in helping them get the mental health care they needed. They have also noted how helpful the care coordination is in helping them navigate the complicated mental health system to get the care they need. As one patient noted (see Appendix p. 7 for more testimonials):

"Oh my gosh, the appointment went great! So far I have a really good feeling about receiving therapy from this place. The woman I met with seems so nice and well educated! Thank you, thank you for hooking me up with these services. It is such a relief for my whole family that I finally have the support system I need to deal with my issues in a safe and healthy way! Thank you!"

OPERATING COSTS
MCPAP for Moms operates with an annual budget of $11.80 per pregnant and postpartum woman per year. This translates to $0.98 per month or $850,000 for 72,000 deliveries annually in Massachusetts.

COMMUNITY PARTNERS
MCPAP for Moms works in close partnership with Motherwoman and William James INTERFACE Referral Service. As part of MCPAP for Moms, Motherwoman is actively training health care leadership in six communities across Massachusetts on strategies to be responsive to the needs of pregnant and postpartum women living with emotional health concerns. This includes establishing new perinatal support groups for mothers and families throughout the Commonwealth. INTERFACE developed and maintains the database used by Care Coordinators
to match community mental health resources (e.g., therapist) to women referred to MCPAP for Moms.

**RESEARCH BUILDING ON MCPAP FOR MOMS**

MCPAP for Moms leadership was recently awarded a U01 grant from the U.S. Centers for Disease Control and Prevention (CDC) to test and disseminate a stepped care intervention for perinatal depression in Ob/Gyn settings. This first-of-its-kind, $2.5 million grant includes a randomized controlled trial comparing MCPAP for Moms to an enhanced intervention that will include MCPAP for Moms and some additional collaborative care approaches (including case management, systematic patient monitoring, stepped care, and implementation assistance among others). This will allow for the collection of outcome data on MCPAP for Moms (including treatment rates and depression outcomes), while also testing an enhanced intervention that will build on the MCPAP for Moms program. This is a particularly noteworthy accomplishment as only one U01 grant was awarded in U.S. This demonstrates the role of MCPAP for Moms and its leadership in developing and setting the standard of care to address perinatal depression in obstetric settings.

**SUMMARY AND FUTURE**

MCPAP for Moms is the first program of its kind in the nation to address perinatal mental health in obstetric, primary care and psychiatry settings statewide. MCPAP for Moms goes beyond promoting postpartum depression screening; it seeks to detect maternal mental health concerns in pregnancy and the postpartum period. It builds the capacity of frontline providers to not only screen for maternal mental health but also provide treatment when needed. The volume of encounters, number of women served, and low cost suggest that MCPAP for Moms is a feasible approach to help frontline providers prevent, identify, and manage perinatal depressions and other mental health concerns. The ongoing and critical problem of insufficient access to psychiatric care for the general population is accentuated for the perinatal population. MCPAP for Moms can be sustainable, as it is modeled on MCPAP, a successful, sustainable model that has been replicated in 32 states to support pediatricians as they address the psychiatric needs of their patients.

With its early success, MCPAP for Moms has garnered broad interest from stakeholders around the country interested in establishing similar programs in other states. Several states with existing MCPAP programs are actively working to start MCPAP for Moms type programs, including Wisconsin, who just received a $1,300,000 grant to implement a program modeled off MCPAP for Moms. It has also led to the introduction of HR. 3235 and S.2311, the Bringing Postpartum Depression Out of the Shadows Act of 2015, in the United House of Representatives and Senate, respectively (see Appendix p. 90-100). These bipartisan bicameral legislative initiatives would appropriate $5,000,000 for each fiscal year 2016-2020 to be used
for at least three states to establish programs similar to MCPAP for Moms. This initiative demonstrates the potential for MCPAP for Moms to set standards for care across the nation.

I believe our MCPAP for Moms leadership team is worthy of recognition for their dedication, enthusiasm, and tireless efforts. I greatly look forward to a day when all of our fellows regardless of District or state have access to a similar resource. I humbly submit ACOG District I’s MCPAP for Moms program for consideration of the Council of District Chairs Service Recognition Award, as it deserves national recognition - this recognition would facilitate awareness of, and thus early dissemination of, this key and pioneering program to other Districts.

Sincerely

[Signature]
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Improving perinatal depression care: the Massachusetts Child Psychiatry Access Project for Moms

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Objective: Perinatal depression is common and associated with poor birth, infant and child outcomes. Screening for perinatal depression alone does not improve treatment rates or patient outcomes. This paper describes the development, implementation and outcomes of a new and low-cost population-based program to help providers address perinatal depression, the Massachusetts Child Psychiatry Access Project (MCPAP) for Moms.

Method: MCPAP for Moms builds providers’ capacity to address perinatal depression through (1) trainings and toolkits on depression screening, assessment and treatment; (2) telephonic access to perinatal psychiatric consultation for providers serving pregnant and postpartum women; and (3) care coordination to link women with individual psychotherapy and support groups.

Results: In the first 18 months, MCPAP for Moms enrolled 87 Ob/Gyn practices, conducted 100 trainings and served 1123 women. Of telephone consultations provided, 64% were with obstetric providers/midwives and 16% were with psychiatrists. MCPAP for Moms costs $8.38 per perinatal woman per year ($0.70 per month) or $600,000 for 71,618 deliveries annually in Massachusetts.

Conclusion: The volume of encounters, number of women served and low cost suggest that MCPAP for Moms is a feasible, acceptable and sustainable approach that can help frontline providers effectively identify and manage perinatal depression.

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1. Introduction

Perinatal depression is a widespread problem that may complicate birth [1], infant [2] and child outcomes [3–5]. While 1 in 7 women suffers from perinatal depression [6], the vast majority go untreated [7–10]. Because pregnant and postpartum women have frequent contact with perinatal health care professionals, the perinatal period is an ideal time to screen for, assess and treat perinatal depression [7]. However, screening alone does not improve treatment rates or patient outcomes [11–15].

Recommendations and legislation supporting screening for perinatal depression are increasing. The American College of Obstetricians and Gynecologists recently changed their committee opinion from insuffi cient evidence to support for universal antepartum or postpartum screening [16] to recommend screening at least once during the perinatal period [17]. The United States Preventative Services Task Force also recently made a Grade B recommendation to screen pregnant and postpartum women for depression when supports are in place to assure accurate diagnosis, effective treatment and follow-up [18]. To help pregnant and postpartum women enter mental health treatment, screening must be coupled with strategies that build patient, provider and practice-level capacity to address depression [15,19–21].

Addressing perinatal depression will ultimately require a practical and sustainable platform. Such a model is offered by the Massachusetts Child Psychiatry Access Project (MCPAP), a successful population-based model for delivering psychiatric care in pediatric settings that has been widely disseminated and implemented across the U.S. [22,23]. MCPAP is recognized by the Agency for Healthcare Research and Quality as an

Disclosures: The first author has received salary and funding support from the Massachusetts Department of Mental Health via the Massachusetts Child Psychiatry Access Project (MCPAP) for Moms and is the Medical Director of MCPAP for Moms. The second author has received salary and funding support from the Massachusetts Department of Mental Health via the MCPAP for Moms and is the Program Director of MCPAP for Moms. The third author serves as a representative to the MA section of the American College of Obstetricians and Gynecologists on the MA Governor’s Commission on Postpartum Depression and as an Obstetric Liaison to MCPAP for Moms. The fourth author has received salary and funding support from the Massachusetts Departments of Mental Health and the Medical Director of MCPAP. The fifth author received salary and funding support from the Massachusetts Department of Mental Health via the MCPAP and is the Program Director of MCPAP. The last author received salary and funding support from the Massachusetts Department of Mental Health via the MCPAP and is the Founding Director of MCPAP. The first author had full access to all the data in the study and takes responsibility for the integrity of the data and accuracy of the data analysis.

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http://dx.doi.org/10.1016/j.genhosppsych.2016.03.002
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MCPAP for Moms was developed and implemented in Massachusetts to respond to the critical public health issue of perinatal depression. MCPAP for Moms aims to improve perinatal depression treatment participation by building the capacity of frontline medical providers serving pregnant and postpartum women. MCPAP for Moms focuses on depression during pregnancy as well as in the postpartum period because >50% of women with postpartum depression enter pregnancy depressed or have an onset during pregnancy [25]. Active outreach, engagement and enrollment are targeted to obstetric providers as they have the most contact with pregnant and postpartum women. Pediatric, adult psychiatric, adult primary care providers or any other provider serving pregnant or postpartum women are also encouraged to use MCPAP for Moms for consultation regarding any mental health concern. For example, general psychiatrists can obtain consultations to build their capacity to provide evidence-based treatment for pregnant and postpartum women. Additional consultation and care coordination services are available to family medicine and pediatric primary care providers screening for depression during well-child visits in the first year of life.

2.2. Funding and legislation

In July 2013, Massachusetts passed legislation to develop and implement MCPAP for Moms. By July 2015, the legislative budget included a specific appropriation for MCPAP for Moms. MCPAP for Moms is funded by the Massachusetts Department of Mental Health. In 2014, the Massachusetts legislature added budgetary language stating that commercial insurers will be surcharged proportionately for their utilization of the MCPAP programs [22]. For fiscal year 2014–2015, 50% of the women served by MCPAP for Moms were commercially insured; thus, the surcharge covers this population. The political will and funding for the program is the result of long-term advocacy by several broad-based coalitions of professional and consumer stakeholders working with public policy makers committed to finding systemic solutions to address perinatal depression.

Central planning, administration and coordination of the program are provided by a managed behavioral health organization (Massachusetts Behavioral Health Partnership, a subsidiary of Beacon Health Options). MCPAP for Moms serves all pregnant and postpartum women in the state regardless of a mother’s or family’s insurance status and is available to all providers caring for these women.

2.3. Development

MCPAP for Moms was conceptualized and developed between November 1, 2013 and June 30, 2014. MCPAP for Moms has three teams hosted within Psychiatry Departments at academic medical centers in three distinct geographic regions. Each team is reimbursed for direct and indirect expenses through annual contracts with the Massachusetts Behavioral Health Partnership. Total operating cost of the program, excluding start-up administrative expenses and community capacity building, is $8.38 per pregnant and postpartum woman per year ($0.70 per month) or $600,000 for 71,618 deliveries [26] annually in Massachusetts.

MCPAP for Moms provides (1) trainings and toolkits for providers and staff on depression screening, assessment and treatment; (2) telephonic access to real-time perinatal psychiatric consultation for providers; and (3) care coordination to provide linkages with community-based resources including individual psychotherapy and support groups. Massachusetts’ providers call a statewide toll-free number to access consultation with a perinatal psychiatrist and care coordinator during business hours, Monday through Friday. MCPAP for Moms also offers preconception consultation and encourages screening for fathers and adoptive parents.

2.4. Practice engagement

During development and initial implementation, obstetric practices were engaged through presentations at regional medical conferences, grand rounds, practice level trainings and other personal and professional networks. MCPAP for Moms leadership developed relationships with individual stakeholders and professional societies to facilitate broad engagement. Two obstetric liaisons (one being TMS) were designated to help develop and maintain relationships with professional societies, individual providers and leaders at birthing hospitals and practices throughout the state. Several professional societies included introductions to and information about MCPAP for Moms in their newsletters, email blasts and other communications. MCPAP for Moms consulting psychiatrists proactively called individual practices, described the program and offered to visit the practice to conduct a training. In order to facilitate engagement, MCPAP for Moms also developed and distributed brochures for patients and providers, psychoeducational handouts, magnets, pens, lanyards and notepads.

2.5. Partnerships

MCPAP for Moms partners with two organizations in Massachusetts to support the work of the program. The first, William James College INTERFACE, developed and maintains a customized database of targeted, perinatal community mental health supports and providers for use by MCPAP for Moms care coordinators. The second, MotherWoman, is a grass roots nonprofit organization. MCPAP for Moms funds MotherWoman to develop community capacity to address depression in addition to support groups for postpartum women using their community-based perinatal support model. William James College INTERFACE and MotherWoman each have contracts for service and function completely independently of MCPAP for Moms.

2.6. MCPAP for Moms operations

2.6.1. Staffing

MCPAP for Moms serves all of Massachusetts with 1 full-time equivalent (FTE) perinatal psychiatrist and 2.3 FTE care coordinators divided between three MCPAP for Moms regions. The leadership team consists of a medical director (NB), a program director (KB), a lead care coordinator and a project assistant who are devoted to program development, operations and implementation. Before the program was launched, efforts focused on (1) developing the MCPAP for Moms toolkit, trainings and website; (2) identifying contacts with obstetric practices and delivering hospitals; and (3) operationalizing day-to-day implementation of the program. Post launch, the focus shifted to scheduling trainings, enrolling obstetric practices, creating tracking databases for care coordination resources, educating community mental health providers and creating an operations manual.

2.6.2. Training, enrollment and clinical services

MCPAP for Moms recommends that obstetric providers screen for depression at three time points: the first prenatal visit, at 24–28 weeks gestational age and at 6 weeks postpartum. High-risk women with a positive depression screen during pregnancy or a history
of depression should also be screened at 2 weeks postpartum. The goal of MCPAP for Moms is to enroll all Massachusetts obstetric practices such that all 71,618 women who give birth each year [26] have access to mental health care through their obstetric providers who will be equipped to manage depression and other mental health concerns. The MCPAP for Moms team establishes relationships with obstetric providers through 1-h on-site trainings conducted by a MCPAP for Moms consulting perinatal psychiatrist. The training provides an orientation to the program and didactics in how to detect, assess and manage perinatal depression and other mental health concerns (training PowerPoint and all MCPAP for Moms materials available at www.mcpapformoms.org). Before the MCPAP for Moms launch, training materials and toolkits were developed and refined based on iterative feedback from obstetric providers and staff. The training materials and toolkit was then beta tested at an obstetric practice [27]. After MCPAP was launched, qualitative and quantitative feedback was elicited via surveys and informal discussions, and training materials and toolkits were revised based on feedback received. Practices must participate in a training prior to enrollment. Booster sessions are conducted upon request.

All MCPAP for Moms calls are first answered by a care coordinator who gathers basic information to assess the nature and urgency of the need. This information is shared securely with the on-call MCPAP for Moms psychiatrist who then calls the provider to initiate the consultation. Telephone consultations are intended to occur within 30 min of initiation, while the patient is still in the providers’ office.

Consultations are intended to serve as individualized, case-based education for providers. The knowledge, skills and comfort level of providers are taken into account by the MCPAP for Moms psychiatrist during each consultation and the teaching and case-based education is tailored to the provider seeking consultation. The consulting MCPAP for Moms psychiatrist also asks providers questions in order to understand whether evidence-based treatment is being offered to the patient being discussed. Available evidence-based treatment options for each case are discussed as well as education by MCPAP for Moms psychiatric consultant to the provider.

When telephone consultations are not sufficient to answer providers’ clinical questions, MCPAP for Moms psychiatrists can provide a one-time, face-to-face consultation with the patient. Outpatient consultations are scheduled as soon as possible, generally within 2 weeks from initial contact. Face-to-face consultations last approximately 1 h and are followed by consultation letters with recommendations for the provider and referred patient, within 48 h of the appointment. The MCPAP for Moms psychiatrist does not initiate treatment; a recommendation is made for treatment to be managed by the obstetrician or for a referral to a psychiatrist. Recommendations for and referrals to support groups or individual therapists are also often made.

Care coordinators are responsible for the identification, referral and coordination of mental health services. Care coordinators use the INTERFACE database of community mental health supports and providers with expertise in perinatal mental health to match patient needs (e.g., location, insurance) to available resources. Resources and referrals are shared with the calling provider via secure email, fax or telephone. If clinically indicated during the telephone or face-to-face consultation, the care coordinator can call the patient directly to help them identify and schedule community mental health services. For example, if during the telephone or face-to-face consultation it becomes clear that the patient needs a psychiatrist, patients can be referred to the care coordinator for assistance in establishing care with a psychiatric provider. Results of care coordination are reported back to the referring provider. For all cases in which the care coordinator is in contact with a patient, there is a follow-up call approximately 1 month after care is scheduled, to check on progress and determine if more supports are indicated. The care coordinator documents outcomes in the MCPAP for Moms database and updates the referring provider within the next business day.

Care coordinators maintain close relationships with community mental health agencies and keep up with changes in wait times and availability of clinicians. If the wait time for an outpatient psychiatrist is deemed unacceptably long, depending on the clinical situation, the MCPAP for Moms psychiatrist can see the patient for follow-up and continue to make recommendations to the referring provider until an outpatient appointment with a psychiatrist can be secured.

2.7. Data collection

2.7.1. Setting

Data were collected from all providers who utilized MCPAP for Moms from June 30, 2014 (start of program) through February 29, 2016. Each discrete activity (e.g., telephonic perinatal psychiatric consultation, face-to-face assessment, care coordination event, follow-up inquiry) is considered an encounter. Each encounter is entered into a secure, web-based, Health Insurance Portability and Accountability Act-compliant structured-query language database. Data are transmitted securely to the central server with identifying information accessible only to the members of the MCPAP for Moms team. This work did not meet criteria for human subject research by the institutional review board at the University of Massachusetts Medical School.

2.7.2. Utilization measures

MCPAP for Moms utilization was assessed by the number of provider calls, care coordination encounters and telephone and face-face consultations with MCPAP for Moms psychiatrists. Data were also collected for encounter outcomes. To describe providers and patients participating in the program, the clinical setting, provider type and patient insurance coverage were assessed.

2.7.3. Patient outcome measures

2.7.3.1. Edinburgh Postnatal Depression Scale (EPDS). EPDS scores were collected during MCPAP for Moms psychiatrists’ telephone and/or face-to-face consultations with providers. The EPDS is a validated, self-administered questionnaire that is most commonly used to screen for depression during pregnancy and the postpartum period [28]. The intensity of depression symptoms is rated for the preceding 7 days by answering 10 multiple-choice items [28]. Each item is scored on a 4-point scale for a total score range of 0–30 with higher scores reflecting a greater severity of symptoms [28]. Scores that indicate depression begin from 9 to 13 [29]. EPDS scores ≥ 9 indicate “possible” depression and those ≥ 12 indicate “probable” depression with a sensitivity of 86% and a specificity of 78% [28]. Based on prior studies [28,29], EPDS data were categorized into not depressed (EPDS score 0–8), mild depression (EPDS 9–12), moderate depression (EPDS 13–18) and severe depression (EPDS ≥ 19).

2.7.3.2. Patient Health Questionnaire (PHQ-9). If the PHQ-9 was used by the providers, scores were collected during MCPAP for Moms psychiatrists’ telephone consultations with providers. The PHQ-9 is a nine-item self-report questionnaire that has been widely validated for use in primary care settings [30]. In general adult populations, PHQ-9 scores ≥ 10 indicate depression with a sensitivity of 74–88% and a specificity of 88–91% [30]. In pregnant populations, its sensitivity and specificity [30] are comparable to the EPDS [31]. The PHQ-9 data were categorized into not depressed (PHQ-9 0–9), mild depression (PHQ-9 10–14), moderate depression (PHQ-9 15–19) and severe depression (PHQ-9 ≥ 20).

3. Results

During the first 18 months of implementation, 100 obstetric practices with 350 obstetric providers were trained. MCPAP for Moms has enrolled 47% of all Massachusetts obstetric practices (n = 87) and served 1123 women since inception (Fig. 1). MCPAP for Moms also
developed a website with 25 pages of content that has received an average of 1290 page views per month since the program’s launch. The total number of encounters according to services provided and provider type from June 30, 2014 until February 29, 2016 are listed in Table 1. Barriers to engagement were encountered when approaching busy practices in which there were no preexisting relationships. Barriers were also encountered in practices with preexisting mental health resources. MCPAP for Moms leadership worked with these practices to build on and enhance their existing mental health supports. Building on existing relationships and professional networks facilitated engagement. Presentations at statewide conferences held by professional societies often garnered interest and engagement. Additionally, presentations at numerous other venues (e.g., grand rounds) allowed for piqued interest and a catalyst for further discussions and engagement.

Of the 1123 patients served, 217 (23%) were in the first trimester, 158 (16%) were in the second trimester, 135 (14%) were in the third trimester and 367 (40%) were postpartum. Of postpartum patients, 162 (17%) were lactating. Of remaining encounters, 18 (2%) addressed pre-conception, 18 (2%) focused on perinatal loss and 3 (1%) on miscarriage. (17%) were lactating. Of remaining encounters, 18 (2%) addressed pre-conception, 18 (2%) focused on perinatal loss and 3 (1%) on miscarriage.

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Of the 297 women whose providers reported an EPDS score, 35 (12%) were ≤ 8, 53 (18%) were 9–12, 111 (37%) were 13–18 and 98 (33%) were ≥ 19. Of the 41 women whose providers reported a PHQ-9 score, 24 (59%) were ≤ 9, 6 (15%) were 10–14, 8 (20%) were 15–19 and 3 (1%) were ≥ 20. Thus, 279 (83%) of women whose providers reported an EPDS score had a depression score indicative of depression (EPDS ≥ 9 or and PHQ-9 ≥ 10). Of women with a EPDS screen, 184 (62%) reported never having thoughts of harming themselves, 37 (12%) reported hardly ever having thoughts of harming themselves, 20 (7%) reported sometimes having thoughts of harming themselves and 6 (2%) reported quite often having thoughts of harming themselves.

During the 976 telephone encounters with providers, a wide range of diagnoses were discussed during the consultations. Of the total patients served, more than one psychiatric diagnosis was discussed among 623 (55%) of the patients, more than two diagnoses were discussed among 245 (22%) and more than three diagnoses were discussed among 103 (9%) patients. Frequently discussed disorders included, in descending order, unspecified depressive disorder (46% of encounters; n = 446), unspecified anxiety disorder (36%; n = 342) and major depressive disorder (15%; n = 139). Other nonspecified diagnoses (n = 101) were discussed during 11% of calls. Less commonly discussed diagnoses included posttraumatic stress disorder (n = 47), opioid use disorder (n = 45), panic disorder (n = 28), adjustment disorder (n = 22), bipolar I (n = 22), unspecified trauma/stress-related disorders (n = 22), obsessive compulsive disorder (n = 15), attention deficit hyperactivity disorder (n = 20), schizophrenia (n = 11), alcohol use disorder (n = 10), borderline personality disorder (n = 9), cocaine use disorder (n = 7), schizoaffective disorder (n = 13), bipolar II (n = 6), cannabis use disorder (n = 9), bipolar I with psychotic features (n = 8), generalized anxiety disorder (n = 6), complicated grief disorder (n = 3), persistent depression (dysthymia) (n = 1) and substance/medication-induced depressive disorder (n = 1).

Resources-Community Access was discussed in 55% of the consultations and medication changes in 55% (Table 2). Medication changes were discussed in 529 (55%) of the telephone encounters. Medications

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Encounters according to services provided and provider type from June 30, 2014 to February 29, 2016 for 1123 women served</strong></td>
</tr>
<tr>
<td>Provider Type</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Obstetrician</td>
</tr>
<tr>
<td>Midwife</td>
</tr>
<tr>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Family Physician</td>
</tr>
<tr>
<td>Physician Assistants/Nurse Practitioner</td>
</tr>
<tr>
<td>Internal Medicine Physician</td>
</tr>
<tr>
<td>Pediatrician</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

* Includes encounters with nonproviders and hallway, email and follow-up consultations.
were initiated in 98 (10%), increased in 88 (9%), changed in 61 (6%), tapered in 26 (3%) and decreased in 18 (2%). During 119 (12%) of the encounters, medications were added. Referrals were made for initiation of psychiatric medication treatment in 83 (9%) of encounters.

Specific medications discussed during telephone encounters also varied and ordered most to least frequent for overall encounters were selective serotonin reuptake inhibitors (53%), benzodiazepines (16%), other antidepressants (10%), atypical antipsychotics (9%), lamotrigine (6%), other sleep/anxiety agents (6%) and mood stabilizers (5%), including serotonin–norepinephrine reuptake inhibitors (4%), lithium (2%), typical antipsychotics (2%), haloperidol (1%) and perphenazine (1%).

There were a wide range of outcomes of the initial telephone encounters (Table 3).

### 4. Discussion

MCPAP for Moms is a new population-based program that addresses perinatal mental health in obstetric, primary care and psychiatry settings statewide. Unlike much of the legislation, task force and professional society recommendations, MCPAP for Moms goes beyond promoting postpartum depression screening; it seeks to detect maternal mental health concerns in pregnancy and the postpartum period. It builds the capacity of frontline providers to not only screen for maternal mental health but also provide treatment when needed. The volume of encounters, number of women served and low cost suggest that MCPAP for Moms is a feasible approach to help frontline providers prevent, identify and manage perinatal depression and other mental health concerns.

**Table 3**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back to Provider</td>
<td>749</td>
<td>78%</td>
</tr>
<tr>
<td>Refer to Outpatient Therapist</td>
<td>365</td>
<td>38%</td>
</tr>
<tr>
<td>Care Coordination: Contact Patient</td>
<td>341</td>
<td>36%</td>
</tr>
<tr>
<td>Refer to a New Psychiatrist</td>
<td>172</td>
<td>18%</td>
</tr>
<tr>
<td>Face-to-Face Visit</td>
<td>108</td>
<td>11%</td>
</tr>
<tr>
<td>Care Coordination: Resources to Provider</td>
<td>74</td>
<td>8%</td>
</tr>
<tr>
<td>Refer to Support Group</td>
<td>45</td>
<td>5%</td>
</tr>
<tr>
<td>None</td>
<td>32</td>
<td>3%</td>
</tr>
<tr>
<td>Refer to an Existing Psychiatrist</td>
<td>23</td>
<td>2%</td>
</tr>
<tr>
<td>Bridge Treatment with PCP</td>
<td>13</td>
<td>1%</td>
</tr>
<tr>
<td>Refer to Psychiatric Emergency Services</td>
<td>7</td>
<td>1%</td>
</tr>
<tr>
<td>Refer to Parent/Infant Therapy</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Refer to Mobile Crisis Services</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Refer to Partial Hospital</td>
<td>2</td>
<td>0%</td>
</tr>
</tbody>
</table>

MCPAP for Moms facilitates access to psychiatric treatment for pregnant women. Despite the negative impact of untreated depression during pregnancy, psychiatric providers can be reluctant to treat pregnant women [32–35], which can leave the burden of mental health care to Ob/Gyn providers. Ob/Gyn providers perceive community mental health clinicians’ reluctance to provide pharmacotherapy for pregnant women as a major barrier to mental health care during pregnancy [32]. For example, women may be dropped from treatment upon telling their psychiatric provider that they are pregnant and thus unable to access ongoing mental health care [33]. The training and consultation for general psychiatrists provided by MCPAP for Moms may mitigate this barrier and enhance access to mental health care, which in turn may help prevent relapse into illness that can occur [36–38] when women’s psychiatric medications are discontinued precipitously during pregnancy.

Perinatal psychiatrists are an extremely limited resource, and too few exist to provide direct care to all women in need. MCPAP for Moms dramatically expands the capacity of this clinical workforce by leveraging expert perinatal psychiatry consultation and care coordination to help frontline obstetric providers detect, assess and manage perinatal depression. Frontline obstetric and pediatric providers may choose not to screen for perinatal depression because they do not have a referral or treatment source [19,20]. MCPAP for Moms addresses this barrier. Managing the majority of pregnant and postpartum women with mental health concerns in obstetric or primary care settings can also allow women with more complicated or refractory illness to be referred to psychiatric providers for ongoing treatment. This is particularly relevant in an era of changing health care and movement toward integrated care.

There are several limitations to our utilization and program evaluation. Our evaluation is vulnerable to selection bias because we do not have information for practices that are not yet engaged in the program nor do we have information on women with perinatal depression whose providers did not outreach to MCPAP for Moms. Outcomes for women whose providers utilize MCPAP for Moms could also be influenced by other contextual factors. Reporting bias may also be present because the person collecting the evaluation data is also delivering the intervention or coordinating care. While we have information regarding which treatments were discussed during telephone encounters, we do not have data on the treatment women received or how long did it took for a woman to be assessed and receive depression care. We also do not yet have data on adequacy of medication dosing, attendance at therapy treatment, adherence to recommended depression care and improvement in depression symptoms. Thus, we are unable to link improved access through program utilization with patient treatment participation and depression outcomes. However, the efficacy of perinatal depression care, when evidence-based treatments are provided, is well-established [39–41]; MCPAP for Moms provides a model for improving access to effective treatments. Thus, this paper provides critical information about the feasibility, acceptability and uptake by providers of a program that aims to help access evidence-based treatments on a population-based level.

Understanding the impact of the MCPAP for Moms program on mental health clinical outcomes is essential and requires further study. Future resources and research efforts should also focus on proactively working with perinatal care providers to develop systematic stepped care approaches to ensure that their patients do not fall through cracks in the depression care pathway. Examples of such approaches could include clinician-specific implementation of proactive treatment engagement, patient monitoring and stepped treatment response to depression screening and assessment. Investigators (NB, TMS, KB and JA) were recently awarded funding from the Centers for Disease Control and Prevention (Grant Number: 1U01 DP006093) to conduct a cluster randomized-controlled trial to compare the effectiveness of MCPAP for Moms versus MCPAP for Moms plus clinic-specific implementation of stepped care and proactive treatment engagement, on patient outcomes. This new grant opportunity will assess improvement in
depression severity and treatment participation in pregnancy through 12 months postpartum and will allow for the testing of a more intensive program while also conducting a naturalistic study of the existing MCPAP for Moms program.

The ongoing and critical problem of insufficient access to psychiatric care for the general population is accentuated for the perinatal population. MCPAP for Moms may be sustainable as it is modeled on MCPAP, a successful, sustainable, evidence-based model that has been replicated in 32 states for support of pediatricians as they address the psychiatric needs of their patients [22,23]. Several states with an existing MCPAP are actively working to start MCPAP for Moms type programs, including Washington, Wisconsin, Maryland and Illinois. States considering adopting a similar program should consider their geographic and population density and unique characteristics (e.g., telemedicine technology for states with lower population density and greater geographic area). MCPAP for Moms may be within grasp of mostOb/Gyn clinics/practices for states with lower population density and greater geographic area).

Acknowledgments

The authors received funding/support for this project from the Massachusetts Department of Mental Health. The funding source did not have any role in the study design, data collection, analysis or interpretation of data.

These findings were presented at the 2nd Biennial Perinatal Mental Health Meeting in Chicago, IL, in November 3, 2015 and at 62nd Annual Meeting of the Academy of Psychosomatic Medicine in New Orleans, LA, on November 13th, 2015.

References

TESTIMONIALS

“You guys are amazing! I absolutely LOVE this therapist... She is so nice, understanding and I am very comfortable with our treatment plan. I cannot thank you guys enough. I really really appreciate all you have done.” –Mom

“I just called the program to look for a referral for counseling for a patient – what a wonderful and easy process.” —OB/GYN

“Oh my gosh the appointment went great! So far I have a really good feeling about receiving therapy from this place. The woman I met with seems so nice and well educated! Thank you, thank you for hooking me up with these services. It is such a relief for my whole family that I finally have the support system I need to deal with my issues in a safe and healthy way! Thank you!” —Mom

“Thanks again. I can’t tell you how helpful the MCPAP for Moms consultations have been for me personally as a psychiatric nurse practitioner working with pregnant moms who are trying to make the best treatment decisions possible for themselves and their babies.” —Nurse Practitioner

“I had a patient Monday who said she was getting increasingly depressed (about 24 weeks pregnant) and could not get into her previous counseling/psych office. She scored 21 on EPDS. I called MCPAP for Moms, got a call back from psychiatrist within the hour, and patient was going to be called and get an appt to see a psychiatrist this Friday. There is no other service that can offer this to our patients.” —Ob/Gyn

“It is hard to argue against a program that is so beneficial to moms and families and is cost efficient!” —Ob/Gyn

“I tell all the doctors in our office that this is really working (M4M referral system), you guys are great, and I have no complaints when it comes to MCPAP for Moms.” —Medical Assistant
There is a growing sense of urgency to identify better care and treatment approaches for perinatal depression (depression occurring during pregnancy or within one year of delivery). Obstetric and primary care providers often have limited access to mental health resources and supports needed to address perinatal depression in their patients. MCPAP for Moms is available to provide real-time psychiatric consultation and care coordination to help providers and their patients. The program is free and available for all pregnant or postpartum women throughout Massachusetts regardless of type of health insurance.

MCPAP for Moms builds on the successful Massachusetts Child Psychiatry Access Project (MCPAP). MCPAP was created in 2004 because children were unable to effectively access psychiatric care and pediatric providers were not equipped to manage children’s psychiatric needs. MCPAP assists pediatric providers through telephone consultation, the availability of face-to-face consultation, care coordination, and ongoing education. MCPAP for Moms expands MCPAP to help front-line perinatal care providers address depression and mental health concerns.

Funding for MCPAP for Moms is provided by the Commonwealth of Massachusetts Department of Mental Health.

855-MOM-MCPAP  mcpapformoms.org

Our goal is to improve outcomes for babies, children, and families by helping pregnant and postpartum women access and engage in depression treatment.

Follow us

Copyright 2014 MCPAP. MCPAP consents to the copying, republishing, redistributing or otherwise reproducing of this work as long as the resultant work carries with it express attribution of authorship to MCPAP.
Provider Resources

Trainings and toolkits for providers and their staff based on evidence-based guidelines for: depression screening, triage and referral, risks and benefits of medications, and discussion of screening results and treatment options.

Real-time psychiatric consultation and care coordination for obstetric, pediatric, primary care, and psychiatric providers serving pregnant and postpartum women.

Pediatricians should refer moms with mental health concerns or positive screening results to their obstetric or primary care providers or call MCPAP for Moms.

Linkages with community-based resources including mental health care, support groups, and other resources to support the wellness and mental health of pregnant and postpartum women.

Family Resources

MCPAP for Moms is partnering with MotherWoman and the William James College Interface Referral Service to develop community resources and supports across the state for women with depression. Visit the “Mothers and Families” tab at www.MCPAPforMoms.org for support and resource information. We encourage mothers to talk with their providers about MCPAP for Moms. Providers can then call MCPAP for Moms for consultation.

MCPAP Educational Services

To access MCPAP for Moms call:
855-MOM-MCPAP (666-6272)
Monday through Friday
9:00 a.m. – 5:00 p.m.

