

IN BETWEEN TIME: INTERCONCEPTION HEALTH CARE STARTING WITH THE POSTPARTUM VISIT

PART 1: ROUTINE POSTPARTUM CARE FOR EVERY WOMAN

THE NATIONAL PRECONCEPTION CURRICULUM
& RESOURCE GUIDE FOR CLINICIANS

MODULE 4

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TARGET AUDIENCE

- Clinicians, including physicians, nurse midwives, nurse practitioners and physician assistants, who provide postpartum care

ACCREDITATION AND CREDIT DESIGNATION STATEMENTS

- **Accreditation Statement**—This activity has been planned and implemented in accordance with the requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of **Albert Einstein College of Medicine** and the **University of North Carolina Center for Maternal & Infant Health**. **Albert Einstein College of Medicine** is accredited by the ACCME to provide continuing medical education for physicians.
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LEARNING OBJECTIVES

- Explain how the postpartum visit introduces and advances interconception care
- Discuss the rationale for interconception care and its potential impact on women's health and on future pregnancy outcomes
- Identify a framework for individualizing care to each woman's health profile
- Describe the significance of interpregnancy intervals on future pregnancy outcomes

OUTLINE

- Rationale for interconception care
- Examination of 10 core content areas for postpartum care
- Review evidence about interpregnancy intervals
- Case study applying the postpartum care framework

WHEN IS THE “INTERCONCEPTION” PERIOD?

- It is defined as the period between pregnancies
 - It begins at the end of one pregnancy
 - It ends with the conception of the next pregnancy
- It can only be defined retrospectively which presents a conundrum

THE CONUNDRUM: WHICH OF THESE POSTPARTUM WOMEN WILL
BECOME PREGNANT AGAIN—THAT IS: WHICH ARE IN THE
INTERCONCEPTION PHASE OF CHILDBEARING?





WHETHER THE WOMAN EVER BECOMES PREGNANT AGAIN...

ADDRESSING HER KNOWN RISKS FOR MORBIDITIES AND MORTALITY MUST BE A
PRIORITY IN OUR CARE.





AN UNDER-UTILIZED INTERCONCEPTION/PREVENTION OPPORTUNITY:

THE POSTPARTUM VISIT



AN UNDER-UTILIZED INTERCONCEPTION/PREVENTION OPPORTUNITY

- The postpartum visit is often framed as the end of an episode of care (pregnancy) rather than the beginning of the next stage in a woman's health care needs
- Properly utilized, the postpartum visit offers opportunity to impact:
 - The woman's short and long term health status
 - The woman's and fetus' health in any future pregnancies
 - The health of any future children

UNFORTUNATELY, THE POSTPARTUM EXAM IS FAR FROM UNIVERSAL

- Commercially insured women: 81% have a postpartum visit 3-8 weeks after giving birth
- Medicaid insured women: 64% have a postpartum visit 3-8 weeks after giving birth
- Self pay: Unknown, likely lower than other groups

USDHHS, Women's Health, USA, 2013

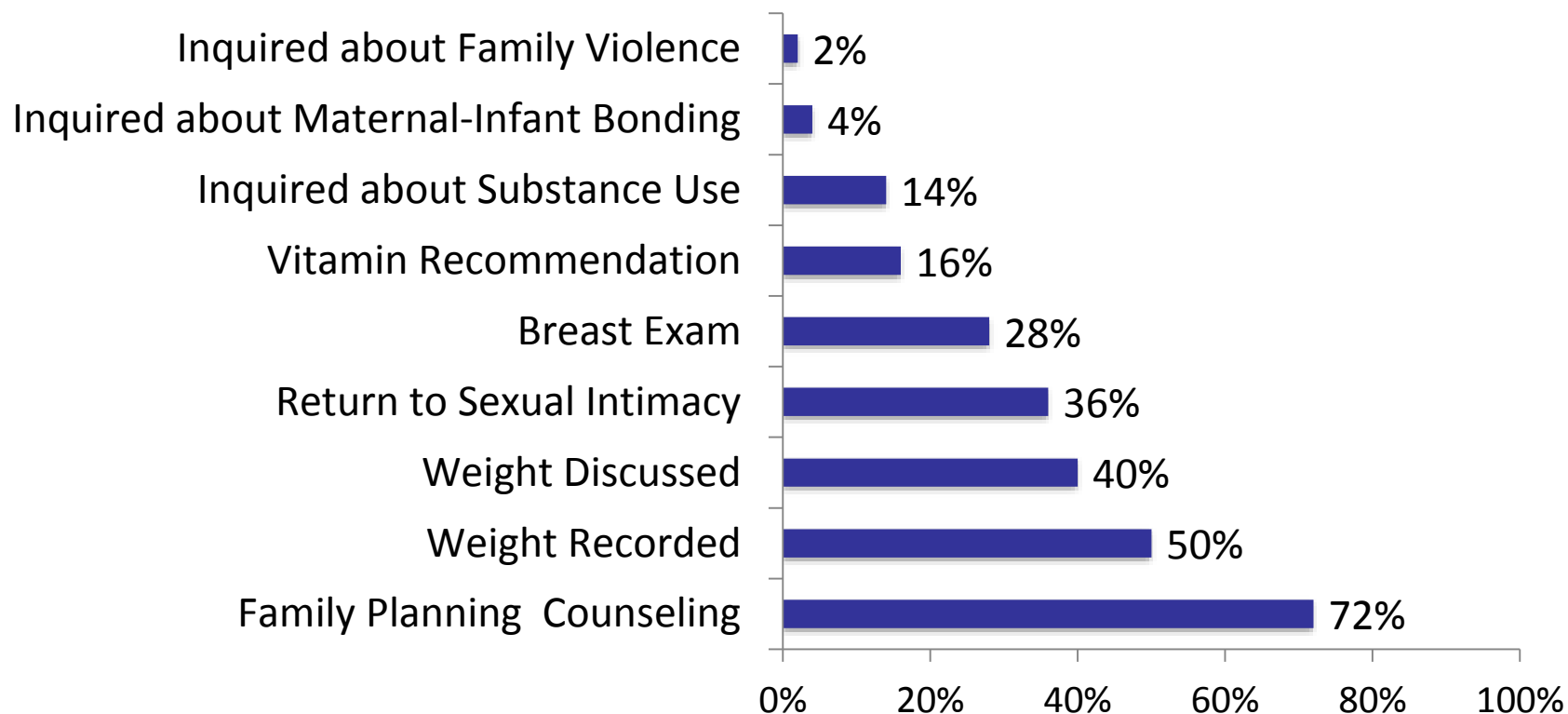
WHY SUCH POOR ATTENDANCE?

- Possible Reasons:
 - Inconvenient for new mother
 - Competing maternal priorities
 - Not sure of purpose
 - Previous poor experience with the visit
 - Unresolved traumas about birth experience
 - Fear of scolding
 - No connection with the provider the woman will be seeing

WHY SUCH POOR ATTENDANCE—CONT.?

