Doula Resource Training

TIPQC
Tennessee Initiative for Perinatal Quality Care

Agenda

Greetings & Welcome

State Perinatal Quality Collaborative

Supporting clients with Preeclampsia & Hypertension

POST BIRTH WARNING Signs & Resources

Trauma Informed Care for Clients

Q&A

Closing Remarks

TIPQC
Tennessee Initiative for Perinatal Quality Care

State Perinatal Quality Collaborative

Established in 2008

Advance health and improve outcomes

Over 30 QI projects

Current Projects: Cardiac Conditions of Obstetric Care, Necrotizing Enterocolitis & Best for ALL

Trainings/ educational opportunities, data management & analysis & Community Resource Council

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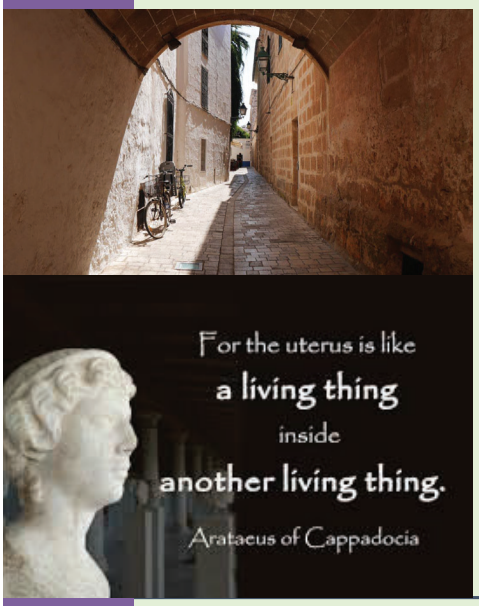
Supporting Clients with Preeclampsia & Hypertension

What you will learn

- Historical perspective
- Basic pathophysiology of pre-eclampsia and spectrum of disease
- Pre-eclampsia screening and diagnosis
- Signs and symptoms
- How to Manage and when to refer for high level of care
- Monitoring
- Doula support role
- Cultural considerations and myth busting

What is Pre-eclampsia Historical Perspective



Preeclampsia: The Disease of Theories

- Historical Perspective
- Disease of convulsions in pregnancy described in ancient text from Africa, China and Europe
- Eclampsia comes from the Greek word meaning "lightening"
- 4th and 5th Century
  - Greeks and Egyptians believed the womb could move around in the body
  - An "unhappy uterus" was the cause of many ailments including preeclampsia
  - Women were either wet or dry and a dried-up uterus was in search of moisture
  - 4 types of convulsions-head, stomach, uterus or chilled extremities

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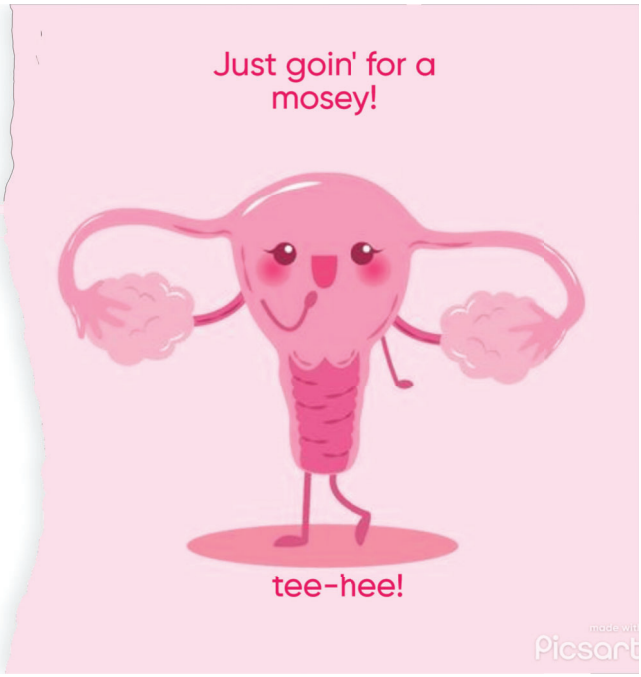
Wandering Uterus



Preeclampsia

Accounts for 1 in 5 maternal deaths

Accounts for 1 in 7 premature births

Incidence of preeclampsia is increasing

Disparities in maternal outcome

Leading cause of maternal death

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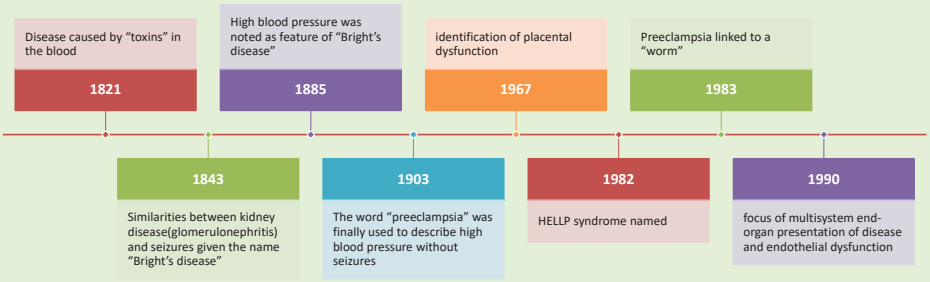
Progression of Thought



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Middle ages

- Charms, faith healing and prayers

17-18th Century

- Blood letting
- Opiates
- Meat restriction
- Development of lying-in hospitals

18-19th Century

- Prevention of Eclampsia
  - Dark Room
  - Large Doses of opiates
  - Delay of Delivery

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Treatment of Pre-eclampsia over time

- 20th Century
  - 1906-Magnesium sulfate introduced
  - Recognition that delivery "cured" the disease
  - Since 1960's-very little change
    - Routine prenatal care
    - Hospitalization
    - Bedrest
    - Evaluation of symptoms
    - Blood pressure management
  - 21st Century
    - Focus on 2 stages of disease
      - Abnormal implantation
      - Maternal response
      - Re-thinking "toxins"-angiogenic factors