A care coordinator will answer the provider’s call and help determine the need to consult with a MCPAP for Moms psychiatrist, a care coordinator, or both.

The following outcomes may result from a telephone consultation. The MCPAP for Moms psychiatrist may:

- Answer the provider’s question
- Recommend a face-to-face evaluation with the patient for further assessment
- Refer the provider and the patient/family to a care coordinator for assistance connecting with resources in the patient’s community

MCPAP for Moms is available to provide training on-site at hospitals and obstetric and primary care practices. Please e-mail mcpap@beaconhealthoptions.com to schedule a training or grand rounds.

Promoting Maternal Mental Health During and After Pregnancy

One in Seven

One out of every seven women experience depression during pregnancy or in the first year postpartum. Depression during this time is twice as common as gestational diabetes.
What is MCPAP for Moms?

*MCPAP for Moms* is a first in the nation, statewide program to assist medical professionals in supporting your emotional and mental health during your pregnancy and the year following birth or adoption.

If you and/or your health care provider are concerned about your emotional and mental health, your provider may decide to call *MCPAP for Moms* for:

- A phone consultation with a *MCPAP for Moms* psychiatrist to discuss treatment options to recommend for you
- A one-time visit for you with a *MCPAP for Moms* psychiatrist. The psychiatrist will provide personalized recommendations to you and your provider
- A list of community-based mental health resources to share with you
- Assistance in identifying and/or scheduling community-based mental health resources that may include therapy, a psychiatrist, or a support group

Please visit [www.mcpapformoms.org](http://www.mcpapformoms.org) and click the “For Mothers and Families” tab to learn more about:

- Community-based support groups
- Resources for pregnant and postpartum women
- Tip Sheets for talking with your primary care provider about mental health concerns
- Hotlines and social media supports
- Resources for fathers and partners
- Parenting and family supports including early intervention and home visiting
- Resources for loss related to pregnancy and/or childbirth

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Funding for *MCPAP for Moms* is provided by the Commonwealth of Massachusetts Department of Mental Health.
Having or adopting a baby comes with a lot of life changes and transitions. These can be stressful and can affect your health and the health of your baby. It is very common to experience anxiety, crying, difficulty concentrating or sleeping, sadness or guilt during this challenging time.

One in seven women report experiencing depression during pregnancy or in the first year after giving birth or adopting. It is very common to have difficulties or feel depressed during this time. You may be thinking: “This is supposed to be a happy and exciting time; why am I feeling so anxious and sad?” This is called perinatal depression or anxiety.

Getting help is the best thing you can do for you and your baby. If you are concerned about how you are feeling, talk to your obstetrician, midwife, primary care provider, or your baby’s pediatrician.

It may also help to talk to friends or family. Your medical providers may notice that you aren’t yourself and ask you about how you are feeling. They may use a screening tool to get a better sense of how you are doing.

Fathers and partners may also suffer from perinatal depression or anxiety. Encourage your partner to ask for help.

You Are Not Alone
MCPAP for Moms promotes maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to one year after delivery to effectively prevent, identify, and manage depression.

Provider Resources

Trainings and toolkits for providers and their staff on evidence-based guidelines for: depression screening, triage and referral, risks and benefits of medications, and discussion of screening results and treatment options.

One in Eight

One out of every eight women experience depression during pregnancy.
### Assessment of Depression Severity and Treatment Options

<table>
<thead>
<tr>
<th>EPDS SCORE or clinical assessment</th>
<th>LIMITED TO NO SYMPTOMS</th>
<th>MILD SYMPTOMS</th>
<th>MODERATE SYMPTOMS</th>
<th>SEVERE SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LIMITED TO NO SYMPTOMS</strong></td>
<td>Reports occasional sadness</td>
<td>Mild apparent sadness but brightens up easily</td>
<td>Reports pervasive feelings of sadness or gloominess</td>
<td>Reports continuous sadness and misery</td>
</tr>
<tr>
<td><strong>SIGNS AND SYMPTOMS OF DEPRESSION</strong></td>
<td>Placid - only reflecting inner tension</td>
<td>Occasional feelings of edginess and inner tension</td>
<td>Continuous feelings of inner tension/intermittent panic</td>
<td>Unrelenting dread or anguish, overwhelming panic</td>
</tr>
<tr>
<td><strong>TREATMENT OPTIONS</strong></td>
<td>Sleeps as usual</td>
<td>Slight difficulty dropping off to sleep</td>
<td>Sleep reduced or broken by at least two hours</td>
<td>Less than two or three hours sleep</td>
</tr>
<tr>
<td><strong>NO difficulties in concentrating</strong></td>
<td>Normal or increased appetite</td>
<td>Slightly reduced appetite</td>
<td>No appetite - food is tasteless</td>
<td>Needs persuasion to eat</td>
</tr>
<tr>
<td><strong>NO difficulty starting everyday activities</strong></td>
<td>No difficulties in concentrating</td>
<td>Occasional difficulty in concentrating</td>
<td>Difficulty concentrating and sustaining thoughts</td>
<td>Unable to read or converse without great initiative</td>
</tr>
<tr>
<td><strong>Normal interest in surroundings &amp; friends</strong></td>
<td>No difficulty starting everyday activities</td>
<td>Mild difficulties starting everyday activities</td>
<td>Difficulty starting simple, everyday activities</td>
<td>Unable to do anything without help</td>
</tr>
<tr>
<td><strong>No thoughts of self-reproach, inferiority</strong></td>
<td>Normal interest in surroundings &amp; friends</td>
<td>Reduced interest in surroundings &amp; friends</td>
<td>Loss of interest in surroundings and friends</td>
<td>Emotionally paralyzed, inability to feel anger, grief or pleasure</td>
</tr>
<tr>
<td><strong>No suicidal ideation</strong></td>
<td>No thoughts of self-reproach, inferiority</td>
<td>Mild thoughts of self-reproach, inferiority</td>
<td>Persistent self-accusations, self-reproach</td>
<td>Delusions of ruin, remorse or unredeemable sin</td>
</tr>
</tbody>
</table>

### Limited or no symptoms of depression

- Therapy for mother
- Dyadic therapy for mother/baby
- Community/social support (including support groups)
- Consider as augmentation: Complementary/Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)
- Support with dysregulated baby; crying, sleep, feeding problems
- Physical activity
- Self-care (sleep, hygiene, healthy diet)

### Severe symptoms of depression

- Consider inpatient hospitalization when safety or ability to care for self is a concern
- Strongly consider medication
- Consider as augmentation: Complementary/Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)
- Support with dysregulated baby; crying, sleep, feeding problems
- Physical activity
- Self-care (sleep, hygiene, healthy diet)

---

*Information adapted from: Montgomery SA, Asberg M: A new depression scale designed to be sensitive to change. *British Journal of Psychiatry* 134:382-389, 1979*
<table>
<thead>
<tr>
<th>What is it?</th>
<th>Baby Blues</th>
<th>Perinatal Depression</th>
<th>Perinatal Anxiety</th>
<th>Posttraumatic Disorder (PTSD)</th>
<th>Obsessive-Compulsive Disorder</th>
<th>Postpartum Psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience</td>
<td>Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy, then very sad, or cry for no apparent reason.</td>
<td>Depressive episode that occurs during pregnancy or within a year of giving birth.</td>
<td>A range of anxiety disorders, including generalized anxiety, panic, social anxiety and PTSD, experienced during pregnancy or the postpartum period.</td>
<td>Disturbing anxiety symptoms experienced after traumatic events(s).</td>
<td>Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. Rituals (e.g., counting, cleaning, hand washing). May occur with or without depression.</td>
<td>Very rare and serious. Sudden onset of psychotic symptoms following childbirth (increased risk with bipolar disorder). Usually involves poor insight about illness/symptoms, making it extremely dangerous.</td>
</tr>
<tr>
<td>When does it start?</td>
<td>First week after delivery. Peaks 3-5 days after delivery and usually resolves 10-12 days postpartum.</td>
<td>Most often occurs in the first 3 months postpartum. May begin after weaning baby or when menstrual cycle resumes.</td>
<td>Immediately after delivery to 6 weeks postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes.</td>
<td>May be present before pregnancy/birth. Can present as a result of traumatic birth. Underlying PTSD can also be worsened by traumatic birth.</td>
<td>1 week to 3 months postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes. May also occur in pregnancy.</td>
<td>Typically presents rapidly after birth. Onset is usually between 2 – 12 weeks after delivery. Watch carefully if sleep deprived for &gt;48 hours.</td>
</tr>
<tr>
<td>Risk factors</td>
<td>Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.</td>
<td>Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.</td>
<td>Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.</td>
<td>Lack of partner support, elevated depression symptoms, more physical problems since birth, less health promoting behaviors. Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.</td>
<td>Family history of OCD, other anxiety disorders. Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.</td>
<td>Bipolar disorder, history of psychosis, history of postpartum psychosis (80% will relapse), family history of psychotic illness, sleep deprivation, medication discontinuation for bipolar disorder (especially when done quickly). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.</td>
</tr>
<tr>
<td>How long does it last?</td>
<td>A few hours to a few weeks.</td>
<td>2 weeks to a year or longer. Symptom onset may be gradual.</td>
<td>From weeks to months longer.</td>
<td>From 1 month to longer.</td>
<td>From weeks to months longer.</td>
<td>Until treated.</td>
</tr>
<tr>
<td>How often does it occur?</td>
<td>Occurs in up to 85% of women.</td>
<td>Occurs in up to 19% of women.</td>
<td>Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in .5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2-7% of early postpartum women.</td>
<td>Occurs in 2-15% of women. Presents after childbirth in 2-9% of women.</td>
<td>In up to 4% of women.</td>
<td>In 1-2 or 3 in 1,000 births.</td>
</tr>
<tr>
<td>What happens?</td>
<td>Women experience dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability. Postpartum depression is independent of blues, but blues is a risk factor for postpartum depression.</td>
<td>Change in appetite, sleep, energy, motivation, and concentration. May experience negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotic symptoms.</td>
<td>Fear and anxiety, panic attacks, shortness of breath, rapid pulse, diziness, chest or stomach pains, fear of detachment/doom, fear of going crazy or dying. May have intrusive thoughts.</td>
<td>Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event.</td>
<td>Disturbing repetitive thoughts (which may include harming baby), adapting compulsive behavior to prevent baby from being harmed (secondary to obsessive thoughts about harming baby that scare women).</td>
<td>Mood fluctuation, confusion, marked cognitive impairment. Bizarre behavior, insomnia, visual and auditory hallucinations and unusual (e.g. tactile and olfactory) hallucinations. May have moments of lucidity. May include altruistic delusions about infanticide and/or homicide and/or suicide that need to be addressed immediately.</td>
</tr>
<tr>
<td>Resources and treatment</td>
<td>May resolve naturally. Resources include support groups, psycho-education (see MCPAP for Moms website and materials for detailed information) and sleep hygiene (asking/accepting other help during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications.</td>
<td>For depression, anxiety, PTSD and OCD, treatment options include individual therapy, dyadic therapy for mother and baby, and medication. Resources include support groups, psycho-education, and complementary and alternative therapies including exercise and yoga. Encourage self-care including healthy diet and massage. Encourage engagement in social and community supports (including support groups) (see MCPAP for Moms website and materials for detailed resources). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications.</td>
<td>Additional complementary and alternative therapies options for depression include bright light therapy, Omega-3, fatty acids, acupunctive and folate.</td>
<td>Requires immediate psychiatric help. Hospitalization usually necessary. Medication is usually indicated. If history of postpartum psychosis, preventative treatment is needed in subsequent pregnancies. Encourage sleep hygiene for prevention (e.g. consistent sleep/wake times, help with feedings at night).</td>
<td>Requirements 4-6.</td>
<td>None.</td>
</tr>
</tbody>
</table>

Notes:
1 Adapted from Susan Hickman, Ph.D., Director of the Postpartum Mood Disorder Clinic, San Diego; Valerie D. Raskin, M.D., Assistant Professor of Clinical Psychiatry at the University of Chicago, IL (“Parents’ September 1996”)

*Summary of Emotional Complications During Pregnancy and the Postpartum Period*
### Assessing Thoughts of Harming Baby

<table>
<thead>
<tr>
<th>Thoughts of Harming Baby that Occur Secondary to Obsessions/Anxiety</th>
<th>Thoughts of Harming Baby that Occur Secondary to Postpartum Psychosis /Suspected Postpartum Psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Good insight</td>
<td>• Poor insight</td>
</tr>
<tr>
<td>• Thoughts are intrusive and scary</td>
<td>• Psychotic symptoms</td>
</tr>
<tr>
<td>• No psychotic symptoms</td>
<td>• Delusional beliefs with distortion of reality present</td>
</tr>
<tr>
<td>• Thoughts cause anxiety</td>
<td></td>
</tr>
<tr>
<td><strong>Suggests not at risk of harming baby</strong></td>
<td><strong>Suggests at risk of harming baby</strong></td>
</tr>
</tbody>
</table>

### Suggests Medication May Not be Indicated

- Mild depression based on clinical assessment
- No suicidal ideation
- Engaged in psycho-therapy or other non-medicaiton treatment
- Depression has improved with psychotherapy in the past
- Able to care for self/baby
- Strong preference and access to psychotherapy

### Suggests Medication Treatment Should be Considered

- Moderate/severe depression based on clinical assessment
- Suicidal ideation
- Difficulty functioning caring for self/baby
- Psychotic symptoms present (call MCPAP for Moms)
- History of severe depression and/or suicide ideation/ attempts
- Comorbid anxiety dx/sxs

### Risk Factors for Postpartum Depression

- Personal history of major or postpartum depression
- Family history of PPD
- Gestational diabetes
- Difficulty breastfeeding
- Fetal/Newborn loss
- Lack of personal or community resources
- Financial challenges
- Complications of pregnancy, labor/delivery, or infant’s health
- Teen pregnancy
- Unplanned pregnancy
- Major life stressors
- Violent or abusive relationship
- Isolation from family or friends
- Substance use/addiction

### Other Considerations During Clinical Assessment

- Past history of psychiatric diagnosis
- Previous counseling or psychotherapy
- Previous psychiatric medication
- History of other psychiatric treatments such as support groups
- History of substance use or substance use treatment
- Anxiety and worry
- Trauma history
- Domestic violence

### How to Talk about Perinatal Depression with Moms

- How are you feeling about being pregnant/a mother?
- What things are you most happy about?
- What things are you most concerned about?
- Do you have anyone you can talk to that you trust?
- How is your partner doing?
- Are you able to enjoy your baby?

---

1 This guideline has been adapted from materials made available by HealthTeamWorks and the Colorado Department of Public Health and Environment (CDPHE) [http://www.healthteamworks.org/guidelines/depression.html](http://www.healthteamworks.org/guidelines/depression.html).

MCPAP for Moms: Promoting maternal mental health during and after pregnancy

Revision 07.24.14

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Funding provided by the Massachusetts Department of Mental Health
Depression Screening Algorithm for Obstetric Providers

The EPDS should be administered during:
- Initial intake or first obstetrics visit
- Visit following Glucola test
- If high-risk patient,* 2 weeks postpartum
- 6 weeks postpartum visit

**EPDS Score**

- Score <10
  - Does not suggest depression
    - Clinical support staff educates woman about the importance of emotional wellness
    - Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.
    - Contact clinical support staff to arrange follow-up care if needed. Give woman information about community resources (e.g., support groups, MCPAP for Moms website – www.mcpapformoms.org), and we encourage women to engage in social supports. If woman is already in treatment, ensure follow up appointment is scheduled.

- Score ≥ 10
  - Suggests patient is depressed
    1. Assess to determine most appropriate treatment (refer to Assessment of Depression Severity and Treatment Options and Key Clinical Considerations documents)
    2. Always consider comorbid psychiatric illnesses (e.g., psychosis, substance use) and medical cause of depression (e.g., anemia, thyroid disorders).
    - If antidepressant medication is indicated
      1. Screen for bipolar disorder (refer to Bipolar Depression Screen)
      2. Refer to Recommended Steps before Beginning Antidepressant Medication Algorithm and Antidepressant Treatment Algorithm
      3. Offer psychotherapy

- Positive score on question 10
  - Suggests patient may be at risk of self-harm or suicide
    - Do NOT leave woman/baby in room alone until further assessment or treatment plan has been established.
    - Immediately assess further:
      1. In the past two weeks, how often have you thought of hurting yourself?
      2. Have you ever attempted to hurt yourself in the past?
      3. Have you thought about how you could harm yourself?
    - Document assessment and plan in medical record.
    - If there is a clinical question, call MCPAP for Moms 855-Mom-MCPAP (855-666-6272) or refer to emergency services.

**ALWAYS DISCUSS ALL SUPPORT/TREATMENT OPTIONS INCLUDING PSYCHOEDUCATION, COMMUNITY, & PSYCHOSOCIAL SUPPORTS**

* High-risk = women with a history of Depression or a positive EPDS Score, or those taking or who have taken psychiatric medications.
The EPDS should be administered during:
- Initial intake or first obstetrics visit
- Visit following Glucola test
- If high-risk patient,* 2 weeks postpartum
- 6 weeks postpartum visit

Clinical support staff explains EPDS

Emotional complications are very common during pregnancy and/or after birth. 1 in 8 women experience depression, anxiety or frightening thoughts during this time. It is important that we screen for depression because it is twice as common as diabetes and it often happens for the first time during pregnancy or after birth. It can also impact as diabetes and it often happens for the first time over the next months and want to support you. We will be seeing you a lot over the next months and want to support you.

If first EPDS screen

Clinical support staff explains EPDS

If subsequent EPDS screen

Give EPDS to woman to complete

EPDS Score

If subsequent EPDS screen

- Score <10

Does not suggest depression

Clinical support staff educates woman about the importance of emotional wellness:

From the screen, it seems like you are doing well. Having a baby is always challenging and every woman deserves support. Do you have any concerns that you would like to talk to us about?

Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

Contact clinical support staff to arrange follow-up care if needed. Give woman information about community resources (e.g., support groups, MCPAP for Moms website - www.mcpapformoms.org).

My office staff and I are available to help you and provide ongoing support.

If woman is already in treatment, ensure follow up appointment is scheduled.

If first EPDS screen

Clinical support staff explains EPDS

If subsequent EPDS screen

- Score ≥ 10

Suggests patient is depressed

You may be having a difficult time or be depressed. What things are you most concerned about? Getting help is the best thing you can do for you and your baby. It can also help you cope with the stressful things in your life (give examples). You may not be able to change your situation right now; you can change how you cope with it. Many effective support options are available.

Assess to determine most appropriate treatment (refer to Assessment of Depression Severity and Treatment Options and Key Clinical Considerations documents)

Always consider comorbid psychiatric illnesses (e.g., psychosis, substance use) and medical cause of depression (e.g., anemia, thyroid disorders).

If antidepressant medication is indicated

1. Screen for bipolar disorder (refer to Bipolar Depression Screen)
2. Refer to Recommended Steps before Beginning Antidepressant Medication Algorithm and Antidepressant Treatment Algorithm
3. Offer psychotherapy

If second EPDS screen

Positive score on question 10

Suggests patient may be at risk of self-harm or suicide

It sounds like you are having a lot of strong feelings. It is really common for women to experience these kinds of feelings. Many effective support options are available. I would like to talk to you more about how you have been feeling recently.

Do NOT leave woman/baby in room alone until further assessment or treatment plan has been established.

Immediately assess further:
1. In the past two weeks, how often have you thought of hurting yourself?
2. Have you ever attempted to hurt yourself in the past?
3. Have you thought about how you could harm yourself?

If concerned about the safety of woman/baby: You and you baby deserve for you to feel well. Let’s talk about ways we can support you.

Document assessment and plan in medical record. If there is a clinical question, call MCPAP for Moms 855-Mom-MCPAP (855-666-6272) or refer to emergency services.

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Edinburgh Postnatal Depression Scale\(^1\) (EPDS)

Name: ______________________________  Address: ______________________________

Your Date of Birth: ____________________   ___________________________

Baby’s Date of Birth: ___________________ Phone: __________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- Yes, all the time
- Yes, most of the time  This would mean: “I have felt happy most of the time” during the past week.
- No, not very often
- No, not at all

Please complete the other questions in the same way.

In the past 7 days:

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

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

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

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

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

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

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

8. I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

9. I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

10. The thought of harming myself has occurred to me
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

Administered/Reviewed by ______________________________    Date  ______________________________

---


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Edinburgh Postnatal Depression Scale\(^1\) (EPDS)

Postpartum depression is the most common complication of childbearing.\(^2\) The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt \textit{during the previous week}. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women’s Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

### SCORING

**QUESTIONS 1, 2, \& 4 (without an \*)**

Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

**QUESTIONS 3, 5-10 (marked with an \*)**

Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

<table>
<thead>
<tr>
<th>Maximum score:</th>
<th>30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible Depression:</td>
<td>10 or greater</td>
</tr>
<tr>
<td>Always look at item 10 (suicidal thoughts)</td>
<td></td>
</tr>
</tbody>
</table>

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### Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.


Bipolar Disorder Screen

This algorithm can be used when treatment with antidepressants is indicated, in conjunction with the Depression Screening Algorithm for Obstetric Providers.

In this algorithm, the provider speaks the italicized text and summarizes other text.

Screen for bipolar disorder

1. Some people have periods lasting several days or longer when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this lasting several days or longer?

2. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you started arguments, shouted at people, or hit people?

If yes to questions 1 and/or 2

Continue screen for bipolar disorder

3. People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in ways they would normally think are inappropriate. Did you ever have any of these changes during your episodes of being (excited and full of energy/very irritable or grouchy)?

If yes to question 3

The screen suggests the patient may have bipolar

If you have questions or need telephone consultation with a psychiatrist call MCPAP for Moms 855-Mom-MCPAP (855-666-6272)

If no to question 3

Refer to the Recommended Steps before Beginning Antidepressant Medication Algorithm

CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT 855-666-6272

1Taken from the Composite International Diagnostic Interview-Based Bipolar Disorder Screening Scale (Kessler, Akiskal, Angst et al., 2006)
### Recommended Steps before Beginning Antidepressant Medication Algorithm

*Discussion should include yet not be limited to the below*

#### Counsel patient about antidepressant use:
- No decision regarding whether to use antidepressants during pregnancy is perfect or risk free
- SSRIs are among the best studied class of medications during pregnancy
- Both medication and non-medication options should be considered
- Encourage non-medication treatments (e.g., psychotherapy) in addition to medication treatment or as an alternative when clinically appropriate

<table>
<thead>
<tr>
<th>Risks of antidepressant use during pregnancy</th>
<th>Risks of under treatment or no treatment of depression during pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small, but inconsistent increased risk of birth defects when taken in first trimester, particularly with paroxetine</td>
<td>Increases the risk of postpartum depression</td>
</tr>
<tr>
<td>The preponderance of evidence does not suggest birth complications</td>
<td>Birth complications</td>
</tr>
<tr>
<td>Studies do not suggest long-term neurobehavioral effects on children</td>
<td>Can make it harder for moms to take care of themselves and their babies</td>
</tr>
<tr>
<td>Possible transient neonatal symptoms</td>
<td>Can make it harder for moms to bond with their babies</td>
</tr>
</tbody>
</table>

- **If pregnant:** *In your situation, the benefits of taking an antidepressant outweigh the chance of the things we just discussed.*
- **If lactating:** *SSRIs and some other antidepressants are considered a reasonable treatment option during breastfeeding. The benefits of breastfeeding while taking antidepressants generally outweigh the risks.*

SEE ANTIDEPRESSANT TREATMENT ALGORITHM ON BACK FOR GUIDELINES RE: PRESCRIBING MEDICATIONS

### CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT 855-666-6272
Antidepressant Treatment Algorithm
(use in conjunction with Depression Screening Algorithm for Obstetric Providers)

Is patient currently taking an antidepressant?

Yes

If medication has helped and patient is on a low dose: increase dose of current medication (see table below)

No

If patient on therapeutic dose for 4-8 weeks that has not helped: consider changing medication. If questions contact MCPAP for Moms for consultation

Does patient have a history of taking an antidepressant that has helped?

Yes

Prescribe antidepressant that helped patient in the past (see table below)

No

Use sertraline, fluoxetine or citalopram (see table below)

To minimize side effects, half the recommended dose is used initially for 2 days, then increase in small increments as tolerated.

<table>
<thead>
<tr>
<th>First line treatment (SSRIs)</th>
<th>Second line treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>sertraline (Zoloft) 50-200 mg</strong>&lt;br&gt;Increase in 50 mg increments</td>
<td><strong>paroxetine (Paxil) 20-60mg</strong>&lt;br&gt;Increase in 10 mg increments</td>
</tr>
<tr>
<td><strong>fluoxetine (Prozac) 20-60 mg</strong>&lt;br&gt;Increase in 10 mg increments</td>
<td><strong>venlafaxine (Effexor) 75-300mg</strong>&lt;br&gt;Increase in 75 mg increments</td>
</tr>
<tr>
<td><strong>citalopram (Celexa) 20-40 mg</strong>&lt;br&gt;Increase in 10 mg increments</td>
<td><strong>bupropion (Wellbutrin) 300-450mg</strong>&lt;br&gt;Increase in 75 mg increments</td>
</tr>
<tr>
<td><strong>escitalopram (Lexapro) 10-20mg</strong>&lt;br&gt;Increase in 10 mg increments</td>
<td><strong>fluvoxamine (Luvox) 50-200mg</strong>&lt;br&gt;Increase in 50 mg increments</td>
</tr>
<tr>
<td><strong>duloxetine (Cymbalta) 30-60mg</strong>&lt;br&gt;Increase in 20 mg increments</td>
<td><strong>mirtazapine (Remeron) 15-45mg</strong>&lt;br&gt;Increase in 15 mg increments</td>
</tr>
</tbody>
</table>

* Considered a safer alternative in lactation because they have the lowest degree of translactal passage and fewest reported adverse effects compared to other antidepressants. In general, if an antidepressant has helped it is best to continue it during lactation.

Reevaluate depression treatment in 2-4 weeks via EPDS & clinical assessment

<table>
<thead>
<tr>
<th>If no/minimal clinical improvements after 4-8 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If patient has no or minimal side effects, increase dose.</td>
</tr>
<tr>
<td>2. If patient has side effects, switch to a different med.</td>
</tr>
</tbody>
</table>

Reevaluate every month and at postpartum visit. Refer back to patient’s provider and/or clinical support staff for psychiatric care once OB care is complete. Contact MCPAP for Moms if it is difficult to coordinate ongoing psychiatric care. Continue to engage woman in psychotherapy, support groups and other non-medication treatments.

CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT 855-666-6272
Promoting Maternal Mental Health During and After Pregnancy

Nancy Byatt, DO, MS, MBA, FAPM
Medical Director, MCPAP for Moms
1 in 7 women suffer from perinatal depression.

Perinatal depression is twice as common as gestational diabetes

- Depression: 10 – 15 in 100
- Diabetes: 3 - 7 in 100

Two-thirds of perinatal depression begins before birth

- Pregnancy: 33%
- Before pregnancy: 27%
- Postpartum: 40%


Wisner et al. JAMA Psychiatry 2013
Optimizing perinatal mental health could break the transgenerational impact of maternal depression

Perinatal depression effects mom, child & family

- Poor health care
- Substance abuse
- Preeclampsia
- Maternal suicide

- Low birth weight
- Preterm delivery
- Cognitive delays
- Behavioral problems
Perinatal depression is under-diagnosed and under-treated

Byatt et al. Obstetrics and Gynecology. 2015

Barriers to Treatment

- **Patient**: Lack of detection, fear/stigma, limited access
- **Provider**: Lack of training, discomfort, few resources
- **Systems**: Lack of integrated care, screening not routine, isolated providers

Women do not disclose symptoms or seek care

Underutilization of treatment

Unprepared providers, with limited resources

Poor Outcomes

www.chroniccare.org
The perinatal period is ideal for the detection and treatment of depression

80% of depression is treated by primary care providers

Regular opportunities to screen and engage women in treatment

Front line providers of all types have a pivotal role

Transforming obstetrical and pediatric practice to include depression care could provide a solution
In 2010, Massachusetts passed a Postpartum Depression Act

- PPD Commission
- PPD Screening Regulation (if screen must report CPT S3005, 0-6 months)
- MCPAP for Moms Funding

Massachusetts Child Psychiatry Access Project

- Education
- 855-Mom-MCPAP
- Care Coordination
Telephone Consultation

| Obstetric providers/Midwives | Family Medicine | Psychiatric providers | Primary care providers | Pediatric providers |

1-855-Mom-MCPAP

Patients should provide consent in order for you to share personal information with MCPAP for Moms
1-855-Mom-MCPAP

Patients should provide consent in order for you to share personal information with MCPAP for Moms

During telephone consult care coordination is determined based on acuity, severity and need

<table>
<thead>
<tr>
<th>Contact Provider</th>
<th>Patient Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care coordinator will identify 2-3 targeted resources to deliver via phone or email</td>
<td>Care coordinator will contact mom and work with her to schedule appointment</td>
</tr>
<tr>
<td>Does not involve speaking with mom</td>
<td>Care coordinator will follow up after 1 month</td>
</tr>
</tbody>
</table>
Enrolled practices that can call directly for care coordination provider contact

OB Case Worker

OB Nursing Staff

OB Social Worker

OB Care Provider

Care Coordination

Enroll in MCPAP for Moms today!

<table>
<thead>
<tr>
<th>Practice Name:</th>
<th>Practice Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Practice Phone:</th>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Practice Site 1 Name &amp; Address:</th>
</tr>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Practice Site 2 Name &amp; Address:</th>
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<table>
<thead>
<tr>
<th>Practice Site 3 Name &amp; Address:</th>
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<table>
<thead>
<tr>
<th>Number of Deliveries Annually:</th>
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<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Manager/Social Worker on Site?</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, Care Manager/Social Worker name:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Improved outcomes for moms, babies and families

Obs 80% & Psychiatrists 20%
Bidirectional relationship between depression and infertility likely exists

Preconception planning is critical

Attempting conception and being pregnant can be (often are) stressful

Therapy is evidence based treatment for depression and anxiety

If on psychiatric medication, preconception is an opportunity to plan and streamline treatment

Call MCPAP for Moms
1. 1st pre-natal visit
2. 26-28 weeks
3. Birth
4. 2 weeks post-partum
5. 6 weeks post-partum

- Administer Edinburgh Postnatal Depression Scale
- Administer EPDS for high-risk patients

Steps after a positive screen

- Assess severity and comorbidities
- Consider all treatment and support options
- Consider patient preference
- Rule out bipolar disorder
- Consider treatment risks/benefits
Edinburgh Postnatal Depression Scale (EPDS)

- Validated in pregnancy and postpartum
- 10 items
- Asks about self-harm

Steps after a positive screen

- **Assess severity and comorbidities**
- Consider all treatment and support options
- Consider patient preference
- Rule out bipolar disorder
- Consider treatment risks/benefits
EPDS scores range 0 - 30

- **< 10**: Depression unlikely
- **≥10**: Possible depression
- **≥ 13**: Probable depression

Screening is reimbursed once during pregnancy and once postpartum for MassHealth patients

- **Use Code S3005**
  - Behavioral health need is identified
  - Modifier U3

- **Use Code S3005**
  - No Behavioral health need is identified
  - Modifier U4
**Baby Blues**
- ≤ 2 wk
- Mood lability
- High emotionality

**Depression**
- ≥ 2 wks
- Guilt, feeling worthless
- Suicidal thoughts
- Impacts functioning

Assess for other comorbidities and medical causes

- PTSD and other anxiety disorders
- Eating disorders
- Substance abuse
- Medical causes

Check TSH, CBC, B12, Vitamin D, and folate
Risk of harm to baby

**OCD/anxiety**
- Good insight
- Thoughts are intrusive and scary
- No psychotic symptoms
- Thoughts cause anxiety

**Postpartum Psychosis**
- Poor insight
- Psychotic symptoms
- Delusional beliefs or distorted reality present

Low risk

High risk

---

**Suicide Risk Assessment**

**High Risk**
- History of suicide attempt
- High lethality of prior attempts
- Recent attempt
- Current plan
- Current intent
- Substance use
- Lack of protective factors (including social support)

**Lower Risk**
- No prior attempts
- If prior attempts, low lethality & high rescue potential
- No plan
- No intent
- No substance use
- Protective factors
Key clinical considerations after a positive screen

- Severity
- Consider all treatment and support options
- Patient preference
- Bipolar vs. unipolar depression
- Consider treatment risks/benefits

Education about various treatment and support options is imperative
Meds not indicated

Medication Assessment

Meds indicated

Mild depression
No suicidal ideation
Able to care for self/baby
Engaged in psychotherapy
Depression has improved with psychotherapy in the past
Strong preference and access to psychotherapy

Moderate/severe depression
Suicidal ideation
Difficulty functioning caring for self/baby
Psychotic symptoms present
History of severe depression and/or suicide ideation/attempts
Comorbid anxiety

Linkages with support groups and community resources

Support the wellness and mental health of perinatal women
Can refer moms to [mcpapformoms.org](http://mcpapformoms.org)

Steps after a positive screen

- Assess severity and comorbidities
- Consider all treatment and support options
- Consider patient preference
- Rule out bipolar disorder
- Consider treatment risks/benefits
Ask women what type of treatment they prefer

*There are effective options for treatment during pregnancy and breastfeeding.*

*Depression is very common during pregnancy and the postpartum period.*

*There is no risk free decision.*

*Women need to take medication during pregnancy for all sort of things.*

---

Steps after a positive screen

- Assess severity and comorbidities
- Consider all treatment and support options
- Consider patient preference
- Rule out bipolar disorder
- Consider treatment risks/benefits
Imperative to address bipolar disorder

Bipolar Disorder 23%

Unipolar Depressive Disorder 69%

Other Disorders 7%

Bipolar disorder increases risk of postpartum psychosis

1-2/1000 women

>70% bipolar disorder

24 hrs – 3 weeks postpartum

Mood symptoms, psychotic symptoms & disorientation

R/o medical causes of delirium

Psychiatric emergency

4% risk of infanticide with postpartum psychosis
Bipolar Disorder Screen

Steps after a positive screen

- Assess severity and comorbidities
- Consider all treatment and support options
- Consider patient preference
- Rule out bipolar disorder
- Consider treatment risks/benefits
Treatment - Recommended Steps Before Beginning Antidepressant Treatment

No decision is risk free

SSRIs are among the best studied classes of medications used in pregnancy

Case of Ms. Y

Absolute risk of birth defects when antidepressants taken in first trimester is small

Data is inconsistent, paxil has most been controversial

Possible transient neonatal symptoms with exposure to antidepressants

Transient and self-limited syndrome that may occur in up to 30% of neonates
No data to support taper in third trimester


Absolute risk of persistent pulmonary hypertension (PPHN) appears small

Baseline rate of 1-2 per 1000 births, may increase to 3-4 in 1000 births

Small increase risk of preterm labor & low birth weight

Depression can also increase risk of preterm labor and low birth weight

Studies do not suggest long-term neurobehavioral effects on children
There is no such thing as no exposure

Need to balance and discuss the risks and benefits of medication treatment and risks of untreated depression

Antidepressants treatment algorithm

Antidepressant Currently

- Yes
  - Is it helping?
    - Yes
      - Continue meds
    - No
      - Has a past med been helpful?
        - Yes
          - Use past med that worked
        - No
          - New med or call MCPAP For Moms for Consultation

- No
  - Is dose maximized?
    - Yes
      - Change med or call MCPAP For Moms for Consultation
    - No
      - Increase dose
Start antidepressants at a low dose and increase in small increments every 2 days

<table>
<thead>
<tr>
<th>SSRIs</th>
<th>Starting &amp; Increment Dose (mg/day)</th>
<th>Target Dose (mg/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>sertraline (Zoloft)</td>
<td>25</td>
<td>75-200</td>
</tr>
<tr>
<td>citalopram (Celexa)</td>
<td>10</td>
<td>20-40</td>
</tr>
<tr>
<td>escitalopram (Lexapro)</td>
<td>5</td>
<td>10-20</td>
</tr>
<tr>
<td>fluoxetine (Prozac)</td>
<td>10</td>
<td>20-80</td>
</tr>
</tbody>
</table>

Tell women only to increase dose if tolerating. Otherwise, wait until side effects dissipate before increasing.
General side effects of antidepressants

Temporary
- Nausea
- Constipation/Diarrhea
- Lightheaded
- Headaches

Long-term
- Increase in appetite/weight gain
- Sexual side effects
- Vivid dreams/insomnia

Direct patients to take medication with food to decrease side effects

After starting antidepressant re-administer EPDS

Re-administer EPDS and reevaluate after 2 weeks

Little/no improvement (EPDS >10)
- Increase medication

Improvement (EPDS < 10)
- Reevaluate monthly
Prescribing principles for pregnancy and breastfeeding

- Use what has worked (considering available reproductive safety information)
- Use lowest EFFECTIVE dose
- Minimize switching
- Monotherapy preferable
- Be aware of need to adjust dose
- Discourage stopping SSRIs prior to delivery

Breastfeeding generally should not preclude treatment with antidepressants

SSRIs and some other antidepressants are considered a reasonable option during breastfeeding
Sertraline, paroxetine, & fluvoxamine have lowest passage into milk

Steps after a positive screen

- Assess severity and comorbidities
- Consider all treatment and support options
- Consider patient preference
- Rule out bipolar disorder
- Consider treatment risks/benefits
Please call us with any questions as we are to here to help you

1-855-Mom-MCPAP

www.mcpapformoms.org

Enroll in MCPAP for Moms today!