- Covered by global fees so no incentive for providers
- Framed as the end of a health care event rather than the beginning of the “rest of a woman’s life”

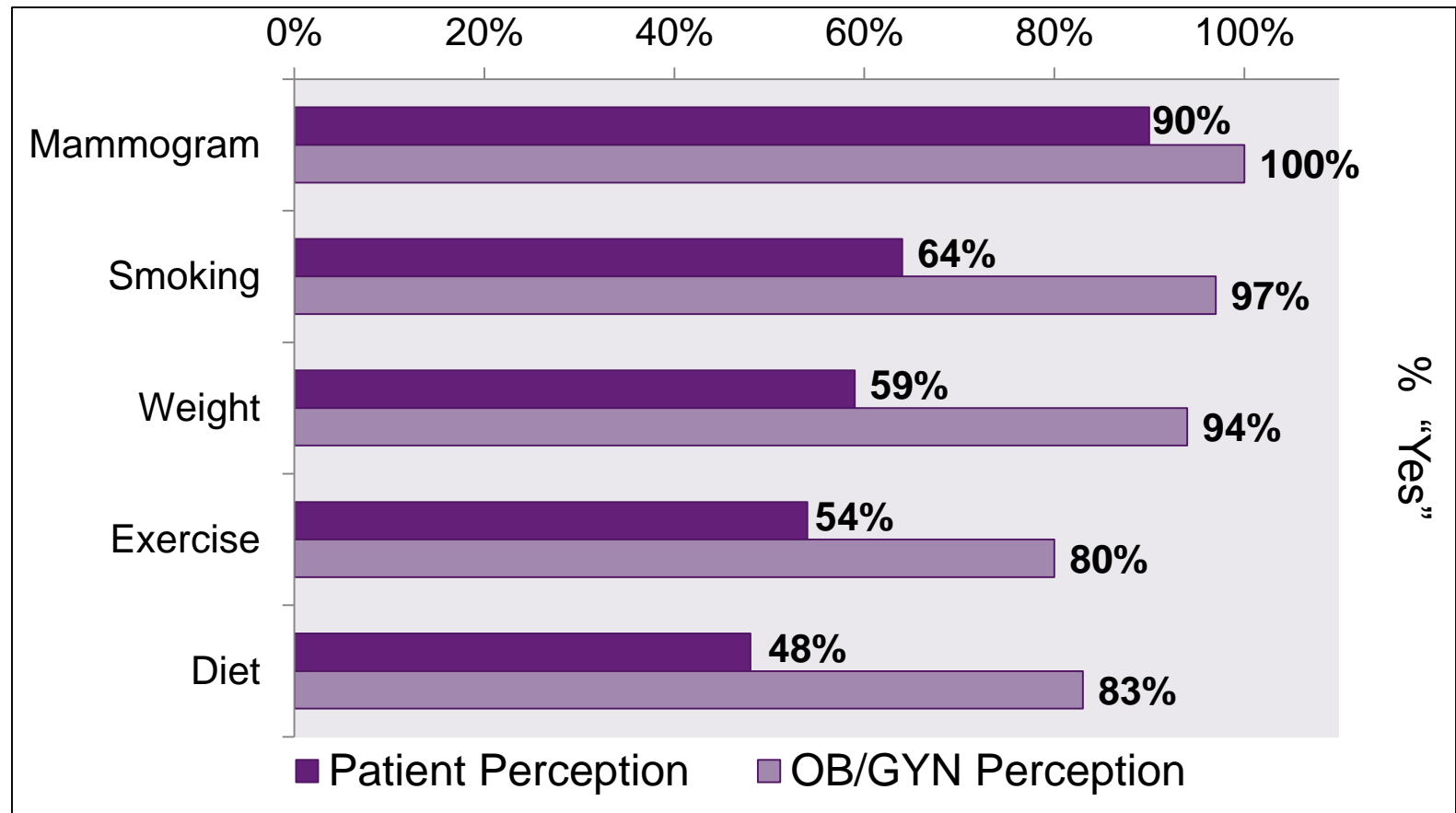
IF THEY COME—WHAT IS OFFERED? CHART REVIEWS OF 400 POSTPARTUM VISITS





**YOU MAY LOOK AT THE LIST AND SAY THAT YOU
COVER THOSE TOPICS...**

...BUT THERE IS A DISCONNECT BETWEEN WHAT WOMEN AND PROVIDERS BELIEVE WAS ADDRESSED DURING THE LAST VISIT



Unpublished data from Rosser, Brusati, 2013

STRATEGIES FOR WORKING SMART

- There are a finite number of minutes for each clinician-client/patient encounter making efficiency essential.
 - Review the woman's prenatal and intrapartum record before the encounter so that special needs can be anticipated.
 - Actively engage women in preparing for their postpartum encounters by asking them to complete previsit assessments that will facilitate addressing key topics. These can be completed:
 - Online from home computer
 - Online in the practice's waiting room
 - Via paper and pencil strategies mailed to the home
 - By a paper and pencil questionnaire in waiting room

STRATEGIES FOR WORKING SMART

- Make the previsit assessment short with a focus on gathering critical information to enhance the provision of patient-centered care.
- Examples include:
 - Identification of woman's top three health concerns
 - Completion of Edinburgh Postnatal Depression Scale (EPDS)
 - Desired weight
 - Wishes about future pregnancies and, if desired, expected interpregnancy interval
 - Preferred contraceptive method

STRATEGIES FOR WORKING SMART

- Have a staff member utilize phone “check-ins” with women in the early postpartum period to assess for breastfeeding problems, assure appointment for the postpartum visit and prepare them for that visit (for instance, if they will need a glucose test, etc.)
- Empower every member of your office team to work to their full capacity with respect to licensing and scope of practice. For instance, identify someone to be the resource for women who:
 - Desire information/referrals for smoking cessation
 - Screen positive for interpersonal violence
 - Desire strategies/referrals for weight loss
 - Need education about the correct use of their chosen contraceptive method

STRATEGIES FOR WORKING SMART

- Referring women to appropriately prepared staff members is likely to decrease the fear that assessing difficult topics will derail the clinic schedule for the rest of the day
- Before delegating to other members of your practice, you need assurance that:
 - **THEY** are appropriately prepared to counsel on evidence-based approaches for dealing with the specific issues assigned to them (through professional education, local CE programs or online resources)
 - **YOU** are knowledgeable of the information and strategies they are promoting

STRATEGIES FOR WORKING SMART

- Refer to these staff members liberally
- Be sure that all staff members are comfortable and diligent in recording their assessments and recommendation/interventions into the medical record to promote seamless communication and continuity of care
- Assure that you and your staff know the resources in your community that can assist women who need help dealing with health risks and challenges
- Engage women in home visiting programs where available to support desired behavior changes (such as tobacco cessation, weight loss, engagement in exercise, etc)
- Organize the actual postpartum exam to cover key content areas



FOCUSING ON “10” CORE CONTENT AREAS: A USEFUL STRATEGY FOR ORGANIZING THE POSTPARTUM VISIT



THE “BIG 10” FOR EVERY POSTPARTUM WOMAN

1. Attending the Postpartum Visit

At the visit, assess and address:

2. **Weight and Nutrient Intake**
3. **Physical Exercise**
4. **Tobacco Avoidance**
5. **Responsible Alcohol Consumption**
6. **Interpersonal Violence**
7. **Depression and Other Perinatal Mood Disorders**
8. **Immunizations**
9. **Desires about Interpregnancy Interval**
10. **Contraception and Sexually Transmitted Infection (STI) Risks**

BEYOND THE “BIG 10”

- Additional considerations in the postpartum care of women with Special Risks are covered in Part 2 of “In Between Time”. Included are examples of care for:
 - Women with chronic diseases
 - Women who experienced maternal complications
- Interconception care following adverse fetal and neonatal outcomes will be addressed in a subsequent unit



EXPLORING EACH OF THE “BIG 10”





#1. ATTENDING THE POSTPARTUM VISIT

REQUIRES ACTIVE MARKETING OF THE VISIT



ATTENDING THE POSTPARTUM VISIT

- **Scope of Need: Know Your Numbers**
 - What percent of the women for whom you provide prenatal care receive a postpartum exam by 6-8 weeks after giving birth?
 - Is the rate the same for the various subpopulations in your practice (primiparous, multiparous, commercially insured, publicly insured, etc.)?
- **Use Your Numbers to Make a Plan**
 - What specific strategies could your practice use to increase utilization of the postpartum visit by all women it serves?

ATTENDING THE POSTPARTUM VISIT

Some suggestions for increasing attendance:

- Market postpartum visit like we market early and continuous prenatal care
 - Make appointment for the postpartum visit before discharge from hospital
 - Have office/clinic staff call each new mother 1-2 weeks after delivery to check on status and to remind of visit
 - Engage public health home visiting and other outreach activities
- Utilize **many** avenues to market the visit:
 - Prenatal care
 - CBE classes
 - Postpartum discharge instructions

ATTENDING THE POSTPARTUM VISIT

More avenues for marketing the visit (continued):

- Home visiting nurses and community health workers
- Neonatal Intensive Care Units (NICU)
- Well child providers
- Women, Infants, and Children Supplemental Nutrition programs (WIC)
- Social marketing strategies (could reach new mothers as well as their support persons such as partners, mothers, etc.)
- Provide outreach to all women who fail to make an appointment or miss it (may involve partnering with home visiting programs, etc.)

