Summer 2025

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

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Incidence of Hypertensive Disorders

- Worldwide: 3-14%
- USA: 3-5% with Increase of 25%
- Midsouth: 25%
- Twin Pregnancies: 14%
- History of Preeclampsia: 18%
- Top Cause of Maternal Mortality

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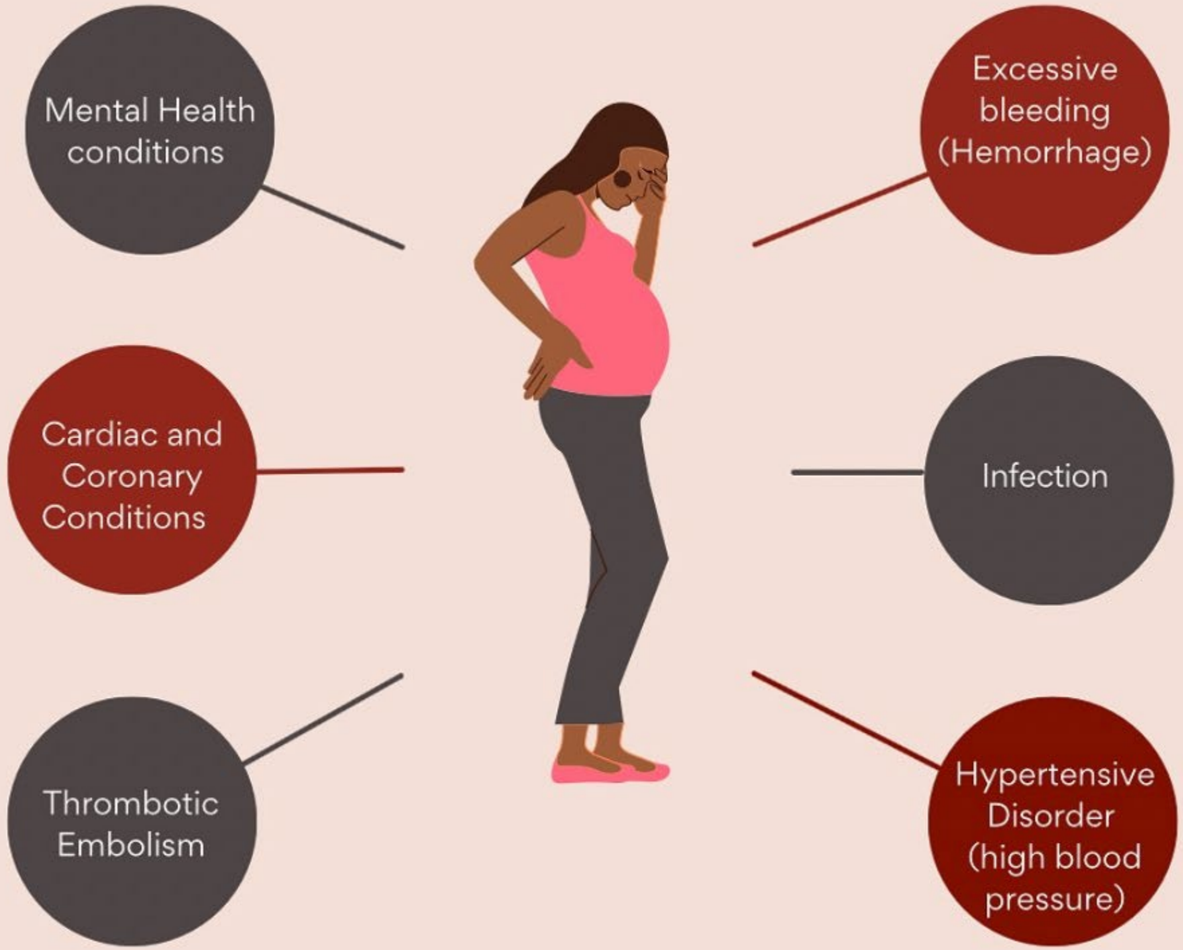
Causes of Maternal Mortality



saving mothers

Source: CDC Newsroom, Four in 5 pregnancy-related deaths in the U.S. are preventable