MCPAP for Moms Enrollment Agreement

Practice Name: ____________________________
Practice Address: _________________________
Practice Phone: _________________________

[If applicable] Practice Site 2 Name & Address: ____________________________

[If applicable] Practice Site 3 Name & Address: ____________________________

Number of Deliveries Annually: ____________________________

Care Manager/Social Worker on Site? Yes / No

If Yes, Care Manager/Social Worker name: ____________________________
In summary, our aim is to promote maternal and child health by building the capacity of front line providers to address perinatal depression.
Call 1-855-Mom-MCPAP
www.mcpapformoms.org

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Thank you!
MCPAP for Moms: A Primer for Pediatric Providers

Authors: Biebel, K., Byatt, N., Ravech, M., & Straus, J.

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Funding provided by the Massachusetts Department of Mental Health
MCPAP for Moms: A Primer for Pediatric Providers

MCPAP for Moms aims to improve outcomes for babies, children, and families by helping pregnant and postpartum women access and engage in depression treatment.

Pediatric providers in Massachusetts are well acquainted with the Massachusetts Child Psychiatry Access Project (MCPAP), created in response to the widespread lack of access to child psychiatry. MCPAP has been broadly accepted by pediatric primary care clinicians, and is recognized as enhancing the capacity of pediatric providers to treat children and adolescents with behavioral health issues.

In 2014, MCPAP launched a new program, MCPAP for Moms, to promote maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to one year after delivery to effectively prevent, identify and manage depression. MCPAP for Moms aims to help pediatric providers screen mothers and fathers for postpartum depression within the context of well-child care.

MCPAP for Moms aims to:
- Implement universal screening for depression during pregnancy and postpartum for the approximately 72,000 women who deliver babies in Massachusetts each year;
- Increase access to mental health care among pregnant and postpartum women; and,
- Improve mental health outcomes for mothers and fathers, and thereby improve outcomes for babies and families.

Why is postpartum depression important to pediatric providers?

Postpartum depression (PPD) is a widespread problem that can complicate birth,\(^1\) infant,\(^2\) and child outcomes.\(^3\)-\(^5\) Perinatal depression - depression before, during, and in the year following pregnancy - can have far-reaching, harmful effects for all family members. One in five women screen positive for depression during their first postpartum year.\(^6\) One in three fathers in families struggling with maternal depression experience PPD themselves.\(^7\) Depression in fathers may present differently than in mothers. Men with depression are more likely to report substance abuse and disturbances in work and social functioning.\(^8\) Adoptive parents have similar rates of depression as birth parents during the postpartum period.\(^9,10\) Individuals with a family history of depression, substance abuse, or a personal history of depression are at increased risk for perinatal depression.\(^11\) Large health disparities in the U.S. place low-income and racial and ethnic minority families at increased risk for parental depression, stress, and poorer child outcomes compared to affluent families.\(^12\)

Birth outcomes can be adversely affected by depression in pregnancy,\(^1,13-16\) and PPD can have a long-term impact on child outcomes. PPD is associated with attachment insecurity,\(^3\) difficult infant/childhood temperament,\(^3,17\) developmental delay, and impaired language development.\(^4,5\) Treatment of maternal depression until remission is associated with decreased psychiatric symptoms and improved functioning outcomes among offspring.\(^18,19\) Despite the profound negative effects on mother and child, some of which improve with depression treatment,\(^18,19\) the vast majority of women with PPD go untreated.\(^20-23\)

What is known about PPD screening in pediatric settings?

Most perinatal care or obstetrical settings only see women and screen for PPD at the 4-6 week
Pediatricians providing care for children under the age of five may be the only medical provider many mothers see during the child’s first year of life. PPD can be identified in pediatric settings during the first postpartum year. Training pediatric providers to detect and address PPD can enhance pediatric providers’ impact on maternal mental health, carrying the potential to have a trans-generational impact.

**How does MCPAP for Moms help pediatric providers and practices?**

MCPAP for Moms can help pediatric providers in two distinct ways. MCPAP for Moms can support pediatric providers as they provide well-care to infants and their families. MCPAP for Moms can also assist pediatric providers when they need support around perinatal mental health concerns as they care for pregnant and postpartum teenagers.

*MCPAP for Moms encourages all pediatric providers to screen for postpartum depression in:*

- mothers and fathers of infant patients during well-child visits; and
- pregnant or postpartum women receiving primary care from a pediatric provider

Available screening instruments include the Patient Health Questionnaire (PHQ-2 or PHQ-9: a validated questionnaire to screen and measure depression and its severity), or the Edinburgh Postnatal Depression Screen (EPDS - a widely-used and validated 10-item questionnaire to identify women experiencing depression during pregnancy and the postpartum period). The PHQ-2 is part of the Survey of Wellbeing of Young Children (SWYC). The PHQ-2, PHQ-9, and EPDS can be found in the Appendix or at [www.mcpapformoms.org/toolkits/pediatricprovider.aspx](http://www.mcpapformoms.org/toolkits/pediatricprovider.aspx).

**Can I bill for screening?**

If you are using the SWYC with the embedded PHQ-2, you can bill using 96110. For other screening tools, at this time, please consult the infant’s insurer.

**When an infant is the patient.**

Well-child visits provide an ideal opportunity to detect and address PPD. As pediatric providers are most often not providing primary care to mothers, their main role is one of screening and referral. MCPAP for Moms can help pediatric providers screen for and address PPD and other mental health concerns during well-child visits. PPD screening is recommended for mothers and fathers as part of well-child visits (and at other times if indicated) at:

- Within first month
- 2 month visit
- 4 month visit
- 6 month visit
- 9-12 month visit

MCPAP for Moms provides a [Depression Screening Algorithm for Pediatric Providers During Well-Child Visits](#) (see Appendix), which offers step-by-step guidelines for administering and responding to a PPD screen. While the majority of mothers and fathers will not screen positive for PPD, the postpartum period can be challenging, and depression and other mental health concerns can arise at any time.
The baby’s behavior offers a window into the emotional state of the family. Problems of crying, sleep and feeding are intimately intertwined with perinatal emotional complications, both as cause and result. Parents’ mood affects the baby, and baby’s mood affects the parent. Time spent in the primary care setting addressing these issues in the context of evaluating the parents’ emotional wellbeing can be a first step in treatment.

For all parents with a positive screen:
1. If the parent is already in mental health treatment, refer to/notify* parent’s mental health provider.
2. Give parent information about community resources (e.g., support groups, MCPAP for Moms resource card, and MCPAP for Moms website- [www.mcpapformoms.org](http://www.mcpapformoms.org)).
3. Refer to/notify* parent’s PCP and/or OB/GYN for monitoring and follow-up. You may recommend that the PCP or OB/GYN call MCPAP for Moms if they have clinical questions about the parent.
4. Engage natural supports* and encourage parent to utilize them. Most likely you will have only one parent in the office when a screen is positive. A depressed parent who is alone or feeling alone is at higher risk for suicide. It is important for someone else in the parent’s life to be aware of the presence of depression and be able to step in to help.
5. If the pediatric provider has clinical questions, call MCPAP or MCPAP for Moms (855-MOM-MCPAP/855-666-6272).
6. Assess if there is an acute crisis or safety concern. If there is a crisis or safety concern, refer to parent’s local Emergency Services. For MassHealth members, contact the local Emergency Services Program at 877-382-1609.

We recommend and expect that pediatric providers and their office staff will refer parents to an adult provider such as her PCP or OB/GYN. If there is difficulty referring women to their PCP or OB/GYN, pediatric providers may call MCPAP for Moms for assistance in identifying mental health providers in the parent’s community.

MCPAP for Moms recommends that pediatric providers document the screening result in the medical record as you would with other risk factors that may affect the child health such as substance use or domestic violence. MCPAP for Moms recommends that pediatric practices continue to use their current strategies for appropriately documenting potentially sensitive family information.

When a pregnant/postpartum young mother is the patient.

MCPAP for Moms recommends that pediatric providers caring for pregnant teens or postpartum young mothers screen for depression during pregnancy and in the postpartum period. New mothers should also be screened for PPD during well-child visits. Questions that arise specific to mental health concerns during screening and/or providing care for a pregnant teen or postpartum young mother should be directed as follows:

For perinatal psychiatry questions. Pediatric providers can call MCPAP for Moms (855-MOM-MCPAP/855-666-6272) to speak with a MCPAP for Moms perinatal psychiatrist for consultation regarding mental health care. If it is determined that the patient needs additional mental health services (e.g., a therapist, a support group), a MCPAP for Moms Care Coordinator can work to

* Obtain parent’s consent
identify and/or schedule services. Additional information on PPD during pregnancy is available at [www.mcpapformoms.org](http://www.mcpapformoms.org).

For general child psychiatry questions. Pediatric providers can call their MCPAP regional hub to speak to a MCPAP child psychiatrist for a consultation and/or the MCPAP Care Coordinator to identify and/or schedule mental health services for the mom. MCPAP and MCPAP for Moms psychiatrists and Care Coordinators will work together to consult on cases, and identify appropriate mental health resources.

**Antidepressant medications and lactation.**

Considerations for lactating women:

- SSRIs (and some other antidepressants) are considered a reasonable treatment option during breastfeeding.
- When antidepressants are indicated, the benefits of breastfeeding while taking antidepressants generally outweigh the risks.
- Most psychiatric medications are passed into breast milk, though in very low amounts.
- The benefits of other psychiatric medications, including benzodiazepines, antiepileptics, stimulants, and antipsychotics, may outweigh the risks of the medication during breastfeeding.
- It is important to consider the risk of untreated illness to the mother-baby dyad and balance this with the risk of medication use during breastfeeding.
- It is crucial that evaluation of the risks and benefits of medication use during breastfeeding is done on a patient-by-patient basis and considers the needs of the family.
- Recommendations are ideally made collaboratively with well-informed patients and family members.
- Monitor for side effects in nursing infants.

We also recommend the NIH website [LactMed](https://lactmed.nih.gov), which contains information on medications to which breastfeeding mothers may exposed. Providers can also download the [LactMed app for mobile devices](https://lactmed.nih.gov/app). We encourage providers to call MCPAP for Moms for any questions regarding the use of antidepressants or other psychiatric medications during breastfeeding. Pediatric providers can also visit the [MCPAP for Moms](http://www.mcpapformoms.org) website for additional information and treatment algorithms.

**MCPAP for Moms Pediatric Toolkit.**

The MCPAP for Moms Pediatric Toolkit provides information to support pediatric providers as they detect and screen for mental health concerns. We recommend pediatric providers review the toolkit. The complete MCPAP for Moms Pediatric Toolkit can be found at [www.mcpapformoms.org](http://www.mcpapformoms.org) under “Provider Toolkit/MCPAP for Moms toolkit – Pediatric Provider.”

**Assessment Tools.** Highlights the range of depression and mental health concerns that may occur postpartum, possible treatment options, and key issues to consider when assessing mental health status during the postpartum period.

- **Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women.** Provides key information/concepts to consider when assessing the mental health of pregnant and postpartum women.
• **Summary of Emotional Complications During Pregnancy and the Postpartum Period.**

An overview of the range of emotional complications that can occur during pregnancy and postpartum including Baby Blues, Perinatal Depression, Perinatal Anxiety, Posttraumatic Disorder (PTSD), Obsessive-Compulsive Disorder (OCD), and Postpartum Psychosis.

**Screening Tools & Algorithms.** Includes depression screens and a depression screening algorithm designed for pediatric providers.

- Patient Health Questionnaire – 2 (PHQ-2)
- Patient Health Questionnaire – 9 (PHQ-9)
- Edinburgh Postnatal Depression Scale (EPDS)
- Postpartum Depression Screening Algorithm for Pediatric Providers during Well-Child Visits. Provides guidance on administering the PHQ-2, PHQ-9 or EPDS and next steps depending on the score. Side one is a simplified version of the algorithm. Side two provides more detailed information including talking points and suggested language re: how to discuss the screen and resultant scores with a parent.

**Community resources - MCPAP for Moms partners.**

Key to the success of MCPAP for Moms are partnerships with two critical community-based organizations, to help facilitate linkages to resources including mental health care, support groups, and other activities to support the wellness and mental health of pregnant and postpartum women. MCPAP for Moms is partnering with MotherWoman and MSPP Interface Referral Service to develop community resources and link women with perinatal supports across the state.

MotherWoman is partnering with community providers across the Commonwealth to provide training and development around the Community-based Perinatal Support Model (CPSM), an intervention that addresses the challenge of ensuring that mothers experiencing perinatal depression receive the care and treatment they need. CPSM assists communities in their efforts to effectively prevent, identify, and treat mothers with perinatal depression both within agencies and organizations and across systems of care by addressing barriers at the maternal, provider and system levels. MotherWoman has developed perinatal community coalitions and support groups for mothers with children under the age of one in six communities in Massachusetts (Springfield, Cape and the Islands, New Bedford, Lynn, Brockton, and Worcester). MotherWoman will continue to expand this model to additional communities.

The Massachusetts School of Professional Psychology (MSPP) Interface Referral Service is working with MCPAP for Moms to collect and categorize resources specifically related to perinatal mental health and wellness. These resources are utilized and updated daily, and accessed by the MCPAP for Moms Care Coordinators as they refer and coordinate mental health care for vulnerable parents. Support group resources can be found on the [MCPAP for Moms website](#) under the “For Mothers and Families” tab.

**Home visiting programs.**

Massachusetts home visiting programs offer voluntary, family-focused services to expecting or new families with infants and children. Services are predominately provided in a family’s home. Many home visiting programs offer group-based services as well. Home visits are provided in a routine and sustained manner, ranging from a weekly to a monthly basis. Typically families are eligible to remain in home visiting programs for three to five years, although this varies by individual program. Home visiting services are delivered by trained home visiting professionals or
paraprofessionals, with the goal of addressing specific issues based upon the family’s eligibility for
the program. While each home visiting program has different eligibility criteria — and thus delivers
different services to their participants— there are many elements that are consistent across
programs. The common core elements of most home visiting programs include, but are not limited
to: addressing mother and child health, safety, and mental health; positive parenting; child
development and school readiness; and injury prevention including safe homes. These programs
also introduce parents to education and employment opportunities. The home visitor works
collaboratively with the family to set family goals, provide screenings, assessments and parenting
information, make referrals on behalf of families, and connect families to any other community-
based resources as needed. The following are some of the outcomes that home visiting programs
across the country have demonstrated:

- Increased rates of teen moms staying in school and graduating
- Increased access to primary care medical services
- Increased child immunization rates
- Improved parent-child bonding
- Improved school readiness
- Decreased number of low-birth weight babies
- Decreased number of child abuse and neglect cases
- Decreased families’ need for welfare, or TANF (Temporary Assistance to Needy Families)
  and other social services

For home visiting resources please see the For Mothers and Families tab, Resources for Pregnant
and Postpartum Women on the MCPAP for Moms website.

MCPAP for Moms web-based resources for pediatric providers.

There are many web-based resources available to support pediatric providers, and their patients
and families. The MCPAP for Moms website provides detailed information about how MCPAP for
Moms works, FAQs, and online resources to assist providers on various issues specific to PPD
including evidence-based approaches and medication decision-making.

- MCPAP for Moms website – www.mcpapformoms.org
  - Provider Toolkit/MCPAP for Moms Toolkit – Pediatric Providers: Provides all the
    Assessment Tools, and Screening Tools and Algorithms that make up the Pediatric
    Provider Toolkit. All tools are available for download.
  - Provider Toolkit/MCPAP for Moms Toolkit – Adult Providers: Provides additional
    information about the delivery of treatment, including information about
    medication and lactation, and services to parents experiencing PPD and other
    mental health concerns by adult primary care providers.
  - For Mothers and Families: General information pertaining to PPD as well as in-
    person, online, and telephone support options for mothers and fathers.
      - Talking to Your Provider about Perinatal Mental Health Concerns: Provides
        guidance for parents talking with providers about their mental health
        concerns.
      - How to Find a PCP: Provides step-by-step instructions to help parents find
        and choose a PCP.
References


We encourage all providers to use the S3005 billing code that allows the Dept of Public Health to track screening across specialties and regions.

Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits

Parent completes the PHQ-2, PHQ-9 or EPDS screen during the following well child visits and during other visits as indicated:
- Within first month
- 2 month visit
- 4 month visit
- 6 month visit
- 9-12 month visit

If first screen for depression

Clinical support staff explains screen
Give screen to parent to complete in the waiting room or in a private exam room.

PHQ-2 < 3; PHQ-9 or EPDS < 10

Score does not suggest depression
Clinical support staff educates parent about the importance of emotional wellness.

Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

Suggests parent may be at risk of self-harm or suicide
Do NOT leave parent/baby in room alone until further assessment or treatment plan has been established. Immediately assess further.

If there is a clinical question, provider calls MCPAP regional hub. For safety concerns, refer to emergency services. Document the assessment and plan in medical record.

If there are clinical questions (including questions about medications that may be taken during lactation), call MCPAP for Moms.

If subsequent screen for depression

Give screen to parent to complete in the waiting room or in a private exam room.

PHQ-9 or EPDS ≥ 10

If positive score on self-harm question
Score suggests depression

1. If parent is already in mental health treatment, refer to/notify* parent’s provider.
2. Give parent community resource information (e.g., MCPAP for Moms card, and website)
3. Refer to/notify* parent’s PCP and/or OB/GYN for monitoring and follow-up.
4. Engage natural supports* and encourage parent to utilize them.

*Obtain parent’s consent

For all positive screens

Provider documents clinical plan based on screening results. Not required to include screen as part of the medical record.
Parent completes the PHQ-2, PHQ-9 or EPDS screen during the following well-child visits and during other visits as indicated:
- Within first month
- 2 month visit
- 4 month visit
- 6 month visit
- 9-12 month visit

If first screen for depression

Clinical support staff explains screen

Emotional complications are very common during pregnancy and or after birth. 1 in 8 women experience depression, anxiety or frightening thoughts during this time. It is important that we screen for depression because it is twice as common as diabetes and it often happens for the first time during pregnancy or after birth. It can also impact you and your baby’s health. Dads can also experience depression or anxiety before or after the baby is born. We will be seeing you and your baby a lot over the next few months/years and want to support you.

Give screen to parent to complete in the waiting room or in a private exam room.

Score does not suggest depression

Clinical support staff educates parent about the importance of emotional wellness:

From the screen, it seems like you are doing well. Having a baby is always challenging and every parent deserves support. Do you have any concerns that you would like to talk to us about?

Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

Suggests parent may be at risk of self-harm or suicide

It sounds like you are having a lot of strong feelings. It is common for parents to experience these kinds of feelings. Many effective support options are available. I would like to talk to you about how you have been feeling recently.

Do NOT leave parent/baby in room alone until further assessment or treatment plan is established. Immediately assess further:

1. In the past two weeks, how often have you thought of hurting yourself?
2. Have you ever attempted to hurt yourself in the past?
3. Have you thought about how you could harm yourself?

If concerned about the safety of parent/baby: You and your baby deserve for you to feel well. Let’s talk about ways that we can support you. If there is a clinical question, call MCPAP regional hub. For safety concerns, refer to emergency services. Document in medical record.

If subsequent screen for depression

Parent completes the PHQ-2, PHQ-9 or EPDS screen. Provider/nurse tallies score.

PHQ-2 ≥ 3
Administer PHQ-9 or EPDS

PHQ-2 <3; PHQ-9 or EPDS<10

PHQ-9 or EPDS ≥ 10

Score suggests depression

You may be having a difficult time or be depressed. What things are you most concerned about? Getting help is the best thing you can do for you and your baby. It can also help you cope with the stressful things in your life (give examples). You may not be able to change your situation right now; you can change how you cope with it. Many effective support options are available.

If positive score on self-harm question

For all positive screens

1. If parent is already in mental health treatment, refer to/notify* parent’s provider.
2. Give parent community resource information (e.g., MCPAP for Moms card, and website)
3. Refer to/notify* parent’s PCP and/or OB/GYN for monitoring and follow-up.
4. Engage natural supports* and encourage parent to utilize them.

*Obtain parent’s consent

Provider steps for positive screens

Provider documents clinical plan based on screening results. Not required to include screen as part of the medical record.

If there are clinical questions (including questions about medications that may be taken during lactation), call MCPAP for Moms.
Charting postpartum depression

Advocates want to identify at-risk mothers before tragedy strikes, but universal screening is not an easy sell

WHENEVER SHE PICKED UP a knife, Jamie Zahlaway Belsito thought about stabbing herself. The thought intruded so often that the mother-to-be thought it was a sign that having a baby was a mistake.

The dark-haired, vivacious former Philips executive used to jet back and forth between Boston and the technology company’s headquarters in the Netherlands. Belsito had been a Washington lobbyist working on business immigration reform, and an accomplished flamenco dancer.

But late in her pregnancy five years ago, Belsito got laid off. At age 35, she was at risk for complications and had already had one miscarriage. She began avoiding touching anything sharp. It was “just horrific to even have something that was so absurd go through your brain,” Belsito says.

She had complications during labor and ended up delivering her daughter, Hadia, by emergency caesarian section. Soon after she got home with Hadia, her husband left on one of his regular business trips. Belsito did not know it at the time, but Hadia had dairy and soy allergies. The infant cried, threw up all over, and did not sleep well. Belsito cried all the time, too. She sought help from her doctor, but antidepressants did not help. “I just wanted to go to sleep and never wake up,” she says of those dark times in her Beverly home.
With growing recognition of the risks of untreated depression on women and their children, some Bay State lawmakers, health care providers, and insurers believe that Massachusetts needs to reorient the way the health care system handles the emotional complications of pregnancy and childbirth. Postpartum depression is one of the most common complications of pregnancy and the postpartum period. What’s more, the condition can be detected using a simple questionnaire, and many women respond well to treatment. “This is so minor—to use a screening tool,” says Rep. Ellen Story, who co-chairs the state’s Special Legislative Commission on Postpartum Depression.

But universal screening is proving to be a hard sell. Story, an Amherst Democrat, has filed several postpartum depression screening bills over the past six years, including one to mandate statewide screening for all women and one to mandate screening for MassHealth patients. The proposals have gone nowhere. No one is vehemently opposed to screening, but the issue hasn’t gained enough traction to make it a priority on Beacon Hill.

**Understanding postpartum depression**

In the weeks after her daughter’s birth, Belsito knew something was seriously wrong. The thoughts about knives had stopped, but she did not feel any better. She eventually located a postpartum depression Meetup group at Beverly Hospital, and decided to go. No one else did. Social workers there gave her a list of phone numbers to call. “That was it,” she says.

After making a couple of calls, Belsito found a therapist and went with Haida to see her once a week. She started dancing again and her life gradually returned to normal. But when she became pregnant again, the thoughts about knives returned. She had another emergency caesarian and a second little girl who had trouble sleeping without her. On a summer day walking along the Merrimack in Newburyport with her family, an ugly thought popped into her head: What if she threw the baby into the water?

Belsito knew she needed help fast. A therapist told Belsito she could see her in six to eight weeks. Belsito told her doctor that she might not make it that long. Instead, Belsito, who had
moved to Topsfield, tracked down her old therapist who agreed to see the entire family. The social worker told Belsito’s husband, “What she is dealing with is totally real.”

Postpartum depression is a global term that encompasses the three types of emotional complications that a woman might experience after delivery: baby blues, postpartum depression, and postpartum psychosis. Roughly 8 to 20 percent of all women suffer from postpartum depression following a child’s birth. Health care professionals also use the term perinatal depression to describe the condition and the period when it occurs, anytime during pregnancy through the first year after childbirth.

There were nearly 72,000 births to Massachusetts mothers in 2013. At the urging of the state commission, the Department of Public Health set up a screening pilot program in 2014 that targeted more than 2,000 pregnant and postpartum, mostly low-income, patients at four community health centers in Holyoke, Lynn, Jamaica Plain, and Worcester. The pilot program found that, overall, about 12 percent of women who were screened had depression symptoms ranging from mild to severe.

The program evaluated 1,059 postpartum women: 839 (79 percent) of them received a postpartum depression questionnaire. Of the women who agreed to take the survey, 50 women (6 percent) had symptoms that indicated mild depression. Another 48 women (6 percent) had moderate to severe depression symptoms. The Patrick administration axed the $200,000 program during last year’s budget cuts.

The hormonal shifts that take place after delivery can affect some women more than others. According to Massachusetts General Hospital’s Center for Women’s Mental Health, many women experience what is commonly known as “baby blues.” Women cry, or get anxious or testy after giving birth. Those symptoms usually disappear after about two weeks and a woman is able to take care of herself and her baby.
New mothers may experience sadness, problems with sleeping or eating, an inability to focus, and thoughts of suicide or hurting their baby. The stress of poverty is also a risk factor for postpartum depression: the rates are more than double for low-income women. Other social factors can also make a woman more prone to the condition, including marital problems, being isolated at home, having anxiety about returning to work, and depression before pregnancy.

Sen. Joan Lovely, a member of the state commission, suspects that she had postpartum depression after the birth of her first child nearly 30 years ago. “I had an anxiety condition before I had children,” says the Salem Democrat, a mother of three 20-something daughters. “After I had my first daughter, I became agoraphobic and could not leave my house for a whole year.” Because she was nursing her daughter, Lovely resisted medication and, instead, had to undergo intensive therapy.

Postpartum depression often goes undetected. Left untreated, depression can lead to complications, including pre-eclampsia (high blood pressure during pregnancy), premature birth, and low birth-weight babies. After the first year, a mother’s depression can lead to her children having anxieties or being prone to disruptive behavior, according to Dr. Nancy Byatt, a psychiatrist who is the medical director for the Massachusetts Child Psychiatry Access Project for Moms. “If a child has mental health or behavior concerns, they don’t usually go away when [that person] becomes a preteen,” says Byatt.

At the opposite end of the spectrum of emotional complications is postpartum psychosis, the most serious type of mental disorder that can occur after childbirth. Women suffering from postpartum psychosis behave erratically and have delusions and hallucinations. The condition affects a small minority, about one-tenth of 1 percent, of women.

Postpartum psychosis usually ends up in the headlines when a woman commits suicide after the birth of a child or kills one or more of her children. Andrea Yates, the Texas woman who drowned her five children in 2001, suffered from psychosis. According to news reports, Miriam Carey, the Connecticut mother killed by police in 2013 after a car chase in Washington, DC, had
depression with psychosis. Carey believed that President Obama had her under surveillance. Her baby, who was in a car seat during the shooting, survived unharmed.

Underlying medical issues, such as thyroid problems, can trigger postpartum psychosis. Shauna Kellar, an elementary school teacher turned stay-at-home mom, experienced periods of psychosis after the birth of her older daughter in 2006. Her first postpartum experience was horrific, complete with a stay in Berkshire Medical Center’s psychiatric unit, “on enough meds to tranquilize a horse,” she says. Nearly two years later, the Richmond woman says she was “100 percent better.”

But Kellar nearly died as a result of a second bout of postpartum emotional complications after the birth of her son three years later. She had abnormal thyroid levels again. Her doctors’ inability to calibrate her thyroid and psychiatric medications caused major complications. During one psychotic episode, Kellar called her mother to tell her that she planned to baptize her son in the bathtub because Jesus was coming to save the world.

After multiple hospitalizations, two suicide attempts, and electroconvulsive therapy in a Saratoga, New York, mental health treatment center, she came under the care of a Boston-area psychiatrist who tried to have her committed to St. Elizabeth’s Medical Center in Boston. After a judge intervened and ordered him to find a better solution, her meds got tweaked, her thyroid returned to normal, and she recovered two weeks later.

Today Kellar is back to teaching and is writing a memoir. She plans to visit Disney World with her husband and kids. “Postpartum depression is different in each person,” she says. “There is no standard treatment plan for each mom.”

Most women do not want to admit that they have a problem because they fear being compared to women like Yates or Carey. They worry that being treated for mental illness means that their children might be taken away from them. “Society is going to judge what they don’t even know,” says Belsito, now a volunteer with the North Shore Postpartum Depression Task Force.
Belsito says that’s why it’s important to remove the stigma surrounding postpartum depression, and to explain that it is very common and that most cases are mild to moderate and respond well to treatment. “If the absolute, extreme heartbreak situations of women who have hurt their children or have hurt themselves ends up being what postpartum depression is, no mom will ever talk about it because who wants to associate themselves with that?” she asks.

The stigma surrounding mental illness and postpartum depression can be a powerful deterrent to getting treatment. Motherhood is supposed to be one of the most idyllic periods of a woman’s life. The reality is that the first year after childbirth is physically taxing and emotionally draining. Images in the media of slim, stylish mothers cradling clean, happy babies don’t jibe with the daily grind of vomit-stained clothes, dirty diapers, and cranky infants that only sleep a few hours at a time. The novelty of a raising a newborn quickly wears off as family and friends return to their own busy lives, often miles away.

“We have just perpetuated the myth that pregnancy is a glowing time for all women and that having a baby is the most glorious life experience ever,” says Deborah Issokson, a psychologist in Wellesley and Pembroke who specializes in perinatal mental health. “It isn’t as simple as you have your baby, you go home, and all the ladies in the neighborhood gather with their babies in their buggies and have coffee together. That’s not how people live anymore.”
Looking for signs
The aim of screening is to identify at-risk women and help reduce stigma around postpartum depression by handling it as a routine feature of a woman’s medical visit, much like testing for hypertension and gestational diabetes. The Edinburgh Postnatal Depression Scale is one type of questionnaire used by health care providers to identify women who may be at-risk for postpartum depression. The survey consists of 10 questions that help judge a woman’s mood: whether she has bouts of crying, has trouble sleeping, or is thinking about harming herself. A score of 10 or higher indicates that a woman might be suffering from depression.

Treatment for postpartum depression includes talk therapy, one-on-one or in a support group, and antidepressants (although some breastfeeding mothers prefer not to take them). “If you can get a mom or an expectant mom the help that she needs early in the pregnancy, then potentially you can prevent postpartum depression,” says Byatt.

Only a handful of states, including Illinois, New Jersey, and West Virginia, screen all mothers for postpartum depression. Illinois legislators mandated screening more than a decade ago after a woman suffering from postpartum depression committed suicide. Illinois law requires health care providers to screen women, but under state regulations a provider merely has to invite pregnant patients to complete a questionnaire; the woman is not required to complete it. Illinois reimburses doctors for screening of both Medicaid and private patients.

Some doctors have been reluctant to screen women in part because they do not have mental health training and aren’t sure what the next treatment steps ought to be. There’s a fear, too, that a woman might fall through the cracks if a provider fails to keep tabs on her. “There needs to be a system in place,” says Byatt. “Doing the screen itself isn’t going to change her outcome; it needs to be followed up.”

To help Bay State health care providers determine what to do about a woman who might be depressed, the Department of Mental Health launched the Massachusetts Child Psychiatry Access Project for Moms (MCPAP for Moms) in 2014. MCPAP for Moms provides statewide
consultations for obstetricians, pediatricians, nurses, midwives, and others who work with pregnant women and new mothers. The telephone resource and referral service relies on hubs at Brigham and Women’s Hospital in Boston, UMass Memorial Medical Center in Worcester, and Baystate Medical Center in Springfield.