#2. WEIGHT AND NUTRIENT INTAKE

EXPLORING THE “BIG 10”

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE

Scope of Need:

- 43% of pregnant women gain weight in excess of the national recommendations
- Epidemiologic studies indicate that substantial weight gain associated with childbearing is an important risk factor for overweight and obesity in midlife which are strong independent predictors of cardiovascular disease, metabolic syndrome, Type 2 Diabetes Mellitus (T2DM), and early mortality
- It is unclear whether becoming overweight after pregnancy is most associated with high gestational gain, altered postpartum lifestyle habits or a combination of these and other influences

Gunderson, Childbearing and Obesity In Women. Obstet Gynecol Clin North Am, 2009, 34(2): 317-332

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE

The majority of postpartum women desire strategies for weight loss* but many providers are afraid to bring the topic up

*Ohlendorf J, et. al Weight-management information needs of postpartum women, MCN 17(1), 2012.

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE

Among the reasons providers put forth for avoiding discussions of weight are:

- “Women don’t want to talk about their weights”
- **“When I bring up the topic my clients shut down or become very defensive”**
- “Overweight and obese women already know they are overweight or obese—so what’s the point?”
- **“There’s nothing I can say that will make a difference so why bother?”**
- “I’ve got my own weight problems—why is my client going to listen to me?”

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE

Is It Possible to Help Women Successfully Lose Weight?

Despite common concerns, there are simple strategies which may have favorable impact

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE

- Introduce the Postpartum Weight Retention Topic by:

- Normalizing the topic
- Employing patient-centered strategies

- Examples of normalizing and engaging statements and questions:

“Many women carry excess weight after giving birth and some of the women I see are pretty discouraged when they think about weight loss. What are you thinking about your current weight?”

“One of the things we talk about with every woman we see is weight--Have you thought about a weight you think would be a good goal for you?”

“Many women I see are unhappy about their weight. Do you have a weight goal you want to reach?”

National Healthy Start Association Interconception Care Toolkit © Moos, 2015

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE

Strategies to Sensitively Address Women's Weight Issues:

- Do NOT counsel around the Body Mass Index (BMI)
 - The BMI is a clinical tool that alerts you of the woman's weight status and whether her status is changing
 - The BMI is just a number (often an overwhelming number) which isn't meaningful to most women
 - The BMI does not reflect body fat (for instance, women engaged in athletic endeavors may have high BMIs but low body fat)
- Use strategies that leave the door open to return to the conversation at a later visit

National Healthy Start Association Interconception Care Toolkit © Moos, 2015

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE

Strategies to Sensitively Address Women's Weight Issues:

- Use language that lacks judgment so reference healthy weight or retained pregnancy weight rather than excess weight, overweight or obese
- Encourage reasonable and achievable goal setting—a good place to start is losing retained gestational weight gain
- Congratulate on achievements such as amount of weight she has already lost
- Provide specific recommendations
 - May mean referral to a nutritionist or member of your staff who has the time and expertise to help with the development of patient specific strategies

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE

Research Highlights Successful Strategies

- A meta analysis of high quality research found postpartum women who took part in a diet or diet plus exercise program lost significantly more weight than women entered in no weight loss program or in exercise alone (Nascimento, et al. Int J Obesity, 2014,38 626-635.)
- A combination of diet and exercise may be preferable because of cardiorespiratory and body fat benefits
- Postpartum interventions that combined exercise with intensive dietary changes and monitoring resulted in greater postpartum weight loss than dietary counseling or exercise alone

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE

Components of Successful Weight Loss Initiatives:

- A realistic goal set by the woman which includes specific plans to achieve her goal including:
 - Strategies for decreased calorie intake and for increased exercise.
 - Strategies for self or group monitoring of progress
 - Options include Weight Watchers, Take Off Pounds Sensibly (TOPS), smart phone apps, other community programs, etc
 - Strategies to deal with non-adherence with plans and disappointments to avoid abandoning the goal, altogether

National Healthy Start Association Interconception Care Toolkit © Moos, 2015

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE

Nutrient adequacy:

A woman's diet should be quickly assessed for adequacy of nutrients

- Women who are vegetarians/vegans should be encouraged to supplement their diet with vitamin B12 (available as a single supplement or as part of an OTC multivitamin)
- Generally, women who are breastfeeding and eating a varied diet do not need extra supplementation
- All women of childbearing age/potential should receive a clear recommendation for daily folic acid supplementation

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE (FOLIC ACID)

- The Centers for Disease Control and Prevention (CDC) recommend that all women of childbearing age, consume 0.4 mg (400 mcg) of synthetic folic acid daily
<http://www.cdc.gov/ncbddd/folicacid/recommendations.html>
- The United States Preventive Services Task Force (USPSTF) recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4-0.8 mg of folic acid daily (Grade A)
<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/folic-acid-to-prevent-neural-tube-defects-preventive-medication>
- The National Academy of Sciences Institute of Medicine recommends that women capable of pregnancy take 400 mcg of synthetic folic acid daily, from fortified foods, or supplements or a combination of the two, in addition to consuming food with folate from a varied diet
<http://books.nap.edu/openbook.php?isbn=0309065542&page=196#pagetop>
- Some women should be counselled about the need for higher doses of folic acid prior to a subsequent pregnancy because of their elevated risk for a pregnancy complicated by a neural tube defect
<http://beforeandbeyond.org/toolkit/desires-pregnancy/nutrition>

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE (FOLIC ACID)

From Recommendation to Practice:

- Ask each woman if she is taking any supplements such as multivitamins
- Advise all women of childbearing potential to begin taking 0.4 mg (400 mcg) of synthetic folic acid daily from supplements and/or fortified food sources (such as highly-fortified breakfast cereals) AND to consume folate-rich foods daily (e.g., green, leafy vegetables) as soon as their prenatal vitamins run out
<http://beforeandbeyond.org/toolkit/desires-pregnancy/nutrition>.
- This amount of folic acid is easily available in OTC multivitamins or in single nutrient supplements

ASSESS AND ADDRESS: WEIGHT AND NUTRIENT INTAKE (FOLIC ACID)

■ From Recommendation to Practice:

- Counsel women at high risk for pregnancies complicated by a Neural Tube Defect (NTD) about:
 - Importance of planning their future pregnancies
 - To visit their health care provider before attempting to become pregnant so that additional folic acid can be prescribed (current recommendation is 4.0 mg beginning 1 month prior to conception and continued through the first trimester)
- For more information about women at high risk for neural tube defects go to <http://beforeandbeyond.org/toolkit/desires-pregnancy/nutrition>

#3. PHYSICAL EXERCISE NEEDS

EXPLORING THE “BIG 10”

ASSESS AND ADDRESS: EXERCISE NEEDS

Scope of Need:

- Routine exercise, irrespective of weight status, has been documented to have major health benefits
- The Federal Physical Activity Guidelines include recommendations for both aerobic physical activity and muscle-strengthening
 - Healthy women should get at least 150 minutes (2 hours and 30 minutes) per week of moderate-intensity aerobic activity, such as brisk walking, during and after pregnancy. It is best to spread this activity throughout the week and it can be broken into ten minute increments
 - In addition, women should participate in muscle-strengthening activities, such as using resistance bands or weights, and engaging in yoga, 2 times per week

<http://www.cdc.gov/physicalactivity/basics/pregnancy/index.htm>

ASSESS AND ADDRESS: EXERCISE NEEDS

Scope of Need (continued):

- Amongst all women in 2013:
 - 50.2% met the aerobic recommendation for 150 minutes of moderate-intensity activity each week
 - 24.5% met the muscle strengthening guidelines of engagement > 2 times a week
 - 17.9% met both guidelines

http://www.cdc.gov/physicalactivity/downloads/HurleyMMWR-PAwebhighlight4_9_2final.pdf

Encouraging **all** women to meet the national exercise guidelines will positively impact their health long into the future