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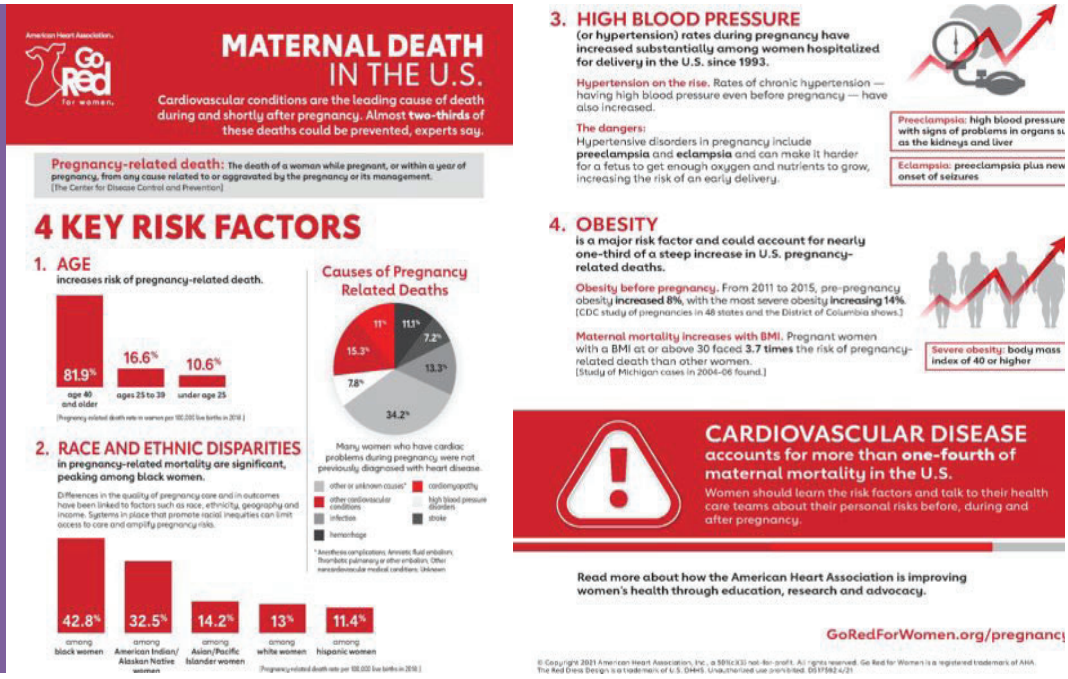

Pathophysiology

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Cardiovascular Physiology

- Increase in blood volume of 30-50%
- Increase in cardiac output of 30-50%
  - Increase begins in the first trimester (7 weeks) peaks at 20-24 weeks gestation
- Heart rate increases by 10-20 bpm
- Systemic vascular resistance is decreased by 30%
- Hypercoagulable state
- Marked fluctuations in volume status during labor and delivery

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Hemodynamic Adaptations

- Blood pressures
  - Decreases as early as 6-8 weeks gestation over preconception values
  - Nadir occurs in the second trimester
    - Diastolic and mean arterial pressure decrease more than systolic blood pressure

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Blood Pressure in Pregnancy

- BPs will fall during 2nd and early 3rd trimester, return to baseline at term
  - Slight increase noted in labor
- Maternal positioning may influence measurement of BP
  - BP less when taken with patient on side
  - BP may improve initially in patients placed on bedrest
- Patients with pre-existing HTN will exhibit greater percentage drop in BP

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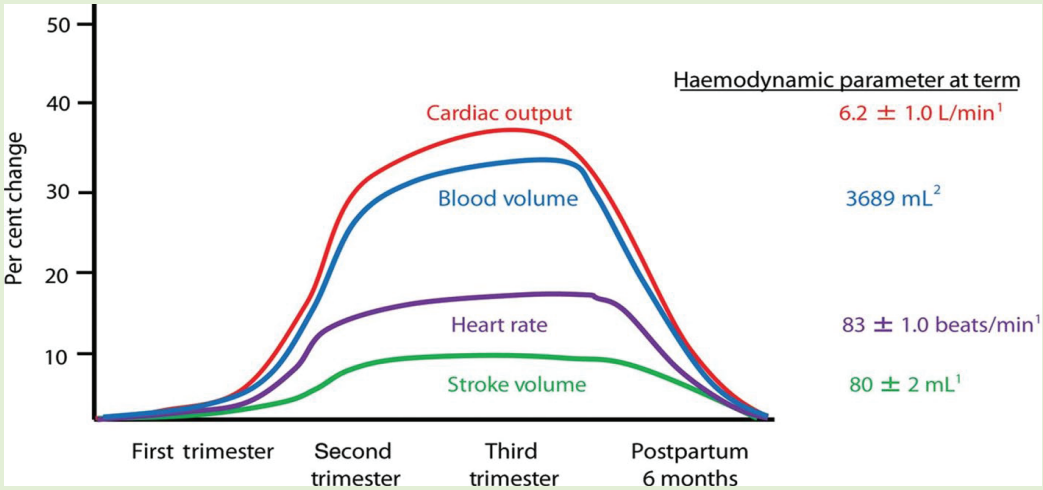

LX Liu, Z Arany. Cardiovasc Res 2014;101:545-553

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Hypertensive disorders in pregnancy[1,2]

Hypertensive disorders of pregnancy

PE	GH	chrHTN with superimposed PE	chrHTN
BP elevation at > 20 weeks gestation in the presence of proteinuria and/or other systemic findings[a]	BP elevation at > 20 weeks gestation in the absence of proteinuria or other systemic findings[a]	Chronic hypertension in association with PE	Hypertension that predates pregnancy

PE without severe features	PE with severe features	Eclampsia	HELLP syndrome
Hypertension with proteinuria or other systemic findings[a]	Often characterised by additional complications and progressive deterioration of maternal and fetal conditions[b]	The presence of new-onset grand mal seizures in a person with PE	Hemolysis, elevated liver enzymes, low platelet count

[a]Thrombocytopenia, impaired liver function, the new development of renal insufficiency, pulmonary edema or new-onset cerebral or visual disturbances; [b]Pulmonary edema, myocardial infarction, stroke, acute respiratory distress syndrome, coagulopathy, severe renal failure, and retinal injury.
chrHTN, chronic hypertension; GH, gestational hypertension; PE, preeclampsia.
1. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2013;122:1122–1131
2. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;135:e237–e260.