Psychiatrists and care coordinators offer doctors real-time consultation on issues such as drug safety and provide information about trainings, support groups, and other local resources. In the first six months of operation, the program handled more than 500 calls and assisted more than 300 hundred women. The cost of the program for fiscal 2016 is $600,000.

Nationwide, the American College of Obstetricians and Gynecologists is not on board with mandated screening. The group has advised its members that “there is insufficient evidence to support a firm recommendation for universal or postpartum screening.” That view is unlikely to shift until more states have ways to connect doctors with treatment options and more evidence that screening is effective.

Dr. Tiffany Moore Simas, an obstetrician/gynecologist who teaches at the University of Massachusetts Medical School, describes doctors’ reservations this way: “What everybody has been up in arms about is: We screen, we identify depression, and then what?” says Moore Simas, who is a member of the state postpartum commission. “Is it enough to give a woman the name and a number for a place to go? Is she going to actually engage in treatment?”

Also complicating the issue is the fact that for many postpartum women, their main interaction with the health care system is through their child’s pediatrician. Pediatricians have been reluctant to screen women because the child, not the mother, is their patient.

Some Bay State pediatricians want to shift more attention to mothers because a parent’s depression can have an impact on the child. “You can screen for development problems, but can you screen for predicting mental health disorders long-term or behavioral health disorders in young infants?” says Dr. Michael Yogman, a pediatrician who sits on the state commission.
“The answer was clearly screening mothers for postpartum depression because maternal depression affects the mother and child interaction.”

Insurers are lukewarm on screening. The Massachusetts Association of Health Plans, which has a seat on the state commission, has yet to take a position. Elizabeth Murphy, the association’s public policy and regulatory affairs manager, says that while screening makes sense, the decision to screen is best left up to individual providers. “With some women, there is some sensitivity around this,” Murphy says. “There is also a fear by some providers that if a woman is suffering from postpartum depression...that she may be less likely to go to a doctor’s visit because she doesn’t want the doctor to see that.”

Reimbursement for screening is also an issue. “I have been arguing for the better part of seven or eight years that the refusal of Medicaid to pay for postpartum depression screening was just harmful,” Yogman, the pediatrician, says. “Pediatricians are asked to do so many things, and if the insurers don’t value [screening] to reimburse for it, even minimally, they are just not going to do it. There are too many other things to do.”

**Behind the screen**

Story has not gotten much traction on a statewide screening program, but she believes that screening is key. “Because it is prevention, it saves money,” she says. “If you can get somebody in a group talking about the terrible thoughts that she is having and get her to understand that she is not the worst mother in the world, then you may save her from a psychiatric hospital.” Story spearheaded the effort to set up a statewide postpartum commission in 2010. The group, composed of more than 30 lawmakers, public health officials, doctors, and advocates, examines research and works to raise awareness. The first two screening bills that Story introduced did not advance. In January, Story re-introduced a bill that would mandate screening for MassHealth patients and restore funding to the pilot screening program.
Rep. Ellen Story of Amherst is finding that mandatory screening for postpartum depression is a tough sell.

There is no statewide data currently available on who screens for postpartum depression and who does not. Under a compromise plan after universal screening failed, state public health officials agreed to collect data annually on available screening programs. Health care providers must report their findings to the department early next year. To overcome the obstacles involved in tracking information through electronic records, which had dampened the interest in screening among some providers, state health care officials devised a special tracking code for them to use to submit data to the department.

While state health care officials continue to mull the cost of MassHealth screening, the Joint Committee on Health Care Finance put the statewide price tag at an estimated $101,000.

The Baker administration has adopted a wait-and-see approach. “MassHealth does cover many types of wellness screenings and views postpartum depression as an important issue,” said
Rhonda Mann, the Executive Office of Health and Human Services communications director, in a statement. “We do plan on taking a serious look at any evidence-based screening that has the support of the public health community.”

“The money piece of this always gets in the way,” says Lovely. “We are talking about the health of the mother and the health of her child. Doesn’t that trump anything else? If a mom is struggling, who knows if the symptoms of postpartum depression could go from mild to severe?”

*Photographs by Meghan Moore*
Keep Mothers in Mind for Mother's Day and Mental Health Month

Claudia Gold  
MAY 8, 2014 11:37 AM

In recognition of May as National Mental Health Awareness Month, President Obama made a proclamation that included this statement:

My Administration is also investing in programs that promote mental health among young people.

While he went on to speak of working with teachers and students, my hope is that Obama will recognize that prevention starts with parents and babies. A social and cultural valuing of parents, as occurs in countries like Australia and Finland, is the path to a truly preventive model.

A recent issue of the journal *Current Problems in Pediatric and Adolescent Health Care* identifies the following:

The presence of parental psychological problems, such as depression or anxiety, can lead to prolonged periods of disorganized parent-infant social interaction, compromising long-term infant outcomes. A wealth of studies has shown that maternal depression is a strong predictor of infants' social, emotional, and cognitive problems throughout the lifespan.

Representative Ellen Story and her Postpartum Depression Commission have recognized this fact. While the initial focus of the group had been on
screening for postpartum depression, it has expanded to focus on the emotional well being of parents during pregnancy and in the postpartum period. This includes supporting of strong, healthy parent-child relationships.

One of the initiatives is a new program **MCPAP for Moms**. The aim of the program is to provide statewide support for pediatricians, obstetricians and other clinicians who have the opportunity to identify and treat new parents who may be struggling with a range of perinatal emotional complications. MCPAP for Moms is partnering with the wonderful organization, **MotherWoman**, to integrate the community based perinatal support model.

**D.W. Winnicott** observed in his work as a pediatrician and psychoanalyst what he termed the "ordinary devoted mother." In the early weeks and months, when the infant is completely helpless, he relies on this devotion. When his caregivers are present in this way, development proceeds in a healthy direction. But when a parent is, in the words of Winnicott's biographer **Adam Phillips**, "preoccupied by something else," in the face of such things as social isolation, depression, anxiety or even PTSD, containing the helpless baby can be very difficult. Add a fussy baby to the mix, and this is where development can first get off track.

I am happy to be part of the MCPAP for Moms initiative because its leaders recognize the need to the focus is on the relationship. It is not only about treating the mother, but also bringing in the baby - identifying stressed early relationships and finding ways to support those relationships.
The baby is an active participant from the start. Crying, sleep and feeding problems often affect the emotional well being of new parents. The baby's mood can affect the parents, and the parents' mood can affect the baby. Parent and baby can interact in a way that causes worsening of each other's distress. This is the point at which help is needed— for the parent, for the baby, for the relationship.

By valuing the role of parents, and investing resources in the early weeks, months, and years when the baby's brain is most rapidly developing, we will be engaging in promotion of mental health and primary prevention of mental illness.
CommonHealth

Falling Into The Postpartum Mood Disorder Abyss: A Personal Story

By Deb Wachenheim  
Guest Contributor

Over the past two days, The New York Times published a series of articles about postpartum depression and other related mood disorders. The first article looked at the science and policy on this topic and highlights a few women’s stories.

Today’s article is about my sister, Cindy Wachenheim, who took her own life in March of 2013 after struggling for six months with postpartum mood disorders. I say mood disorders because it was not just depression (and the fact that there are other postpartum mood disorders in addition to postpartum depression was something about which I was previously completely unaware). She had extreme anxiety about, and obsession with, her baby’s health and she was depressed because she believed she caused him to have serious health problems. Also, according to what I have been told by experts, she may have been psychotic: she was so convinced that something was seriously wrong with her baby — despite doctors telling her otherwise — that she strapped him to her chest when she jumped out of her apartment window, believing, I can only assume, that this was what was best for him. Thank goodness, he survived and is thriving.

Beyond what is written in the article, I think it is important to give more detail and information on some resources and policy activities in Massachusetts, in the hope that this could possibly help others who are facing similar struggles. As is mentioned in the article, I reached out to Cindy’s son’s pediatrician after Cindy had gone to see her multiple times about her concerns.

Pediatricians are key to screening for postpartum mood disorders and making referrals for needed treatment. Most women see their OB a few weeks after giving birth and if everything seems okay at that point then they are sent on their way until the following year’s annual exam.

However, woman bring their infants to see the pediatrician many times over that first year. It is pediatricians who could notice if something seems to not be right with the mother. There are efforts to have pediatricians more involved in regular screening and referral. I want to mention in particular the MCPAP for Moms program in Massachusetts. This is a terrific resource for pediatricians who need information about referrals and ways to assist moms who they believe are struggling. Also, the state Department of Public Health is currently accepting testimony on its draft regulations to implement a law on health care provider reporting on screening for postpartum depression. You can read the draft regulations and learn how to submit comments on the DPH website.
There are so many more aspects of Cindy's story that I could talk about — the isolation that must have impacted her mental health (both with no family living nearby and, eventually, the isolation that came with her deep depression); the dangers of falling into the “black hole” of Internet “health” research; the difficulty of trying to find a mental health care provider who is the “right fit” when you are in the midst of a mental health crisis; the societal belief that women should be naturally wonderful mothers and should be supermoms who can handle everything. And, with that, there’s the shame and guilt that comes when you realize you can’t handle everything the way you thought you should.

My family and I will always have a deep hole in our hearts because of the loss of Cindy. In her memory and honor, we are speaking up and telling my sister's story so we can raise awareness, reduce stigma and help others who are struggling with postpartum mood disorders or who have a loved one who is struggling.

*Deb Wachenheim is the Health Quality Manager for the Boston-based consumer advocacy group Health Care For All.*

Please follow our [community rules](#) when engaging in comment discussion on this site.
Program helping moms with postpartum depression get a fresh start

MCPAP for Moms is state-funded program

Link to watch video: http://www.wcvb.com/health/program-helping-moms-with-postpartum-depression-get-a-fresh-start/32652994
Hotline helps in postpartum depression battle

By Geraldine A. Collier

The hotline phone at MCPAP for Moms has rung more than 1,000 times since it was activated in July of 2014, each ring signifying that somewhere there’s a troubled woman and a healthcare provider who wants to help, but whose training never covered perinatal depression.

A little over a year ago, one of those calls came from an obstetrician who was taking care of Amanda Martin, a Charlton resident, who had recently delivered her first child, a daughter she and her husband Jonathan named Ella.

“I always had anxiety and depression, but while I was pregnant I wasn’t on any medication, because I was doing fine without it,” said Amanda. “But, as soon as I delivered, I had them order the medication that I was normally on.” However, the dosage ordered was wrong for Amanda at that time, so she just kept getting worse, getting sadder and more depressed.

Amanda admits “it was a really dark time. Sometimes I just didn’t want to be a mom any more,” she said. “I don’t think I can do this,” she told her obstetrician.

Risks for developing postpartum depression include:

- Depressive or anxiety symptoms in pregnancy
- A history of prior postpartum depression
- A history of prior depression or anxiety
- Poor support from family, partner or friends
- Current or recent stressful events
- Current or prior postpartum blues
- Maternal neuroticism (anxious personality)
- Difficult infant temperament

The call by the obstetrician to the hotline for MCPAP for Moms — an outgrowth of the Massachusetts Psychiatry Access Project — resulted in Amanda being set up with an appointment with a psychiatrist, who figured out the problem with the dosage and changed it. Amanda was also set up with an appointment with a therapist.

“Postpartum depression is twice as common in pregnant women as diabetes,” said Dr. Nancy Byatt, medical director for MCPAP for Moms. In fact, screening for diabetes “has become such a routine part of obstetrical care, it would be considered malpractice not to screen for diabetes,” she added.

However, screening for perinatal depression (prenatal and postpartum) even though it affects one out of seven women, has not been a standard part of obstetrical care.

Nothing in Dr. Tiffany Moore Simas’s medical school education (she graduated in 2000) or the internship and residency that followed prepared her to deal with perinatal depression.

However, in her obstetrical/gynecological practice at UMass Memorial Medical Center, Dr. Simas has been fortunate to have her practice include a social worker and also have access to a perinatal psychiatrist.

Postpartum depression is twice as common in pregnant women as diabetes said Dr. anc B att medica director for PAP for oms. n fact screening for dia etes has ecome such a routine part of o stetrica care it would e considered ma practice not to screen for dia etes she added.

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In the average private practice, an obstetrician/gynecologist doesn’t necessarily have access to that degree of resources,” said Dr. Simas, who is an associate professor of obstetrics, gynecology, and pediatrics at the UMass Medical School.

Any provider who cares for pregnant women wants to take care of the whole woman,” said Dr. Simas, who also serves as the lead obstetrical liaison to MCPAP for Moms.

“We really want women to feel comfortable about opening up to us,” she said, adding that “if the general public realized how common this is, it would become more of a general conversation.”

That may come about because of a recent proposal by the U.S. Preventative Services Task Force that has shone the spotlight on perinatal depression by recommending that screening should be implemented for all pregnant women.

However, the task force also recognized that screening alone is not enough.

“There needs to be intervention in place coupled with screening to make sure that once depression is detected there are resources where she noted Dr. Byatt, who is also an assistant professor of psychiatry, obstetrics, and gynecology at the University of Massachusetts Medical School.

While other states may be prompted by the task force’s recommendation to start putting together resources, Massachusetts is well ahead of the pack with its Massachusetts Child Psychiatry Access Project and now the MCPAP for Moms program.

The goal of our program is to build the capacity of frontline providers who are working with pregnant and postpartum women so that they can provide the care that women need,” said Dr. Byatt.

So far, percent of Massachusetts health care providers which includes obstetricians, midwives, primary care doctors, pediatricians, and psychiatrists have been trained in how to detect, assess, and manage depression. They have been equipped with a toolkit — a special one for pediatric providers — and a screening algorithm.

Besides training, MCPAP for Moms offers consultation to providers who have questions. A phone call to (855) 666-6272 by health care providers is answered by a care coordinator who relays the question to one of the perinatal psychiatrists involved in the program.

The goal is to provide a callback with an answer to the provider’s question within 30 minutes of the call being received.

“If there is still a question, we can offer a patient a face-to-face consultation at any of our three hospitals: Baystate Medical Center in Springfield; UMass Memorial Medical Center, and Brigham and Women’s Hospital in Boston,” said Dr. Byatt.

“We make recommendations to the patient and send a note to the provider providing the details so the provider can continue to work with and manage the patient,” said Dr. Byatt. The care coordinator can arrange for the appointment and coordinate with the patient’s insurance.

RNs at our hospitals for non-English speaking patients can make appointments at each step along the process.

About 30 percent of women develop depression during pregnancy and 40 percent during the postpartum period after delivery.

Understanding what women are dealing with is in the past as we as those with no past history. Depression is the goal of Dr. Kristina M. Deligiannidis, a psychiatrist who is the director of the Depression Specialty Clinic at UMass Memorial.

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With a five-year, $900,000 clinical research grant from the National Institutes of Health, Dr. Deligiannidis is looking at sex hormones and the role they may play in depression.

"Sex hormones have very strong effects on brain chemistry, which affects how different areas of the brain talk to each other," said Dr. Deligiannidis, who is also an associate professor of psychiatry, obstetrics and gynecology at UMass Medical School.

"We hypothesize that, in those women who go on to develop depression in the postpartum, their brain chemistry doesn’t adapt to the big changes in sex hormones that occur during pregnancy when the levels are really high and then early after giving birth when the levels plummet. That could trigger an episode of depression."

Through blood tests, Dr. Deligiannidis looks at the biomarkers in women who are at risk for developing postpartum depression. "To do this, we compare blood samples between women who are at low risk and those who are at high risk. We then compare the brain chemistry between those two groups after the women deliver their infants to see if there are differences."

As for Amanda Martin, she continues to see her therapist, but will, hopefully, also be seeing her obstetrician soon again. She and Jonathan are trying for a little sister or brother for Ella.
H. R. 3235

To amend the Public Health Service Act to authorize the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, to make grants to States for screening and treatment for maternal depression.

IN THE HOUSE OF REPRESENTATIVES
JULY 28, 2015

Ms. CLARK of Massachusetts (for herself and Mr. COSTELLO of Pennsylvania) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend the Public Health Service Act to authorize the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, to make grants to States for screening and treatment for maternal depression.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Bringing Postpartum Depression Out of the Shadows Act of 2015”.

SECTION 2. FINDINGS.

The Congress finds as follows:
(1) Depression is a medical, physiologic illness—not a sign of weakness or poor parenting.

(2) Maternal depression includes major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery.

(3) An estimated 9 to 16 percent of new mothers experience postpartum depression.

(4) Every year, more than 400,000 infants are born to mothers who have depression, which makes perinatal depression the most underdiagnosed obstetric complication in the United States.

(5) The consequences of maternal depression include poor bonding between mother and infant, which may have negative effects on cognitive development, social-emotional development, and behavior of the child.

(6) Maternal suicide exceeds hemorrhage and hypertensive disorders as a cause of maternal mortality.

(7) About 90 percent of women who have maternal depression can be treated successfully with a combination of medication and counseling.

(8) States and professional organizations are taking the lead in addressing this problem, through
public awareness campaigns, resource collection, and
even promoting phone consultations.

(9) The Congress should provide resources to
support State teams, and help them find innovative
solutions to this problem.

SEC. 3. SCREENING AND TREATMENT FOR MATERNAL DE-
PRESSION.

The Public Health Service Act is amended by insert-
ing after section 317L of such Act (42 U.S.C. 247b–13)
the following:

“SEC. 317L–1. SCREENING AND TREATMENT FOR MATER-
NAL DEPRESSION.

“(a) GRANTS.—The Secretary, acting through the
Administrator of the Health Resources and Services Ad-
ministration, may make grants to States to establish, ex-
pand, or maintain culturally competent programs for
screening and treatment of women who are pregnant, or
who have given birth within the preceding 12 months, for
maternal depression.

“(b) NUMBER.—The Secretary shall make grants
under this section to not fewer than 3 States.

“(c) APPLICATION.—To seek a grant under this sec-
tion, a State shall submit an application to the Secretary
at such time, in such manner, and containing such infor-
information as the Secretary may require. At a minimum, any such application shall include explanations of—

“(1) how the State’s proposed program will increase the percentage of women screened and treated for maternal depression in one or more communities; and

“(2) how the State’s proposed program, if expanded, would lead to substantial increases in screening and treatment for maternal depression.

“(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to States proposing to expand or enhance screening for maternal depression in primary care settings, including family medicine, general internal medicine, general pediatrics, preventive medicine, obstetrics and gynecology, and psychiatry.

“(e) USE OF FUNDS.—The activities eligible for funding through a grant under subsection (a)—

“(1) shall include—

“(A) providing appropriate training to health care providers; and

“(B) providing relevant resources to health care providers, including information on maternal depression screening, treatment, and followup support, and linkages to community-based resources; and
“(2) may include—

“(A) enabling health care providers (including obstetrician-gynecologists, pediatricians, psychiatrists, mental health care providers, and adult primary care clinicians) to provide or receive real-time psychiatric consultation (in-person or remotely) to aid in the treatment of pregnant and postpartum women;

“(B) conducting a public awareness campaign;

“(C) funding start-up costs for phone lines, websites, the collection and dissemination of information, and other relevant resources and services; and

“(D) establishing linkages with and among community-based resources, including mental health resources, primary care resources, and support groups.

“(f) Authorization of Appropriations.—To carry out this section, there are authorized to be appropriated $5,000,000 for each of fiscal years 2016 through 2020.”.
November 10, 2016

Ms Linda Kinnane
ACOG
409 12th Street SW
Washington DC 20024

Dear Ms Kinnane:

On behalf of District III, I am pleased to nominate the New Jersey Section project entitled “Maternal Health Awareness Day” for consideration for the 2016 CDC Service Recognition Award.

I have enclosed a Summary of the project and the Senate Joint Resolution.

Thank you for your consideration of this worthy project.

Sincerely,

Ann Honebrink, MD
Chair, District III
Proposed Proclamation by the New Jersey State legislature for a Maternal Health Awareness Day (Annually)

The New Jersey Section of ACOG has long supported maternal mortality and review in the State of New Jersey since the early 1970’s. The review committee consists of volunteers and is a multi-specialty group of providers who provide women’s health care services including members who are obstetricians, social service workers, substance abuse counselors, anesthesia providers, pathology providers and others. The group meets for times a year and reviews each maternal death in detail. A detailed report is compiled with recommendations from the committee to improve and decrease pregnancy related maternal mortality rates. The details of the most recent report can be found at the link below.


However the committee members voiced the concern that maternal health awareness and problems such as pregnancy related morbidity and mortality are often not on the “radar screen” of the general public, legislators and insurance companies. Therefore it is the objective of the proclamation to increase maternal health awareness on a yearly basis for all residents of the state including providers of women’s healthcare services, the general public, legislators, insurance company executives and other interested parties. It was apparent from our discussions at the maternal mortality meetings that our detailed reports which included recommendations and suggested improvements for the more common pregnancy related maternal deaths issues often went unacted upon by those who had the power to do so. Some of the recommendations were insurance coverage issues, some were legislative issues, some were patient related issues, and some were societal problems such as substance abuse.

Dr. Joseph Apuzzio Immediate Past Chair of ACOG District III and Vice Chair of Rutgers New Jersey Medical School Newark, New Jersey and Dr. Gloria Bachmann Interim Chair Rutgers Robert Wood Johnson Medical School New Brunswick, New Jersey along with Ms. Robyn D’Oria AWHONN Section Chair and representatives of the Tara Hansen Foundation met with New Jersey State Senator and Chair of the Health and Human Services Committee Honorable Joseph Vitale concerning the above. The result of the meeting was the development of a proclamation proclaiming “Maternal Health Awareness day” in the State of New Jersey. The tentative date is January 23, 2017 which coincides with the AIM role out for New Jersey. Media will be present during the presentation so that the proclamation will get state wide exposure. The proclamation will be presented during a session of the New Jersey legislature in order to obtain maximal media exposure.

It is with this intention to raise awareness of maternal health problems with the hope that the proclamation will assist in decreasing some of the barriers to improving pregnancy related maternal morbidity and mortality.
SENATE JOINT RESOLUTION
No. 92

STATE OF NEW JERSEY
217th LEGISLATURE

INTRODUCED NOVEMBER 10, 2016

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)

SYNOPSIS
Designates January 23 of each year as “Maternal Health Awareness Day” in New Jersey.

CURRENT VERSION OF TEXT
As introduced.
A JOINT RESOLUTION designating January 23 of each year as
“Maternal Health Awareness Day” in New Jersey, in memory of
Tara Hansen and all other women who die from causes related to
childbirth.

WHEREAS, The number of pregnancy-related deaths in the United
States (the number of women who die during pregnancy, or within
one year after childbirth, from any cause that is related to, or
aggravated by, the pregnancy) has continued to rise, despite recent
advances in medical science and technology; and

WHEREAS, In 1986, the federal Centers for Disease Control and
Prevention (CDC) implemented a Pregnancy Mortality Surveillance
System to obtain information about the frequency and causes of
pregnancy-related death in the United States; and

WHEREAS, Despite declines in maternal deaths in other parts of the
world, the data collected under the Pregnancy Mortality
Surveillance System has shown a steady increase in the number of
reported pregnancy-related deaths in the United States, from a low
of 7.2 deaths per 100,000 live births in 1987, to a high of 17.8
deaths per 100,000 live births in 2009 and 2011; and

WHEREAS, In 2012, the most recent year for which surveillance data is
available, there were approximately 16 pregnancy-related deaths
per every 100,000 live births in the United States; and

WHEREAS, The Pregnancy Mortality Surveillance System indicates
that the rate of pregnancy-related deaths varies by race, ethnicity,
and age, with the highest mortality rate being evidenced among
black women, who suffered an average of 41 deaths per every
100,000 live births in 2012; and

WHEREAS, The most recent State-level data available on this issue
indicates that, from 2006 to 2008, the average pregnancy-related
mortality rate in New Jersey was 14.4 deaths per 100,000 births
across all racial and ethnic subgroups, with a significantly higher
rate of death for black women in the State, which is consistent with
national statistics; and

WHEREAS, A number of initiatives have been developed over the
years to address the issue of pregnancy-related mortality, and while
most of these initiatives have failed to effectuate a reduction in the
rate of pregnancy-related deaths, some more recently-developed
initiatives in this area are showing promise; and

WHEREAS, These promising initiatives include the Safe Motherhood
Initiative, which was developed by the American College of
Obstetricians and Gynecologists (ACOG); the Postpartum
Hemorrhage Project, which was developed by the Association of
Women’s Health, Obstetric, and Neonatal Nurses (AWHONN); the
“Stop, Look, and Listen!” educational maternal safety campaign,
which was developed by the Tara Hansen Foundation, the Rutgers
Robert Wood Johnson Medical School, and Robert Wood Johnson
University Hospital, and is supported and promoted by Rutgers
New Jersey Medical School; and the Alliance for Innovation on Maternal Health (AIM), which is a national partnership of organizations that is poised to reduce severe maternal morbidity through initiatives that are being implemented in New Jersey and other states; and

WHEREAS, On a Statewide basis, the New Jersey Section of ACOG, the New Jersey Obstetrical and Gynecological Society, the New Jersey Section of AWHONN, and the New Jersey Affiliate of the American College of Nurse Midwives, have each indicated their full support for these initiatives; and

WHEREAS, The mission of the Tara Hansen Foundation’s “Stop, Look, and Listen!” campaign is to increase public and professional awareness of pregnancy-related deaths, empower and encourage women to more readily report pregnancy-related medical issues, and increase the awareness and responsiveness of health care practitioners and medical teams in association with potentially fatal pregnancy-related medical issues; and

WHEREAS, The Tara Hansen Foundation was established in 2012 in response to the death of Tara Hansen, a young special education teacher and citizen of New Jersey who died only six days after the birth of her first child as a result of undiagnosed pregnancy-related complications, despite having a low-risk pregnancy; and

WHEREAS, The “Stop, Look, and Listen!” campaign is specifically designed to educate patients and health care practitioners about the importance of using a deliberative stop, look, and listen approach in response to maternal health complaints or other indications of maternal distress, as a means to prevent maternal deaths like Tara’s; and

WHEREAS, The AIM program, which is being implemented in New Jersey, is a four-year national program that is being funded through a cooperative agreement between the Maternal and Child Health Bureau and the Health Resources and Services Administration; and

WHEREAS, The stated goal of the AIM program is to reduce severe maternal morbidity by preventing 100,000 severe complications during labor and delivery, and preventing 1,000 maternal deaths, through the year 2018; and

WHEREAS, The AIM program aligns national, state, and local efforts to improve maternal health and safety; develops maternal safety bundles; and promotes the implementation of these bundles in all birth facilities, in order to better ensure consistency in maternal care; and

WHEREAS, The AIM program’s maternal safety bundles address such issues as obstetric hemorrhage; severe hypertension/preeclampsia; maternal prevention of venous thromboembolism; the safe reduction of primary cesarean births and increase of support for intended vaginal births; the reduction of peripartum racial disparities; postpartum care basics for maternal safety; patient,
family, and staff support after a severe maternal event; and obstetric
management of women with opioid dependence; and
WHEREAS, The AIM Program facilitates multidisciplinary and
interagency collaboration between states and hospitals; supports
continuous and harmonized data-driven quality improvement
processes; and provides evidence-based resources to streamline
bundle implementation; and
WHEREAS, The core partners of the AIM Program in New Jersey
include the New Jersey Section of ACOG, the New Jersey
Obstetrical and Gynecological Society, the New Jersey Section of
AWHONN, and the New Jersey Affiliate of the American College
of Nurse Midwives; and
WHEREAS, In order to improve public and professional awareness of
the issues related to maternal health and mortality, and promote the
various promising initiatives that are being undertaken to reduce
maternal mortality, it is both reasonable and appropriate to establish
“Maternal Health Awareness Day” in the State and annually invite
community members and health care professionals, on that day, to
participate in appropriate activities relating to maternal health,
safety, and mortality; now, therefore,

BE IT RESOLVED by the Senate and General Assembly of the
State of New Jersey:

1. January 23 of each year shall be designated as “Maternal
Health Awareness Day,” in order to raise public and professional
awareness about important maternal health, safety, and mortality
issues; highlight obstetrical pathways that promote maternal safety;
educate the citizens of New Jersey about promising maternal health
initiatives, including public initiatives like the “Stop, Look, and
Listen” campaign, and professional initiatives, like the AIM
Program, which focus on improving patient safety and decreasing
maternal mortality; and encourage the development of new
programs and initiatives that are designed to proactively address
issues of maternal health and mortality.

2. The Governor shall annually issue a proclamation
recognizing January 23 as “Maternal Health Awareness Day” in
New Jersey, and calling upon public officials and citizens of the
State to observe the day with appropriate activities and programs.

3. This joint resolution shall take effect immediately.

STATEMENT

This joint resolution would designate January 23 of each year as
“Maternal Health Awareness Day” in New Jersey.
The day would be intended to: (1) raise public and professional awareness about maternal health, safety, and mortality, and the obstetrical pathways that promote maternal safety; (2) educate the citizenry about the promising public and professional campaigns and initiatives that focus on improving maternal health and safety, and decreasing maternal mortality; and (3) encourage the development of new initiatives and campaigns that are designed to address important maternal health issues.

Although maternal death rates have declined in other parts of the world, the rate of pregnancy-related deaths in this nation has continued to rise, despite recent advancements in medical science and technology. In 1986, the federal Centers for Disease Control and Prevention (CDC) implemented a Pregnancy Mortality Surveillance System to obtain information about the frequency and causes of pregnancy-related death in the United States, and the data collected has shown a steady increase in the number of reported pregnancy-related deaths, from a low of 7.2 deaths per 100,000 live births in 1987, to a high of 17.8 deaths per 100,000 live births in 2009 and 2011.

In 2012, the most recent year for which surveillance data is available, there were approximately 16 pregnancy-related deaths per every 100,000 live births in the United States, with the highest mortality rate being evidenced among black women, who suffered an average of 41 deaths per every 100,000 live births. The most recent State-level data available on this issue indicates that similar racial disparity trends exist in New Jersey.

Several recently-developed maternal health initiatives, however, have adopted a promising approach to reducing the number of maternal deaths and increasing public and professional awareness of maternal health and safety issues. These promising initiatives include the Safe Motherhood Initiative, which was developed by the American College of Obstetricians and Gynecologists (ACOG); the Postpartum Hemorrhage Project, which was developed by the Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN); the “Stop, Look, and Listen!” educational maternal safety campaign, which was developed by the Tara Hansen Foundation, the Rutgers Robert Wood Johnson Medical School, and Robert Wood Johnson University Hospital, and is supported and promoted by Rutgers New Jersey Medical School; and the Alliance for Innovation on Maternal Health (AIM), which is a national partnership of organizations that is poised to reduce severe maternal morbidity through initiatives implemented in New Jersey and other states. The designation of “Maternal Health Awareness Day” would promote greater public and professional awareness of, and participation in, these initiatives, and would encourage the establishment of other, similar programs.

The resolution calls upon the Governor to annually issue a
proclamation recognizing January 23rd as “Maternal Health Awareness Day” in New Jersey, and calling upon public officials and citizens of the State to observe the day with appropriate activities and programs.
December 29, 2016

Dear CDC Members,

With great pride, District VI submits the nomination of our Wisconsin Section, ACOG (WI-ACOG) for consideration for the 2016 CDC Service Recognition Award, based on the Section’s involvement as a founding member of the Wisconsin Perinatal Quality Collaborative (WisPQC), and in particular for the Section’s commitment in promoting WisPQC’s new breast-feeding improvement initiative.

WI-ACOG is a founding member of WisPQC which was established in 2014, with a mission to improve perinatal health outcomes, promote equity in perinatal care, promote risk based appropriate care, and improved quality of care across continue them for all women and infants in Wisconsin. The Wisconsin Association for Perinatal Care and the Perinatal Foundation provide administrative support and leadership to WisPQC through a CDC-funded Grant from the Wisconsin Department of Health Services.

WI-ACOG through the support of its members engages local stakeholders including physicians, nurse champions, midwives, NICU staff, hospital leadership and others; and have successfully obtained organizational support from a variety of medical organizations, hospital and other interested parties. Just to name a few, the founding members include: The American Academy of Pediatrics-WI Chapter, the American College of Nurse Midwives-WI affiliate, AWHONN-WI, March of Dimes- WI Chapter, Medical College Wisconsin, St. Mary’s Hospital, University of Wisconsin School of medicine, Wheaten Franciscan Healthcare, Wisconsin Department of Health Services, Wisconsin Hospital Association, and the Wisconsin Medical Society.

WisPQC’s first major initiative, the “beta project”, seeks to improve quality of care for women with hypertension before, during, and after pregnancy. The aim of the beta project is to increase the number of providers, defined as hospitals or health systems who utilize evidence-based protocols for screening and managing women with hypertension in the antepartum, intrapartum, and postpartum periods. The group disseminated a toolkit using the California maternal quality care collaborative as a model. 10 phase I beta sites have implemented institutionally-relevant interventions and are checking for standardized measures across the state. Sites participate in monthly webinars to share best practices and track success. Additional phase II beta sites were enrolled in September 2016.
Due to the 2016 breast-feeding initiated from ACOG, Dr. Hartke, the Wisconsin section chair recommended that breast-feeding promotion as the next project. The toolkit was requested and sent to the WisPQC leaders to develop the project.

For year 2, the group is working on ensuring that as many babies as possible receive breast milk. Data collection begins in 2017 including 8 measures: prenatal education, skin-to-skin contact, rooming-in, supplementation and exclusive breast-feeding. WisPQC has established a breastfeeding work group including WI-ACOG, Pediatrics, local HMOs, the WI Association of Lactation Consultants, the Prenatal Care Coordinator OB Medical Home Project and others. ACOGs Breastfeeding Toolkit has been highlighted as a model.

District VI is extremely proud of the efforts of a very active section, Wisconsin. We would like to applaud, Dr. Kathy Hartke, the WI section char and Dr. Cynthie Anderson, the liaison to the project.

The Wisconsin Section is deserving of the CDC Service Recognition Award.

Sincerely,

Denise M. Elser, MD
Chair, District VI
To: Linda Kinnane (lkinnane@acog.org)
From: Kathy Hartke, MD, Chair, WI-ACOG
Date: November 30, 2016
RE: CDC Award Project Summary Report

The Wisconsin Section, ACOG is pleased to submit this project summary to supplement the nomination made by District VI for the Council of District Chairs (CDC) Service Recognition Award for Projects/Activities by a Section in 2016.