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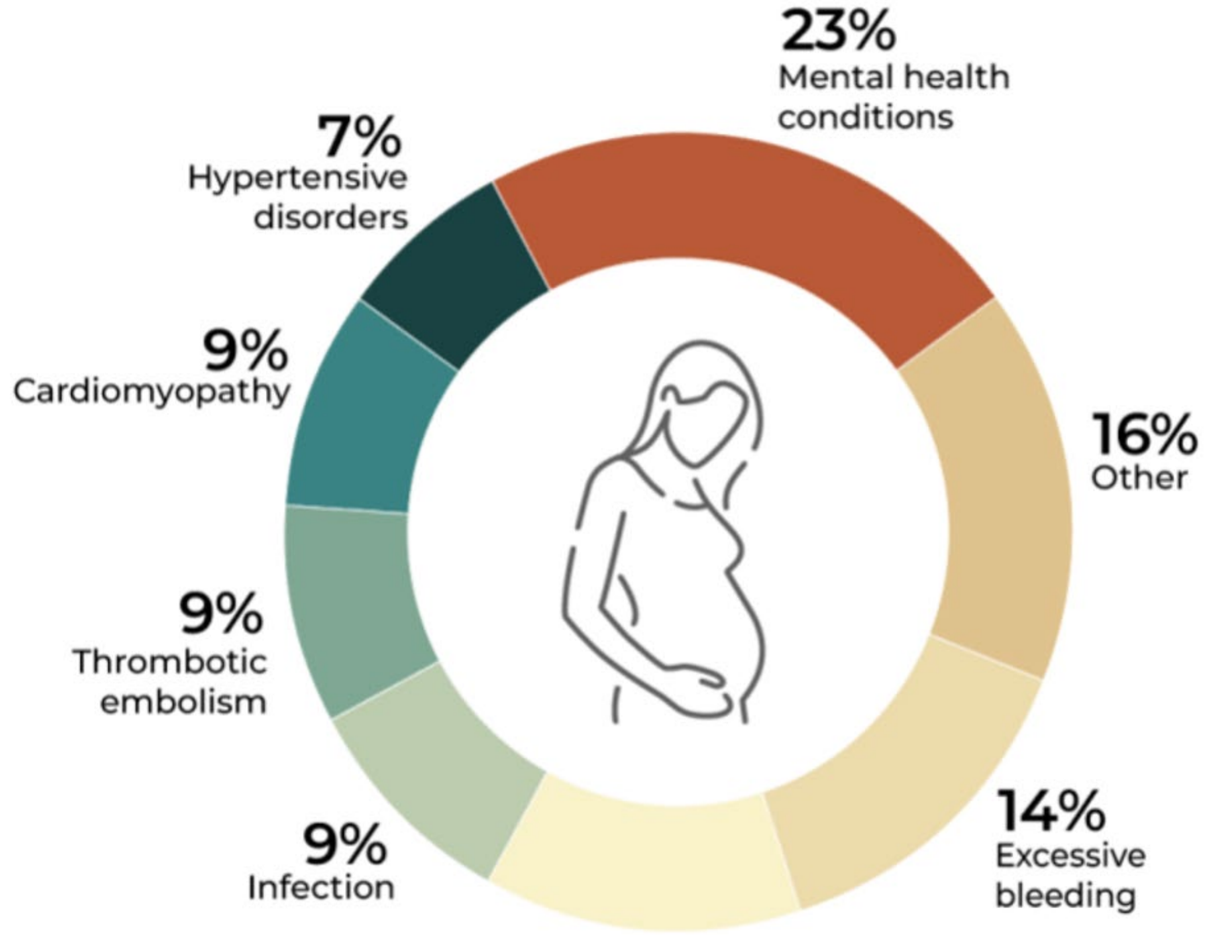
UNITED STATES

Pregnancy-related deaths

Mental health conditions were the leading underlying cause of deaths among pregnant women in the United States between 2017 and 2019.



Source: Centers for Disease Control and Prevention | July 3, 2024

@AJLabs ALJAZEERA

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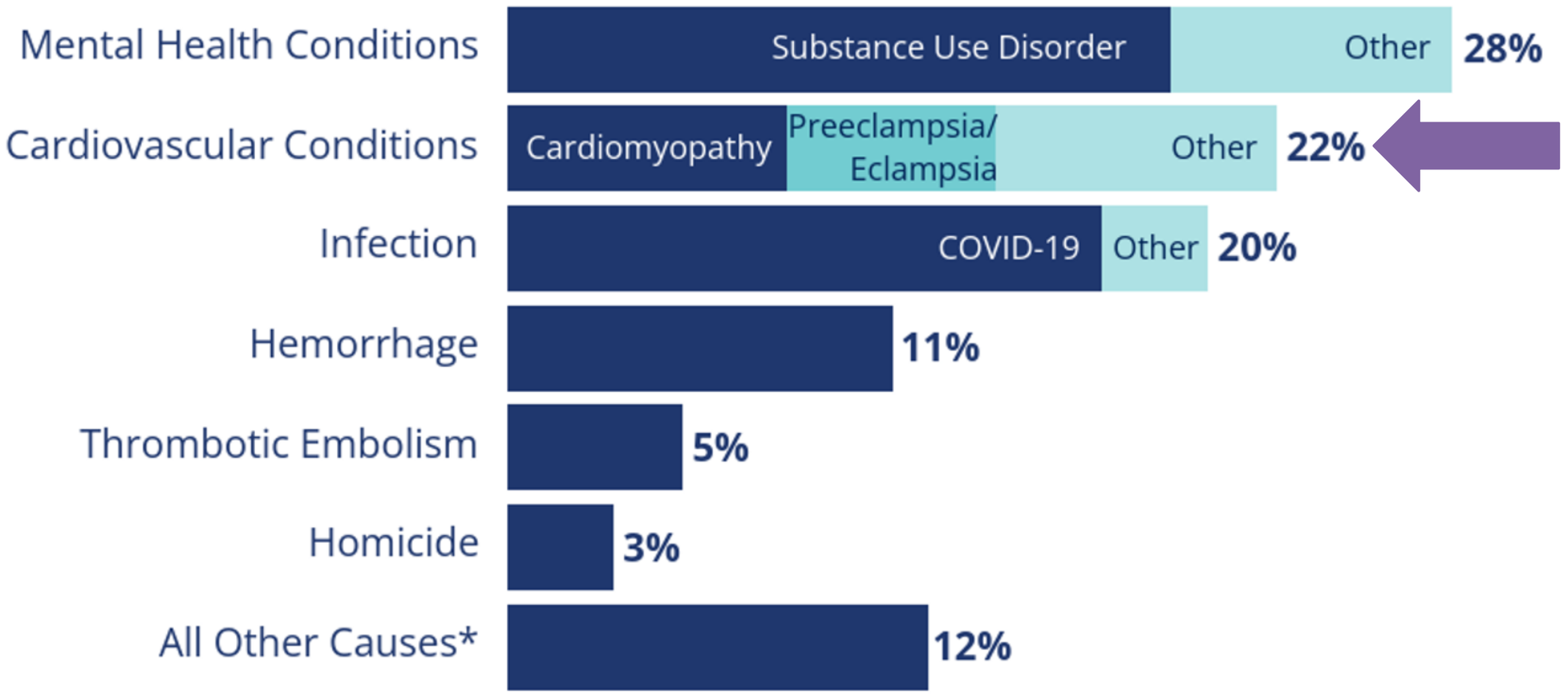
Leading Causes of Pregnancy-Related Deaths, 2020-2022