ASSESS AND ADDRESS: EXERCISE NEEDS

- Women's attitudes about physical exercise in the first year postpartum are **strongly influenced** by information they receive at their postpartum visit <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2828187/>
- Women should be advised of the national recommendations and that meeting them can occur in a variety of ways:
 - Brisk walking as an individual or group activity
 - Structured exercise programs such as joining formal or informal groups, exercising to DVDs, etc
 - Pushing a stroller
 - Doing bursts of brisk activity for at least 10 minutes several times a day

#4. TOBACCO AVOIDANCE

EXPLORING THE “BIG 10”

ASSESS AND ADDRESS: TOBACCO AVOIDANCE

Scope of Need:

- Tobacco remains the leading cause of premature death for US women.
- In 2014, approximately 19.2% of adult women of childbearing age reported smoking.
<http://www.marchofdimes.org/Peristats/ViewSubtopic.aspx?reg=99&top=9&stop=146&lev=1&slev=1&obj=1>
- In 2013, approximately 9% of women smoked during their pregnancy.
http://www.childtrends.org/wp-content/uploads/2014/07/11_Mothers_Who_Smoke_While_Pregnant.pdf
- Postpartum smoking relapse, which is defined as occurring at anytime within one year of giving birth, is reported to be as high as 85%
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2693165/>

ASSESS AND ADDRESS: TOBACCO AVOIDANCE


- Tobacco avoidance and guidance needs to be included in the postpartum exam because women attending this visit may:
 - Currently smoke (or use smokeless tobacco products)
 - Be at risk for resuming tobacco use
 - Be exposed to second hand smoke (which has its own set of health hazards and also contributes to former smokers relapsing)
- Preventing relapse may be facilitated by helping women
 - Develop strategies during prenatal care
 - Reinforce strategies prior to hospital discharge and during the postpartum visit
 - Use of telephone follow up, quit lines, and other encouragements

ASSESS AND ADDRESS: TOBACCO AVOIDANCE

- Each woman should be assessed at each visit, including the postpartum exam, with a standardized query such as this:
https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf
- In the past year how often have you used tobacco products? (never, once or twice, monthly, weekly, daily or almost daily)
- Providing encouragement to women who have remained smoke free is likely beneficial
- For those who have resumed tobacco use or who have never stopped, evidence-based interventions have proven successful

ASSESS AND ADDRESS: TOBACCO AVOIDANCE

- The “5-A” model has been shown to markedly increase cessation rates compared to no professional engagement around tobacco use. (ACOG Guidelines for Women’s Health Care, 4th ed., 2014)
 - The “5A”’s are: **A**sk, **A**dvice, **A**ssess, **A**ssist, **A**rrange
 - Use of the 5-A’s can take less than 3 minutes
 - The model can be employed by physicians, nurses, dentists, psychologists, social workers and others
- For more information about the 5A model, go to:
 - <http://beforeandbeyond.org/toolkit/does-not-desire-pregnancy/substance-use/>
 - Tobacco Use and Women’s Health (ACOG Committee Opinion #503) at <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Tobacco-Use-and-Womens-Health>



One of the many nice resources to help women “kick the habit” is at

<http://www.helpguide.org/articles/addiction/how-to-quit-smoking.htm>

#5. RESPONSIBLE ALCOHOL CONSUMPTION

EXPLORING THE “BIG 10”

ASSESS AND ADDRESS: RESPONSIBLE ALCOHOL CONSUMPTION

Scope of Need:

- Alcohol-related mortality represents the third leading cause of preventable death for women in the U.S.
- Based on 2011-2013 data from the Behavioral Risk Factor Surveillance System (BRFSS),
 - 53.6% of non-pregnant women, aged 18-44 years, used alcohol in the past 30 days
 - Among non-pregnant women, the estimated prevalence of binge drinking in the past 30 days was 18.2%
- Women who discontinue alcohol use before or during pregnancy are likely to resume use in the postpartum period

<http://beforeandbeyond.org/toolkit/does-not-desire-pregnancy/substance-use/>
<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6437a3.htm>
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4435549/>

ASSESS AND ADDRESS: RESPONSIBLE ALCOHOL CONSUMPTION

- Obstetricians-gynecologists [and other providers of women's primary care] have important opportunities for at-risk alcohol use interventions in 3 areas:
 - Identifying women who engage in risky drinking behaviors
 - Encouraging healthy behaviors through brief intervention and education
 - Referring women who are alcohol dependent for professional treatment

ACOG Committee Opinion #496 (reaffirmed 2013).
<http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/At-Risk-Drinking-and-Alcohol-Dependence-Obstetric-and-Gynecologic-Implications>

ASSESS AND ADDRESS: RESPONSIBLE ALCOHOL CONSUMPTION

■ Drinking levels for women

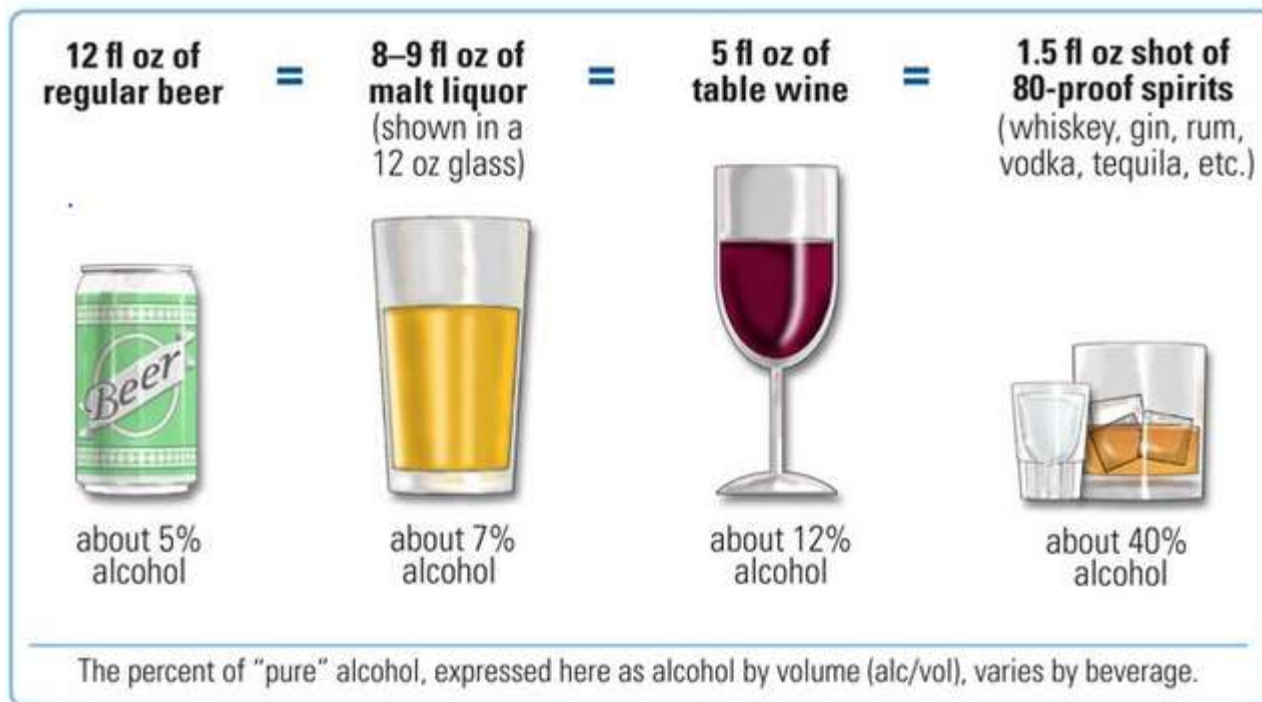
- Moderate drinking is defined as “up to 1 drink per day”
- Binge drinking is defined by a specific blood alcohol concentration which, for women, usually occurs after consuming 4 drinks over approximately 2 hours
- Heavy drinking is defined as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days

<http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking>

ASSESS AND ADDRESS: RESPONSIBLE ALCOHOL CONSUMPTION

■ What is a “standard drink”?