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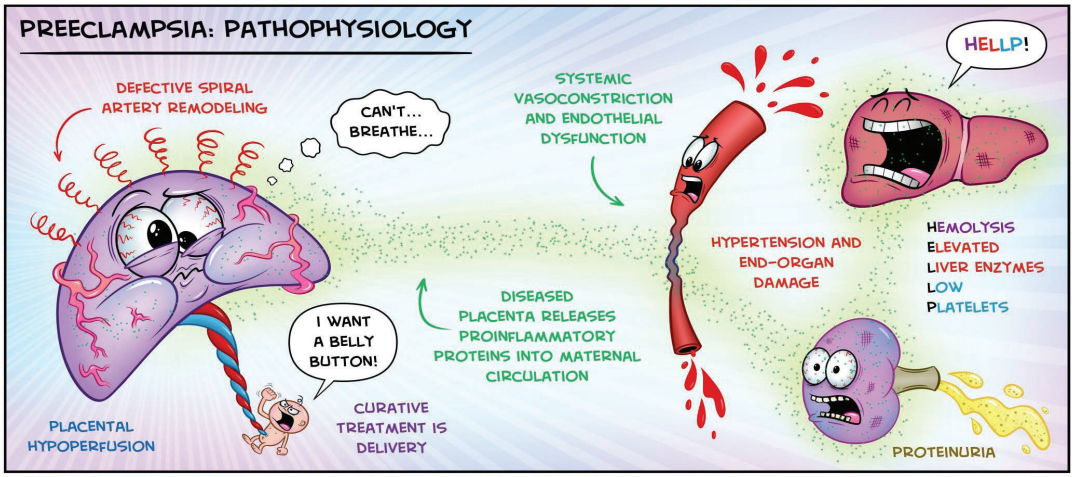
Preeclampsia is a placental disease



Many risk factors have been identified for the development of preeclampsia

Immunological, genetic and environmental risk factors are involved in the development of the disease[1]

Increasing risk

Major risk factors[2]	RR (95% CI)
Prior PE	8.4 (7.1–9.9)
Chronic HTN	5.1 (4.0–6.5)
Pregestational diabetes mellitus	3.7 (3.1–4.3)
Multiple gestation	2.9 (2.6–3.1)
Antiphospholipid syndrome	2.8 (1.8–4.3)
Systematic lupus erythematosus	2.5 (1.0–6.3)
History of stillbirth	2.4 (1.7–3.4)
Pregnancy BMI >25	2.1 (2.0–2.2)
Pre-pregnancy BMI >25	2.1 (1.9–2.4)
Prior placental abruption	2.0 (1.4–2.7)
Assisted reproductive technology	1.8 (1.6–2.1)
Chronic kidney disease	1.8 (1.5–2.1)
Advanced maternal age >35	1.2 (1.1–2.3)

BMI, body mass index; CI, confidence interval; HTN, hypertension; PE, preeclampsia; RR, relative risk.
1. Uzan J, et al. *Vasc Health Risk Manag* 2011;7:467–474; 2. Rana S, et al. *Circ Res* 2019;124:1094–1112.

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Preeclampsia affects many organs of the body

PE can affect the mother's brain, vasculature, lungs, liver and kidney, as well as causing placental dysfunction[1]

The placenta is central to the development of PE[2]

Delivery of the placenta can remove most signs and symptoms of PE; however, in some cases, PE can persist after delivery[3,4]

Brain
- Eclampsia
- Hemorrhagic stroke
- Cerebral edema
- Visual disturbance
- Cortical blindness

Vasculature
- Reduced blood flow (e.g. heart, kidney)
- Systemic endothelial dysfunction
- Coagulopathy
- Thrombocytopenia

Lung
- Pulmonary enema

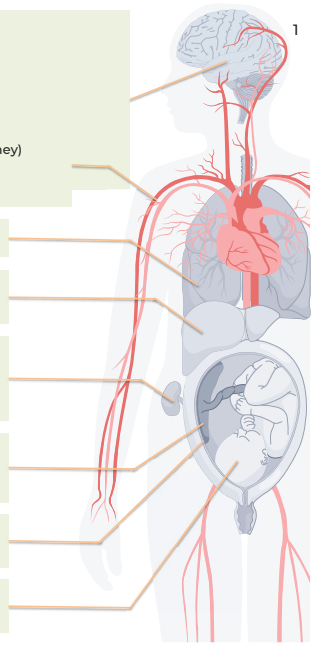
Liver
- Elevated liver enzymes (HELLP)
- Dysfunction and/or rupture

Kidney
- Endothelial injury
- Glomerular endotheliosis
- Proteinuria
- Renal failure

Placenta
- Placental syncytial stress
- Angiogenic imbalance
- Placental abruption

Decidua
- Inadequate spiral artery remodelling

Fetus
- Fetal distress
- Growth restriction



PE, preeclampsia.
1. Dimitriadis E, et al. Nat Rev Dis Primers 2023;9:8; 2. Rana S, et al. *Circ Res* 2019;124:1094–1112; 2. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2013;122:1122–1131; 3. Goel A, et al. *Circulation* 2015;132:1726–1733.