Project Summary

District VI nominated the Wisconsin Section, ACOG (WI-ACOG) for the CDC Service Recognition Award because of the Section’s involvement as a Founding Member of the Wisconsin Perinatal Quality Collaborative (WisPQC), and our full support and commitment in promoting WisPQC’s new breastfeeding improvement initiative. Should WI-ACOG be awarded this honor, funds would be used to build public awareness about the initiative and the important role physicians have in promoting breastfeeding.

WI-ACOG became a founding member of WisPQC, the Wisconsin Perinatal Quality Collaborative, under the leadership of Dr. Kathy Hartke, Section Chair. Dr. Cynthie Anderson has been appointed to serve as the ACOG’s first liaison to the collaborative. To underscore the importance of this role, a motion was passed at the Wisconsin Section, ACOG Annual Business Meeting in August 2016 to allow the Section Chair to annually appoint the Section’s liaison to WisPQC as a voting member of the Section’s Advisory Council.

WisPQC was established in August, 2014, with a mission to improve perinatal health outcomes, promote equity in perinatal care, promote risk-based appropriate care, and improve quality of care across the continuum for all women and infants in Wisconsin. The Wisconsin Association for Perinatal Care (WAPC) and the Perinatal Foundation provide administrative support and leadership to WisPQC through a CDC-funded grant from the Wisconsin Department of Health Services. WAPC consulted with Dr. Elliot Main from the California Quality Collaborative during the development of the WisPQC. He was the featured speaker at the Annual WI Section Conference in August 2016.

WI Section ACOG seeks the support of its members to engage with their local stakeholders including physicians, nursing champions, midwives, NICU colleagues, operational/administrative staff, hospital leadership and others to encourage their organizations to join WisPQC. Member organizations will select a representative(s) to attend meetings and webinars, participate in WisPQC initiatives, and contribute to WisPQC based on available resources including contribution of data, content expertise, support for continuing education, and implementation of quality initiatives. Member organizations will assure
sustainability of WisPQC with the understanding that WisPQC may consider a membership dues structure in the future.

Founding members of WisPQC include:
- American Academy of Pediatrics, Wisconsin Chapter
- American College of Nurse Midwives, Wisconsin Affiliate
- ACOG, Wisconsin Section
- Aurora Health Care
- AWHONN Wisconsin
- Bellin Health Systems
- March of Dimes, Wisconsin Chapter
- Medical College of Wisconsin, Department of Ob-Gyn
- Meriter UnityPoint Health
- Perinatal Foundation
- St. Mary’s Hospital, Madison WI
- University of Wisconsin School of Medicine and Public Health, Dept. of Ob-Gyn
- University of Wisconsin School of Medicine and Public Health, Dept. of Pediatrics
- Wheaton Franciscan Healthcare – All Saints
- Wheaton Franciscan Healthcare – St. Joseph’s and Elmbrook Memorial campuses
- Wisconsin Association for Perinatal Care (WAPC)
- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Department of Health Services
- Wisconsin Hospital Association
- Wisconsin Medical Society
- Wisconsin Neonatal Perinatal Quality Collaborative (WINpqc)

WisPQC's first major initiative, the “Beta Project,” is to improve quality of care for women with hypertension before, during, and after pregnancy. Preliminary data from WI PeriData.Net® show that in Wisconsin, hypertensive disorders affect up to 22% of pregnancies. Hypertensive disorders are leading contributors to neonatal morbidity and mortality, with approximately 15-20% of NICU admissions being associated with maternal hypertension and abruption secondary to severe hypertension as a leading cause of perinatal mortality.

The aim of the Beta Project is to increase the number of providers (defined as hospitals or health systems) who use evidence-based protocols for screening and managing women with hypertension in the antepartum, intrapartum, and postpartum periods. WisPQC disseminated a toolkit using the California Maternal Quality Care Collaborative as a model. Ten Phase I Beta sites have implemented institutionally-relevant interventions and are tracking four standardized measures across the state:
- Maternal length of stay ≥ 72 hours or equivalent outpatient follow up
- Provider Education Implemented
- Universal Consumer Education Implemented
- NICU Admissions

Phase I Beta sites included:
- Upland Hills Health
- La Crosse County Public Health
- Aurora Sinai Medical Center
• Bellin Hospital
• Froedtert Health – Community Memorial Hospital
• Sauk Prairie Healthcare
• St. Mary’s Hospital
• Bridge Community Health Clinic
• St. Vincent

Sites participate in monthly webinars to share best practices and track success. Phase II Beta sites were enrolled in September, 2016.

WisPQC has considered several future initiatives including antibiotic stewardship, breastfeeding promotion, perinatal depression, tobacco use, and others. A priority matrix tool was disseminated to member organizations to guide the selection process.

Due to the 2016 Breastfeeding Initiative from the American College of Obstetricians and Gynecologists, and the efforts that the national office has made to educate obstetricians, Dr. Hartke recommended breastfeeding promotion as the next WisPQC project. The Toolkit was requested and sent to the WisPCQ leaders to develop the project. We will encourage physicians and hospitals to use these tools and improve breastfeeding throughout the state. Dr. Anderson successfully led the discussion and this project was selected as the second initiative by the WisPQC. Both physicians will be serving on the breastfeeding project committee.

*Year 2 WisPQC Initiative—Human Milk Feeding*

The next WisPQC effort focuses on promoting human milk feeding in Wisconsin. WisPQC will highlight breastfeeding as an effective method for improving health outcomes of infants and mothers and will ensure that as many babies as possible receive breast milk. The WAPC Perinatal Data Committee and Ancilla Partners, Inc. have defined evidence-based measures, numerators, denominators, and corresponding new data entry fields and will run reports for participating sites using PeriData.Net®. Data collection will begin in 2017 and participating sites will track and report one or more of 8 measures including prenatal education, skin-to-skin contact, rooming-in, supplementation, and a Joint Commission Measure as outlined in PC-05 statement on exclusive breastfeeding. WI Section ACOG has disseminated information to all WI Section ACOG members through the member newsletter, continues to encourage ACOG members from across the state to engage with and encourage their institutions to join WisPQC, and ensures representation via a WI ACOG delegate to the Breastfeeding Work Group to align statewide efforts with the objectives of ACOG locally and nationally.

**Breastfeeding Measures Include:**

- Prenatal education - 100% documented prenatal education on human milk feeding
- Skin-to-skin - 90% of mothers hold healthy term newborns (≥ 37 weeks 0 days gestation) skin-to-skin, uninterrupted, for at least 60 minutes, or until the completion of the first feeding, beginning within one hour of birth for uncomplicated vaginal births and within 2 hours of uncomplicated Cesarean deliveries
- Skin-to-skin - 90% of mothers hold newborns skin-to-skin while routine newborn procedures and assessments are done after uncomplicated vaginal deliveries (within the first hour)
- Delayed until after the first feed or do it on mom.
- Rooming-in - 90% of healthy term newborns (≥ 37 weeks 0 days gestation), regardless of feeding method, remain with their mothers ≥ 23 hours per day
- Supplementation - Less than 30% of healthy term (≥ 37 weeks 0 days gestation) human milk-fed infants are supplemented with something other than human milk
- Human milk feeding after discharge - Human milk feeding at 1, 3, 6, 12 months or 2, 4, 6, 12 months.
- Exclusive human milk feeding after discharge - Exclusive human milk feeding at 1, 3, 6 months or 2, 4, 6 months.

WisPQC has established a breastfeeding work group that includes statewide stakeholder representation from across disciplines including WI Section ACOG, Pediatrics, local HMOs, the WI Association of Lactation Consultants, the Prenatal Care Coordinator OB Medical Home Project, and many others. ACOG’s Breastfeeding Toolkit has been highlighted as a model.

WisPQC will promote the initiative amongst facilities/agencies in Wisconsin, including a November 29th webinar on PeriData.net Human Milk Feeding data and input. At time of this writing, 50 enrollees are currently signed up for this introductory data webinar. An additional webinar will take place on December 16th, and enrollment ongoing.

Supplementing this report is a data sheet of definitions used by WisPQC, as well as a data sheet being used to drive the breastfeeding initiative that ensures alignment with Joint Commission efforts.

The video link below provides an overview of the Collaborative and highlights the organization’s mission to improve perinatal health outcomes and equity across the continuum for all women and infants in Wisconsin.

View video here: [https://youtu.be/y1VkxNiCb9I](https://youtu.be/y1VkxNiCb9I)
## Human Milk Feeding Measures

<table>
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<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
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<tr>
<td><strong>Prenatal education</strong>&lt;br&gt;100% documented prenatal education on human milk feeding</td>
<td>Documented prenatal education on human milk feeding for patients</td>
<td>All patients receiving prenatal care.</td>
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<td><strong>Skin-to-skin</strong>&lt;br&gt;90% of mothers hold healthy term newborns (≥ 37 weeks 0 days gestation) skin-to-skin, uninterrupted, for at least 60 minutes, or until the completion of the first feeding, beginning within one hour of birth for uncomplicated vaginal births and within 2 hours of uncomplicated Cesarean deliveries</td>
<td>All healthy term newborns (≥ 37 weeks 0 days gestation) who are placed skin-to-skin with their mother for at least 60 minutes, or until completion of the first feeding, beginning within one hour of birth for uncomplicated vaginal births and within 2 hours of uncomplicated Cesarean deliveries</td>
<td>All healthy term newborns (≥ 37 weeks 0 days gestation) born via vaginal or Cesarean birth.</td>
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<td><strong>Exclusions:</strong>&lt;br&gt;- Newborns of mothers who are not responsive, or are unstable following birth;&lt;br&gt;- Newborns of mothers with a severe illness that prevents them from caring for their infants, e.g., sepsis;&lt;br&gt;- Newborns with a diagnosis that requires admission to special care or neonatal intensive care unit at birth;&lt;br&gt;- Newborns who are being adopted whose birth mothers choose not to initiate immediate contact.</td>
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<tr>
<td><strong>Skin-to-skin</strong>&lt;br&gt;90% of mothers hold healthy term newborns (≥ 37 weeks 0 days gestation) skin-to-skin while necessary routine newborn procedures and assessments are done within the first hour after uncomplicated vaginal deliveries.</td>
<td>All healthy term newborns (≥ 37 weeks 0 days gestation) for whom necessary routine newborn procedures and assessments are performed within the first hour while the mother is holding skin-to-skin after uncomplicated vaginal births</td>
<td>All healthy term newborns (≥ 37 weeks 0 days gestation) for whom routine newborn procedures are performed</td>
</tr>
<tr>
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<td></td>
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<tr>
<td>Rooming-in</td>
<td>All healthy term newborns (≥ 37 weeks 0 days gestation), regardless of feeding method, who remain with their mothers ≥ 23 hours per day</td>
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<tr>
<th>Supplementation</th>
<th>Healthy term newborns (≥ 37 weeks 0 days gestation), who receive any human milk and who receive supplementation with water, glucose water, or formula during hospitalization (Excludes glucose used for painful procedures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusions:</td>
<td>* Newborns transferred to/from another hospital * Newborns with galactosemia * Newborns enrolled in clinical trials</td>
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<tr>
<th>Human milk feeding after discharge</th>
<th>All infants who receive human milk at the times indicated: * 1-2, 3-4, 6, 12 months</th>
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<tr>
<th>Exclusive human milk feeding after discharge</th>
<th>All infants who receive human milk exclusively at the times indicated: * 1-2, 3-4, 6 months</th>
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Changes in maternity care improve breastfeeding outcomes.

CDC’s mPINC Reports have what you need to understand and improve care across Wisconsin:

→ 2015 survey scores and ranks
→ Action ideas to improve outcomes
→ Trends across all mPINC surveys:

New! — TOTAL SCORES averaging all hospitals’ scores
— POLICIES for staff training and infant feeding care
— PRACTICES in supplementing breastfed infants
— PROTOCOLS for support after discharge to home

What is mPINC?
mPINC is CDC’s national survey of maternity practices in infant nutrition and care.

What does mPINC measure?
Survey questions measure infant feeding care practices, policies, and staffing expectations in place at hospitals that provide maternity services.

Who is included in mPINC surveys?
Every other year, CDC invites all maternity hospitals* nationwide to participate in mPINC. In 2015, 85% of eligible Wisconsin hospitals took part. (n=82)

* In states with free-standing birth centers, this includes hospitals and birth centers.

Compare TOTAL SCORES from 2007 through 2015:

- 2007 survey: 69
- 2009 survey: 71
- 2011 survey: 76
- 2013 survey: 79
- 2015 survey: 82

Examine IDEAL RESPONSES TO SELECTED ITEMS in Wisconsin hospitals for 2007–2015:

**Complete** Hospital Policies:

Hospital breastfeeding policy includes all 10 model policy elements. (in Structural & Organizational Aspects of Care Delivery)

**Appropriate** Feeding Practices:

Supplemental feedings to breastfeeding infants are rare. (in Feeding of Breastfed Infants)

**Adequate** Discharge Protocols:

Hospital provides appropriate discharge planning (referrals & other multi-modal support). (in Hospital Discharge Care)

Examine IDEAL RESPONSES TO SELECTED ITEMS in Wisconsin hospitals for 2007–2015:

- Complete Hospital Policies:
  - Survey year: 2007
    - Percentage of Wisconsin hospitals with ideal responses
      - 2007: 17%
      - 2009: 19%
      - 2011: 29%
      - 2013: 30%
      - 2015: 34%

- Appropriate Feeding Practices:
  - Survey year: 2007
    - Percentage of Wisconsin hospitals with ideal responses
      - 2007: 19%
      - 2009: 20%
      - 2011: 29%
      - 2013: 35%
      - 2015: 46%

- Adequate Discharge Protocols:
  - Survey year: 2007
    - Percentage of Wisconsin hospitals with ideal responses
      - 2007: 14%
      - 2009: 14%
      - 2011: 39%
      - 2013: 39%
      - 2015: 49%
**Use these results.**

**Action ideas:** Use your mPINC summary data to:

- **Help** hospitals meet Joint Commission Perinatal Care Core Measure breastfeeding requirements.

- **Ensure** hospital staff across Wisconsin are trained in infant feeding care.

- **Celebrate** the 9 Baby-Friendly hospitals in Wisconsin and show how to use mPINC to work toward Baby-Friendly designation.

**Learn** how mPINC works. See questionnaires, past survey results, and read about mPINC.

- Go to www.cdc.gov/mpinc or
- Scan this code: [QR Code]

---

### mPINC Care Dimensions

**Ideal response to each care dimension item**

<table>
<thead>
<tr>
<th>Care Dimension</th>
<th>Percentage of hospitals with ideal response</th>
<th>Care Dimension SUBSCORES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Labor and Delivery Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial skin-to-skin contact is at least 30 min w/in 1 hour (vaginal births)</td>
<td>89%</td>
<td>90</td>
</tr>
<tr>
<td>Initial skin-to-skin contact is at least 30 min w/in 2 hours (cesarean births)</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>Initial breastfeeding opportunity w/in 1 hour (vaginal births)</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>Initial breastfeeding opportunity w/in 2 hours (cesarean births)</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td>Routine procedures are performed skin-to-skin</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td><strong>Feeding of Breastfed Infants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial feeding is breast milk (vaginal births)</td>
<td>90%</td>
<td>92</td>
</tr>
<tr>
<td>Initial feeding is breast milk (cesarean births)</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Supplemental feedings to breastfeeding infants are rare</td>
<td>46%</td>
<td></td>
</tr>
<tr>
<td>Water and glucose water are not used</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td><strong>Breastfeeding Assistance</strong></td>
<td></td>
<td>92</td>
</tr>
<tr>
<td>Infant feeding decision is documented in the patient chart</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>Staff provide breastfeeding advice &amp; instructions to patients</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>Staff teach breastfeeding cues to patients</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>Staff teach patients not to limit suckling time</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td>Staff directly observe &amp; assess breastfeeding</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Staff use a standard feeding assessment tool</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Staff rarely provide pacifiers to breastfeeding infants</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td><strong>Contact Between Mother and Infant</strong></td>
<td></td>
<td>83</td>
</tr>
<tr>
<td>Mother-infant pairs are not separated for postpartum transition</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Mother-infant pairs room-in at night</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Mother-infant pairs are not separated during the hospital stay</td>
<td>39%</td>
<td></td>
</tr>
<tr>
<td>Infant procedures, assessment, &amp; care are in the patient room</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Non-rooming-in infants are brought to mothers at night for feeding</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Discharge Care</strong></td>
<td></td>
<td>77</td>
</tr>
<tr>
<td>Staff provide appropriate discharge planning (referrals &amp; other multi-modal support)</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>Discharge packs containing infant formula samples and marketing products are not given to breastfeeding patients</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td><strong>Staff Training</strong></td>
<td></td>
<td>62</td>
</tr>
<tr>
<td>New staff receive appropriate breastfeeding education</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>Current staff receive appropriate breastfeeding education</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Staff received breastfeeding education in the past year</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td>Competency assessment in bf management &amp; support is at least annual</td>
<td>51%</td>
<td></td>
</tr>
<tr>
<td><strong>Structural &amp; Organizational Aspects of Care Delivery</strong></td>
<td></td>
<td>80</td>
</tr>
<tr>
<td>Breastfeeding policy includes all 10 model policy elements</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding policy is effectively communicated</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Facility documents infant feeding rates in patient population</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Facility provides breastfeeding support to employees</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td>Facility does not receive infant formula free of charge</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding is included in prenatal patient education</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>Facility has a designated staff member who coordinates lactation care</td>
<td>79%</td>
<td></td>
</tr>
</tbody>
</table>

* Scores range from 0 to 100 for each item, dimension of care, facility, and state. The highest, best possible score for each is 100. Each facility and state’s “Total Score” is made up of subscores for practices in each of 7 dimensions of care.

**Ranks range from 1 to 53; 1 is the highest rank. In case of a tie, both are given the same rank.**

† Key items highlighted on page 1.
CDC Service Award Nomination
On behalf of the ACOG Colorado Section

I would like to nominate the ACOG Colorado Section for the CDC Service Award. Over the years, the ACOG Colorado Section has developed a robust and successful education program that has defied the general downward trend we are observing with in-person CME programs. This successful effort has required the efforts of a number of their Fellows who believe in offering high-quality local educational programs.

The offerings include their Hot Topics each January, their Legislative Day in March, their Gyn Conundrums in April, their Annual Summer Educational Symposium in June, their annual maternal morbidity and mortality symposium in October. All of these programs are well-attended, and the ACOG Colorado Section plans to continue to offer them in the future.

I wholeheartedly endorse and recommend the ACOG Colorado Section for the CDC Service Award.

Bob Palmer, MD, Chair
ACOG District VIII
Seattle, WA
ACOG Colorado Section Education Committee

“SUCCESS THROUGH CHANGE”

Council of District Chairs Service Recognition Award

The Colorado Section of ACOG has always been an active section, offering multiple educational meetings for our members each year. For many years we offered monthly dinner meetings with national speakers in collaboration with the University of Colorado OB/GYN Department and Residency and we held a larger summer meeting. As we saw the attendance numbers decline, and the needs of our member’s change, we have transitioned to our current model, in order to best serve the members of the section. 2015-2016 has been a very successful year for the Colorado section, and our well-developed model and unique approach for meetings is something that could work well in other states.

We now offer five meetings per year for our members and other health care professionals in Colorado:

1. Annual summer educational symposium – June

   We gathered for 10 years in Aspen, Colorado for this popular meeting. In 2014, we moved this meeting to Vail – bringing the meeting two hours closer to home for most attendees, and cutting hotel room costs by 57% for attendees. In order to accommodate busy individuals, the Vail location and 10 a.m. start time, has allowed for attendees to stay for only one hotel night, if they desire – but still enjoy a two-day meeting.

   We now meet each June at the Sonnenalp Hotel in Vail, which is a lovely venue, set right in Vail Village. Our meeting attendees enjoy a beautiful weekend in the mountains. This year we added more family friendly options, including a popular kid’s club.

   Our education chair, Dr. Margie Maeder, has done an excellent job at staying current with the topics our attendees will be interested in. She works closely with our section executive and education committees in choosing topics, speakers and format. She carefully reviews all presentation slides ahead of time, and works closely with our presenters to make adjustments to their slides. She has added an interactive element, with audience participation, using Poll Everywhere – in which attendees can answer questions on their phones, and the answers are displayed on a second projection screen. She has utilized expert panels to enhance the discussion and audience participation.

   We enjoyed having Dr. Robert Palmer, the ACOG District VIII chair, as our keynote speaker in 2016 – and attendees enjoyed learning more about ACOG, the district, and how they can become more involved with ACOG activities. The two preceding years we
were honored to have ACOG Presidents speak at our Vail Summer Symposium. In 2014 Dr. James Breeden was our keynote speaker and in 2015 Dr. Jeanne Conry. Our meeting attendees appreciated hearing from both of these national ACOG leaders. All three keynote speakers were very complimentary of the organization, content, format and efficiency of our Vail meeting.

We offer CME at this meeting. We conduct post-meeting surveys, which always yield very positive results from our attendees about the speakers, topics, venue, and overall meeting.

We have turned around the finances of the summer meeting. We have gone from losing $14,000 on the meeting, to making $8,000 this year, not including the staff time of our meeting planners which is critically important to having a successful meeting. We have been able to do this without cutting back in the quality of program offered to our attendees. We successfully increased the number of exhibitors and the exhibiting rate – while also adding exhibit hall “games” for the attendees, which increased traffic to exhibitors. We eliminated the expensive printed syllabus, and instead offer presentation slides in various digital formats. We moved from an open bar, to a drink ticket system, saving thousands of dollars. Each year we have purchased more of our own A/V equipment, and this year we used 100% of our own equipment, saving thousands of dollars. We have closely monitored food & beverage quantities, so that we are never in a situation of excess food and costs.

The marketing costs for the meetings has been significantly decreased, by moving from an expensive eight-page brochure, moving to a postcard and increased e-mail communication. The ACOG national office staff have played a critical role in our success – by supporting regular updates to our webpage, 1-2 e-mails per month to our section members, social media updates to the District VIII Facebook page, and ongoing guidance in navigating how to best communicate with our members.

2. Annual Maternal Morbidity and Mortality Symposium – October

This is our best attended meeting of the year. This year marks the 3rd annual Harvey Cohen, MD Maternal Morbidity and Mortality Symposium. We plan this in partnership with the Colorado Sections of AWHONN and ACNM. Dr. Maeder works closely in collaboration with local leaders of AWHONN and ACNM in selecting current topics in maternal morbidity and mortality. A call for case study submissions goes out to the Colorado members of ACOG, AWHONN and ACNM. The committee also sends e-mail requests for cases they are not aware of from rural areas across the state. For many cases, we have multiple presenters – with collaboration from team members.
The 2016 meeting topics include: mental health issues, diabetes in pregnancy, infection cases, unique case of bleeding, postpartum headache & nausea, complex case of cancer in pregnancy, post-partum hemorrhage, and liver disease. We also always include a presentation by the State of Colorado Maternal Mortality Review Committee (MMRC).

This is a very popular meeting, with nearly 200 attendees each year. The 2016 meeting is over 5 weeks away, but our attendee registration numbers are trending to be significantly higher than previous years.

The interaction at this meeting between attendees - physicians, nurses, and certified nurse midwives – is very positive, and shows the collaborative effort in women’s health care that occurs every day.

We first offered an October meeting in Denver in 2012, which resulted in a loss of almost $22,000. Our 2015 October meeting had a profit of almost $3,000 not including the meeting planner’s salary. We have used similar cost saving strategies in this meeting as with our summer mountain meeting. We have leveraged and further developed our partnerships with pharmaceutical and medical equipment companies to grow our exhibiting opportunities, selling out of exhibit space each year. For the 2016 meeting, we are five weeks out, and already have secured more exhibitors than we had in 2015. We are at a larger venue this year, and have space to grow the number of exhibitors and attendees.

We also offer CME at this meeting. The post-meeting surveys also show positive feedback about the topics, presenters, format, and overall meeting.

3. Gyn Conundrums – April

A new meeting in 2015, the Gyn Conundrums meeting is something that we plan to repeat each year. Dr. Maeder and the education committee saw a need for discussion around Gyn cases addressing common clinical problems. This is a smaller, half-day meeting, held in Denver. Attendees give very positive reviews of this meeting, and particularly enjoy the intimate setting, and ability to ask questions. The audience participation and discussion is fantastic.

We are able to keep costs low for this meeting because of a generous offer of COPIC, a Colorado physician owned malpractice company to use their meeting space in metro Denver and use their A/V equipment. It is a perfect set up for our meeting, and a creative solution to offer an additional meeting to our members without excessive expense. Also, because this is not a hotel type venue, we are allowed to bring in our own food (breakfast and snacks), saving thousands of dollars by shopping at Costco vs. a hotel.
4. Hot Topics – January

This was a new meeting in 2016. We invited all members to join us for an intimate evening – with a spirited discussion of hot topics, networking, and great opportunity to interact with colleagues. Again, the costs for this meeting were low – as a member generously opened up her home for the event, and we were able to bring in catering from a local restaurant. The hot topic discussion for 2016 was “Addyi, the Little Pink Pill” for premenopausal Hypoactive Sexual Desire Disorder (HSDD). Attendees interested were able to become certified to prescribe flibanserin by completing coursework documentation on site at this meeting.

5. Legislative Day – March

We held our 3rd annual ObGyn Legislative Day in March 2016. This meeting is planned by our legislative committee, including our section lobbyist, legislative chair, the junior fellow leadership, and committee members. Our section meeting planner helps to coordinate logistics, including online registration, materials and catering. Our lobbyist, Dick Brown, does a great job setting up appointments with legislators on both sides of the aisle at the State of Colorado Capitol Building. A topic is selected for ACOG members to discuss in their meetings that day based on an active bill at the time of our Legislative Day. Dick arranges for several legislators to speak to the group. While residents/junior fellows are the primary participants of Legislative Day, we open it up to all members of the Colorado Section of ACOG. We always have a strong participation from our executive committee as well. The legislative day yields positive results and helps to increase our visibility as an expert on women’s health before the Colorado State Legislature.

Colorado Section Meetings - the big picture:

In 2015 and 2016, we have been able to break even on all of our section meetings. We have worked closely with the ACOG Financial Service Center (FSC) over the past several years in transitioning the way we do business. They have been a major key to our success, allowing us to try new methods of processing payments, and meeting the needs of our attendees and exhibitors. We are now working with the FSC to transition our budget reporting from the simplified system that most of the sections utilize, to the standard system that is used more often by districts. This will allow an easy way to have transparency in our meeting reporting, as we will track each meeting separately with the FSC, and section leaders.

In 2012, all attendee registration was done by mail, filling out the form in the brochure, and mailing in a check. We slowly transitioned to allowing attendees to submit registration forms via e-mail and fax, but were still only able to offer check payment. In 2015 the ACOG Financial
Service Center allowed our section to test out registration using Eventbrite.com for all of our meetings. We are now able to ask customized questions of our attendees, gathering additional data. We have saved hundreds of hours each year on processing registrations. And most of all, our attendees now have the convenience of registering online. We now open up our meeting registrations as soon as the venue is booked – 6-10+ months before the meeting has started. In 2016, we were able to move our exhibitor registration to Eventbrite as well, allowing our exhibitors to use their company credit cards to secure space. At the January 2016 ACOG treasurer’s conference, ACOG introduced Eventbrite registrations for all section and district meetings – noting the success of this program in the Colorado Section.

The Colorado Section continues to grow and change each year to best meet the needs of the members. We have an active executive committee that meets monthly, and stays in touch via e-mail weekly, to discuss the needs of the section. Our education and legislative committees are also very active, staying current and providing excellent resources to our members and community. We publish a monthly newsletter for our members, including current events, legislative issues, ACOG history, Message from the Chair, and event flyers, etc. For 2017, we are looking to add livestreaming options for our meetings, in order to reach a larger percentage of our members. We continue to find new ways to reach out to our members, including social media, e-mail communication, and informative webpage.

This model we have developed in Colorado helps address the changing educational needs of our membership. Traditional meeting attendance across the country is at an all time low with the explosion of on-line CME opportunities and ABOG article requirements that meet many of the CME requirements for hospitals and our members. We must try a different approach and in our Section we have had success by being innovative and offering unique educational opportunities. We have interested vendors in attending and supporting these meetings to help minimize our expense and the the expense to our members. We have offered a variety of different topics and venues to decrease expense and have collaborated with other Perinatal Specialties to share knowledge and enhance networking which cannot happen online. Other Sections would benefit from adopting many of these innovations.
<table>
<thead>
<tr>
<th>YEAR</th>
<th>Meeting</th>
<th>Revenue</th>
<th>Expenses</th>
<th>Profit/Loss</th>
<th># Attendees</th>
<th># Exhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>Aspen - June</td>
<td>$24,480</td>
<td>$34,892</td>
<td>-$10,412</td>
<td>57</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Inverness - Oct</td>
<td>$10,960</td>
<td>$32,732</td>
<td>-$21,772</td>
<td>59</td>
<td>8</td>
</tr>
<tr>
<td>2013</td>
<td>Aspen - June</td>
<td>$25,865</td>
<td>$39,688</td>
<td>-$13,823</td>
<td>65</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Inverness - Oct</td>
<td>$17,775</td>
<td>$22,505</td>
<td>-$4,730</td>
<td>80</td>
<td>13</td>
</tr>
<tr>
<td>2014</td>
<td>Vail - June</td>
<td>$20,040</td>
<td>$32,595</td>
<td>-$12,555</td>
<td>78</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>MMM - Oct</td>
<td>$9,700</td>
<td>$21,101</td>
<td>-$11,401</td>
<td>185</td>
<td>15</td>
</tr>
<tr>
<td>2015</td>
<td>Gyn Conundrums - April</td>
<td>$487</td>
<td>$487</td>
<td>$0</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Vail - June</td>
<td>$32,388</td>
<td>$31,201</td>
<td>$1,187</td>
<td>77</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>MMM - Oct</td>
<td>$24,271</td>
<td>$21,298</td>
<td>$2,973</td>
<td>178</td>
<td>28</td>
</tr>
<tr>
<td>2016</td>
<td>Hot Topics - Jan</td>
<td>$575</td>
<td>$550</td>
<td>$25</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Gyn Conundrums - April</td>
<td>$1,258</td>
<td>$971</td>
<td>$287</td>
<td>47</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Vail - June</td>
<td>$41,495</td>
<td>$33,105</td>
<td>$8,390</td>
<td>65</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>MMM - Oct</td>
<td>tbd</td>
<td>tbd</td>
<td>tbd (project to be break even at minimum)</td>
<td>tbd (project 210+)</td>
<td>tbd (project 30+)</td>
</tr>
</tbody>
</table>

# of attendees includes speakers. It does not include staff or exhibitor reps.

expenses do not include meeting planner's time.
SUMMER 2016 EDUCATIONAL SYMPOSIUM

Friday, June 10 at 9:30am to Saturday, June 11 at 1:30pm
Sonnenalp Hotel – Vail Village – Vail, Colorado

REGISTRATION FEES

- Attendee Rate $200
  By May 10th
- Late registration $225
  If space available (after May 10th)
- Student Rate $25
- Resident Rate $75
  (Student & Resident Rate good through May 10th)
- Guest for Reception $40
  Friday 5:30-6:30pm

REGISTER TO ATTEND:
www.acogvail2016.eventbrite.com

For the FULL brochure, bios, and schedule, please go to:
www.acog.org/colorado

CREDITS

- This activity has been approved for
  AMA Category 1 Credit™
- 3 COPIC points (1.5 per day)

BOOK HOTEL
Call: 866-284-4411
and ask for “ACOG” $150 rate!

Sonnenalp Hotel
Book NOW! There are only 5 rooms left for Friday night!
Come up to Vail Friday morning, breakfast at
9:30am, first speaker not until 10:30am

QUESTIONS, CONTACT:
colo.acog@gmail.com

The conference will feature interactive
sessions, case-based reviews, open forums,
and panel discussions.
Topics:

- mental health issues
- diabetes in pregnancy
- infection cases
- unique case of bleeding
- postpartum headache & nausea
- complex case of cancer in pregnancy
- post-partum hemorrhage
- liver disease
- presentation by the State of Colorado Maternal Mortality Review Committee (MMRC)

Register today!

www.mmm2016.eventbrite.com

Cost is $80 per person, or $100 after Sept. 16. $25 for residents & students until Sept. 30.

Scholarships are available — please apply by sending your name, title, hospital, cell & e-mail to colo.acog@gmail.com by Sept. 13. We will notify you by Sept 20. Thank you.

Questions and exhibitor info, contact Sheila Tuitele at colo.acog@gmail.com or 303-355-8848.

Inverness Hotel & Conference Center

200 Inverness Drive West, Englewood, CO 80112
303-799-5800

Credits / Points

- This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Colorado Medical Society and ACOG Colorado Section. The Colorado Medical Society is accredited by the ACCME to provide continuing medical education for physicians.
- The Colorado Medical Society designates this live activity for a maximum of 6.75 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit that is commensurate with the extent of their participation in the activity.
  - 1 CQPIC Point
  - Exempla Good Samaritan Medical Center approved by the California Board of Registered Nursing, Provider Number CEP 15728, for 8.5 contact hours.

Schedule highlights:

8:00am-9:00am — registration, coffee & bagels with exhibitors
9:00am-12:00pm — presentations
12:00pm-1:00pm — lunch with exhibitors
1:00pm-5:30pm — presentations
5:30pm-6:30pm — reception with exhibitors

Updates will be posted at: www.acog.org/colorado
Monday, January 25
at 6pm

Share an ‘intimate’ meeting to learn about

Addyi, the Little Pink Pill.

- Informal opportunity for ACOG members and guests to learn about Addyi through an interactive Q&A
- Hors D’oeuvres, refreshments & beverages will be served.
- Event will be held at a member’s home in Denver, private address provided upon registration.
- Register early, space limited. Deadline to register is January 4th. Register now: www.acoghottopics.eventbrite.com.
- Questions: colo.acog@gmail.com
Gyn conundrums
UNIQUE CASE STUDY PRESENTATIONS

Saturday, April 16, 2016
8:00am - 1:00pm
COPIC offices in Denver

Register by April 2nd
www.acoggyn.eventbrite.com

meeting info

Register to attend:
www.acoggyn.Eventbrite.com

Registration Fees:
$30 by April 2
$40 after April 2
$15 for Students & Residents

Event Includes: Continental Breakfast, Unique case presentations, Interactive discussions, and Networking

QUESTIONS: colo.acog@gmail.com or 303-355-8848

conference speakers

Glenn Bigsby, MD
Karlotta Davis, MD
Victor Dabelea, MD
Julie Lemoine, MD
Misha Miller, MD
Hollie Neujahr, DPT, CLT-LANAPT
Stephen Scott, MD
Sarah Shepard, DO

conference topics

Infection
Gyn Oncology
Pelvic PT
Pediatric Gyn
REI
Robotic/Gyn Surgery
Vulvar cases
Urogyn

7351 East Lowry Blvd.
Denver, CO 80230
Mile High Room

1 COPIC point available
The ACOG Colorado Section would like to invite you to participate in our third annual Ob/Gyn Legislative Day!