<http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/what-standard-drink>



ASSESS AND ADDRESS: RESPONSIBLE ALCOHOL CONSUMPTION

- The USPSTF recommends that all adult patients in a primary care setting be screened for alcohol misuse and provided counseling for risky or harmful drinking
- ACOG recommends the TACE tool (with two additional queries as shown in the next slide) to identify at-risk drinking behaviors
- ACOG believes this approach has the following advantages:
 - More likely to provide appropriate sensitivity for women and for minorities than other common tools (such as CAGE)
 - Using a validated tool is more likely to avoid false positives and false negative screening results

ACOG Committee Opinion #496 (reaffirmed 2013).

<http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/At-Risk-Drinking-and-Alcohol-Dependence-Obstetric-and-Gynecologic->

ASSESS AND ADDRESS: RESPONSIBLE ALCOHOL CONSUMPTION

TACE Screening Tool as Recommended by ACOG

T – **Tolerance**: How many drinks does it take to make you feel high? (More than 2 drinks = 2 points)

A – **Annoyed**: Have people annoyed you by criticizing your drinking? (Yes = 1 point)

C – **Cut down**: Have you ever felt you ought to cut down on your drinking? (Yes = 1 point)

E – **Eye-opener**: Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (Yes = 1 point)

A total score of 2 points or more indicates a positive screen for at-risk drinking

Additional Queries Recommended by ACOG:

- In a typical week, how many drinks do you have that contain alcohol?
(Positive for at-risk drinking if more than 7 drinks)
- In the past 90 days, how many times have you had more than 3 drinks on any one occasion?
(Positive for at-risk drinking if more than one)

ASSESS AND ADDRESS: RESPONSIBLE ALCOHOL CONSUMPTION

- If at risk drinking behaviors are identified, brief office interventions have been demonstrated to be effective
- Women who, following brief office interventions, continue to drink at risky levels or who exhibit signs of alcohol dependence require referral to a substance abuse specialist
- For more information about brief interventions go to:
 - <http://beforeandbeyond.org/toolkit/does-not-desire-pregnancy/substance-use/>
 - ACOG Committee Opinion #496 (reaffirmed 2013). <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/At-Risk-Drinking-and-Alcohol-Dependence-Obstetric-and-Gynecologic-Implications>

ASSESS AND ADDRESS: RESPONSIBLE ALCOHOL CONSUMPTION

- Apply screening tool to **ALL women equally**
 - Assumptions about who to screen can miss large populations of at-risk women
 - A 2011 study found that the highest prevalence of late pregnancy alcohol use was reported by white women who were non-Hispanic, college-educated and at least 35-years-old Cheng D, Kettinger L, Uduhiri K, Hurt L. Alcohol consumption during pregnancy: prevalence and provider assessment. Obstet Gynecol 2011;117:212–7.
 - It can be assumed that these same women will be using alcohol in the postpartum period

ASSESS AND ADDRESS: RESPONSIBLE ALCOHOL CONSUMPTION

■ Alcohol Use and Breastfeeding

- Breastfeeding women who use alcohol despite education/counseling to stop, should be advised to minimize the infant's exposure to alcohol by waiting 3-4 hours after a single drink before breastfeeding
- Research findings consistently report negative consequences of maternal alcohol consumption on breast feeding infants:
 - Altered growth
 - Affected sleep patterns
 - Changes in psychomotor functioning

ACOG Committee Opinion #496 (reaffirmed 2013).

<http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/At-Risk-Drinking-and-Alcohol-Dependence-Obstetric-and-Gynecologic-Implications>

#6. INTIMATE PARTNER VIOLENCE

EXPLORING THE “BIG 10”

ASSESS AND ADDRESS: INTIMATE PARTNER VIOLENCE

- Intimate partner violence (IPV) is defined by the CDC as “physical, sexual or psychological harm by a current or former partner or spouse”
<http://www.cdc.gov/violenceprevention/intimatepartnerviolence/>
- Beyond actual violence it can take the form of isolation, intimidation and stalking as well as reproductive coercion
- Reproductive coercion involves behaviors that
 - Interfere with contraceptive use
 - Involve intentional exposure to STIs
 - Result in pressures to conceive or terminate

ACOG Committee Opinion No 554: Reproductive and sexual coercion at:
<http://www.ncbi.nlm.nih.gov/pubmed/23344307>

ASSESS AND ADDRESS: INTIMATE PARTNER VIOLENCE

Scope of Need

- IPV is most prevalent in women of reproductive age and occurs in all population subgroups irrespective of socio-economic status, education, race, ethnicity and religion
- Women in the military and veterans are at increased risk for IPV
- More than 33% of women in this country are known to have experienced physical violence, stalking by an intimate partner and/or rape but, due to under-reporting, the true prevalence is unknown; at least 325,000 pregnant women are the victims of intentional injury each year
- Violence may begin or escalate during pregnancy and the postpartum period
- Homicide is a leading cause of traumatic maternal death in this country with the majority of perpetrators either current or former intimate partners

<http://beforeandbeyond.org/toolkit/does-not-desire-pregnancy/interpersonal-violence/>

ASSESS AND ADDRESS: INTIMATE PARTNER VIOLENCE

- Introduce the topic by explaining that you regularly ask all women about their safety. ACOG (2012) suggests an introduction such as:
 - “Because violence is so common in many women’s lives and because there is help available for women being abused, I now ask every patient about domestic violence.”
- Explain that her answers will be held in confidence
 - However, clinicians and offices need to be aware of the laws in their specific state relative to IPV as some states may have mandatory reporting.
 - For more information on reporting laws in your state go to:
 - <http://www.acf.hhs.gov/fvpsa>
 - <http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf>

ASSESS AND ADDRESS: INTIMATE PARTNER VIOLENCE

- **Screening should involve face-to-face interactions with the woman and should use a series of direct questions such as:**
 1. Are you in a relationship with a person who threatens or physically hurts you?
 2. Within the past year have you been hit, slapped, kicked or otherwise physically hurt by someone?
 3. Do you ever feel afraid of your partner?
 4. Has anyone forced you to engage in sexual activities that made you feel uncomfortable?"
 5. Does your partner support your decision about when or if you want to become pregnant?

ASSESS AND ADDRESS:

6. INTIMATE PARTNER VIOLENCE

- If the woman answers **“yes”** to any of the **first 4 screening questions**, acknowledge the trauma and your concern for her welfare, provide referrals to local and national resources and encourage the woman to develop a safety plan
- If the woman answers **“no” to question 5** (suggesting the risk of reproductive coercion) investigate if this is because of lack of communication about the issue or lack of partner support for her desires
 - If the latter, consider offering contraceptive choices that are difficult for the partner to detect (e.g. Long-Acting Reversible Contraceptive methods)

ASSESS AND ADDRESS:

6. INTIMATE PARTNER VIOLENCE

- Consider designating a staff member to assume the role of educating women about safety plans and helping them make contacts with appropriate support services
- Handouts and referrals should be handled in a way that protects women from discovery of disclosure
- For more detail and resources go to:
 - <http://beforeandbeyond.org/toolkit/does-not-desire-pregnancy/interpersonal-violence/> and <http://www.acog.org/-/media/Departments/Violence-Against-Women/Reproguidelines.pdf>

#7. DEPRESSION AND OTHER PERINATAL MOOD DISORDERS

EXPLORING THE “BIG 10”

ASSESS AND ADDRESS: DEPRESSION AND OTHER PERINATAL MOOD DISORDERS

Scope of Need:

- Depression during pregnancy occurs in up to 11% of pregnant women; likely to continue into the postpartum period
- Postpartum depression and other mood disorders that are diagnosed in postpartum period or within one year of giving birth, are common and include:
 - Postpartum depression (occurs in **at least 10%** of postpartum women)
 - Postpartum anxiety disorders (also occurs in **about 10%** of postpartum women)
 - Post traumatic stress disorders (occurs in **up to 6%** of postpartum women)
 - Postpartum psychosis (extremely **rare and extremely dangerous** for the woman and for her children)

ASSESS AND ADDRESS: DEPRESSION AND OTHER PERINATAL MOOD DISORDERS

- Symptoms of postpartum depression include:

- Sleep and/or appetite disturbances
- Lack of interest in baby, family, activities
- Feelings of guilt, shame, hopelessness
- Thoughts of harming baby or self



<http://www.postpartum.net/learn-more/depression-during-pregnancy-postpartum/>

- Symptoms last more than two weeks (which differentiates depression from “baby blues” which are common and self-limiting)
- Usually occur in the first 2-3 months after childbirth but may occur at anytime during the first postpartum year