Preeclampsia: Pathophysiology

Less trophoblast invasion and defective uterine spiral arteries

↓

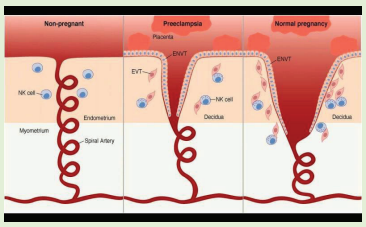
Reduced placental perfusion induces inflammatory changes

↓

Imbalance of angiogenic factors - vascular endothelial growth factor (VEGF), placental growth factor (PIGF), sFlt-1

↓

Maternal vascular endothelial dysfunction



https://coreem.net/core/preeclampsia-and- eclampsia/

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Preeclampsia: Pathophysiology

Vasospasm

Endothelial damage and capillary leakage

Decreased oncotic pressure

Decreased intravascular fluid

Hemoconcentration

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Preeclampsia: Pathophysiology

Phenotype	HR	SV	CO	TPR
High Output Hypertension	↑	↑	↑	↓
High Resistance Hypertension	↓	↓	↓	↑

High Cardiac Output Hypertension:
- Late onset preeclampsia
- Normal fetal growth
- More favorable outcomes

High Resistance Hypertension:
- Early onset Preeclampsia
- Fetal Growth Restriction
- Worse perinatal outcomes

BMI, body mass index; CI, confidence interval; HTN, hypertension; PE, preeclampsia; RR, relative risk.
1. Uzan J, et al. *Vasc Health Risk Manag* 2011;7:467–474; 2. Rana S, et al. *Circ Res* 2019;124:1094–1112.

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Screening and Diagnosis

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Chronic Hypertension

- **Preexisting diagnosis**

1) normal (systolic blood pressure less than 120 mm Hg and diastolic blood pressure less than 80 mm Hg)

2) elevated (systolic blood pressure of 120–129 mm Hg and diastolic blood pressure less than 80 mm Hg)

3) stage 1 hypertension (systolic blood pressure of 130–139 mm Hg or diastolic blood pressure of 80–89 mm Hg)-AHA

4) stage 2 hypertension (systolic blood pressure of 140 mm Hg or more or diastolic blood pressure of 90 mm Hg or more) ACOG

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Gestational Hypertension

New onset hypertension prior to 20 weeks gestation

Blood pressure of ≥ 140/90

- 4 hours apart on 2 separate occasions

No proteinuria

NOTE: More than 50% will develop signs or symptoms of preeclampsia

- More likely if diagnosis prior to 32 weeks gestation

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Preeclampsia - Eclampsia

- **New onset hypertension after 20 weeks gestation**
  - **BP-140/90 on 2 separate occasions 4 hrs. apart**
  - **300 mg protein in 24 hr. specimen**
  - **Edema or weight gain OR in the absence of proteinuria**
    - **Oliguria**
    - **Headache; visual disturbances**
    - **Epigastric pain, nausea**
    - **Pulmonary edema**
    - **HELLP**

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Preeclampsia - Eclampsia

- **Severe features**
  - **BP greater than or equal to 160/110 at least 6hr apart, pt at bed rest**
  - **Oliguria**
  - **Headache; visual disturbances**
  - **Epigastric pain, nausea**
  - **Pulmonary edema**
  - **HELLP**

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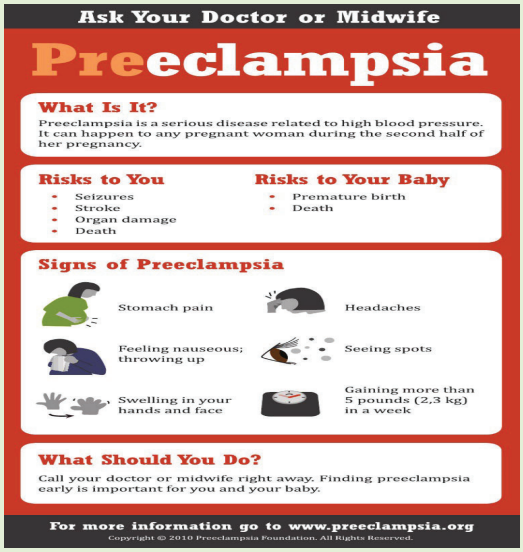
Patient Education



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BP Standard Assessment

- Seated position w/ legs flat, bare upper arm after brief period of rest (preferably 5-10 minutes)
- Manual sphygmomanometer w/ appropriate cuff
  - Use 1st and last audible (Korotkoff 1 and V) sound recorded to nearest 2mmHg
  - Perform 2 additional readings at least 1 minute apart
    - Record HIGHEST reading
- If BP ≥ 140/90 mmHg or higher, repeat within 30 minutes- if still elevated, evaluate patient for preeclampsia
  - Do not reposition patient to either side

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Hypertensive Emergency In Pregnancy

- Systolic BP of 160 mm Hg or greater—2 readings 15 minutes apart

OR

- Diastolic BP of 110 mm Hg or greater –- 2 readings 15 minutes apart

- **Prompt recognition and treatment improves outcomes**

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Treatment of Acute Severe Hypertension In Pregnancy

Goal is to treat within 30-60 minutes of diagnosis

2 blood pressures meeting criteria

ACOG Evidenced based protocols

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Management of Hypertensive Emergencies

- Goals
  - Prevent end-organ damage
  - Avoid eclamptic seizure
  - Immediate and prompt treatment
    - 30 to 60 minutes after diagnosis
- Note:
  - Returning BP to normal should not be a goal

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Management of Hypertensive Emergencies