*Other causes include stroke, neurologic/neurovascular conditions, amniotic fluid embolism, cancer, pulmonary conditions, anesthesia complications, collagen vascular/autoimmune diseases, hematologic conditions, diabetes mellitus, and renal diseases.

2024

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Definition

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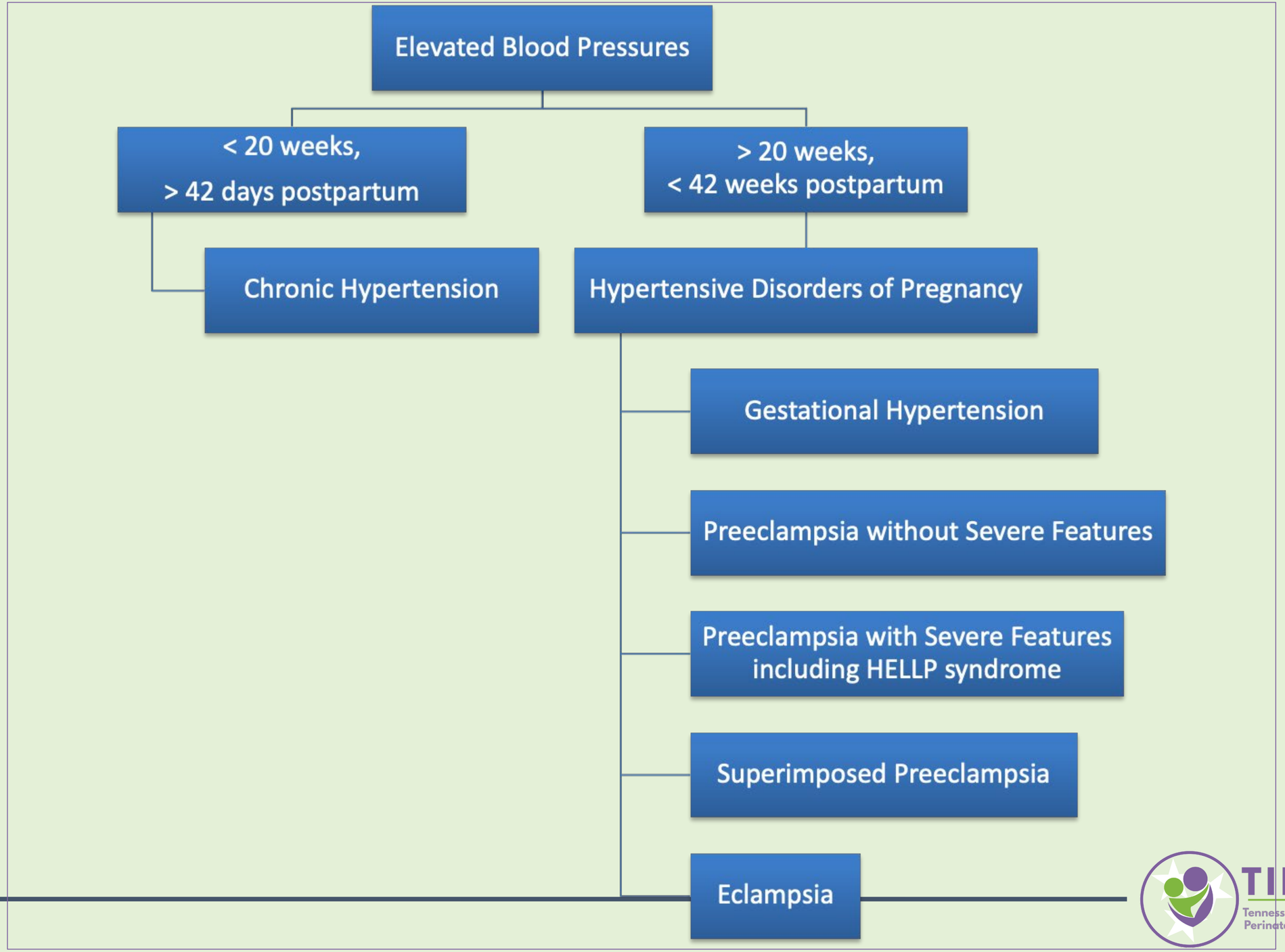