ASSESS AND ADDRESS: DEPRESSION AND OTHER PERINATAL MOOD DISORDERS

- **Screening all women for depression is considered a standard of care:**
 - ACOG recommends that all women be screened at least once during the perinatal period using a standardized tool--but does not endorse a specific tool
 - The tool most often used is the Edinburgh Postnatal Depression Scale (EPDS) because of its high specificity and predictive value as well as its validation across populations

ASSESS AND ADDRESS: DEPRESSION AND OTHER PERINATAL MOOD DISORDERS

- This link takes you to the **EPDS in English**
 - <http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf>
 - You can copy the EPDS for your patients to self-administer in the waiting room or elsewhere
 - The second page of the attachment provides instructions on scoring which can be done by any staff member
- This link takes you to the **EPDS in Spanish:**
 - <https://www.cdph.ca.gov/programs/mcah/Documents/MO-CHVP-EPDS-Spanish.pdf>

ASSESS AND ADDRESS: DEPRESSION AND OTHER PERINATAL MOOD DISORDERS

- **Symptoms of postpartum anxiety disorders can include:**
 - Fast anxious breathing, dizziness, chest tightness
 - Constant worry
 - Feeling that something bad is going to happen
 - Restless sleep
 - Repeated thoughts or images of frightening things happening to the baby
 - Inability to sit still
 - In an attempt to reduce fear, the need to do certain things over and over again. Such compulsions might include needing to clean constantly, washing hands repeatedly and checking the same thing (such as baby's breathing) continually

ASSESS AND ADDRESS: DEPRESSION AND OTHER PERINATAL MOOD DISORDERS

- ACOG suggest one approach for screening for perinatal anxiety disorders is to inquire about intrusive thoughts and insomnia (ACOG Committee Opinion # 630., Screening for Perinatal Depression, May 2015).
- Potential inquiries include:
 - Are you having scary thoughts about your baby or other aspects of your life?
 - Are you having trouble sleeping, even when your baby is asleep?

ASSESS AND ADDRESS: DEPRESSION AND OTHER PERINATAL MOOD DISORDERS

- Symptoms of postpartum post traumatic stress disorder may occur in a woman who has experienced an event that involved actual or threatened danger to herself and/or her baby such as:
 - reliving sexual or physical traumas
 - an emergency cesarean birth
 - a baby who does not cry at birth or is taken to the NICU
 - a stillbirth or infant death, etc
- Women cope with traumas in different ways so what precipitates PTSD in one woman may not create the disorder in another

ASSESS AND ADDRESS: DEPRESSION AND OTHER PERINATAL MOOD DISORDERS

■ **Symptoms of PTSD include:**

- Replaying the event (or trauma) over and over again
- Flashbacks or nightmares
- Avoidance of situations that remind one of the trauma such as people, places and other details of the trauma
- Irritability, difficulty sleeping
- Anxiety and panic attacks
- Feeling detached from reality

<http://www.postpartum.net/learn-more/postpartum-post-traumatic-stress-disorder/>

ASSESS AND ADDRESS: DEPRESSION AND OTHER PERINATAL MOOD DISORDERS

■ **Symptoms of postpartum psychosis include:**

- Delusions or strange beliefs
- Hallucinations
- Hyperirritability
- Hyperactivity
- Decreased need for or inability to sleep
- Paranoia and suspiciousness
- Rapid mood swings
- Difficulty communicating at times

- The **most significant risk factors** for postpartum psychosis are a personal or family history of bipolar disorder or a previous psychotic episode
- Generally occurs within first 2 weeks of giving birth

<http://www.postpartum.net/learn-more/postpartum-psychosis>

ASSESS AND ADDRESS: DEPRESSION AND OTHER PERINATAL MOOD DISORDERS



- Approximately 5% of the women who develop postpartum psychosis will commit suicide and 4% will kill their baby/children which makes timely identification and care critical
- These women require a direct “hand-off” to psychiatric services and **must not be left alone**

#8. IMMUNIZATION STATUS

EXPLORING THE “BIG 10”

ASSESS AND ADDRESS: IMMUNIZATION STATUS

- **Review immune status and provide indicated immunizations**
- The next page provides CDC guidance relative to childbearing
 - The handy chart can be downloaded from http://www.cdc.gov/vaccines/pubs/downloads/f_preg_chart.pdf
- Remember to address influenza immunization needs if seasonally indicated
- In addition to the immunizations listed on the chart, consider initiating or completing the HPV series if the woman is < 26-years-old and not fully immunized
 - Lactation is **not** a contraindication to the HPV vaccine.

CDC IMMUNIZATION RECOMMENDATIONS AROUND PREGNANCY

Vaccine	Before pregnancy	During pregnancy	After pregnancy	Type of Vaccine
Hepatitis A	Yes, if indicated	Yes, if indicated	Yes, if indicated	Inactivated
Hepatitis B	Yes, if indicated	Yes, if indicated	Yes, if indicated	Inactivated
Human Papillomavirus (HPV)	Yes, if indicated, through 26 years of age	No, under study	Yes, if indicated, through 26 years of age	Inactivated
Influenza IIV	Yes	Yes	Yes	Inactivated
Influenza LAIV	Yes, if less than 50 years of age and healthy; avoid conception for 4 weeks	No	Yes, if less than 50 years of age and healthy; avoid conception for 4 weeks	Live
MMR	Yes, if indicated, avoid conception for 4 weeks	No	Yes, if indicated, give immediately postpartum if susceptible to rubella	Live
Meningococcal: • polysaccharide • conjugate	If indicated	If indicated	If indicated	Inactivated Inactivated
Pneumococcal Polysaccharide	If indicated	If indicated	If indicated	Inactivated
Tdap	Yes, if indicated	Yes, vaccinate during each pregnancy ideally between 27 and 36 weeks of gestation	Yes, immediately postpartum, if not received previously	Toxoid/ inactivated
Tetanus/Diphtheria Td	Yes, if indicated	Yes, if indicated, Tdap preferred	Yes, if indicated	Toxoid
Varicella	Yes, if indicated, avoid conception for 4 weeks	No	Yes, if indicated, give immediately postpartum if susceptible	Live

For information on all vaccines, including travel vaccines, use this table with www.cdc.gov/vaccines

#9. DESIRES ABOUT INTERPREGNANCY INTERVALS (IPI)

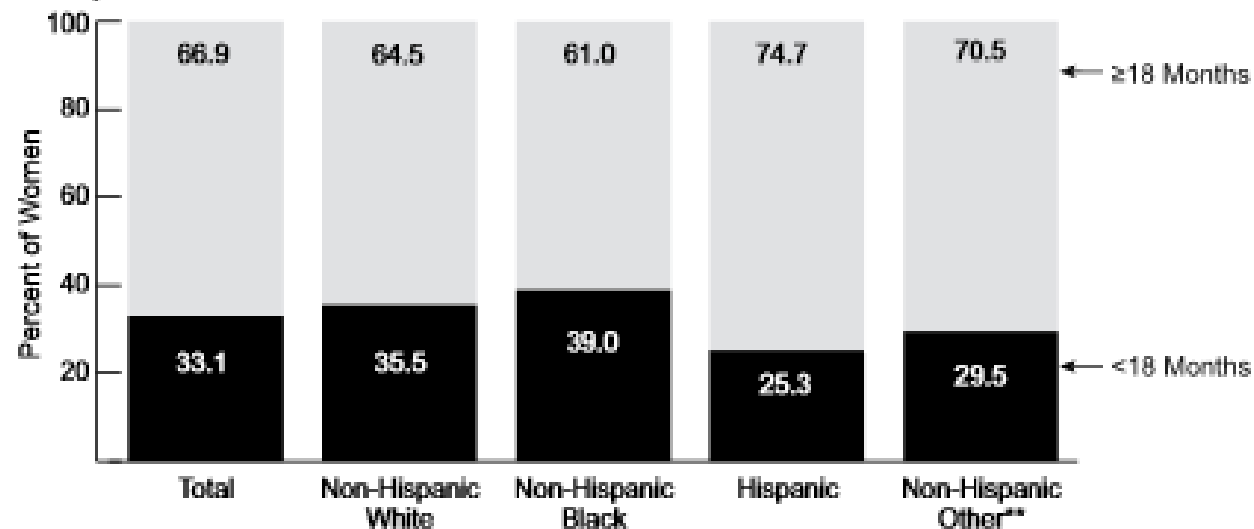
EXPLORING THE “BIG 10”