Standardized Order sets

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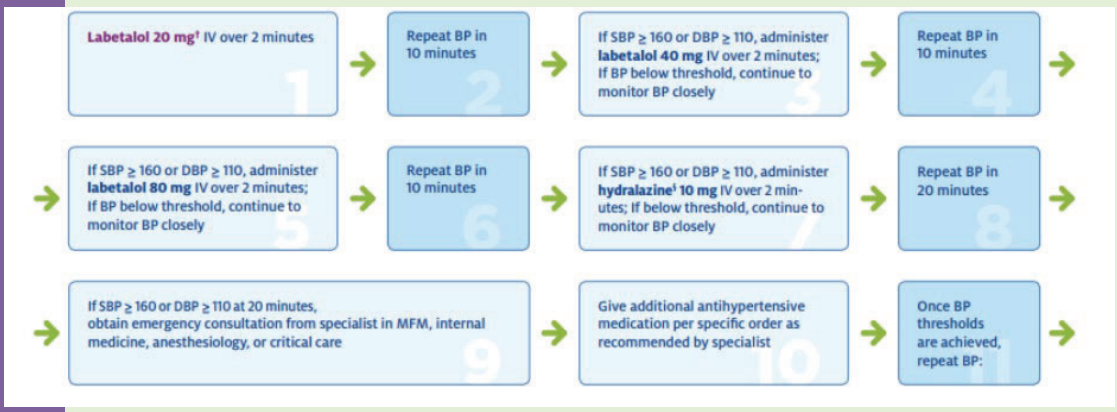
Labetalol



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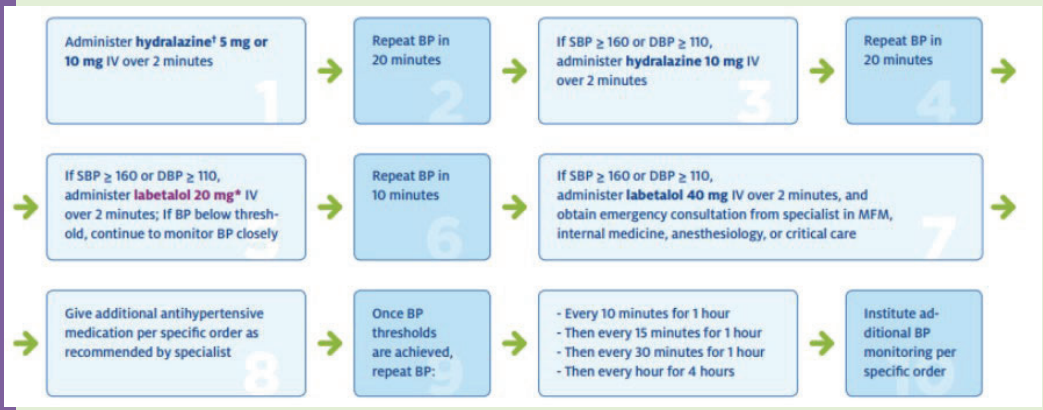
Hydralazine



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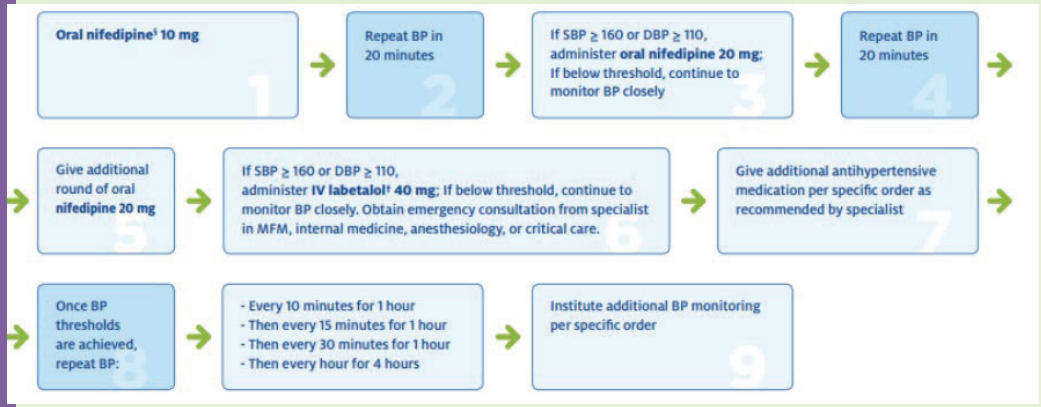
Nifedipine



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Management of Hypertensive Emergencies

Labetalol
- Onset of action 1-2 minutes

Hydralazine
- Onset of action 10-20 minutes

Nifedipine
- Onset of action 5-10 minutes

Nicardipine
- Onset of action-immediately

Management

- **Neuroprophylaxis**
  - **Magnesium sulfate is the drug of choice**
    - **Dose: 4-6gm bolus, followed by 2 gms /hr**
    - **Care should be taken in patients with decreased renal function**

Delivery Recommendations

Gestational Hypertension
- 37 weeks gestation

Chronic Hypertension
- 37-39 weeks

Preeclampsia
- Without severe features-37 weeks
- With severe features-34 weeks or for accelerating disease

Myths and Misconceptions

Myths

- Bedrest is a treatment
- Only unhealthy people get pre-eclampsia
- Pre-eclampsia is rare
- Pre-eclampsia only happens in first pregnancies
- Delivery is the cure for preeclampsia
- Preeclampsia does not affect the baby

Role of the Doula

Preconception

- Discuss risk of pre-eclampsia with patients at risk for hypertension in pregnancy
- Identify risk factors
- Discuss preconception counseling in patients with a history of pre-eclampsia in a previous pregnancy

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Antepartum

- Educate all women about pre-eclampsia and warning signs
- Discuss low dose aspirin in patients at risk for pre-eclampsia
- Encourage home BP monitoring
- Advise patients to seek medical attention for elevated readings