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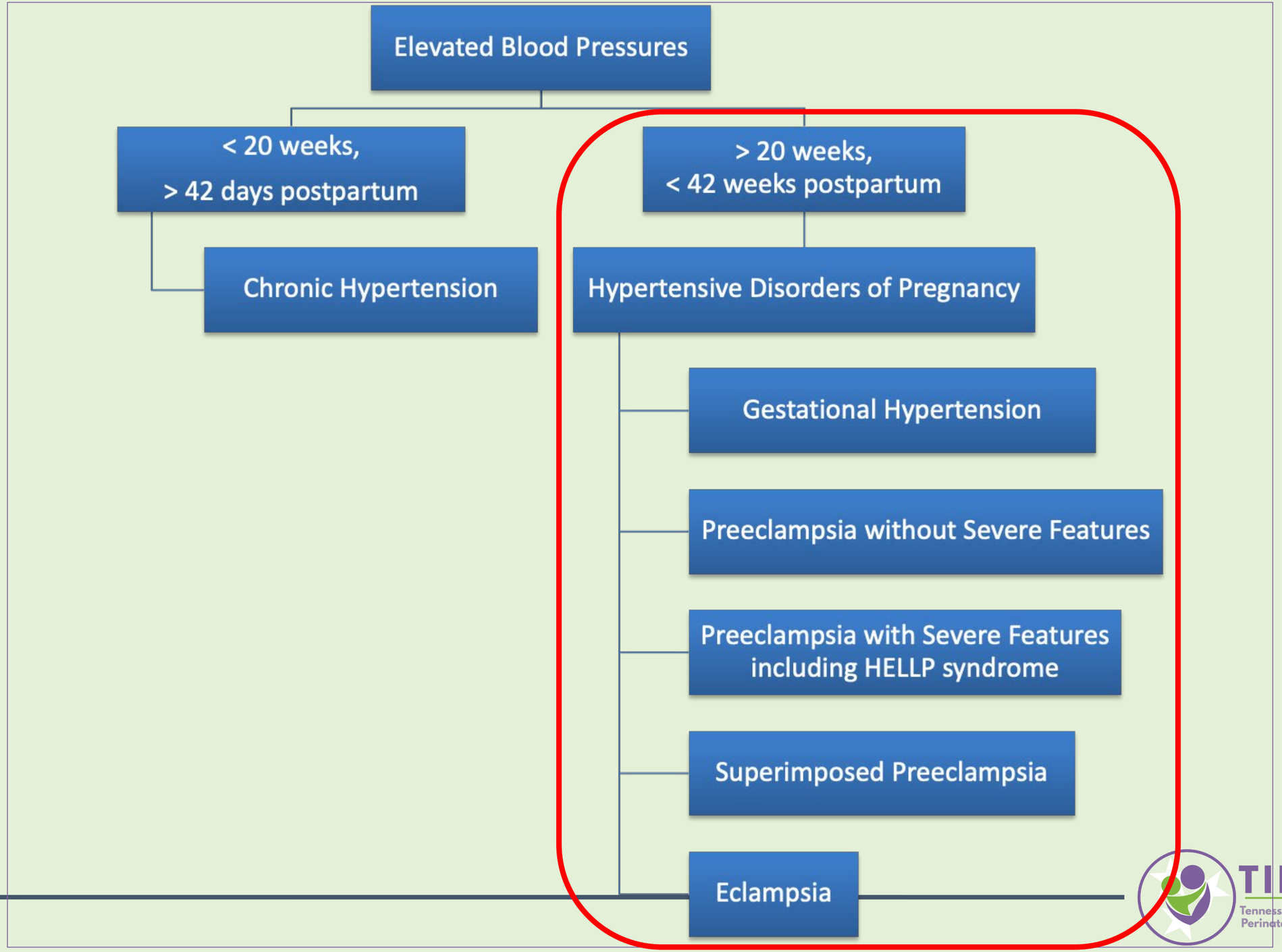

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Presentation

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Blood Pressure Measurement

- **Korotkoff phase V**

- **Appropriate size cuff**
  - **Length 1.5 x upper arm circumference**
  - **Bladder encircles > 80% of the arm**

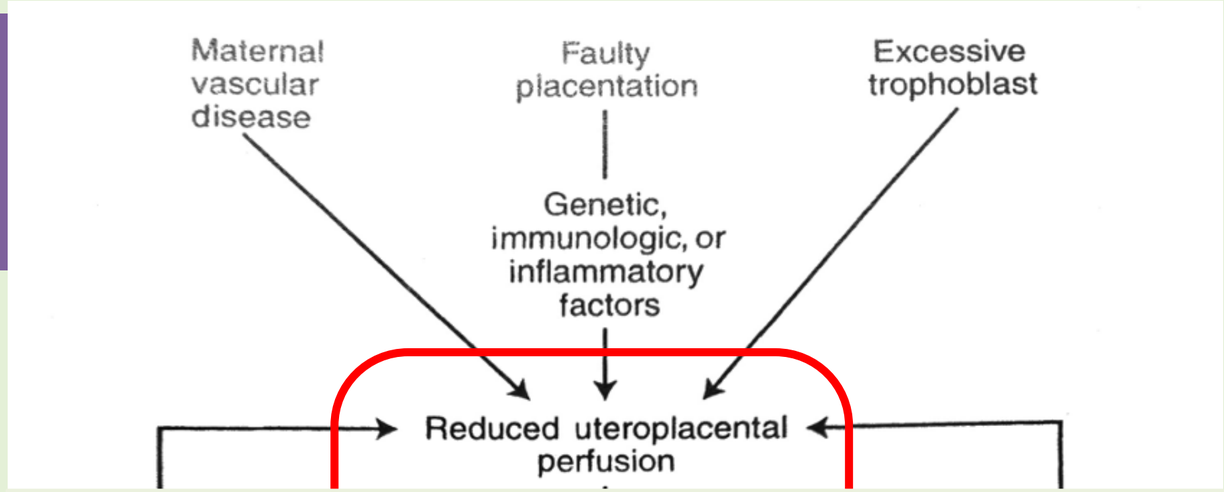
- **Upright position after ≥ 10 minutes rest**
- **Hospitalized**
  - **Either sitting up or LLR position**
  - **Arm level with heart**