ASSESS AND ADDRESS: DESIRES ABOUT INTERPREGNANCY INTERVALS

- Women with IPIs of less than 18 months are 14-47 percent **more likely** to have premature infants
- The most recent data suggests that approximately **one-third** of women, ages 15-44, had an IPI of less than 18 months; 12.4% between 6-11 months and 6.7% less than 6 months (Gemmill & Lindberg. Short interpregnancy intervals in the US. Obstet Gynecol 2013; 122(1):64-71.)
- Rates are higher among African-American, Latina and low-income women
- Some reports indicate rates are also higher in older women and those with a prior poor pregnancy outcome
- Short IPIs are more likely to be reported as **intended** among women who are married; non-Hispanic white; college educated; whose last birth was not afforded through Medicaid. (Gemmill & Lindberg. Short interpregnancy intervals in the US. Obstet Gynecol 2013; 122(1):64-71.)

Pregnancy Spacing Among Women Aged 15-44 Years with a Previous Live Birth,* by Race/Ethnicity, 2006-2010

Source (II.4): Centers for Disease Control and Prevention, National Survey of Family Growth



*Limited to births occurring in the 5 years before the interview. Percentages may not add to 100 due to rounding. **Includes individuals of two or more races.

HOW AND WHY INTERPREGNANCY INTERVALS MATTER

- For each month that IPI was shortened below 18 months:
 - PTB: increased 1.9%
 - LBW increased 3.3%
 - SGA increased 1.5%
- For each month that IPI extended beyond 59 months:
 - PTB increased 0.6%
 - LBW increased 0.9%
 - SGA increased 0.8%

Acronyms: Preterm Birth (PTB) , Low Birthweight (LBW), Small for Gestational Age (SGA)

Conde-Agudelo et al., Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. JAMA, 2006; 295 (15):1809-23.

ASSESS AND ADDRESS: DESIRES ABOUT INTERPREGNANCY INTERVALS (IPI)

- An approach to assessing desires about IPI is to ask the woman (either face-to-face or using a previsit questionnaire):
 - Do you hope to have any more children?
 - If yes, how long would you like to wait until you become pregnant again?

ASSESS AND ADDRESS: DESIRES ABOUT INTERPREGNANCY INTERVALS (IPI)

- If the woman indicates that she hopes to become pregnant with an interval of <18 months:
 - Let her know you hear her desires
 - Acknowledge her specific circumstances (advanced maternal age, cultural expectations, previous outcomes, etc)
 - Provide non-directive counseling about the risks of short IPI on prematurity and birthweight including the protective advantages of each additional month between pregnancies up to 18 months

#10. CONTRACEPTION AND STI RISKS

EXPLORING THE “BIG 10”

ASSESS AND ADDRESS CONTRACEPTION AND STIS

- Provide contraceptive counseling that is consistent with the woman's desires about a future pregnancy. For instance, long-acting reversible contraceptives (LARCs) may be ideal for the woman who is clear she does not hope to become pregnant in the near future or ever again
- If woman indicates she would like to become pregnant again at some time in her future, provide information about decreasing fertility with advancing maternal age so she can make an informed decision about how long to postpone future pregnancies
- If she is uncertain how long she wants to wait until she becomes pregnant, educate about the ideal interconception interval (18-59 months)

ASSESS AND ADDRESS CONTRACEPTION AND STIS

- Match the specific contraceptive method to the woman's medical profile; if she has a medical diagnosis refer to US Medical Eligibility Criteria (USMEC, 2012) for guidance. This resource can be accessed at:
 - www.cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm
- A smart phone app also exists for the USMEC which can be downloaded at:
 - <https://itunes.apple.com/WebObjects/MZStore.woa/wa/viewSoftware?id=595752188&mt=8>

ASSESS AND ADDRESS CONTRACEPTION AND STIS

- Provide the woman with Plan B or other emergency contraception (EC) information if she chooses no contraception or a method that is user-dependent
 - For information on EC go to <http://ec.princeton.edu/index.html> .
- Acknowledge that people's plans often change
 - Encourage the woman to return to your office if she decides to become pregnant before her next routine visit to assure that all available steps to promote the healthiest pregnancy and infant possible have been taken

<http://beforeandbeyond.org/toolkit/does-not-desire-pregnancy/family-planning-and-contraception/>

ASSESS AND ADDRESS CONTRACEPTION AND STIS

- No specific national STI guidelines exist for the postpartum visit; since the postpartum visit should be treated as a well-woman visit, standard screening recommendations should be applied
 - The CDC's 2015 STD Screening Recommendations can be accessed at: <http://www.cdc.gov/std/tg2015/screening-recommendations.htm>
 - **Note:** separate recommendations exist for:
 - Sexually active women under age 25
 - Sexually active women ages 25 and over if at increased risk
 - Pregnant women

ASSESS AND ADDRESS CONTRACEPTION AND STIS

- Women considered “high risk” for acquiring an STI include those who have:
 - A new sex partner
 - More than one sex partner
 - A sex partner with concurrent partners
 - A sex partner who has a sexually transmitted infection
 - Been treated for chlamydia or gonorrhea and not retested 3 months later

THE PHYSICAL EXAM

- The postpartum exam should include the components of the well woman physical exam with special attention to:
 - Vital signs (especially blood pressure if woman had gestational hypertension)
 - Thyroid
 - Breast exam for indications of infection, etc.
 - Abdomen (diastasis, hernias, cesarean incision healing)
 - Perineum (wound healing, fistulas, pelvic support) and bimanual exam (involution and tenderness)
 - Extremities

<http://www.uptodate.com/contents/overview-of-postpartum-care>

WHAT COMES NEXT IN THIS MODULE:

- A case study illustrating the integration of the components into the care of a typical woman and resources to help apply those components
- A link to the post test to obtain CME

CASE STUDY: MJ

ROUTINE POSTPARTUM PATIENT



Preconception
Health+Health Care Initiative

A National Public-Private Partnership

MJ'S RECORD INDICATES

- G2P2
- Had spontaneous vaginal birth at 39.4 weeks GA 6 weeks ago without maternal or infant complications
- Has 15 month old son and newborn daughter
- Height: 63", Weight: 153 (pre-pregnancy 139)
- Rubella immune
- Received Tdap vaccine during 28th week of pregnancy
- Received influenza vaccine at initiation of PNC
- Prenatal vitamins have run out and currently on no supplementation

MJ'S HISTORY INDICATES

- Currently exclusively breastfeeding daughter
- Does not drink or use recreational drugs
- Former smoker, quit during pregnancy, currently smoking 2-3 cigarettes per day
- MJ describes partner as caring and supportive
- Desires 3rd child “close in age” to current children
- EPDS Score of 5– [Link to Tool](#)

APPLYING THE “BIG 10” TO MC

1. Marketing of postpartum visit

- PP appointment made before MC left hospital
- Office contacted her 12 days after giving birth to assess for any problems (none reported) and to remind her of her scheduled appointment

2. Assess and address weight and nutrient intake

- As shown on next slide, MJ's current BMI has moved her into the **“overweight”** category
 - Ask MJ if she has a weight goal she would like to meet
 - If she is happy with current weight, point out that she has 14 pounds of retained pregnancy weight; explain that her general health and her risks for chronic diseases will be improved by losing the retained weight. Help her set a reasonable and achievable goal of 5-10 pound increments
 - Refer to resources such as on next slides

Body Mass Index Table

Normal							Overweight					Obese										Extreme Obesity															
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	
Height (inches)	Body Weight (pounds)																																				
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258	
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267	
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276	
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285	
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295	
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304	
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314	
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324	
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334	
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344	
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354	
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365	
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376	
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386	
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397	
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408	
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420	
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431	
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443	

Source: Adapted from Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report

Some resources to help women with weight loss:

- www.ChooseMyPlate.gov
 - This site offers good information on food choices, portion control and strategies for exchanging low density foods for high density foods that will help your client feel full longer

- The Wisconsin Association for Perinatal Care has created several wonderful resources including “Fast Food Cards” which are pocket size tools to help women find the healthy choices at common food chains. They can be accessed at:
 - http://www.perinatalweb.org/assets/cms/uploads/files/Fast%20Food%20Avery%20Cards_v6_%20FINAL%20w_o%20borders.pdf
 - Separate cards exist for:
 - Burger chains
 - Taco/Mexican chains
 - Sub sandwich chains
 - Italian/Pizza chains
 - Chicken chains
 - Gas stations
 - And general guidance for all fast food restaurant.