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Postpartum

- Continue to encourage home BP monitoring especially the first 2 weeks postpartum
- Recognize the signs and symptoms of postpartum preeclampsia
  - Shortness of breath
  - Headache
  - Fatigue
- Encourage patients to keep postpartum followup
  - 3 days for patients with severe HTN
  - 7 days for all others
- Counsel patients regarding long term risk of cardiovascular disease and arrange follow up

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Key Points

- Preeclampsia is a common complication of pregnancy
- Preeclampsia is NOT about blood pressure but is a multi system disease
- Prompt recognition and treatment of hypertension can reduce maternal and fetal complications
- There are disparities in incidence and outcome in patients with preeclampsia
- Dispelling myths about the disease is essential to improve outcomes
- Doulas can plan an important role is recognition and management of Preeclampisa

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A client at 28 weeks with blood pressure of 141/90, repeat blood pressure 1 day later is 152/90. Urine protein/creatinine ratio: 0.45

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A client at 32 weeks with blood pressure of 142/89, repeat blood pressure 1 hour later is 151/72.

Urine protein/creatinine ratio: 0.45

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A client at 33 weeks with blood pressure of 162/115, repeat blood pressure 2 hours later is 150/95. She also complains of a headache that is not relieved by Tylenol and Compazine.

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A client at 33 weeks with blood pressure of 162/115, repeat blood pressure 20 minutes later is 150/95. She reports severe pain under her right breast.

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A client at 32 weeks with blood pressure of 139/89, repeat blood pressure 6 hours later is 138/87. She also complains of a headache that is not relieved by Tylenol and Compazine.

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A client at 35 weeks with blood pressure of 135/92, repeat blood pressure 6 hours later is 150/101.

24-hour urine protein level: 230.

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A client at 34 weeks with blood pressure of 135/92, repeat blood pressure 4 hours later is 142/90. Urine protein/creatinine ratio is 0.25. She mentions needing to make an eye doctor appointment as recently it's been harder to see clearly with with and without her contacts.

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A client at 33 weeks calls with concern about blood pressures taken at home. Initial blood pressure was 145/95, repeat blood pressure 4 hours later is 152/90. She reports blood pressure was taken with her mother's wrist cuff.

A client at 35 weeks with initial blood pressure of 145/90, repeat blood pressure 4 hours later is 152/90. She reports being told she had high blood pressure 2 years ago. She was started on an unknown blood pressure medication at that time but stopped after 6 months because blood pressure improved.

A client at 21 weeks calls reporting she was sent to the hospital by her doctor because of new onset shortness of breath. She states her initial blood pressure was 145/91, repeat blood pressure 4 hours later is 148/90. A chest X-ray was done, and she was told there is fluid in her lungs.

Prevention of Preeclampsia

Prevention

Low dose Aspirin 81 mg daily starting at 12 weeks through delivery to prevent preeclampsia and adverse perinatal outcomes.

Prevention: Candidates

Risk Level	Risk Factors	Recommendation
High[†]	• History of preeclampsia, especially when accompanied by an adverse outcome • Multifetal gestation • Chronic hypertension • Type 1 or 2 diabetes • Renal disease • Autoimmune disease (systemic lupus erythematosus, antiphospholipid syndrome)	Recommend low-dose aspirin if the patient has one or more of these high-risk factors
Moderate[‡]	• Nulliparity • Obesity (body mass index greater than 30) • Family history of preeclampsia (mother or sister) • Sociodemographic characteristics (African American race, low socioeconomic status) • Age 35 years or older • Personal history factors (eg, low birthweight or small for gestational age, previous adverse pregnancy outcome, more than 10-year pregnancy interval)	Consider low-dose aspirin if the patient has more than one of these moderate-risk factors[§]
Low	• Previous uncomplicated full-term delivery	Do not recommend low-dose aspirin

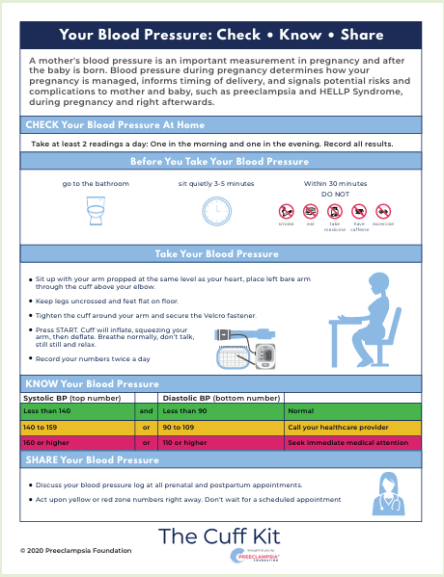
Prevention

- **Calcium may help in calcium deprived population (not in the US)**
- **Vitamin E and C not recommended**
- **No need for salt restriction in pregnancy**
- **Bed rest or restriction of other physical activity not be used for primary prevention.**

May 2025

TennCare announced that pregnant and postpartum members now qualify for home monitoring blood pressure cuff kits at no cost.

BlueCare Tennessee	United Healthcare	Wellpoint
•Home Care Delivered (HCD) 866-332-4193 •Byram Healthcare 877-902-9726 •Aeroflow 844-867-9890	•Adapt Health 844-727-6667 •Byram Healthcare 877-902-9726 •Edge Park Medical Supply 800-321-0591	•Pomelo 901-698-4232



Your Blood Pressure: Check • Know • Share

A mother's blood pressure is an important measurement in pregnancy and after the baby is born. Blood pressure during pregnancy determines how your pregnancy is managed, informs timing of delivery, and signals potential risks and complications to mother and baby, such as preeclampsia and HELLP Syndrome, during pregnancy and right afterwards.

CHECK Your Blood Pressure At Home

Take at least 2 readings a day: One in the morning and one in the evening. Record all results.