- **No tobacco or caffeine x 30 minutes**

- **Mercury Sphygmomanometer preferred**

Report of the National High Blood Pressure Education Program Working Group on High Blood Pressure in Pregnancy. Am J Obstet Gynecol. Jul 2000;183(1):S1-S22.

Pathogenesis



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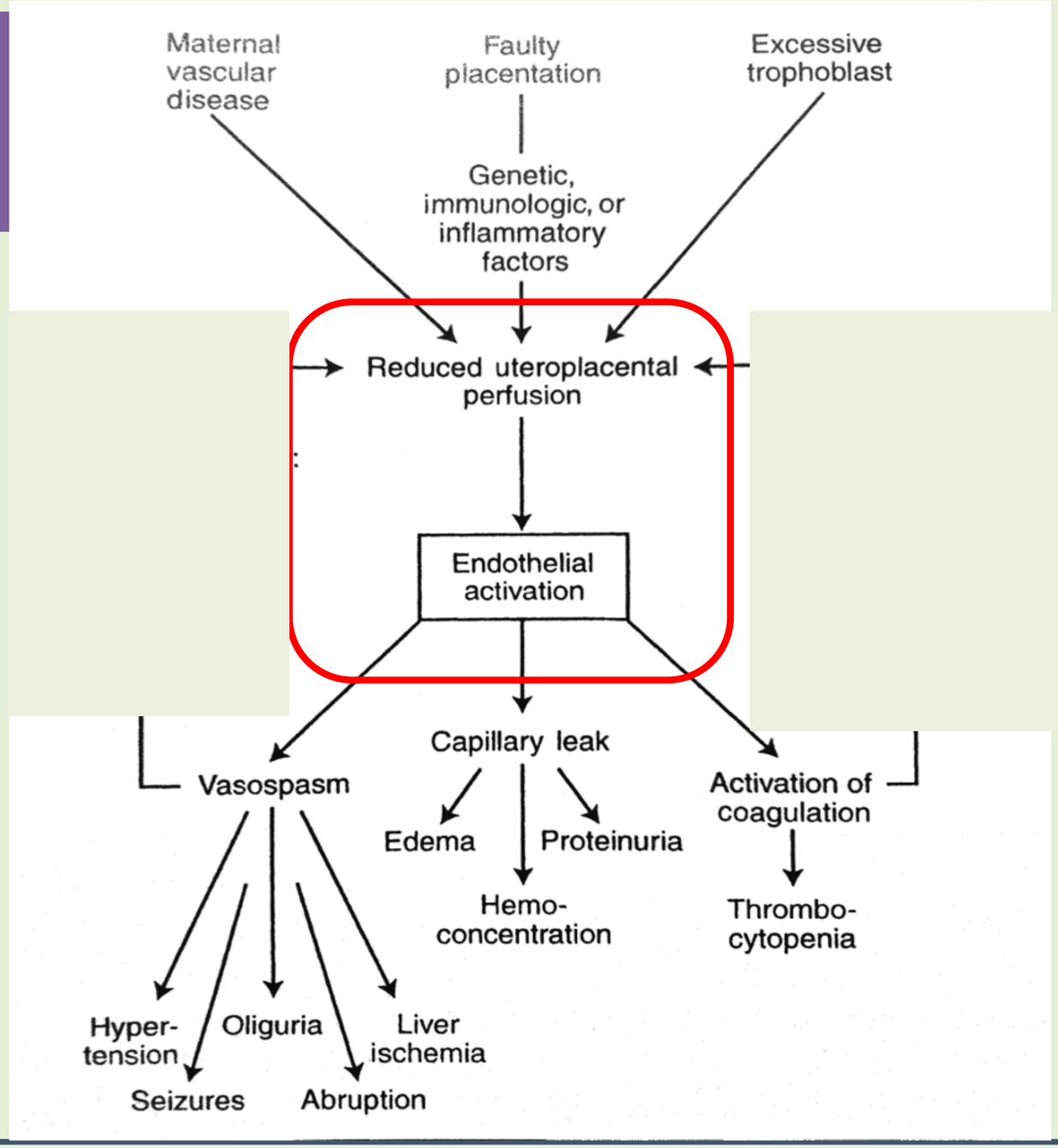
Pathogenesis