- The CDC provides an easy to understand and very helpful handout which underscores how easy it is to fall into common portion-size pitfalls
- It highlights portion control when eating in and eating out and recommends planning ahead to avoid the common pitfalls such as coming to the table feeling “starved”
- Download this resource from:
http://www.cdc.gov/nccdphp/dnpa/nutrition/pdf/portion_size_pitfalls.pdf



- This helpful booklet offered by the CDC does an excellent job of answering common client concerns such as :
 - If I cut calories, won't I be hungry?
 - Can a person really lose weight without eating less?
- It also provides visual examples of food substitutions and strategies to remake recipes to decrease calories
- Download this resource from:
http://www.cdc.gov/nccdphp/dn pa/nutrition/pdf/Energy_Density .pdf

2. Assess and address: **weight and nutrient intake.**

- MJ indicates that her diet is varied but that she no longer takes any vitamins
- Specifically recommend that MJ:
 - Continue to ingest a variety of foods, including fruits and vegetables
 - Start an over-the-counter multivitamin for her own health as well as the health of any future children. You might say “It is my recommendation, based on the research and national guidelines, that you include an over-the-counter multivitamin in your daily habits”

3. Assess and address exercise

- MJ indicates that she is too busy with two children under 15 months to have a routine exercise regimen
- Acknowledge the demands of her life and explain that short bursts (10 minutes at a time) of strenuous activity have proven to be beneficial
 - Ask her if there are some short bursts (such as pushing the children in their stroller; vacuuming, etc.) that she can add to her busy days

4. Assess and address tobacco avoidance

- In response to your “ask” (first of the 5As) MJ indicates she has begun to smoke again—and is now smoking 2-3 cigarettes a day

- **Apply the remaining 5As:** (remember: this strategy takes less than 3 minutes; arranging follow-up can be delegated to a member of your team)
 - Clearly **advise** to quit (e.g. "As your health care provider it is my recommendation that you discontinue your tobacco use for your health and the health of your children. And you know you can do it because you successfully stopped using tobacco during your pregnancy")
 - **assess** willingness to quit, (e.g. "What would you like to do about your smoking? Do you think you could quit smoking in the next week or so?")
 - **assist** with quitting strategies (e.g. "Is there a pattern for when you want a cigarette---we call these smoking triggers; what are some substitute activities to get you past the triggers?")
 - **arrange** follow-up (e.g. "Can I have my nurse call you in two weeks to see how you are doing?")



5. Assess and address responsible alcohol consumption

- MJ is not consuming any alcohol at this time



6. Assess and address interpersonal violence

- MJ denies any interpersonal violence or reproductive coercion

7. Assess and address depression and other perinatal mood disorders

- MJ's EPDS score is 5:
 - Suggests low likelihood of current depression
 - Also reassuring:
 - She has no past history of depression or anxiety;
 - Her affect does not suggest depression
 - She reports no intrusive thoughts or insomnia, suggesting that she is not suffering from perinatal anxiety disorder

MJ's Edinburgh Postnatal Depression Scale (EPDS)

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 Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

- | | |
|---|---|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I always could<input checked="" type="checkbox"/> Not quite so much now<input type="checkbox"/> Definitely not so much now<input type="checkbox"/> Not at all <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> As much as I ever did<input type="checkbox"/> Rather less than I used to<input type="checkbox"/> Definitely less than I used to<input type="checkbox"/> Hardly at all <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, some of the time<input type="checkbox"/> Not very often<input checked="" type="checkbox"/> No, never <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> No, not at all<input checked="" type="checkbox"/> Hardly ever<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> Yes, very often <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite a lot<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> No, not much<input checked="" type="checkbox"/> No, not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time I haven't been able to cope at all<input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual<input checked="" type="checkbox"/> No, most of the time I have coped quite well<input type="checkbox"/> No, I have been coping as well as ever <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, sometimes<input checked="" type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input type="checkbox"/> Not very often<input checked="" type="checkbox"/> No, not at all <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input checked="" type="checkbox"/> Only occasionally<input type="checkbox"/> No, never <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite often<input type="checkbox"/> Sometimes<input type="checkbox"/> Hardly ever<input checked="" type="checkbox"/> Never |
|---|---|

Total = 5





8. Assess and address immunization status

- MJ has no immunization needs

9. Assess and address desires about interpregnancy interval

- MJ expresses desires to become pregnant again in the next 10-12 months
 - Tell MJ that you respect her and her partner's desires about pregnancy planning but that you want her to know that there are some risks in having pregnancies closer together than 18 months
 - Ask if she would like to discuss those risks

10. Assess and address contraception needs and STI protection

- MJ and her partner are in a long term monogamous relationship and do not have risk factors for STIs
- MJ tells you she intends to use the Lactational Amenorrhea Method (LAM) for contraception

- You explain to MJ that this method is quite effective provided she:
 - Breastfeeds every 4 hours during the day
 - Breastfeeds every 6 hours at night
 - And recognizes that another method will be necessary once menstruation begins again
 - She indicates she and her partner will use condoms when her periods resume
 - Encourage her to contact your office if she desires further discussion about birth spacing or contraceptive choices

- If she needs/desires additional information, provide her with a handout such as this one from the Association of Reproductive Health Professionals (ARHP):
 - <https://www.arhp.org/Publications-and-Resources/Patient-Resources/Fact-Sheets/Breastfeeding>
- ARHP has easy to understand and short patient education “Fact Sheets” in English and Spanish on all methods of contraception and on many other topics. Pdfs can be downloaded as needed. The full list can be accessed at:
 - <https://www.arhp.org/publications-and-resources/patient-resources/fact-sheets>

SUMMARY: ROUTINE POSTPARTUM CARE AS A GATEWAY TO WELL WOMAN CARE

- The postpartum visit should be structured to provide comprehensive preventive care individualized to a specific woman
- As is true for the majority of well woman visits, most postpartum women will have relatively uncomplicated needs
- However, the postpartum visit should be offered with the appreciation that it is the first preventive visit of “the rest of this woman’s life” not her last prenatal visit
- Using a 10 point framework, the postpartum visit can be structured to be both meaningful and efficient

CONGRATULATIONS!

YOU ARE NOW DONE WITH MODULE 4

- Now that you have finished Module 4 of the CME curriculum you have these options:
 - Return to <http://beforeandbeyond.org/modules/> to take the post test, complete the evaluation and register for the appropriate CMEs
 - Move on to any of the other CME modules: we recommend they be taken in order but this is not essential
 - **Part 2** of “In Between Time: Interconception Health Care” focuses on the postpartum care of women with chronic diseases and maternal complications of pregnancy. It will be released soon as CME Module 5 and may be of particular interest to you
 - Explore the rest of this website for other content, including the clinical toolkit, to help you incorporate evidence-based preconception and interconception care into your practice

CONGRATULATIONS, YOU ARE NOW DONE WITH MODULE 4!

Now that you have finished Module 4 of the curriculum you have these options:

- Take the post test and register for the appropriate [CMEs](#)
- Move on to any of the other modules: we recommend they be taken in order but this is not essential.
- Explore the rest of this website for the other offerings to help you incorporate evidence-based preconception care into your practice.
- Incorporate the recommendations of this module into your clinical practice.
- Check out the National Preconception Care Clinical Toolkit online [here](#)

MODULE 4 POST TEST

IF YOU DESIRE CME CREDIT FOR MODULE 4, [CLICK HERE](#).