Before You Take Your Blood Pressure

go to the bathroom | sit quietly 3-5 minutes | Within 30 minutes DO NOT: exercise, eat, take medicine, have caffeine, smoke/use nicotine

Take Your Blood Pressure

- Sit up with your arm propped at the same level as your heart, place left bare arm through the cuff above your elbow.
- Keep legs uncrossed and feet flat on floor.
- Tighten the cuff around your arm and secure the Velcro fastener.
- Press START. Cuff will inflate, squeezing your arm, then deflate. Breathe normally, don't talk, still still and relax.
- Record your numbers twice a day

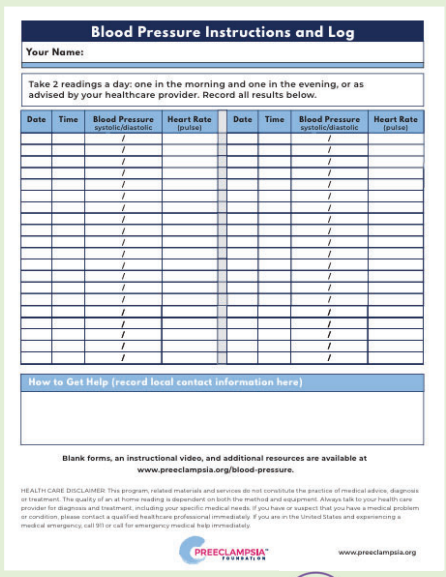
KNOW Your Blood Pressure

Systolic BP (top number)		Diastolic BP (bottom number)	
Less than 140	and	Less than 90	Normal
140 to 159	or	90 to 109	Call your healthcare provider
160 or higher	or	110 or higher	Seek immediate medical attention

SHARE Your Blood Pressure

- Discuss your blood pressure log at all prenatal and postpartum appointments.
- Act upon yellow or red zone numbers right away. Don't wait for a scheduled appointment

The Cuff Kit



Blood Pressure Instructions and Log

Your Name:

Take 2 readings a day: one in the morning and one in the evening, or as advised by your healthcare provider. Record all results below.

Date	Time	Blood Pressure systolic/diastolic	Heart Rate (pulse)	Date	Time	Blood Pressure systolic/diastolic	Heart Rate (pulse)
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How to Get Help (record local contact information here)

Blank forms, an instructional video, and additional resources are available at www.preeclampsia.org/blood-pressure.

PREECLAMPSIA FOUNDATION www.preeclampsia.org

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POSTBIRTH Warning Signs & Resources

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EMERGENCY SIGNS…Call 911

- **Pain in The Chest** ➡ **May Signal Heart or Lung Emergency**
- **Obstructed Breathing** ➡ **Shortness of Breath is Serious**
- **Seizures** ➡ **May be Postpartum Preeclampsia**
- **Thoughts of Harming Self or Others** ➡ **Mental Health Crisis**

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URGENT SIGNS…Call the Provider

- **Heavy Bleeding** → Soaking 1 Pad per Hour or Passing Clots greater than the size of an egg
- **Incision not Healing, Red, or has a Foul Smell** → May Be Infection or Breakdown
- **Red, Painful, Swollen Leg** → Could be a Blood Clot
- **Temperature ≥ 100.4ºF** → May indicated Infection
- **Headache with Vision Changes** → Possible Preeclampsia

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Effective July 1st, 2025

All Tennessee Hospitals and Birth Centers must provide postpartum mothers with information related to POSTBIRTH Warning Signs

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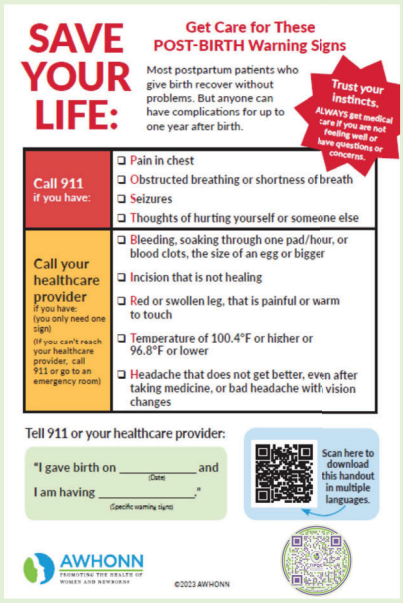

Podcast:
Episode 162

TIPQC Tennessee Initiative for Perinatal Quality Care

Trauma Informed Care for Clients

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The CDC statistics on abuse and violence

- 1 in 4 children experiences some sort of maltreatment (physical, sexual, or emotional abuse).
- 1 in 4 women has experienced domestic violence.
- 1 in 5 women and 1 in 71 men have experienced rape
  - 12% of these women and 30% of these men were younger than 10 years old when they were raped.

THE PREVALENCE OF TRAUMA

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Acute Trauma

Results from exposure to a single overwhelming event.

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Chronic Trauma

Results from extended exposure to traumatizing situations.

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Complex Trauma

Results from a single traumatic event that is **devastating** enough to have long-lasting effects.