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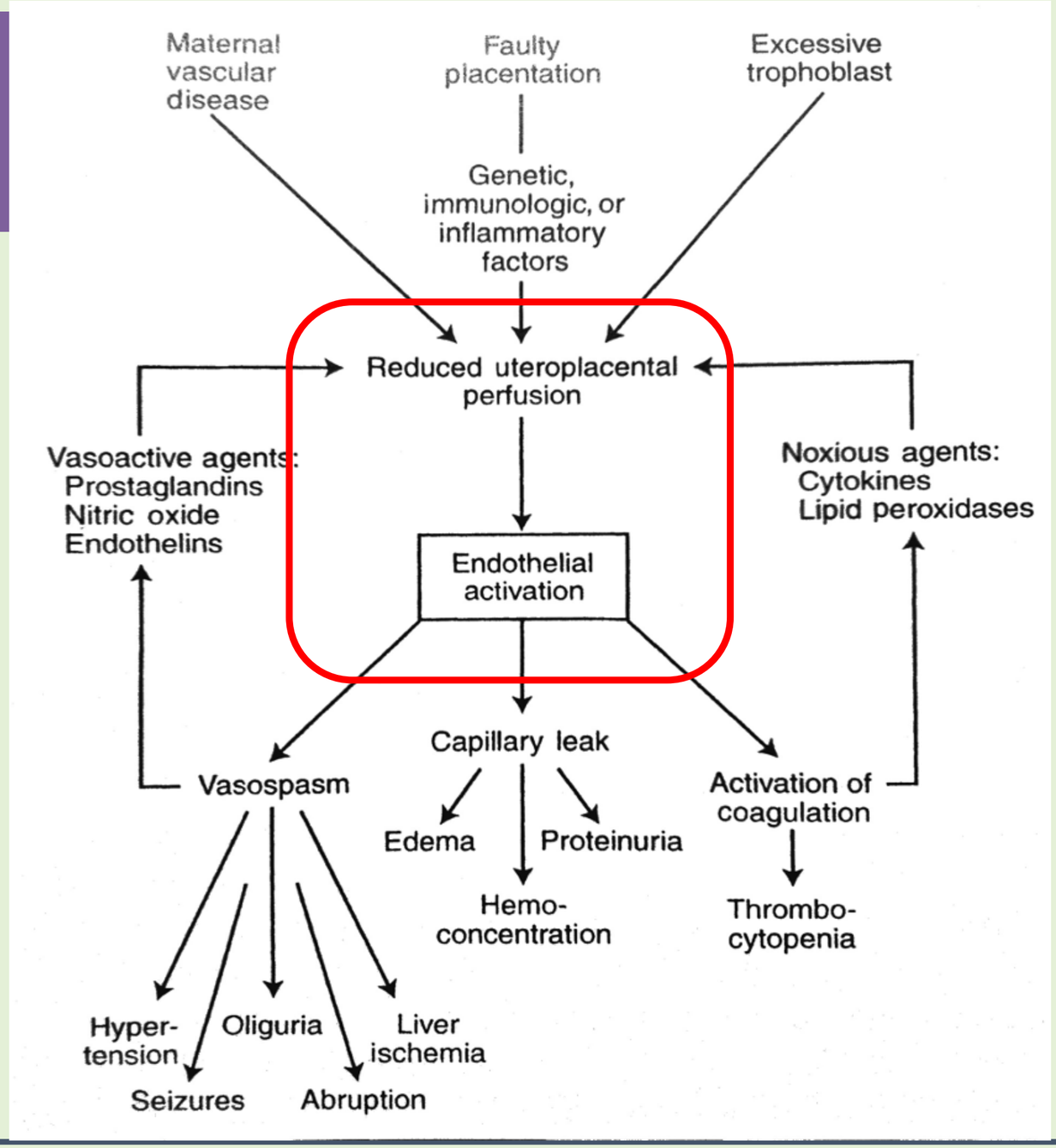