Monday
March 28, 2016
11:30am-4:30pm

Colorado State Capitol Building
200 E Colfax Ave
Denver, CO 80203

Please RSVP by Friday, March 18
Register here to reserve your spot and lunch (FREE)
www.acoglegislative.eventbrite.com

Questions, Email: colo.acog@gmail.com

This event will take the place of Monday Afternoon Lectures for the University of Colorado Ob/Gyn Residents
We are working on possible transportation for residents and will post updates online (see link below) if we are able to procure group transport: www.acog.org/About-ACOG/ACOG-Sections/Colorado-Section
October 3, 2016

Robert Palmer, M.D.
Chair, Council of District Chairs

Re: CDC Service Recognition Award

Dear Dr. Palmer and Fellow District Chairs,

This is a letter of nomination requesting consideration for a District IX project to be evaluated for a prestigious CDC Service Recognition Award. My nomination for this year is our statewide Quality Improvement Project to Promote Vaginal Birth and Reduce Primary Cesarean Births. This has been an enormous effort by numerous California ACOG Fellows as well as a multi-disciplinary group of individuals to help reverse the rising Cesarean birth rate.

In April 2016, the California Maternal Quality of Care Collaborative (CMQCC) released our most recent toolkit entitled “Toolkit to Support Vaginal Birth and Reduce Primary Cesareans.” The lead author was ACOG Fellow Dr. David Lagrew and there were numerous contributors and editors for this comprehensive document. Dr. Hal Lawrence and Dr. Christopher Zahn authored a letter of support after reviewing the document. In their May 24, 2016 letter to me they stated, “We have had the honor to review this comprehensive toolkit and ACOG strongly supports its dissemination and use to address the efforts at reducing the primary Cesarean delivery rate.” In addition, they stated, “This excellent resource and the plan for encouraging awareness and implementation is unquestionably a commendable program to address this issue and should set a benchmark for achieving success in reducing the primary Cesarean delivery rate.” As always, ACOG District IX and the CMQCC have worked in close collaboration to help get this toolkit published.

But the “easy” task is publishing the document and the more difficult job is in implementation. We continue to work with the CMQCC in a multi-pronged effort to help all 251 Labor and Delivery suites in California achieve a reduction in Cesarean birth rates. CMQCC has already launched a 35 hospital collaborative to work with some of the hospitals with higher Cesarean birth rates and will begin a second 35 hospital collaborative later this month. Simultaneously, District IX has secured a large grant from the California Health Care Foundation (CHCF) to help with implementation. We have trained a group of 35 speakers including 15 ACOG Fellows, 15 AWHONN labor and delivery nurses and two CNMs recommended by the California ACNM. The grant allows us to present and
mentor an additional 35 hospitals before the end of 2016. I am certain that our Speaker’s Bureau would like to share their expertise and knowledge with providers outside of California. We would be happy to make presentations in other states and to help “train the trainers” so others can use the publically available toolkit for implementation (download at no cost at CMQCC.org).

It is too early for us to have any data to show the effectiveness of our efforts, but we expect over the next two years to have a dramatic reduction in the Cesarean birth rate in California. Due to the length of the toolkit (which is 159 pages in length), I have not attached a full copy of the document to this letter, but it can easily be downloaded by anyone interested.

I appreciate consideration by the CDC for this District IX activity to be awarded a CDC Service Recognition Award in 2017. This would recognize the impressive accomplishments of a large number of ACOG Fellows working closely with other obstetric providers to improve the health of mothers and babies in California, with a willingness and desire to share this experience with others nationally.

Sincerely yours,

John S. Wachtel, M.D., F.A.C.O.G.
ACOG District IX Speakers Bureau to Promote Vaginal Birth and Safely Reduce Primary Cesareans

As reported in the Obstetric Care Consensus: Safe Reduction of the Primary Cesarean Delivery by the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM), between 1996 and 2011 there was a rapid increase in Cesarean rates resulting in one in three women who gave birth in the United States doing so by cesarean delivery. While Cesarean birth can be life-saving for the fetus, the mother, or both in certain cases, the rapid increase in Cesarean birth rates without clear evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused.

In an effort to portray the risks for current and future pregnancies of Cesarean birth without medical indication, the Council on Patient Safety developed the Safe Reduction of Primary Cesarean Birth safety bundle and the California Maternal Quality Care Collaborative (CMQCC) developed the CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans to implement the safety bundle.

To assist hospitals in implementing this toolkit, ACOG District IX developed a Speakers Bureau to provide education and mentoring. Teams consisting of one obstetrician and one labor and delivery nurse, and a certified nurse midwife when appropriate, are assigned to work with each participating hospital. Speakers Bureau members (15 ACOG Fellows, 15 OB nurses and 2 CNMs) received a full day of training in May 2016 and were selected on the basis of their professional expertise in obstetrics and experience speaking to health care professionals and answering difficult questions.

The support each Speakers Bureau team provides to participating hospitals includes: 1) conducting a planning call with hospital champions and staff; 2) giving a Grand Rounds-style presentation at the hospital (typically 1 hour with an additional hour afterwards for break outs/questions/discussion); and 3) availability for follow up by phone or email after the presentation.

The Speakers Bureau expects to work with a total of 35 hospitals in California. The priority is to assist hospitals that have not yet achieved a NTSV Cesarean Section rate of 23.9% (which is the Healthy People 2020 goal) however the Speakers Bureau has also worked with hospitals with rates below 23.9% to help learn what the safe and optimal rate might be and to understand how hospitals have been able to achieve lower rates.
November 23, 2016

Linda Kinnane
American College of Obstetricians and Gynecologists
Dept. of District and Section Activities
409 12th Street SW
Washington DC 20024-2188

Dear Ms. Kinnane,

The Armed Forces District of the American College of Obstetricians and Gynecologists would like to respectfully submit the Navy’s Patient Safety Bundle for Obstetric Hemorrhage for the ACOG Council of District Chairs Service Recognition Award. In July of 2016, the Navy endorsed and initiated implementation of this bundle across its enterprise which includes sixteen military treatment facilities (MTF) in the U.S. and abroad.

The Navy’s Patient Safety Bundle for Obstetric Hemorrhage was developed by ACOG District X subject matter experts in collaboration with numerous disciplines and a variety of MTFs in the continental United States as well as across the entire globe. By utilizing evidence based medicine and partnering with subject matter experts on the deck plate, a standardized obstetrical hemorrhage bundle was developed to ensure safe patient care and greater staff satisfaction. Specifically, the bundle addressed potential gaps and inconsistencies in the treatment of postpartum hemorrhage (PPH) to ensure that providers have standardized equipment and protocols to address this life threatening situation whether it occurs at a large MTF in CONUS or a smaller MTF OCONUS. The standardization was comprehensive and included education, training, simulation, assessment, management, protocols, electronic medical record order sets, coding, equipment and medication.

Utilizing the framework of the Council on Patient Safety in Women’s Health Care and resources from ACOG and California Maternal Quality Care Collaborative, the bundle was divided into four major areas: readiness, recognition and prevention, response, and reporting. The readiness component includes several areas. First, a standardized seven drawer emergency cart is required on each unit where a pregnant or postpartum patient may be present. This cart has a required inventory to include everything from medications to retractors to Bakri balloons. In addition, immediate access to hemostatic agents and pressure packs are required. Each MTF
also has a defined response team which escalates as the level of hemorrhage rises. Readiness includes protocols on emergency release of blood products as well as a massive transfusion protocol. Unit education is a mandatory component as well.

The recognition and prevention component of the bundle addresses assessment of hemorrhage risks, measurement of cumulative blood loss, and active management of third stage of labor. Each labor unit is required to document hemorrhage risks intrapartum, postpartum, and during transitions of care. A standardized method including the use of quantitative blood loss is included. Most impressively, the active management of labor includes a defined oxytocin concentration and administration protocol so that no matter where a provider or nurse is practicing at a Navy MTF, the concentration of oxytocin and administration is the same. In addition, this standardized oxytocin concentration is also utilized with patients being induce or augmented adding to a uniform process to enhance patient safety.

The response component is comprehensive as well. It includes an Obstetric Emergency Management Plan with Checklist. The plan and checklist divide PPH into three stages and address appropriate personnel notifications, medical or surgical actions, and levels of care. Stage three of the response plan includes a Massive Transfusion Protocol as resources allow and transfer to higher levels of care as needed. Furthermore, these events are associated with significant stress for the family members and healthcare team. To address this, the OB PPH Bundle includes resources to provide support to the family and health care providers.

The last component of the OB PPH Bundle addresses communication through reporting and systems issues. It specifically ensures that TeamSTEPPS serves as the basis for communication and to optimize teamwork by engaging in effective information transfer and a shared mental model. Huddles and post event debriefs after PPH events are required to maximize benefit from each PPH event. In order to collate data each MTF reports outcome measures to a perinatal quality group. All cases of PPH are reviewed by the department head to ensure accuracy of diagnosis and coding.

In summary, a Patient Safety Bundle for Obstetric Hemorrhage was developed for utilization across sixteen Navy MTFs to provide a standardized response with equipment, protocols, and personnel to address postpartum hemorrhage to ensure safe effective evidence based care.

Sincerely,

John O’Boyle, MD
Chair, District X
Esteemed Commanding Officers:

Congratulations! You and your staff have contributed to the development of our first region-wide patient safety collaborative initiative. I am pleased to announce the release of our Post-Partum Bundle Project, the result of a cross-functional working group using evidenced based medicine and standard practice guidelines to develop a sound bundle of clinical practices that will be standardized across the region.

This effort is the first of many initiatives we will undertake to address gaps in providing optimal care identified by our quality review process. Committed to providing safe, high quality care, we will continue to improve the fidelity of our patient safety reporting process and use the information gained to rapidly identify and correct less than optimal practices. As we are doing with the Post-Partum Bundle, we will utilize the Regional Quality Collaborative to implement these best practices throughout the region and the Navy Medicine enterprise. This process is fundamental to becoming a high reliability organization. Although we have completed this endeavor, please know this document, as well as those to come, is a living, dynamic document. It is designed to be improved by feedback from those on the labor deck actually caring for patients. I encourage your continued collaborative efforts to ensure the practices outlined here remain state of the art and in keeping with the best available evidence. Having said that, this document will serve as the methodology of practice going forward and should be disseminated and implemented per the Navy Medicine West Post-Partum Hemorrhage instruction attached.

This document and the methodology used to produce it represent a quantum leap forward in our goal to eliminate patient harm. The bundle you have before you is the result of dedicated professionals from all levels of our organization coming together to share their expertise to solve a vexing clinical problem known to produce significant morbidity. Please honor their commitment to patient safety by ensuring it is thoroughly understood and adopted by your Labor and Delivery team. The working group will be assisting in the roll-out of the bundle; however, your personal involvement in ensuring its implementation and sustainment will be essential if we are to realize its full value.

Thank you in advance for supporting this effort and those efforts that lie ahead. There is hard work ahead if we are to meet our goal of eliminating patient harm. This bundle and the collaborative process used to create it show us, that step by evidenced-based step, we can reach it.

BRUCE L. GILLINGHAM
Rear Admiral, Medical Corps
United States Navy
NAVMEDWEST INSTRUCTION 6320.2

From: Commander, Navy Medicine West

Subj: POSTPARTUM HEMORRHAGE BUNDLE IMPLEMENTATION

Encl: (1) Patient Safety Bundle: Obstetric Hemorrhage

1. Purpose. To establish policy and promote BUMED policy guiding a High Reliability Organization (HRO).

2. Background. In response to the Military Health System review, the Navy Obstetric community developed and promulgated a postpartum hemorrhage toolkit for implementation at all Military Treatment Facilities (MTFs) with an obstetric service. Navy Medicine West (NMW) analysis of causal factors and corrective actions of subsequent postpartum hemorrhage events showed large variance in MTF implementation of the toolkit. This low volume, high acuity event often lacks rapid coordinated responses, effective communication and timely interventions. It is the objective of Navy Medicine West Commands to ensure maximal readiness at all times, prevent postpartum hemorrhage where possible and when necessary, provide a standard and appropriate response to postpartum hemorrhage in order to eliminate adverse patient outcomes.

3. Applicability. This instruction is applicable to all members assigned to NMW headquarters, and to all commands within the NMW area of responsibility.

4. Policy. It is the policy of NMW to ensure total support and compliance with reference (a).

5. Responsibilities

a. NMW Chief Medical Officer (CMO) will:

(1) Aggressively support the postpartum bundle initiative.

(2) Provide education to all MTF CMOs on any statistics and events affecting the intent of the bundle.

6. Action

a. The MTF CMOs will ensure the policy and guidelines provided in reference (a) are implemented.
b. All NMW military and civilian staff providing maternal/newborn care will familiarize themselves with enclosure (1) and this instruction.

c. Any NMW or MTF member requiring clarification or recommending a revision of any element of this instruction is strongly encouraged to seek assistance at the earliest possible time utilizing the chain of command.

[Signature]

B. L. GILLINGHAM

Releasability and distribution:
This instruction is cleared for public release and is available electronically only via the Navy Medicine West SharePoint Web site, https://es.med.navy.mil/sites/nmw/intranet/SitePages/Home.aspx
Navy Medicine West Regional Quality Collaborative

PATIENT SAFETY BUNDLE

OBSTETRIC HEMORRHAGE

11 July 2016
Outline

I. Background

II. Readiness
   A. Hemorrhage Cart
      1. Supplies
      2. Black wristbands
      3. Instruction cards for intrauterine balloon and compression stitches
      4. Hemorrhage checklist
   B. Hemorrhage Medication Kit
   C. Other Hemostatic Agents and Pelvic Pressure Pack
   D. Response Team
   E. Emergency Release and Massive Transfusion protocols
   F. Unit Education, Drills, and Simulation

III. Recognition and Prevention
   A. Assessment of Hemorrhage Risk
   B. Measurement of Cumulative Blood Loss
   C. Active Management of 3rd Stage of Labor

IV. Response
   A. Obstetric Hemorrhage Emergency Management Plan with Checklists
   B. Support Program for Patients, Families and Staff for all Significant Hemorrhages

V. Reporting and Systems Learning
   A. TeamSTEPPS
      1. Huddles
      2. Post-event debriefs
   B. Multidisciplinary Review of Serious Hemorrhages for Systems Issues
   C. Perinatal Quality Improvement Activity
      1. Monitor outcomes
      2. Implement and disseminate lessons learned from drills and actual events

VI. References

VII. Appendices
I. Background

Postpartum hemorrhage is defined as cumulative blood loss equal to or greater than 1000mL or blood loss accompanied by signs/symptoms of hypovolemia within 24 hours following the birth process. While numerous patients have known risk factors for hemorrhage, others may have no risk factors but still experience postpartum hemorrhage. Active preparation and teamwork is essential to optimize patient outcomes at every delivery.

II. Readiness

Since postpartum hemorrhage cannot always be predicted, every labor and delivery and post-partum unit should be 100 percent prepared at every delivery 24/7. The following items are mandatory for readiness.

A. Hemorrhage Cart

1. Supplies – see Appendix A for the complete list of required supplies in the postpartum hemorrhage cart. MTF’s with more than one PPH cart should organize each cart in the same manner. This standardization will improve efficiency of staff utilizing the carts. Each drawer should be labeled on the outside with the specific items contained in the drawer. The postpartum hemorrhage cart should be inventoried if the lock is broken and after every use (in the same manner as code blue carts). All L&D and postpartum staff, including nurses, physicians, certified nurse midwives, corstaff and MA/LVNs should be knowledgeable about the inventory, where in the cart each item is located and the location of the cart(s) in the MTF. It is recommended that each MTF use a 6 drawer cart with a tamper evident lock, as seen in Appendix A.

2. Black wristband - the black wristband, seen in Appendix A, should be placed on the patient’s wrist when vaginal packing or Bakri balloon is placed to tamponade any bleeding from a vaginal sidewall laceration or to manage uterine atony. At the appropriate time, the patient should be informed about the significance of the black wristband. The wristband is a visual reminder of an intentionally placed foreign body. The vaginal packing is removed when hemostasis is achieved. An order should be placed in the Electronic Medical Record stating that a black wristband should remain on the patient’s wrist noting an intentional foreign body has been placed in the vagina. The black wrist band should only be removed when the vaginal packing has been removed. No patient should be discharged with a black wristband in place, signifying a retained foreign body. All staff should be oriented on the significance of a black wrist band representing an intentionally retained foreign body.

3. Instruction cards for intrauterine balloon and compression sutures – see Appendix B and C for instruction cards for the Bakri balloon and uterine compression sutures.

4. Obstetric Hemorrhage Checklist - see Appendix D. The obstetric hemorrhage checklist provides an overview to the management of obstetric hemorrhage by degree of hemorrhage. Each stage addresses personnel to notify, supplies to obtain, actions and a consideration box. Each consideration box provides the clinician and team specific or alternative etiologies of the hemorrhage, and additional actions based upon these etiologies. This checklist should be used by the team during an obstetric hemorrhage to facilitate a stepwise and holistic approach to the
event. The checklist should be retained after the event for use in the debrief and any subsequent quality review. However, the checklist is not part of the medical record.

5. OB Emergency Release — see Appendix E
6. Massive Transfusion Checklist — see Appendix F

B. Hemorrhage Medication Kit

Hemorrhage medications must be immediately available to the delivery and postpartum teams. These medications include:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Max Dose</th>
<th>Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxytocin (Pitocin)</td>
<td>See 3rd stage of labor protocol</td>
<td>IV</td>
<td></td>
<td>see protocol</td>
<td>Avoid undiluted IV infusion</td>
</tr>
<tr>
<td>Oxytocin For injection (Pitocin)</td>
<td>10 Units</td>
<td>IM</td>
<td>X 1 if no IV access</td>
<td>10 Units</td>
<td></td>
</tr>
<tr>
<td>15-methyl PGF2α/ carboprost * for injection (Hemabate)</td>
<td>250 mcg</td>
<td>IM</td>
<td>Q 15 minutes</td>
<td>2 mg or 8 doses</td>
<td>Asthma, Hepatic, renal, cardiovascular disease</td>
</tr>
<tr>
<td>Methylergonovine Maleate* for injection (Methergine)</td>
<td>0.2 mg</td>
<td>IM</td>
<td>Q 2 hours</td>
<td>Not established</td>
<td>Hypertension Raynauds</td>
</tr>
<tr>
<td>Misoprostol** (Cytotec) 200 mcg tabs</td>
<td>dose varies by route</td>
<td>Oral 600 mcg OR Sublingual 800 mcg OR Rectal 1000 mcg</td>
<td>X 1</td>
<td>1 dose of chosen route</td>
<td></td>
</tr>
</tbody>
</table>

*Note: 15-methyl PGF2α/carboprost (Hemabate) should be kept refrigerated. Methylergonovine maleate (Methergine) should be protected from light and kept below 77°F.

**Note: Misoprostol (Cytotec) may have more beneficial effects if given orally but GI distress and fever are more common. The clinician should use clinical judgement regarding route of misoprostol due to theoretical risk of aspiration.

C. Other Hemostatic Agents and Pelvic Pressure Packs

Cesarean hysterectomy is fortunately a rare event occurring approximately 0.77/1000 deliveries. This procedure is often life-saving. However, at times even after completing cesarean hysterectomy the patient may enter disseminated intravascular coagulopathy with continued bleeding after all surgical options are optimized. At those times, the team must have hemostatic agents and pelvic packing supplies to stop nonsurgical bleeding while the coagulopathy is corrected with the transfusion of blood products and clotting factors. Examples of potentially helpful hemostatic agents may include
such commercially available items as: human fibrin sealant (Evicel), hemostatic matrix (Floseal), and absorbable hemostats (Surgicel and Arista). See Appendix G for additional information on topical hemostatic agents. Of note, current studies are underway to determine the safety and efficacy of an antifibrinolytic medication, tranexamic acid (TXA), in the treatment of postpartum hemorrhage. Studies performed on traumatic injuries show reduced mortality from hemorrhage with use of TXA without serious side effects. TXA may be most useful in those facilities where blood bank supplies are limited (platelets not available, etc.). If a clinician chooses to use TXA, 1 gram of TXA intravenously should be administered early in the treatment of severe PPH and before fibrinogen supplementation. This dose can be repeated 30 minutes after the initial dose.

In addition, the team should have knowledge and resources to place compression on oozing vessels in the pelvis with pelvic packing. An example of a commercially available product is Abthera with which many general surgeons are familiar. Likewise, makeshift abdomen packing can be lifesaving with commonly available hospital supplies. See Appendix H for details. Points of caution: the time that a packing is in place should be minimized to only the amount of time required to reverse coagulopathy and obtain hemostasis. Packing carries risks of infection and the longer the packing is in place the higher the likelihood of infection. Patients with packing should receive intravenous antibiotics. Packing should be radiopaque to avoid unintentional retained foreign bodies. Appendix H describes abdominal packing when the abdomen incision is intentionally left open and a pelvic pack for when the abdomen may be closed and the packing removed vaginally.

D. Response Team

The following outlines the personnel required based on the stage of bleeding.

<table>
<thead>
<tr>
<th>Stage 1 = Blood loss &gt; 500 ml with continued bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivering provider and OB on duty (may be same)</td>
</tr>
<tr>
<td>Primary and secondary RN</td>
</tr>
<tr>
<td>Primary and secondary HM/MA/LVN</td>
</tr>
<tr>
<td>Anesthesia Provider</td>
</tr>
<tr>
<td>Blood Bank (notified to Type and Cross 2 units PRBC’s)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 2 = Blood loss &gt; 1000 ml with continued bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical technician and circulating nurse</td>
</tr>
<tr>
<td>Nurse of Day</td>
</tr>
<tr>
<td>Blood Bank (notified of hemorrhage, 2 units PRBC’s to bedside, thaw 2 units FFP)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 3 = Blood loss &gt; 1500 ml with continued bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Surgeon (OB/GYN or General Surgeon)</td>
</tr>
<tr>
<td>Notify lab officer (patient’s labs to take priority) and pathologist</td>
</tr>
<tr>
<td>Chaplain or other patient support personnel</td>
</tr>
</tbody>
</table>

E. Emergency Release and Massive Transfusion Protocols

Every military treatment facility has an emergency release of blood product protocol to obtain blood products quickly in actively bleeding unstable patients who do not have type and cross-matched
products immediately available. See Appendix E. Emergency release of blood products will typically be a verbal order by the provider with completion of required paperwork after patient stabilization. A facilitator is needed to communicate with the blood bank that an obstetrical emergency has occurred requiring immediate blood products. Typically, the facilitator is a nurse who is able to provide additional information to blood bank personnel when asked. If other personnel are used (LVN, MA, corpsman), the blood bank medical director must approve the skill level of personnel that may pick up blood products. A facilitator will need to have the following information immediately available to clearly communicate to the blood bank: Two patient identifiers such as name and date of birth (per MTF instruction), facilitators name, location or room number where products are needed, ordering physician, and facilitator phone number. The lab officer or pathologist should be notified of the request as additional requirements including a massive transfusion protocol may be required. Ideally, O negative blood is preferred for obstetric patients. As time permits, the type and cross lab sample will be obtained and sent to the lab for testing post-emergency release blood use.

While blood product resources at each treatment facility will vary, every facility needs a massive transfusion protocol (MTP) to be initiated at Stage 3 obstetrical hemorrhage with EBL > 1500 mL with continued bleeding and/or unstable vital signs or disseminated intravascular coagulopathy. See Appendix F. Ideally, MTFs should have 6 units of O negative blood. MTF blood banks need to have an adequate inventory to support their MTP requirement. For small to medium sized facilities where blood bank resources may be limited, all surgical and acute care providers must be alerted when an MTP is implemented in order to make appropriate clinical decisions regarding other patients who may need blood products.

F. Unit Education, Drills, and Simulation

While each MTF has different resources and environments of care, all MTF’s can benefit from unit education, unit based drills and post drill debriefs. This section is meant to provide a guideline for the MTFs to modify based on their particular setting. Unit education should include education on all protocols related to PPH and be tailored to each staff’s role. For example, the corpsman would not be expected to know the massive transfusion protocol but they would be expected to know where the blood bank is located to pick up blood products. These essential protocols or knowledge base will include:
- Massive Transfusion Protocol
- OB Hemorrhage Protocol
- Code Purple
- Transfer of patients to the ICU or outside facility
- Access to critical telephone numbers, See Appendix I
- Awareness of physical resources (i.e. where is the PPH cart?)
- How to assess blood loss at delivery (Anesthesia, RN, and delivering providers)
- TeamSTEPPS

Periodic drills that follow a designated protocol for the management of postpartum hemorrhage will improve a labor unit’s ability to respond to and mitigate an adverse outcome. Each labor unit
should conduct and “pass” at least 2 drills involving postpartum hemorrhage quarterly, involving all nursing shifts. If the team fails to perform in an acceptable manner, the evolution should be repeated. See Appendix J for criteria to score the training scenarios. This training should use a comprehensive curriculum that focuses on postpartum hemorrhage and uses TeamSTEPPS. When possible, drills should be conducted in the actual patient care settings so issues related to the physical environment may become obvious. When obstetric emergency simulation mannequins or actors/simulated patients are available, they should be used during the drills in the actual work spaces. Additional drills in the simulation lab are encouraged; however, in situ simulation in the work space can identify systems issues and process improvement that might not be identified otherwise. All units taking care of pregnant patients should be included (i.e. antepartum deck). Protocols, activation criteria and critical interventions can be reinforced by being posted on walls, printed on pocket cards and uploaded as screen savers to promote a sustained culture of safety.

Barriers to effective teamwork should be eliminated. These barriers may include a hierarchical hospital structure, emotional intensity, stress, intimidation, and lack of education and orientation of involved staff.

Unit based drills should include all disciplines (obstetrics, anesthesia, pediatrics, ancillary staff, blood bank, nursing, etc.). All team members should be encouraged to speak up during the simulation debrief.

The concept of a “Just Culture” should be implemented so all team members feel respected and comfortable with asserting observations, suggestions, and opinions. Closed loop communication should always be used.

III. Recognition and Prevention

A. Assessment of Hemorrhage Risk

During a patient’s prenatal care, postpartum hemorrhage risk factors should be identified and addressed in the electronic medical record. In addition, every labor unit must identify and document each patient's risk of hemorrhage at the time of admission. The following table outlines admission risk factors:

<table>
<thead>
<tr>
<th>Medium Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior uterine surgery or multiple laparotomies</td>
<td>Placenta Previa or low lying placenta</td>
</tr>
<tr>
<td>Multiple gestation</td>
<td>Suspected accreta/percreta</td>
</tr>
<tr>
<td>Greater than 4 prior births</td>
<td>Active bleeding</td>
</tr>
<tr>
<td>Prior OB hemorrhage</td>
<td>Known coagulopathy (ITP, Von Willebrands...)</td>
</tr>
<tr>
<td>Large myomas (&gt;5cm)</td>
<td>Platelet Count &lt; 70,000</td>
</tr>
<tr>
<td>Obesity (BMI &gt; 40)</td>
<td>2 or more medium risk factors</td>
</tr>
<tr>
<td>Hematocrit &lt; 30%</td>
<td></td>
</tr>
<tr>
<td>Magnesium sulfate administration</td>
<td></td>
</tr>
<tr>
<td>Uterine overdistension (polyhydramnios)</td>
<td></td>
</tr>
<tr>
<td>Estimated fetal weight &gt; 4,000 grams</td>
<td></td>
</tr>
</tbody>
</table>
All patients should have a minimum of a Type and Screen on admission. A patient who is noted to be at high risk of postpartum hemorrhage must be Typed and Crossed for at least 2 units of packed red blood cells.

A patient’s risk of postpartum hemorrhage may increase during her intrapartum course. Therefore, patients must have their risk assessment updated as their clinical course progresses and at every patient handoff including at shift change. **Prior to delivery, a time-out should be completed and final hemorrhage risks noted by the entire delivery team.** The table below notes additional risk factors that should be identified during her labor course:

<table>
<thead>
<tr>
<th>Medium Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chorioamnionitis</td>
<td>New active bleeding</td>
</tr>
<tr>
<td>Prolonged oxytocin &gt; 24 hours</td>
<td>2 or more medium risk factors (admission or intrapartum combined)</td>
</tr>
<tr>
<td>Prolonged 2nd stage</td>
<td></td>
</tr>
<tr>
<td>Magnesium sulfate administration</td>
<td></td>
</tr>
</tbody>
</table>

Patients may accumulate risk factors even after delivery. Documentation of postpartum hemorrhage risk factors is critical during the prenatal course, upon admission, and during the intrapartum and postpartum periods.

Of note, only tertiary care MTF’s may have the resources to take care of certain high risk patients such as those with placenta accreta, BMI > 50, a significant bleeding disorder, or patients at risk of PPH who decline transfusion. Identification and transfer of these patients prior to anticipated delivery is the prudent course of action.

**B. Measurement of Cumulative Blood Loss**

Since underestimation of blood loss at delivery could result in delay in diagnosis of postpartum hemorrhage, significant efforts should be in place to accurately recognize blood loss. Each labor unit should routinely use under-buttock drapes with a marked graduated plastic cylinder to assist with estimating blood loss as shown in Appendix K. Unit training should be completed biannually with the postpartum drills. These drills should utilize resources to improve the accuracy of estimating blood loss as seen in Appendix L. Staff should be encouraged to participate in practical labs where fixed “blood” volumes are assessed.

While estimating blood loss at the time of routine delivery is acceptable, the delivering provider must be aware of inaccuracies and utilize quantitative blood loss when blood loss exceeds 500 mL. The density of blood is close to the density of water, where one mL is equal to one gram. Quantitative blood loss (QBL) requires knowing the dry weights of pads and gauze so the wet weight can be subtracted from the dry weight to determine the qualitative blood loss. See Appendix M for an example of a worksheet to determine QBL. Of note, the amount of amniotic fluid must be subtracted from total fluid, and can usually be determined as the blood is heavier than the amniotic
fluid and sinks to the bottom of the container. Some facilities may choose to use two suction devices at the time of cesarean delivery: one to suction amniotic fluid and one to suction blood. The provider must use their discretion to allocate appropriate resources to obtain accurate blood loss. For example, it may be more important to ask the RN to administer 15-methyl PGF2a/carboprost (Hemabate) than to weigh a peri-pad.

The use of quantitative blood loss may be of particular use on the postpartum ward where a nurse or corpsman can weigh any pads to accurately report blood loss. As a reminder, postpartum hemorrhage is defined as blood loss equal to or greater than 1000mL within the first 24 hours after delivery. The electronic medical record must accurately and clearly identify all blood losses. The current inpatient electronic health record has several locations to document blood loss, but for uniformity, blood loss should be documented in the output flowsheet as seen in Appendix M.

C. Active Management of the 3rd Stage of Labor

The active management of the 3rd stage of labor includes administration of oxytocin (Pitocin) immediately after delivery of the infant combined with 15 seconds of uterine massage. A standardized administration of oxytocin protocol is essential to patient safety. Administration of oxytocin in the 3rd stage of labor is the one step that has been proven effective in preventing postpartum hemorrhage. Appendix N illustrates the recommended protocol for use after delivery of the infant. The concentration of oxytocin, 30 Units in 500 mL of normal saline, can be used both intrapartum and postpartum. This concentration results in a 1:1 oxytocin administration, where 1 mL/hour is equal to 1 millunit/minute. This protocol administers a physiologically effective dose in a short period of time. If uterine tone does not respond to this oxytocin dose, providers may then quickly move on to other agents to control uterine atony/PPH. In this protocol, after the first bolus of oxytocin, the nurse or anesthesia provider asks the delivering provider if adequate uterine tone has been achieved. The protocol also minimizes excess IV fluid administration which may have adverse effects in patients with pre-eclampsia and other conditions where fluid overload should be avoided. Although IM oxytocin (10 units IM) and other uterotonic (i.e. misoprostol) may be administered in patients without IV access, these medication are not as effective as IV oxytocin. Thus IV oxytocin is the first line choice when possible.

If 500 mL bags of normal saline are unavailable, MTFs may use 60 Units of oxytocin in 1000mL of normal saline. Appendices O, P, Q, and R provide tools for training and for visual checklist displays.

**Registered nurses and anesthesia personnel should be extremely mindful of the IV oxytocin so not to confuse it with any fluids containing magnesium.**

IV. Response

A. Obstetric Hemorrhage Emergency Management Plan with Checklist

**Stage 1** postpartum bleeding is bleeding more than 500 mL with continued bleeding but less than 1000 mL. When this bleeding is encountered, the following actions should be initiated: Notify the
charge RN, delivering provider, staff obstetrician and anesthesia. Obtain the Postpartum Hemorrhage Medication Kit and the Postpartum Hemorrhage Cart. Consider the etiology of the bleeding, including the 4 “T’s”: Tone (uterine atony), Tissue (retained placental fragments), Trauma (cervical or sidewall lacerations), and Thrombin (coagulopathy). While over 80% of postpartum hemorrhage is a result of atony, the other 3 “T’s” should be considered as well as less common causes to include uterine inversion and placenta accreta. Establish a second intravenous line and place a Foley catheter. If not already performed, Type and Crossmatch the patient for 2 units of PRBCs. Administer oxygen as needed to keep maternal oxygen saturation > 95%. Medications to treat uterine atony must be readily available and administered expeditiously. The oxytocin protocol includes administration of 3 units of oxytocin over 3 minutes with an additional 3 units over the next 3 minutes if atony is still noted. The provider should not delay in administering additional uterotonics including 15-methyl PGF2α/carboprost, methylergonovine maleate, and misoprostol. If bleeding continues, the delivery team should consider initiating a “Code Purple.” A Code Purple indicates an obstetrical emergency requiring OB providers, anesthesiologists, and pediatricians. The patient may need to be moved to the operating room. A Bakri intrauterine balloon may be needed to treat atony refractory to medications. The staff should be directed to begin calculating cumulative blood loss measurements.