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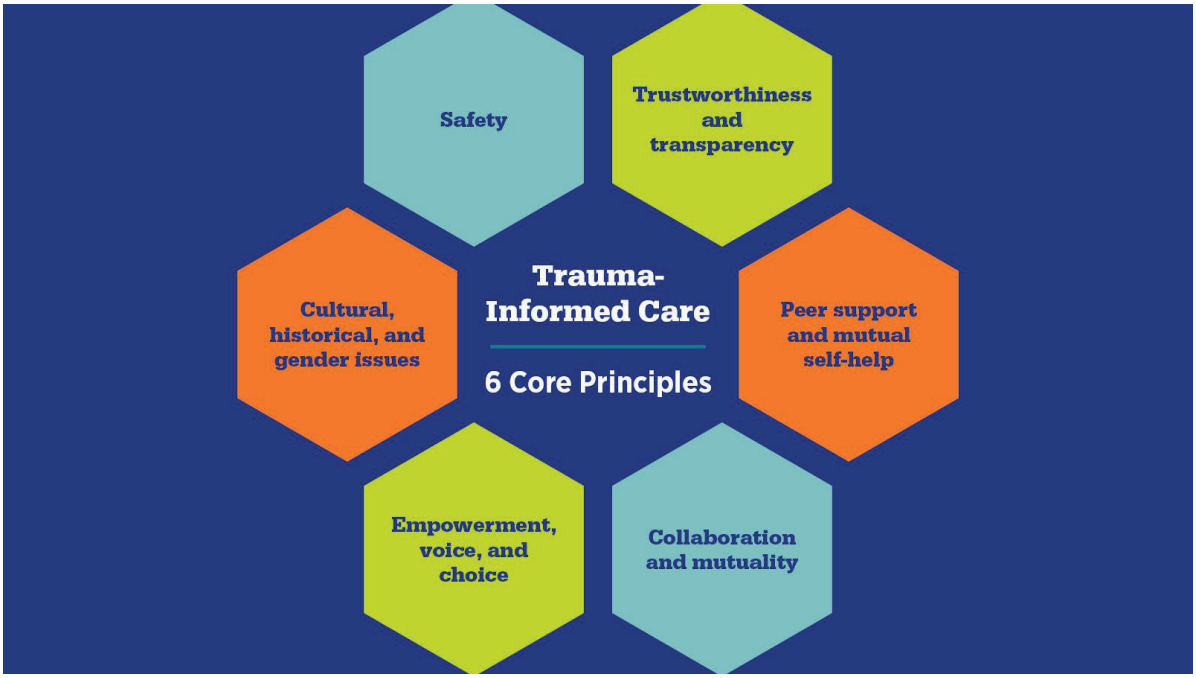
A trauma-informed program, organization, or system:

Realizes	• *Realizes* widespread impact of trauma and understands potential paths for recovery
Recognizes	• *Recognizes* signs and symptoms of trauma in clients, families, staff, and others involved with the system
Responds	• *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices
Resists	• Seeks to actively *Resist* re-traumatization.



Risk Factors for Compassion Fatigue:

1. Being new to the field.
2. History of personal trauma or burnout.
3. Working long hours and/or having large caseloads.
4. Having inadequate support systems.

Vicarious/Secondary Trauma & Compassion Fatigue

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SECONDARY TRAUMA STRESS

Signs of Secondary Traumatic Stress

Emotional
Feeling numb or detached; feeling overwhelmed or maybe even hopeless.

Physical
Having low energy or feeling fatigued.

Behavioral
Changing your routine or engaging in self-destructive coping mechanisms.

Professional
Experiencing low performance of job tasks and responsibilities; feeling low job morale.

Cognitive
Experiencing confusion, diminished concentration,& difficulty with decision making.

Spiritual
Questioning the meaning of life or lacking self-satisfaction.

Interpersonal
Physically withdrawing or becoming emotionally unavailable to your co-workers or your family.

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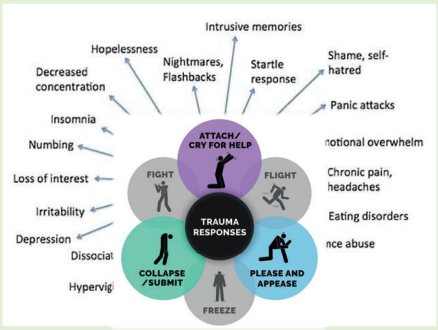
Effects of Trauma on Behavior

- What type of trauma could be at play?
- What are some possible triggers?

They could be obvious or subtle.

How could you respond in a trauma-informed way?



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6 tips for preventing re-traumatization

1. Learn
2. Attunement
3. Causes of Behaviors
4. Use person-centered, strength-based thinking and language.
5. Provide consistency, predictability, and choice-making opportunities.
6. Weigh the physiological, psychological, and social risks

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A Trauma-Informed Perspective Asks

"What happened to you?"

Instead of "What's wrong with you?"

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Partners

March of Dimes

Blue Cross Blue Shield of Tennessee

Vanderbilt University Medical Center

HCA Healthcare TriStar Division

HRSA Health Resources & Services Administration

AWHONN

UnitedHealthcare Community Plan

Wellpoint

NNPQC National Network of Perinatal Quality Collaboratives

VON Vermont Oxford Network

ACOG The American College of Obstetricians and Gynecologists

AIM

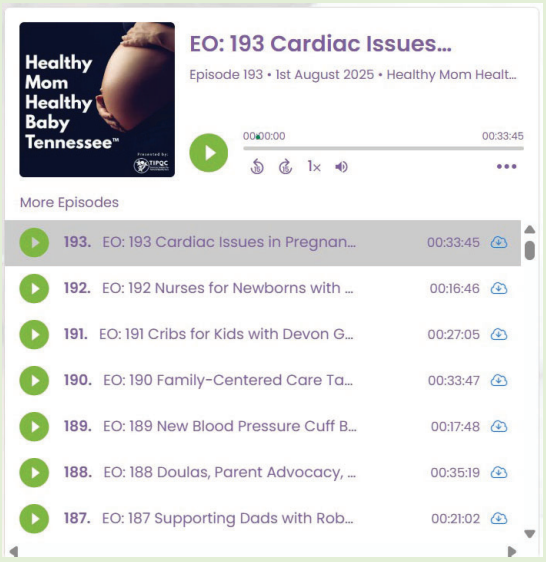
THA Tennessee Center for Patient Safety

TN Department of Health

PSI Postpartum Support International

American Academy of Pediatrics Dedicated to the Health of All Children®

Evaluation



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