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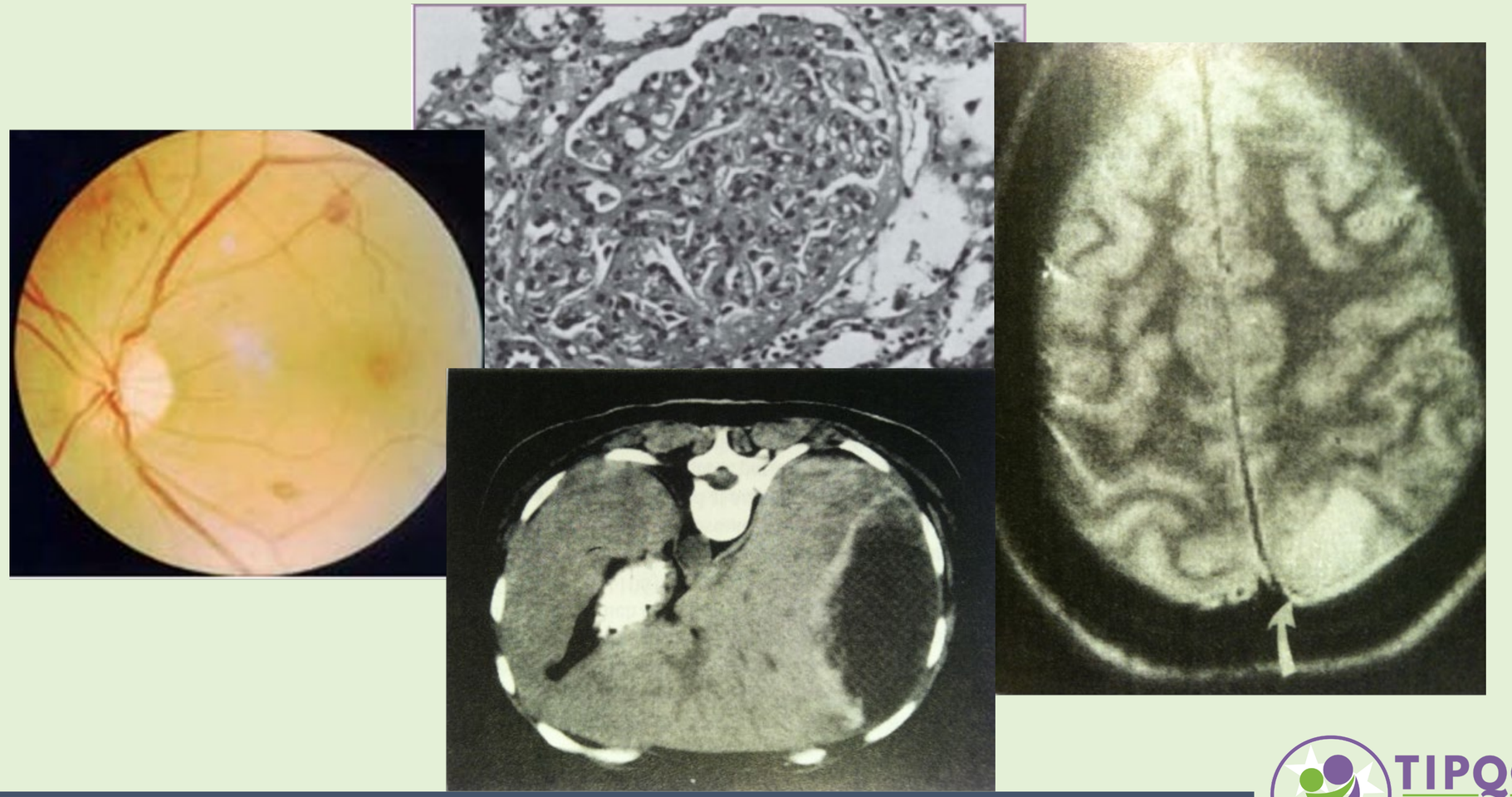
Multi-Organ System Involvement



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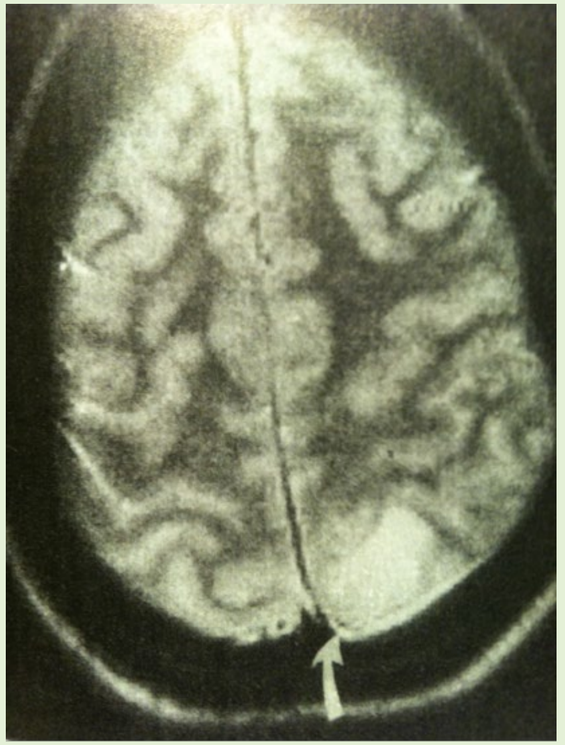
Organ and System Involvement

Neurologic

- Headache
- Blurred Vision
- Scotomata
- Hyperreflexia
- Eclampsia
- Cerebral edema
- **Reversible posterior encephalopathy**
- **Intracranial hemorrhage**
- **Temporary blindness**

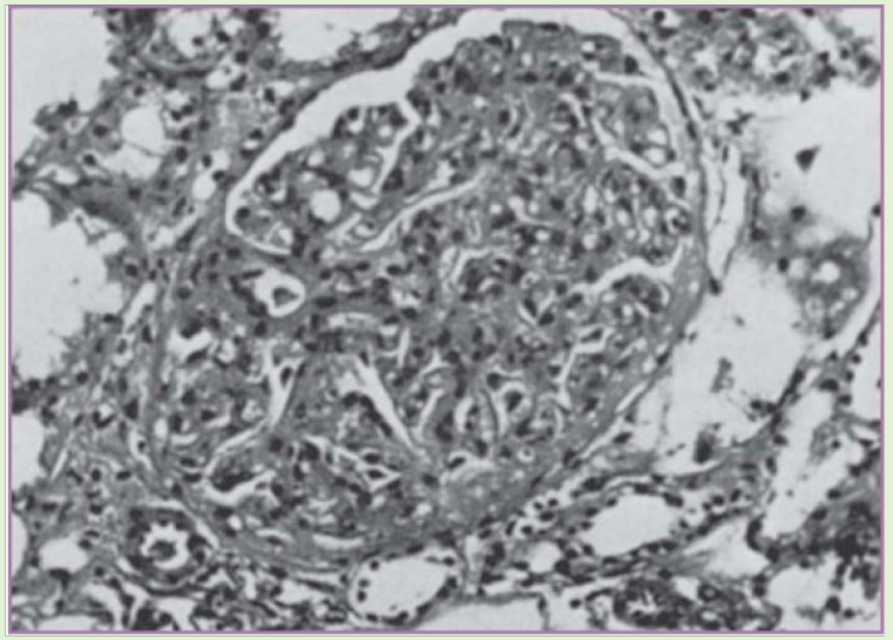


Robert K. Creasy M, Robert Resnik M, Jay D I, MD, eds. Creasy and Resnik's Maternal-Fetal Medicine: Principles and Practice. Sixth ed. Philadelphia, PA: Saunders/Elsevier; 2009.