If a patient continues to bleed > 1000 mL, she has entered **Stage 2** postpartum bleeding requiring additional actions. These actions include bimanual uterine massage, continued uterotonics as needed, movement to the operating room, obtaining STAT labs to assess hemodynamic status, and keeping the patient warm. Continually reassess vital signs and cumulative blood loss. Establish a recorder. Apply sequential compression devices (SCDs). Administer antibiotics as needed. Consider administering blood products. Obtain a rapid infuser with tubing. Obtain an ultrasound to evaluate for retained placental fragments and assistance with Bakri placement if necessary. If a cesarean delivery has been done and the abdomen is open, consider uterine compression sutures prior to placement of the Bakri balloon. If vaginal delivery and vitals are worse than estimated blood loss, consider laparotomy to place compression sutures and evaluate for possible uterine rupture or broad ligament tear.

**Stage 3** is reached when a patient continues to bleed > 1500 mL. At this time, staff should activate the massive transfusion protocol. The recorder will document medications and blood products administered. Repeat STAT labs. Continue to reassess vital signs Q 5 minutes. Administer blood products. Consider intubation and calling additional staff (OB, intensivist, anesthesia second surgeon). If the patient is stable, consider use of interventional radiology for uterine artery embolization if available. Consider exploratory laparotomy with uterine artery ligation, B-Lynch (or other uterine compression sutures) and hysterectomy. When the acuity of the patient exceeds MTF resources, initiate resuscitation and arrange to transfer to a higher level of care at the discretion of the responsible staff physician. See **Appendix D** for the Obstetric Hemorrhage Checklist.

**B. Support Program for Patients, Families and Staff for all Significant Hemorrhages**

All Naval Hospitals have personnel with expertise in unanticipated events and stress. These resources include chaplains, social workers, and mental health providers. A Care Giver Occupation Stress Control (CGOSC) officer is available to provide support to the providers and staff taking care of the
patient. The post-event debrief should include discussion on whether the chaplain, social worker, mental health provider and/or CGOSC officer should be contacted.

Appendix S provides a list of online resources for women, families and clinicians after an obstetric emergency.

V. Reporting and Systems Learning

A. TeamSTEPPS

TeamSTEPPS serves as the basis for communication and provides the opportunity for leadership to optimize teamwork by engaging in effective communication and a shared mental model. Huddles and post-event debriefs are essential for preparation, support, and improvement.

1. Huddles

Prior to carrying out scheduled treatment plans (i.e. cesarean delivery for placenta previa), a team huddle should be completed to establish situational awareness, reinforce plans already in place, and adjust the plan where needed. The huddle should include a brief to review:

- Who is on the team?
- Do all members understand and agree upon goals?
- Are roles and responsibilities understood?
- What is the plan of care?
- Staff and provider’s availability throughout the shift?
- Workload among the team members?
- Are required resources available?

2. Post event debriefs

After a significant patient care event, a debrief should be conducted to share information regarding what went well and what processes need improvement. The team should address the following questions during the debrief:

- Communication clear?
- Roles and responsibilities understood?
- Situation awareness maintained?
- Workload distribution equitable?
- Task assistance requested or offered?
- Were errors made or avoided?
- Availability of resources?
- What went well, what should change, what should improve?

Please see Appendix T for ACOG debrief tools.
3. Transitions of Care

When patients are turned over from one team to another, a formal transition of care takes place. Reviewing and updating a patient’s postpartum hemorrhage risk is part of this process, and should be communicated to the care team and documented in the patient record.

B. Multidisciplinary Review of Serious Hemorrhages for Systems Issues

1. The following events should be considered severe maternal morbidity and reviewed:
   - Pregnant, peripartum or postpartum women receiving 4 or more units of blood products.
   - Pregnant, peripartum or postpartum women admitted to an ICU.
   - Other pregnant, peripartum, or postpartum women who have an unexpected and severe medical event- at the discretion of the birth facility.

2. A multidisciplinary team should review the event. This team should include:
   - Obstetrical providers
   - Obstetric care nurses
   - Ancillary and support staff
   - Anesthesia providers
   - Pediatric providers (if newborn involved)
   - Blood Bank Medical Director
   - Quality Management staff

4. Events should be reviewed as close as possible to the event and the following questions asked:
   - Was the hemorrhage recognized in a timely fashion?
   - Were signs of hypovolemia recognized a timely fashion?
   - Were risk factors identified and addressed proactively?
   - Were supplies and medications readily available?
   - Were transfusions administered in a timely fashion? Was the MTP order given at the appropriate time? Was the MTP responded to in a timely fashion?
   - Were appropriate interventions (e.g. medications, balloon, sutures, etc.) used in a timely fashion?
   - Were modifiable risk factors (e.g. oxytocin, induction, chorioamnionitis, delay in delivery) managed appropriately?
   - Was sufficient assistance (e.g. additional doctors, nurses, or others) requested and received?
   - Was communication effective? Were TeamSTEPPS principles used?

C. Perinatal Quality Improvement

1. Each MTF should report outcome measures to their respective perinatal quality group. The OB and/or Family Medicine Department Heads should review ALL cases of postpartum hemorrhage to ensure accuracy of diagnosis and coding. Appropriate practice and lessons learned should be shared in a nonjudgmental setting with all involved disciplines present.
Prospective collection of the following data will occur for ongoing analysis:

a. Patient demographics
b. Hemorrhage outcomes
   1. Stage (1, 2 or 3) of postpartum hemorrhage
   2. RBC Transfusion (number of units) / other blood products (number of units)
   3. Hysterectomy
   4. Disseminated intravascular coagulopathy
   5. ICU admission or transfer to a higher level of care

2. Every MTF will have a formal committee to monitor metrics and delivery outcomes. This does not need to be a stand-alone committee but may be a part of an existing committee. They will collate system issues lessons learned from drills, simulations and events, and use the information to improve processes with the goal of eliminating all preventable postpartum hemorrhage. The perinatal staff at each MTF will provide feedback, lessons learned and improvement opportunities to the NMW perinatal clinical community and the NMW Regional Quality Collaborative on a quarterly basis. Minor changes/improvements to the NMW PPH Bundle will be communicated throughout the NMW obstetric community via the NMW PPH lead when needed. The clinical community will consider a major rewrite annually or sooner if alternate practices become the standard of care.
REFERENCES


15. California Maternal Quality Care Collaborative (CMQCC).


20. Team STEPPS 2.0 Team Strategies & Tools to Enhance Performance & Patient Safety.

21. The America Congress of Obstetricians and Gynecologists (ACOG), Safe Motherhood Initiative.

List of Appendices

A  Postpartum Hemorrhage Cart Inventory, Black Wrist Band and Cart
B  Instruction for Bakri Balloon Placement
C  Illustration of Uterine Compression Sutures
D  Obstetric Hemorrhage Checklist
E  OB Emergency Release Procedure
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N  Active Management of Third Stage of Labor Protocol
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P  Postpartum Oxytocin Protocol and Pump Programming
Q  Summary of Amount of Oxytocin Administered in the Third Stage of Labor
R  Training Material for Pump Programming of Oxytocin Protocol
S  Resources for Women, Families, and Clinicians after an Obstetric Emergency
T  ACOG Debrief Tool
U  Appendix Material for MTF Use and Personalization
# Appendix A

## Postpartum Hemorrhage Cart Inventory

<table>
<thead>
<tr>
<th>Item</th>
<th>QTY</th>
<th>Exp date</th>
<th>Item</th>
<th>QTY</th>
<th>Exp date</th>
</tr>
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<td><strong>Instruments</strong></td>
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<td><strong>IV/Blood Draw/Med Administration</strong></td>
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<td>Vaginal sidewall retractors (1 Right Angle, 1 Brieske, and 1 Sims Retractor)</td>
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<td>IV Start Kits</td>
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<td>Alcohol prep pads</td>
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<td>Long needle holder</td>
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<td></td>
<td>2x2 Gauze</td>
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<td></td>
<td>Tegaderm</td>
<td>4</td>
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<td>Kelly curved clamp</td>
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<td></td>
<td>1&quot; Plastic tape</td>
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</tr>
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<td>Long Russian forceps</td>
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<td></td>
<td>1&quot; silk tape</td>
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<td>Banjo curette</td>
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<td>Stat lock</td>
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<tr>
<td>Ring forceps</td>
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<td></td>
<td>16G IV</td>
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<td>18G IV</td>
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<td></td>
<td></td>
<td></td>
<td>21G Butterfly needle</td>
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<td><strong>Vacutainer</strong></td>
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<td>Bakri balloon</td>
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<td>5 mL normal saline flush</td>
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<td>Normal saline 1 L Injection (flush balloon drainage port and tubing)</td>
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<td>Blood collection tubes (specific colors per MTF)</td>
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<tr>
<td>Normal saline or sterile water 500 mL irrigation (to fill balloon)</td>
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<td>T&amp;C</td>
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<td>60 cc syringe</td>
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<td>CBC</td>
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<td>Vaginal pack (radiopaque gauze)</td>
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<td>Coags, D-dimer, Fibrinogen</td>
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<td>18G 1.5&quot; needle</td>
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<tr>
<td>Sterile gloves size 7.0</td>
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<td>21G 1.5&quot; needle</td>
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<td>Blood tubing</td>
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<td>Lubricating jelly</td>
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<td>Pressure bags</td>
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<td><strong>Bakri intrauterine balloon instructions</strong></td>
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<td>Emergency Release of Blood Procedure</td>
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<td><strong>Compression stitches diagram</strong></td>
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<td>Massive Transfusion Protocol</td>
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</table>
Appendix A (continued)

Black wrist band to signify intentional retained foreign body (i.e. vaginal packing)

6 drawer storage cart with tamper evident lock
Appendix B  Instruction for Bakri Balloon Placement

Tamponade Technique for Postpartum Hemorrhage

Refer to the Instructions for Use for complete information on product usage and proper indications and contraindications.

1 Evaluating and Monitoring the Patient
- Assess the patient's postpartum hemorrhage and its cause.
- Determine possible contraindications to the use of the Bakri Postpartum Balloon.
- Confirm that the uterus is free of placental attachments or fragments and that there are no lacerations.
- Evaluate the patient for:
  - Vital signs
  - Active and total blood loss
  - Pelvic examination
  - Blood pressure
  - Hematocrit level
  - Urine output
  - Urine tone
- Continue monitoring the patient carefully throughout the process.

2 Determining Uterine Volume
- Estimate the uterine cavity's volume by direct or ultrasonographic examination.
- Place the predetermined volume of sterile fluid in a separate container. Do not rely on a syringe to verify the volume.
- If using 500 cc, note the predetermined volume for rapid instillation.
- The maximum balloon volume is 500 cc.

3 Inserting the Balloon
Transvaginal Placement, Perineal Delivery (See Fig. 1)
- Insert the balloon portion of the catheter into the uterus, making certain that the entire balloon is inserted past the cervical canal and internal os.

Transabdominal Placement, Perineal Delivery (See Fig. 2)
- Pass the uninflated balloon, inflation port first, through the incision into the uterus and cervix. Remove the stopcock to facilitate placement. If desired, have an assistant pull the balloon shaft through the vaginal canal until the base contacts the internal cervical os.
- Close the incision, being careful not to puncture the uninflated balloon with the suture.

4 Filling the Balloon with Sterile Liquid
- Never inflate with air, carbon dioxide or any other gas.
- Do not fill with more than 500 cc. Over-infusion may result in the balloon being displaced into the vagina.
- Ensure that all product components are intact and that the hysterotomy is securely sutured prior to inflating the balloon.
- Place a Foley catheter in the patient's bladder to collect urine and monitor urine output.
- Using the enclosed syringe, or rapid instillation components, fill the balloon to the predetermined volume through the stopcock.
- Traction may be applied to the balloon shaft to ensure proper contact between the balloon and the tissue surface by redirecting the balloon shaft to the patient's leg or attaching it to a weight (not to exceed 900 g).
- Use ultrasound to confirm proper placement of the balloon once the balloon is inflated to the predetermined volume.

5 Flushing the Lumen and Monitoring Hemostasis
- Flush the balloon drainage port and side with sterile isotonic saline to clear clots. (The appropriate volume of saline and frequency of flushing should be determined by attending medical staff)
- Connect the collection port to a fluid collection bag to monitor hemostasis.
- Monitor the patient for signs of increased bleeding and uterine cramping.
- Continue evaluating the patient for signs listed in Step 1.

6 Removing the Balloon
- Maximum indwelling time: 24 hours.
- The timing of balloon removal should be determined by the attending clinician upon evaluation of the patient once bleeding has been controlled and the patient is stable.
- Release the traction on the shaft and remove any vaginal packing.
- Aspirate balloon contents until the balloon is completely empty.
- Gently retract the balloon and discard it.
- Monitor the patient for signs of bleeding.

Illustrations for Inserting the Bakri Balloon (Step 3)

Fig. 1: Transvaginal Placement, Postpartum Delivery

Fig. 2: Transabdominal Placement, Postpartum Delivery

Explanation of Proper Placement

Proper Placement
- Inflated Bakri balloon inflated inside the uterus and internal os.
- The balloon is positioned in the correct anatomical relationship to the endometrium.
- The balloon is inflated to the predetermined volume.

If the Balloon Becomes Displaced
- Empty the balloon.
- Reposition the balloon.
- Reinflate if the balloon is still inflated.
- If balloon is deflated, repeat Step 4.

To Prevent Displacement
- If necessary, pack the vagina with sterile, absorbent material.
- Do not extend the packing into the uterus.

Steps for the Use of Rapid Instillation Components

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Appendix C
Illustration of uterine compression sutures from ACOG District II
Safe Motherhood Initiative Maternal Safety Bundle for Obstetric Hemorrhage

For an additional description of the procedure, refer to:

The recommended suture is #1 or #2 chromic or #1 monocryl on a 65-70 mm curved needle, a long suture with a large needle. Early absorbable suture should be used to avoid separated loops that could entrap bowel as the uterus involutes.
OBSTETRIC HEMORRHAGE CHECKLIST

Date: ____________________________
Team members: Nurse(s): ____________________________
Providers: ____________________________
Anesthesia: ____________________________
Other staff: ____________________________

Patient identification:

STAGE ONE:
EBL > 500 ml with CONTINUED BLEEDING

Notify:
☐ OB Provider & OB on duty
☐ Primary & 2ndary RN
☐ Primary & 2ndary HM
☐ Anesthesia

Obtain:
☐ PPH Medication Kit
☐ PPH Cart

Action:
☐ Fundal massage
☐ Vitals Q5 minutes
☐ Medications (see below)
☐ IV access (2 large bore)
☐ Type & Crossmatch patient
☐ Consider obtaining STAT labs (CBC, Chem11, PT/PTT, T&F, fibrinogen)
☐ Oxygen to maintain O2 sat > 95%
☐ Foley catheter
☐ Keep patient warm
☐ Weigh materials, record cumulative blood loss Q5 minutes
☐ Rule out retained products or laceration

Consider:
☐ Initiate CODE PURPLE
☐ Move patient to Operating Room
☐ Intrauterine balloon

STAGE TWO:
EBL > 1000 ml with CONTINUED BLEEDING

Notify:
☐ Surgical Tech and Circulating RN
☐ NDD (nurse of day)
☐ Blood Bank

Obtain:
☐ Rapid infuser
☐ Rapid infuser tubing
☐ Ultrasound

Action:
☐ Bimanual uterine massage
☐ Continue uterotonin medication
☐ Move patient to OR and initiate CODE PURPLE
☐ Consider obtaining STAT labs (CBC, Chem11, PT/PTT, T&F, fibrinogen) and arterial blood gas
☐ Continue vital signs and cumulative blood loss Q5 minutes
☐ Keep patient warm with bear hugger
☐ Apply 3CDs
☐ Administer antibiotics as ordered
☐ Set up Rapid blood infuser
☐ Oxygen to maintain O2 sat > 95%
☐ Consider administering 2 units of PRBCs and thaw FFP (TRANSFUSE BASED ON CLINICAL SIGNS. DO NOT WAIT FOR ALL LAB RESULTS)

Consider:
☐ Transfer to ICU/Higher level of care
☐ Call additional staff (OB/intensivist/anesthesiologist)
☐ Possible intubation
☐ Selective Embolization (IR)

STAGE THREE:
EBL > 1500 ml with CONTINUED BLEEDING
Vitals unstable or suspicion for DIC

Notify:
☐ Second surgeon
☐ Chaplain for family support
☐ Lab Officer/Pathologist

Obtain:
☐ Rapid infuser
☐ Rapid infuser tubing
☐ Ultrasound

Action:
☐ Activate Massive Transfusion Protocol
☐ Establish a reporter to document meds/blood products
☐ Repeat labs q30-60 minutes
☐ Continue vital signs and cumulative measured blood loss Q5 minutes
☐ Continue uterotonin medication as ordered
☐ Administration of blood products
  ☐ 1 unit of PRBC to 1 unit of FFP
  ☐ When platelets arrive: 1 unit of PRBC to 1 unit of FFP
  ☐ With aggressive continuous transfusion consider cryoprecipitate

Consider:
☐ Uterine artery ligation
☐ Hysterectomy

Think:
Interventions based on etiology not yet completed
Prevent hypothermia, acidemia
Conservative or Definitive Surgery:
  ☐ Uterine artery ligation
  ☐ Hysterectomy

Not an Official Patient Record Form. Do not put in patient medical record.
(For Staff Use ONLY)
Appendix E

OB Emergency Release Procedure

( Lab Specimen Tube Guide must be edited with appropriate tube color)

To avoid unnecessary delay, Emergency Release SHOULD be a verbal order from a provider with forms completed after the patient’s clinical status is stable.

**EMERGENCY RELEASE REQUEST INITIATED**

**Limited Response**
*Request for the Emergency Release of up to 4 units RBCs
*Typically for unstable patients without active bleeding and when the need for additional blood products is not anticipated
*When not enough time to wait for cross matched blood
*Can be used for emergency release of other blood products (FFP, etc.)

**Blood Bank is called by Facilitator (PHONE #)**

* Patient name
* DOB or patient identifier
* Facilitator name
* Location, room number
* Ordering physician
* Facilitator phone number

**Obtain Labs:**
When possible Type & Crossmatch (one time)
CBC, Coags, Fibrinogen (consider D-dimer)

**Lab Officer / Pathologist:**
Lab Officer / Pathologist consult with Clinical Team to determine additional requirements and need to escalate to Massive Transfusion Protocol.

**Lab Specimen Tube Guide**
*T&C/T&S – tube color
*CBC – tube color
*Coags, D-dimer, Fibrinogen – tube color
*Chem 11 – tube color
Appendix F
OB Massive Transfusion Protocol
( Lab Specimen Tube Guide must be edited with appropriate tube color)

Massive Transfusion Protocol (MTP) Algorithm

MASSIVE TRANSFUSION PROTOCOL INITIATED
by Attending physician or Anesthesiologist
Activate Command MTP (page overhead)

- OBL > 1500 mL, > 2 units PRBC's given, DIC suspected
- Anticipate need of 6 PRBC's within 2 hours
- Persistent hypotension or tachycardia and active bleeding
- Transfusion > 4 PRBCs within 1 hour
- Replacement of 50% blood volume within 3 hours
- DIC

MTP Facilitator designated or assumes role

Blood Bank is called by MTP Facilitator [PHONE#]
- Patient name
- Location, room number
- DOB or patient identifier
- Ordering physician
- Facilitator phone number

Obtain Labs:
- Type & Crossmatch [one time]
- CBC, Coags, Fibrinogen (consider D-dimer)

Blood Bank:
- 6 units RBCs: Type specific and/or O-negative, in cooler
- 4 units FFP
- 1 pack plt (or 4:1)
- pending MTP blood product availability

Working Transfusion Goal: 1 PRBC : 1 FFP : 1 PLT : 1 CRYO
Blood Bank notifies Facilitator as products become available
- Initiate blood product procurement (if needed, MTP specific)

Obtain Labs:
- Every 30 min or as clinically indicated
- CBC, Coags, Fibrinogen, consider ABG, Ca²⁺, Mg²⁺, D-dimer
- pending MTP capabilities (iStat, etc)

Attending physician or Anesthesiologist's decision to CEASE MTP
Immediately notify Blood Bank [PHONE#]

MTP Facilitator Roles:
- Lab communication
- Designates Runner and Recorder
- Transfusion documentation
- Tracks and communicates lab and blood product updates

Transfusion Guidelines:
- INR > 1.5
- CONSIDER 4 units FFP
- Fibrinogen < 80 mg/dL
- CONSIDER 2 units CRYO
- Platelet < 50,000
- CONSIDER 1 unit apheresis PLTs

Lab Specimen Tube Guide:
- T&C/T&S - color
- CBC - color
- Coags, D-dimer, Fibrinogen - color
- Chem 11 - color
## Topical Hemostatic Agents

<table>
<thead>
<tr>
<th>Agent</th>
<th>Derivative</th>
<th>Mechanism of Action</th>
<th>Pearls</th>
<th>Absorption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geofoam powder and sponge</td>
<td>Purified porcine skin gelatin</td>
<td>Surface acts in intrinsic coagulation pathway. Requires presence of clotting factors and cofactors.</td>
<td>Absorbs 45x its weight in blood and expands 200% of its initial volume.</td>
<td>Completely absorbed in 4-6 weeks.</td>
</tr>
<tr>
<td>Oxidized regenerated cellulose (Surgical)</td>
<td>Acidic plant based extract</td>
<td>Surface acts in intrinsic coagulation pathway. Requires presence of clotting factors and cofactors. May cause small vessel constriction due to acidic nature.</td>
<td>Relatively bacteriostatic. Needs to be applied to a dry surface. Results in a ring-enhancing lesion on post-op CT, can be mistaken for abscess.</td>
<td>Completely absorbed in 4-8 weeks.</td>
</tr>
<tr>
<td>Microfibrillar collagen (Avitene)</td>
<td>Collagen derived from bovine skin</td>
<td>Works proximally in intrinsic coagulation pathway, relies on the presence of active clotting factors to function. Directly activates platelets.</td>
<td>Binds tightly to blood surfaces, no need to achieve a dry field. Mixing with thrombin preparations and normal saline results in a hemostatic paste.</td>
<td>Completely absorbed in 3 months.</td>
</tr>
<tr>
<td>Topical thrombin</td>
<td>Bovine extract</td>
<td>A powder that is dissolved in water or sterile saline before use. Primarily conversion of fibrinogen to fibrin. Ineffective in the presence of inadequate fibrinogen.</td>
<td>DO NOT inject intravenously — extensive intravascular clotting. Usual amount applied is 5,000 units, concentration of 1,000-2,000 units/mL. Absorbable gelatin sponge strips may be immersed in the thrombin solution and placed on bleeding site.</td>
<td>N/A</td>
</tr>
<tr>
<td>Product</td>
<td>Effect</td>
<td>Application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fibrin sealant (FloSeal)</strong></td>
<td>Bovine thrombin directly activates fibrinogen and converts it to fibrin monomers. Works in the common pathway, bypassing all other necessary clotting factors. Requires presence of functional fibrinogen to work. Granules of gelatin expand by approximately 20% and physically restrict blood flow.</td>
<td>Risk of transmitting infectious agents (viruses and theoretically CJD – prions) b/c of human plasma origin. User advised not to disrupt by physical manipulation. Designed for activation on wet, actively bleeding tissue. Stops bleeding in 90 seconds. May be used up to 2h after activation. May serve as a nidus for infection and abscess formation. Use is contraindicates in the presence of infection.</td>
<td>Absorbed in 6-8 weeks</td>
<td></td>
</tr>
<tr>
<td><strong>Microporous polysaccharide spheres (Arista)</strong></td>
<td>Synthetic Powder</td>
<td>Use of &gt;50g can alter glucose load in patients with diabetes.</td>
<td>24-48 hours</td>
<td></td>
</tr>
</tbody>
</table>
Appendix H

1. Vacuum Abdominal Pack from MTF supplies:

   Necessary materials:  Mayo stand cover OR a 10/10 drape
   4 blue surgical towels
   2 Jackson-Pratt drains
   1 Ioban Incise Drape
   1 portable wound vacuum or low continuous wall suction

Description of assembly: Cut an 18" x 24" (approximate) from sterile mayo stand cover (or use a 10/10 drape). Cut fenestrations in the cover (or drape). Place it evenly as possible in the abdomen and pelvis over the bowels and under the anterior abdomen fascia. Place 2 folded blue towels over the incision. Place 2 flat JP drains above these towels. Place 2 more blue towels over the JP drains. Cover everything with Ioban. Connect to low continuous suction or wound vacuum. (See diagram below.)

![Diagram of Vacuum Abdominal Pack]

3. **The Pelvic Pressure Pack** as described by G. A. Dildy III

**Necessary Materials:**
- Sterile bag like the one shown in the picture below (i.e. X-ray cassette drape)
- Gauze rolls or laparotomy sponges tied end to end
- IV tubing
- IV bag

**Description of assembly:** Obtain a sterile bag like the x-ray cassette bag shown below. Fill with gauze to the appropriate size of the pelvis. Pass the neck of the gauze and bag from the abdomen through the vagina in the post hysterectomy patient. Tie the IV tubing to the neck of the bag and suspend the 1 L bag of IV fluid off the bed, to apply traction and pressure to the pelvis, tamponading the bleeding.

![Image of the Pelvic Pressure Pack](image)

4. Illustration of the Pelvic Pressure Pack as described by G. A. Dildy III
Appendix I

Example of critical numbers that should be immediately available on every labor unit

<table>
<thead>
<tr>
<th>Provider</th>
<th>Primary number</th>
<th>Secondary number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiologist or CRNA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Bank</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code Purple</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duty Pathologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interventional Radiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse of Day (NOD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB Provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Backup OB or Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR Tech</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacist on Call</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaplain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Giver Occupational Stress Control</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix J

Physician/CNM Postpartum Hemorrhage
Performance Checklist

Team Members: 

Date: ___________________________ Evaluator: ___________________________

<table>
<thead>
<tr>
<th>Assessment/Action</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider assesses PPH risk factors</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider recognizes postpartum hemorrhage</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider/Team calls for additional assistance</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider calls for additional supplies (i.e. Hemorrhage Cart or Bag)</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider assesses for retained products of conception</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Inspects placenta to see if intact</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider inspects vagina for lacerations</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider inspects cervix for lacerations</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider recognizes bleeding is coming from the uterus</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider performs fundal massage</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider starts a second IV</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider orders labs including coags</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider administers medication to correct atony</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Methergine: Correct dose (0.2 mg) Correct route (IM)</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Hemabate: Correct dose (250 mcg) Correct route (IM)</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Cytotec: Correct dose (1000 mcg) Correct route (per rectum)</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider activates the Massive Transfusion Protocol if appropriate</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider recognizes need for operative intervention if appropriate</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Team obtains Obstetric Hemorrhage Checklist</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Team follows protocol on OB Hemorrhage Checklist</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Provider counsels patient and family on PPH and management</td>
<td>Yes / No / N/A</td>
</tr>
</tbody>
</table>
Total time required to correct hemorrhage

Inappropriate Actions:

| Failure to recognize PPH in a timely manner | YES if done |
| Delay calling for help | YES if done |
| Delay in administering blood products | YES if done |

Overall, how prepared was the provider for managing PP Hemorrhage?

| Not prepared at all | Reasonably prepared | Well prepared |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Please rate the provider’s performance during the PP Hemorrhage scenario:

| Poor | Average | Outstanding |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

How well did the TEAM:

| ORIENT members (SBAR) during the scenario as they arrive | Evaluation |
| NA / Unacceptable / Poor / Average / Good / Perfect |
| Call for ADDITIONAL ASSISTANCE in a timely manner | NA / Unacceptable / Poor / Average / Good / Perfect |
| Utilize CLOSED-LOOP COMMUNICATION | NA / Unacceptable / Poor / Average / Good / Perfect |
| PRIORITIZE medical interventions | NA / Unacceptable / Poor / Average / Good / Perfect |
| Utilize PATIENT FRIENDLY language and tone | NA / Unacceptable / Poor / Average / Good / Perfect |

Please rate the following:

| OVERALL TEAM COMMUNICATION | Evaluation |
| NA / Unacceptable / Poor / Average / Good / Perfect |
| OVERALL TEAM PERFORMANCE | NA / Unacceptable / Poor / Average / Good / Perfect |

Overall Performance: PASS FAIL

Summarize & Review Lessons Learned / Process Improvements:
# Nursing Postpartum Hemorrhage

## Performance Checklist

Team Members: ____________________________

Date: ________________________  Evaluator: ____________________________

<table>
<thead>
<tr>
<th>Assessment/Action</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse calls for assistance and anesthesia</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Nurse retrieves and administers medications as requested by physician</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Nurse places a second IV</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Nurse obtains labs per order and begins preparing for possible need for transfusion of blood products</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Nurse documents EBL (pad count)</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Nurse continuously assessing vital signs</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Nurse puts OR tech on stand-by</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Administered medication to correct atony</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td><strong>Methergine:</strong> Correct dose (0.2 mg)</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Correct route (IM)</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td><strong>Hemabate:</strong> Correct dose (250 mcg)</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Correct route (IM)</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td><strong>Cytotec:</strong> Correct dose (1000 mcg)</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Correct route (per rectum)</td>
<td>Yes / No / N/A</td>
</tr>
<tr>
<td>Nurse provides reassurance to patient and family</td>
<td>Yes / No / N/A</td>
</tr>
</tbody>
</table>

### Inappropriate Actions:

- Failure to identify possible contraindications to medications (i.e. asthma, elevated pressures)
- Failure to recognize postpartum hemorrhage

**Overall, how prepared was the nurse for managing PP Hemorrhage?**

<table>
<thead>
<tr>
<th>Not prepared at all</th>
<th>Reasonably prepared</th>
<th>Well prepared</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

**Please rate the nurse’s performance during the PP Hemorrhage scenario:**

- Extremely Poor
- Average
- Outstanding

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well did the TEAM:</td>
<td>Evaluation</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORIENT new members (SBAR) during the scenario as they arrive</td>
<td>NA / Unacceptable / Poor / Average / Good / Perfect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call for ADDITIONAL ASSISTANCE in a timely manner</td>
<td>NA / Unacceptable / Poor / Average / Good / Perfect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilize CLOSED-LOOP COMMUNICATION</td>
<td>NA / Unacceptable / Poor / Average / Good / Perfect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRIORITIZE medical interventions</td>
<td>NA / Unacceptable / Poor / Average / Good / Perfect</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilize PATIENT FRIENDLY language and tone</td>
<td>NA / Unacceptable / Poor / Average / Good / Perfect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Please rate the following:</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVERALL TEAM COMMUNICATION</td>
<td>NA / Unacceptable / Poor / Average / Good / Perfect</td>
</tr>
<tr>
<td>OVERALL TEAM PERFORMANCE</td>
<td>NA / Unacceptable / Poor / Average / Good / Perfect</td>
</tr>
</tbody>
</table>

Overall Performance: PASS  FAIL

Summarize & Review Lessons Learned / Process Improvements:
Appendix K

Example of an under-buttock drape with a marked graduated plastic cylinder

Under Buttocks Drapes

300 ml

900 ml

OB Hemorrhage Toolkit: CMQCC
Appendix L

Examples of Estimating Blood Loss

Appendix M

Qualitative Blood Loss Worksheet

Example only – Each MTF must list and weigh their own materials

This QBL worksheet is not placed in the medical record

<table>
<thead>
<tr>
<th>Item</th>
<th>Dry Weight (grams)</th>
<th>Wet weight (grams)</th>
<th>Wet minus dry weight= mLs of fluid/blood</th>
<th>Total per Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covidien Curity Maternity Pads (maxi pads)</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB Pad (large white pad)</td>
<td>70</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed pad, linen (smaller green chux)</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevail large chux pads</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RF Detect Premium sterile lap 18x18 (both SVD cart and OR)</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduated Container volume</td>
<td>Estimated amniotic fluid volume</td>
<td>Container #1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Irrigation fluid volume</td>
<td>Container #2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non Blood subtotal</td>
<td>Subtract non-blood</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL QUALITATIVE BLOOD LOSS (QBL) in mL
Appendix M (con’t)

Essentris Documentation of Estimated Blood Loss
Appendix N

ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR (AMTSL) PROTOCOL

PURPOSE:
To institute an infusion based oxytocin protocol for the third stage of labor and post-partum patients.

SUPPORTIVE DATA: Oxytocin administration during the third stage of labor and immediate post-partum period is effective in preventing uterine atony and hemorrhage. Recent literature has supported a peak effective dose of oxytocin and use of a protocol for administration of oxytocin and other uterotonicics for best prevention and management of post-partum hemorrhage.

1. Scope
   a. This protocol covers oxytocin administration during the third stage of labor and postpartum period.
   b. This protocol DOES NOT cover oxytocin administration for augmentation of labor.

2. Procedure Post Delivery with IV Access
   a. Post Delivery - Oxytocin infusion will be initiated upon delivery of the anterior shoulder or upon delivery of the infant.

      ii. The infusion will be prepared as premixed bags of oxytocin 30 units in 500 mL of normal saline, for a concentration of 60 milliunits/mL. If 500 mL bags of normal saline are not available, 60 units of oxytocin in 1000 mL of normal saline bags may be used to obtain the same concentration. Both of these concentrations deliver: 1mL/hour = 1 milliunit/minute
      iii. Oxytocin infusions will be administered via hospital-approved infusion pumps at the closest port to the patient. Pumps will be programmed using only the preprogrammed guardrails drug library.
      iv. A bolus of 3 units (50 mL) will be given at time of delivery.
         a. Bolus over 3 minutes (1000 milliunits/min x 3 minutes = 50mL = 3 units).
         b. Bolus may be repeated x1 if uterine tone is deemed "inadequate" by delivering provider.
      v. After bolus, the infusion will be continued at 300 milliunits/min (300 mL/hour) for one hour.
      vi. The time of initiation of infusion will be documented.
      vii. After the first hour, the oxytocin infusion will be decreased to 60 milliunits/min (60 mL/hour) for 3 hours, for a total of 4 hours of oxytocin infusion after delivery.
      viii. Four hours after initiation, the oxytocin infusion will be discontinued. Maintain the saline lock if indicated.
      iii. At the provider’s discretion, the infusion may be continued.
   b. Vaginal Delivery

      i. At the time of delivery of the infant, the L&D RN will initiate the oxytocin bolus 3 units (50 mL) over 3 minutes ("rapid bolus"), with a second bolus if needed as
determined by delivering provider. Then the oxytocin infusion will be maintained at 300 milliunits/min (300 mL/hour) for 1 hour.

ii. After 1 hour, the L&D RN, will then reduce the infusion to 60 milliunits/min (60 mL/hour) for 3 additional hours.

c. Cesarean Delivery

i. At the time of delivery of the infant, the anesthesia provider will initiate an oxytocin bolus of 3 units (50 mL) over 3 minutes ("rapid bolus") with a second bolus if needed as determined by delivering provider. Then the oxytocin infusion will be maintained at 300 milliunits/min (300 mL/hour) for 1 hour.

ii. The anesthesia provider will document in their PACU orders the time of initiation of the oxytocin infusion. Nursing will document it on the MAR.

iii. The L&D PACU RN will continue the 300 milliunits/min oxytocin infusion until all 18 units have infused, and then reduce the infusion to 60 milliunits/min (60 mL/hour) for 3 additional hours.

Sample inpatient order set for AMTSL oxytocin infusion

<table>
<thead>
<tr>
<th>Name</th>
<th>Freq</th>
<th>Amount</th>
<th>Dose</th>
<th>Volume (mL)</th>
<th>Rate (mL/hr)</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>NS+OXYTOCIN</td>
<td>30(Unit)</td>
<td>1000(mUnit/min)</td>
<td>500</td>
<td>1000</td>
<td>1000</td>
<td>BOLUS. 3 Units equals 50 mL over 3 min. SET VTBI to 350 mL.</td>
</tr>
<tr>
<td>NS+OXYTOCIN</td>
<td>30(Unit)</td>
<td>1000(mUnit/min)</td>
<td>500</td>
<td>1000</td>
<td>1000</td>
<td>2nd BOLUS IF Ordered. 3 Units equals 50 mL over 3 min. Reset VTBI at 350 mL</td>
</tr>
<tr>
<td>NS+OXYTOCIN</td>
<td>30(Unit)</td>
<td>300(mUnit/min)</td>
<td>500</td>
<td>300</td>
<td>300</td>
<td>18 Units/hr equals 300 mL/min or 300 mL over 1 hour.</td>
</tr>
<tr>
<td>NS+OXYTOCIN</td>
<td>30(Unit)</td>
<td>60(mUnit/2/min)</td>
<td>500</td>
<td>60</td>
<td>60</td>
<td>3.6 Units/HR equals 60 mL/min or 180 mL over 3 hours. SET VTBI at 180 mL</td>
</tr>
</tbody>
</table>

3. Procedure Post Delivery without IV Access

Intravenous oxytocin should be considered the standard approach for the active management of the third stage of labor. An alternative method of administering oxytocin is to administer 10 units of oxytocin intramuscularly. For women without intravenous access or who refuse oxytocin in the third stage, they should be offered an alternative to include 600 mcg of oral misoprostol or 1000 mcg of rectal misoprostol.

4. Procedure for Inadequate Uterine Tone

a. Infuse oxytocin 3 unit bolus (50 mL) over 3 minutes intravenously. (1000 milliunits/min x 3 minutes = 50mL = 3 units).

b. If after the initial 3 unit bolus (50 mL), uterine tone is deemed inadequate by the obstetric provider, repeat the 3 unit (50 mL) bolus over 3 minutes.
   i. Perform fundal or bimanual uterine massage.
   ii. Ensure the post-partum hemorrhage bag or cart and postpartum hemorrhage medications are in the room.

c. After the second bolus, if tone remains inadequate, additional uterotonic medications should be administered per provider’s orders including:
i. Methylergonovine maleate (Methergine) 0.2 mg IM every 2 hours

ii. 15-methyl PGF2α/ carboprost (Hemabate) 250 mcg IM (or intra-myometrium) every 15 minutes up to 8 doses (2 mg)

iii. Misoprostol (Cytotec) 600 mcg orally, 800 mcg sublingual or 1000 mcg per rectum

d. Additional therapy for hemorrhage should occur per the Postpartum Hemorrhage protocol and/or OB massive transfusion protocol.
Appendix O

Oxytocin Protocol

DELIVERY

OXYTOCIN Bolus 3 Units

Adequate uterine tone?

NO

OXYTOCIN Bolus 3 Units

NO

OXYTOCIN 300 milliunits/min x 1 hour

YES

OXYTOCIN 60 milliunits/min x 3 hours

YES

OXYTOCIN 300 milliunits/min x 1 hour

TREAT PPH/Atony

NO

OXYTOCIN 60 milliunits/min x 3 hours
Appendix P

Postpartum oxytocin protocol and pump programming for 30 units oxytocin in 500mL normal saline

DELIVERY

OXYTOCIN Bolus 3 Units
(3000 milliunits/min x 3 min = 900ml)

Set VTBI at 350mL
(50ml for rapid bolus plus 300mL for the 30 units over the first hour)
Deliver “Rapid Bolus”

Adequate uterine tone?

NO

Re-set VTBI at 350mL
(50ml for rapid bolus plus 300mL for the 30 units over the first hour)
Deliver “Rapid Bolus”

YES

OXYTOCIN Bolus 3 Units

OXYTOCIN 300 milliunits/min x 1 hour

Pump should auto default to this setting
(VTBI 300mL, Dose @ 300 milliunits/min)

Adequate uterine tone?

NO

OXYTOCIN 300 milliunits/min

TREAT PPH/Atony

YES

OXYTOCIN 60 milliunits/min x 3 hours

Set VTBI to 180mL
Set Dose @ 60milliunits/min

OXYTOCIN 300 milliunits/min x 1 hour

Pump should auto default to this setting
(VTBI 300mL, Dose @ 300 milliunits/min)

OXYTOCIN 60 milliunits/min x 3 hours

Set VTBI to 180mL
Set Dose @ 60milliunits/min
Appendix Q

Simplified Summary of Amount of Oxytocin Administered in Third Stage of Labor:

### No Uterine Atony Present (routine)

<table>
<thead>
<tr>
<th>Units</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 units</td>
<td>3 minutes</td>
</tr>
<tr>
<td>18 units</td>
<td>1 hour</td>
</tr>
<tr>
<td>10.8 units</td>
<td>3 hours</td>
</tr>
<tr>
<td>Total = 31.8 units</td>
<td></td>
</tr>
</tbody>
</table>

### Uterine Atony Present

<table>
<thead>
<tr>
<th>Units</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 units</td>
<td>3 minutes</td>
</tr>
<tr>
<td>3 units</td>
<td>3 minutes</td>
</tr>
<tr>
<td>18 units</td>
<td>1 hour</td>
</tr>
<tr>
<td>10.8 units</td>
<td>3 hours</td>
</tr>
<tr>
<td>Total = 34.8 units</td>
<td></td>
</tr>
</tbody>
</table>
Appendix R

Training Material for Pump Programming of Oxytocin Protocol

(Download slide deck from Appendix U)
Getting to the Program
- Select 'Postpartum'
- Confirm correct HECV concentration
- 30 Units in 500 ml

Confirm new concentration
- Again, confirm by hitting 'NEXT'
- 20 units x 1,000 milliliters = 20,000 units
- 1 unit
- 10,000 units = 10 milliliters
- 500 ml
- 1 unit
- SO if you are running 1 ml/hr, you are giving 5 ml/hour.

- This is the #1 SAFETY advantage of the concentration method.

Set your first hour infusion
- Suggest 310 ml/hr for IVB
- Set Dose (4th slide) at 300 milliliters/hr (310 ml/hr)

Give your initial Bolus
- Once you have programmed for the Concentration Method, hit 'BOLUS'
- Select 'RAPID BOLUS' for you can put in duration of 3 minutes. It will be the same:

Begin the Bolus
- Hit 'START' to begin bolus
- Confirm the warning screen "Yes"
- "I'm trying to get rid of the warning—please may get extra until the next manual programming"

Bolus over 3 minutes
- Your pump should be running at 50 ml/hr
- The bolus runs over 3 minutes
- (You Look Too Foamy)
Start infusion after bolus
- If you paused your pump, it will attempt to start your 300 milliliters/min infusion, and it should have 500 mL left—use bolus!

Second bolus
- When you select duration, again, select "RAPID BOLUS" (or 3 minutes)
- When the bolus is complete the 300 milliliters/min continuous infusion will resume

Second Bolus Complete
- If your patient is having ongoing hemorrhage or atony
  MOVE TO CLINICAL ASSESSMENT
  PROCEED TO IMMEDIATE PROTOCOL

Overview
- Administer initial 50 milliliters/min bolus at delivery
- If adequate uterine tone, administer 300 milliliters/min x 1 hour
- Then administer 60 milliliters/min x 3 hours
- If uterine tone is inadequate, deliver 2nd 50 milliliters/min bolus
  Initiate 300 milliliters/min x 1 hour
- If uterine tone is adequate, then administer 60 milliliters/min x 3 hours
- If uterine tone is inadequate initiate treatment for PPH/Atony

Bottom Line
- Oxytocin in 3rd stage of labor is key for prevention of PPH
- There is a peak effect of bolus oxytocin
- Current practice: Variable timing of postpartum oxytocin administration
- Suggested evidence-based protocol
- This protocol will: practice
  - Allow providers to titrate doses in a more efficient way when additional oxytocin is still needed
  - Allow more consistency with oxytocin administration
  - Avoid excessive dosing and unnecessary adverse effects
Appendix S

From the California Maternal Quality Care Collaborative
CMQCCOBSTETRICHEMORRHAGETOOLKIT Version 2.0  3/24/15

RESOURCES FOR WOMEN, FAMILIES AND CLINICIANS AFTER AN OBSTETRIC EMERGENCY

After an obstetric emergency, many women seek to understand what happened to them and to find a supportive community. Increasingly, online resources provide a space for women who experience these rare events to gather and share stories and information. While not all these may apply to severe hemorrhage, many of the resources are useful after any obstetric emergency.

BIRTH TRAUMA RESOURCES FOR WOMEN & FAMILIES

- **PATTCh**: [http://pattch.org/](http://pattch.org/) PATTCh is a collective of birth and mental health experts dedicated to the prevention and treatment of traumatic childbirth. Resources for women, families and health care providers, including a comprehensive [Traumatic Birth Prevention & Resource Guide](http://pattch.org/)

- **Solace for Mothers**: [http://www.solaceformothers.org/](http://www.solaceformothers.org/) Solace for Mothers is an organization designed for the sole purpose of providing and creating support for women who have experienced childbirth as traumatic. Contact: [info@solaceformothers.org](mailto:info@solaceformothers.org)
  - *Comforting a Woman Traumatized by her Birth Experience*: Article from [http://theunnecesarean.com/](http://theunnecesarean.com/), *Women from the Solace for Mothers message boards collaborated to create this list of common things said to women in the postpartum period and how they might be interpreted by women who feel traumatized by their birth and/or have postpartum depression or PTSD.*


CONDITION-SPECIFIC RESOURCES WITH GENERAL APPLICABILITY FOR WOMEN & FAMILIES

- **Amniotic Fluid Embolism Foundation**: [http://afesupport.org/](http://afesupport.org/) This foundation is the only patient advocacy organization serving those affected or devastated by amniotic fluid embolism. Their mission is to fund research, raise public awareness and provide support for those whose lives have been touched by this often-fatal maternal health complication. Online Guides: Families in Crisis;
Families Grieving the Loss of a Loved One; Fathers Grieving the Loss of a Spouse; Families Grieving the Loss of an Infant; etc.

- **Preeclampsia Foundation**: (http://www.preeclampsia.org/) The Preeclampsia Foundation is an empowered community of patients and experts, with a diverse array of resources and support. They provide support and advocacy for the people whose lives have been or will be affected by the condition—mothers, babies, fathers and their families. Online resources and tools for women, families and clinicians.

- **Cardiomyopathy**: My Heart Sisters (http://www.myheartsisters.com/)

- **MITSS (Medically Induced Trauma Support Services)** (http://www.mitss.org/) is a non-profit organization whose mission is “To Support Healing and Restore Hope to patients, families, and clinicians impacted by medical errors and adverse medical events.”
  - Toolkit for staff support: www.mitss tools.org/tool-kit-for-staff-support-for-healthcare-organizations.html

**GENERAL MEDICAL AND TRAUMA RESOURCES FOR CLINICIANS**

- **ACOG**: "Healing Our Own: Adverse Events in Obstetrics and Gynecology" Available to ACOG members only via website

- **Risking Connection**: (http://www.riskingconnection.com/) Risking Connection® teaches a relational framework and skills for working with survivors of traumatic experiences. The focus is on relationship as healing and on self-care for service providers. Some information here is helping provider recognize trauma the patient brings with her but the issues presented-safety, empowerment, etc. apply in any trauma situation.

- **Health Care Toolbox**: (http://healthcaretoolbox.org/index.php/what-providers-can-do/d-e-f-protocol-for-trauma-informed-pediatric-care.html) This is for pediatric patients but it is evidenced-based, and is simply and clearly presented. "A-B-C" orients providers to the crucial first steps to save a life (Airway, Breathing, Circulation). "D-E-F" can help providers remember the key initial steps for children's emotional recovery from illness or injury. Health care providers are experts in treating illness, restoring functioning, and saving lives.

- **Women's Health Research at Yale**: (http://medicine.yale.edu/whr/research/cores/trauma.aspx#page1) The Trauma Core of Women's Health Research at Yale studies issues unique to female veterans, women, and children. Lots of information and resources.
Appendix T
ACOG Debrief Tool

Obstetric Team Debriefing Form

Remember: Debriefing is meant to be a learning experience and a way to address both human factors and systems issues to improve the response for next time. There is to be no blaming/finger-pointing.

Type of event: ___________________________ Date of event: ___________________________

Location of event: ___________________________

Members of team present: (check all that apply)
☐ Primary RN ☐ Primary MD ☐ Charge RN ☐ Resident(s)
☐ Anesthesia personnel ☐ Neonatology personnel. ☐ MFM leader ☐ Patient Safety Officer
☐ Nurse Manager ☐ OR/Surgical tech ☐ Unit Clerk ☐ Other RNs

Thinking about how the obstetric emergency was managed,

Identify what went well:
(Check if yes)
☐ Communication
☐ Role clarity (leader/supporting roles identified and assigned)
☐ Teamwork
☐ Situational awareness
☐ Decision-making
☐ Other: ___________________________

Identify opportunities for improvement:
"human factors" (Check if yes)
☐ Communication
☐ Role clarity (leader/supporting roles identified and assigned)
☐ Teamwork
☐ Situational awareness
☐ Decision-making
☐ Other: ___________________________

Identify opportunities for improvement:
"systems issue" (Check if yes)
☐ Equipment
☐ Medication
☐ Blood product availability
☐ Inadequate support (in unit or other areas of the hospital)
☐ Delays in transporting the patient (within hospital or to another facility)
☐ Other: ___________________________

Safe Motherhood Initiative
Obstetric Team Debriefing Form

For identified issues, fill in table below

<table>
<thead>
<tr>
<th>Issue</th>
<th>Actions to be Taken</th>
<th>Person Responsible</th>
</tr>
</thead>
<tbody>
<tr>
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Safe Motherhood Initiative
<table>
<thead>
<tr>
<th>Appendix U</th>
</tr>
</thead>
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<td>Appendix Material for MTF Use and Personalization</td>
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<th>Obstetric Hemorrhage Checklist Final 31 May.pub</th>
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<td>Emergency Release Procedure 31 May 20</td>
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<tr>
<td>MTP 31 May 2016.doc</td>
</tr>
<tr>
<td>Oxytocin Training RN PPT_8 Jul 16.pptx</td>
</tr>
</tbody>
</table>
Oxytocin Protocol
Protocol Overview
Alaris Pump Programming
DELIVERY

OXYTOCIN
Bolus 50 milliliters/min
(3 Units x 3 min)

Adequate uterine tone?

NO

2nd Bolus
Re-set VTBI at 350 mL
(50 mL for rapid bolus plus 300 mL for the 18 Units over first hour)
Deliver "Rapid Bolus:"

YES

OXYTOCIN
Bolus 50 milliliters/min
(3 Units x 3 min)

Pump auto default to this setting:
VTBI 300, Dose @ 300 milliliters/min

Adequate uterine tone?

NO

OXYTOCIN
300 milliliters/min
(18 Units/hr) x 1 hour

Pump auto default to this setting:
VTBI 300, Dose @ 300 milliliters/min

TREAT PPH/Atony

YES

PUMP 60 milliliters/min
(3.6 Units/hr) x 3 hours

Set VTBI at 350 mL
(50 mL for rapid bolus plus 300 mL for the 18 Units over first hour)
Deliver "Rapid Bolus:"

OXYTOCIN
300 milliliters/min
(18 Units/hr) x 1 hour

Pump auto default to this setting:
VTBI 300, Dose @ 300 milliliters/min

OXYTOCIN
60 milliliters/min
(3.6 Units/hr) x 3 hours

Set VTBI at 180 mL
Dose @ 60 milliliters/min
Getting to the Program

- Turn on pump "SYSTEM ON"
- Select "New Patient"
- Select "Adult Medsurg/OB"
Getting to the Program

1. Hit "CONFIRM" for patient ID
2. Hit "CHANNEL SELECT" on the appropriate channel
Getting to the Program

- Hit "GUARDRAIL DRUGS"
- Select "K-O"
Getting to the Program

Select "O"

Select "oxytocin OBGYN"
Getting to the Program

Select "Postpartum"

Confirm correct NEW concentration

30 Units in 500 mL
Confirm new concentration

- Again, confirm by hitting “NEXT”

30 Units x 1,000 milliunits = 500mL 1 Unit

30,000 milliunits = 60 milliunits
500mL 1mL

SO, if you are running 1 ml/hr you are giving 1 milliunit/minute...

This is the 1:1 SAFETY advantage of this concentration:

milliunits/min = mL/hr
Set your first hour infusion

- Suggest "350mL" for VTBI
- Set Dose (and rate) at 300 milliunits/min (300mL/hr)
Give your initial Bolus

- Once your have programmed for the Continuous infusion, hit
  "BOLUS."
- Select "RAPID BOLUS" (or you can put in duration of 3 minutes, it will be the same)
Begin the Bolus

- Hit "**START**" to begin bolus
- Confirm the warning screen "**Yes**"

(I’m trying to get rid of this warning—it may not get fixed until the next Alaris programming)
Bolus over 3 minutes

- Your pump should be running at 999 mL/hr
- The bolus goes over 3 minutes
- (this feels like forever)
Start infusion after bolus

- If you preset your pump, it will default to start your 300 milliunits/min infusion, and it should have 300mL left— one hour!!
If you need a second bolus

- Hit "Channel Select"
- Change VTBI to 350 mL
- (50 mL for 2nd bolus + 300 mL for continuous infusion)
- Hit "Bolus"
- Input "3" Units
Second bolus

- When you select duration, again, select "RAPID BOLUS" (or 3 minutes)
- When the bolus is complete the 300 milliunit/minute continuous infusion will resume
Second Bolus Complete

If your patient is having ongoing hemorrhage or atony:

MOVE TO OTHER AGENTS

PROCEED TO HEMORRHAGE PROTOCOL
Overview

- Administer initial 50 milliunits/min bolus at delivery
- If adequate uterine tone, administer 300 milliunits/min x 1 hour
- Then administer 60 milliunits/min x 3 hours

- If uterine tone is inadequate, deliver 2\textsuperscript{nd} 50 milliunits/min bolus
- Initiate 300 milliunits/min x 1 hour

- If uterine tone is adequate, then administer 60 milliunits/min x 3 hours
- If uterine tone is inadequate initiate treatment for PPH/Atony
Bottom Line

- Oxytocin in 3rd stage of labor is key for prevention of PPH
- There is a peak effect of bolus oxytocin

- Current practice: Variable timing of postpartum oxytocin administration
- Suggested evidence-based protocol

- This protocol will:
  - STANDARDIZE practice
  - Allow providers to MOVE ON to other uterotonics when additional oxytocin will no longer help
  - REDUCE IV FLUID with oxytocin administration
  - IMPROVE OUTCOMES - we will study this!
**OBSTETRIC HEMORRHAGE CHECKLIST**

**Date:**

**Team members:** Nurse(s):
Providers:
Anesthesia:

**Patient Identification:**

<table>
<thead>
<tr>
<th>STAGE THREE:</th>
<th>EBL &gt; 1500 ml with CONTINUOUS BLEEDING + Vitals unstable or suspicion for DIC</th>
</tr>
</thead>
</table>
| Notify:      | □ Second surgeon
□ Chaplain for family support
□ Lab Officer/ Pathologist |
| Obtain:      | □ Active Massive Transfusion Protocol
□ Establish a reporter to document meds / blood products
□ Repeat labs q30-60 minutes
□ Continue vital signs and cumulative measured blood loss Q.5 minutes
□ Continue uterine medication as ordered
□ Administration of blood products
  • 1 unit of PRBC to 1 unit of FFP
  • When platelets arrive: 1 unit of PRBC to 1 unit of FFP
  • With aggressive continuous transfusion consider cryoprecipitate |
| Action:      | □ Transfer to ICU/Higher level of care
□ Calling additional staff (OB/ intensivist/ anesthesia)
□ Possible intubation
□ Selective Embolization (IR) |

<table>
<thead>
<tr>
<th>STAGE TWO:</th>
<th>EBL &gt; 1000 ml with CONTINUOUS BLEEDING</th>
</tr>
</thead>
</table>
| Notify:     | □ Surgical Tech and Circulating RN
□ NOD (nurse of day)
□ Blood Bank |
| Obtain:     | □ Rapid Infuser
□ Rapid Infuser tubing
□ Ultrasound |
| Action:     | □ Bimanual uterine massage
□ Continue uterine medication
□ Move patient to OR and intiate CODE PURPLE
□ Consider obtaining STAT labs (CBC, Chem11, PT/PTT, & fibrinogen) and arterial blood gas
□ Continue vital signs and cumulative blood loss q 5 minutes
□ Keep patient warm with bear hugger
□ Apply SCDS
□ Administer antibiotics as ordered
□ Set up Rapid blood infuser
□ Oxygen to maintain O2 sats > 95%
□ Consider administering 2 units of PRBCs and thaw FFP (TRANSFUSE BASED ON CLINICAL SIGNS. DO NOT WAIT FOR ALL LAB RESULTS)
| Document:   | Unit number, Time administered. |

<table>
<thead>
<tr>
<th>STAGE ONE:</th>
<th>EBL &gt; 500 ml with CONTINUOUS BLEEDING</th>
</tr>
</thead>
</table>
| Notify:     | □ OB Provider & OB on duty
□ Primary & 2ndary RN
□ Primary & 2ndary HM
□ Anesthesia |
| Obtain:     | □ PPH Medication Kit
□ PPH Cart |
| Action:     | □ Fundal massage
□ Vitals Q5 minutes
□ Medications (see below)
□ IV access (2 large bore)
□ Type & Crossmatch patient
□ Consider obtaining STAT labs (CBC, Chem11, PT/PTT, & fibrinogen)
□ Oxygen to maintain O2 sats > 95%
□ Foley catheter
□ Keep patient warm
□ Weigh materials, record cumulative blood loss Q 5 minutes
□ Rule out retained products or laceration |

**Think:**
- Consider possible etiology:
  - Tone—stony
  - Tissue—retained
  - Trauma-cervix / sidewall
  - Thrombin-coagulopathy
  - Uterine inversion
  - Placenta accreta

**Medication:**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pitocin</td>
<td>0.2 mg IM</td>
<td>3 units over 3 minutes and repeat times one, then per protocol</td>
</tr>
<tr>
<td>Methohexine</td>
<td>250 mg IM if not hypertensive; can repeat dose q 2-4 hours</td>
<td></td>
</tr>
<tr>
<td>Hemabate</td>
<td>600 mcg orally or 800 mcg sublingual or 1000 mcg per rectum one time</td>
<td></td>
</tr>
<tr>
<td>Cytotec</td>
<td>60 mcg</td>
<td>q2-4 hours</td>
</tr>
</tbody>
</table>

**Consider:**

- Initiate CODE PURPLE
- Move patient to Operating Room
- Intrauterine balloon

**Think:**
- Vaginal birth
  - Tone (Uterine stony) → Intrauterine balloon
  - Trauma → Visualize and repair
  - Tissue → D&C
- C-section:
  - B-lynch or Hayman compression sutures
  - Intrauterine balloon

**Interventions based on etiology not yet completed**

**Prevent hypothermia, acidemia**

**Conservative or Definitive Surgery:**
- Uterine artery ligation
- Hysterectomy

---

*Not an Official Patient Record Form. Do not put in patient medical record.*
(For Staff Use ONLY)
Emergency Release Procedure

**Limited Response**
* Request for the Emergency Release of up to 4 units RBCs
* Typically for unstable patients without active bleeding and when the need for additional blood products is not anticipated
* When not enough time to wait for cross matched blood
* Can be used for emergency release of other blood products (FFP, etc.)

Blood Bank is called by Facilitator (PHONE #)
* Patient name
* DOB or patient identifier
* Facilitator name
* Location, room number
* Ordering physician
* Facilitator phone number

Obtain Labs:
If possible Type & Crossmatch (one time)
CBC, Coags, Fibrinogen (consider D-dimer)

Lab Officer / Pathologist:
Lab Officer / Pathologist consult with Clinical Team to determine additional requirements and need to escalate to Massive Transfusion Protocol.

**Lab Specimen Tube Guide**
* T&C/T&$ – color
* CBC – color
* Coags, D-dimer, fibrinogen – color
* Chem 11 - color
Massive Transfusion Protocol (MTP) Algorithm

MASSIVE TRANSFUSION PROTOCOL INITIATED
by Attending physician or Anesthesiologist
Activate Command MTP (page overhead)

- OB EBL > 1500 mL, > 2 units PRBC's given, DIC suspected
- Anticipate need of 6 PRBC's within 2 hours
- Persistent hypotension or tachycardia and active bleeding
- Transfusion > 4 PRBCs within 1 hour
- Replacement of 50% blood volume within 3 hours
- DIC

MTP Facilitator designated or assumes role

Blood Bank is called by MTP Facilitator (PHONE#)
- Patient name
- DOB or patient identifier
- Facilitator name
- Location, room number
- Ordering physician
- Facilitator phone number

Obtain Labs:
Type & Crossmatch (one time)
CBC, Coags, Fibrinogen (consider D-dimer)

Blood Bank:
6 units RBCs: Type specific and/or O-negative, in cooler
4 units FFP
1 pack plt (or 4:4:1)

Working Transfusion Goal 1 PRBC : 1 FFP : 1 PLT : 1 CRYO
Blood Bank notifies Facilitator as products become available
- Initiate blood product procurement (if needed, MTF specific)

Obtain Labs:
Every 30 min or as clinically indicated
CBC, Coags, Fibrinogen, consider ABG, Ca+, Mg, D-dimer
- pending MTF capabilities (istat, etc)

Attending physician or Anesthesiologist's decision to CEASE MTP
Immediately notify Blood Bank (PHONE#)

MTP Facilitator Role:
- Lab communication
- Designates Runner and Recorder
- Transfusion documentation
- Tracks and communicates lab and blood product updates

Transfusion Guidelines
- INR > 1.5
CONSIDER 4 units FFP
- Fibrinogen < 80 mg/dL
CONSIDER 2 units CRYO
- Platelet < 50,000
CONSIDER 1 unit apheresis PLTs

Lab Specimen Tube Guide
- T&C/T&S – color
- CBC – color
- Coags, D-dimer, fibrinogen – color
- Chem 11 – color
Council of District Chairs Service Recognition Award
ACOG District XII
Council of Residency Program Directors
Smoking Cessation Initiative
November 2016
November 23, 2016

Linda Kinnane
American College of Obstetricians and Gynecologists
Dept. of District and Section Activities
409 12th Street SW
Washington DC 20024-2188

Dear Ms. Kinnane,

As the Chair of ACOG District XII, I would like to recommend ACOG District XII for the Council of District Chairs (CDC) Service Recognition Award for the Smoking Cessation Initiative implemented by the ACOG District XII Council of Residency Program Directors.

In August of 2014, ACOG District XII formed the Council of Residency Program Directors (CRPD), led by Julie DeCesare, MD. The Council of Residency Program Directors is a forum for developing residents by collaborating with ACOG District XII leadership. The Council has representation from each of the seven (7) residency programs in the state of Florida. The goal of this group is representation from each residency program to promote scholarly activity, resident involvement in ACOG District XII.

In the Fall of 2014, the CRPD began working on the Smoking Cessation project with the intention to create a state-wide quality project, focusing on smoking in pregnancy. It has been long known that tobacco use is associated with deleterious effect on the fetus. As residency clinics tend to serve some of the most under resourced communities in the state of Florida, our intervention was aimed at educating resident physicians and providers of residency clinics on smoking cessation. The expectation was to impact and improve the cessation rates in the pregnant women of Florida.

Thru the support of ACOG District XII and Area Health Education Center (AHEC), trainees at all seven of the residency programs in the state of Florida received online and face to face education on the importance of smoking cessation in pregnancy. Over 100 residents received education to promote awareness regarding the importance of this initiative. Rates of referrals from each program site where tracked, and data is still being collected on the rates of smoking cessation during pregnancy.

In conclusion, this project was successful in demonstrating that residency programs can be useful vehicles to launch quality projects. Included with this letter of recommendation is an overview of the initiative. It is my hope that you will strongly consider the ACOG District XII Council of Residency Program Directors for the ACOG CDC Service Recognition Award.

Please feel free to contact me if you have any questions.

Sincerely,

Karen E. Harris, MD, MPH
Chair
ACOG District XII (Florida)
Research Protocol:

1. Study Title:
Tobacco Cessation in Pregnancy following Standardized Education in Residency Training

2. Study Personnel /Study Sites:
(Each site will obtain own IRB with the PD the PI and any additional faculty members co-pi)

University of Florida at Sacred Heart Hospital
PI: Julie DeCesare, MD jdecesar@shhpens.org
Co PI: Brittney Williams, MD Lindsay McAlpin, MD

University of Florida College of Medicine Gainesville
PI: John Davis, MD davisjd@ufl.edu
Co PI: Kay Roussos -Ross, MD

University of Florida College of Medicine Jacksonville
PI: Kelly Best, MD kelly.best@jax.ufl.edu

Bayfront Residency Program
Marilyn Fudge, MD Marilyn.Fudge@hma.com

Orlando Regional Medical Center
John Busowski, MD johnbusowski@hotmail.com

University of Miami
Carols Medina, MD CMedina@med.miami.edu

University of South Florida College of Medicine
James Palmer, MD jpalmer@health.usf.edu

3. Project Vision:
To create a state wide quality improvement project on tobacco cessation with participation from all residency programs in the state of Florida.

4. Research Question:
Can we improve quit rates in pregnant women whom smoker or use tobacco products thru a focused provided based, multi- site residency program educational initiative.

5. Background:
It has been long known that tobacco use is associated with deleterious effect on the fetus. Maternal smoking is associated with congenital malformations, miscarriage, placental problems (abruption and abnormal placentation), preterm birth, and intrauterine growth restriction (1). Infants born to women who smoke cigarettes during pregnancy are on average 200g smaller in comparison to infants born to mothers who do not smoke cigarettes, as the tobacco reduced blood flow to the placenta (2). Studies have shown that the adverse effects on the fetus can be eliminated if smoking is ceased in early pregnancy (3). Smoking has also been shown to be higher pregnant women with low social economic status as well as a lack of health insurance (4). In addition to the effects on the developing fetus, children of smokers
have higher rates of asthma, obesity and colic (5). Pregnancy affords a unique time to provide smoking cessation education, as evidence has demonstrated that many pregnant women are motivated to quit.

As residency clinics tend to serve some of the most under resourced communities in the state of Florida, our intervention of educating resident physicians and providers of residency clinics on smoking cessation will hopefully impact and improve the quit rates in the pregnant women whom we care for.

6. Study Methodology – Multi-site Observation Prospective Cohort Study

Objective
The aim of this project is to use Area Health Education Center (AHEC) as a resource support to provide physician (house staff and attending) education on smoking cessation. The focus will be on smoking cessation in pregnant women. The intent is to utilize provider education as part of a comprehensive strategy to improve rates of tobacco cessation pregnant women.

Study Population
The study groups with be the pregnant patients whom smoke or use tobacco related products in our existing clinic and referral areas. Baseline zip code data will be utilized for data tracking purposes.

Additional study participants will be the resident and attending physicians, midlevel provides and nurses who participate in the educational modules.

Study Design
In this multi-site observational cohort study, resident physicians and attending physician from the participating residency programs will be trained in methods of tobacco cessation using AHEC resources. Resident providers will be expected to complete 3-hours of online modules, and attend one (1) in person didactic session on tobacco cessation. An additional hour of online may be substituted for the in person didactics if scheduling should allow. Resident attending staff and midlevel providers and nursing staff will also be required to complete 2-hours of tobacco cessation education via a combination of online and in person didactics.

Data on pregnant smokers will be tracked via AHEC provided zip code based data, and will be tracked pre and post intervention. Data will be looked at 3-month intervals for a period of one-year post intervention.

Data on rates of provider and nursing education will also be tracked via the AHEC web site.

Data on number of patients educated will be tracked.

7. Outcomes

Primary Outcome:
A pre-and post intervention analysis of the data bases on number of pregnant smokers and longitudinal quit rates. Population based zip code data from the populations service by the residency programs will be tracked.

Secondary Outcomes:
1. Number of pregnant smokers and quit rates.
2. Number of physicians (attending/ house staff) educated on tobacco cessation.
3. Number of nursing/ancillary personal educated
4. Number of patients educated on smoking cessation.

8. Possible Risks
There are no anticipated physician risks. AHEC population based tobacco data is currently being collected, and use of this data base will not pose any risk to the patients or providers. Providers will be strongly encouraged to complete the educational modules, and compliance will be tracked, however there will not be any repercussions for those choosing to not participating in the educational portion of this project.

9. Bibliography


(5) ACOG Committee opinion Number 471: November 2010. Committee on Health Care for Underserved Women and Committee on Office Practice.