Organ and System Involvement

Renal

- **Glomerular capillary endotheliosis**
- **Proteinuria**
- **Decreased GFR**
- **Increased Creatinine**
- **Oliguria <20ml/hr(2hrs)**
- **Renal failure**



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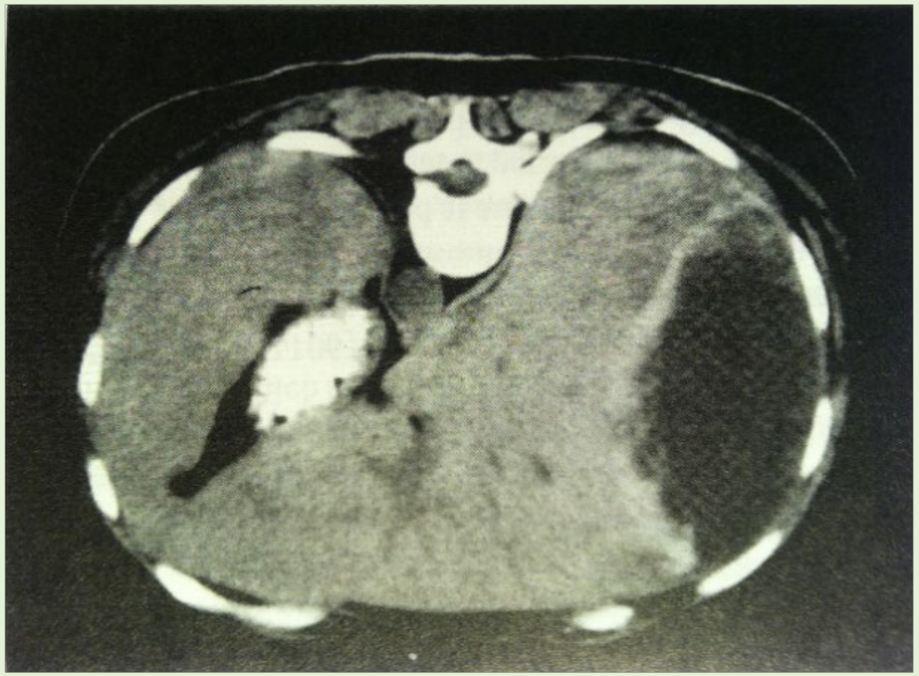
Organ and System Involvement

Liver

- **Pathologic changes**
  - **Hemorrhage into hepatic cellular columns**
  - **Vasospasm with hepatic infarction near sinusoids extending to near portal vessels**
- **Alterations of LFTs**
- **Subcapsular hematoma**
- **Liver rupture**



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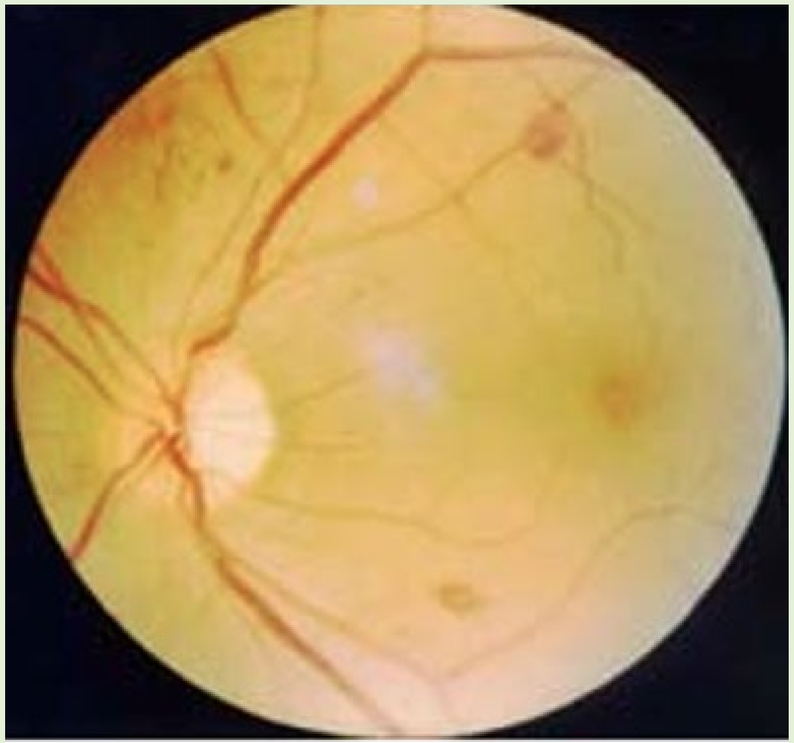
Organ and System Involvement

Vascular Changes

- Hemoconcentration
- Changes in vascular reactivity
- Capillary leak

Retinal Changes

- Vascular narrowing
- Segmental spasms



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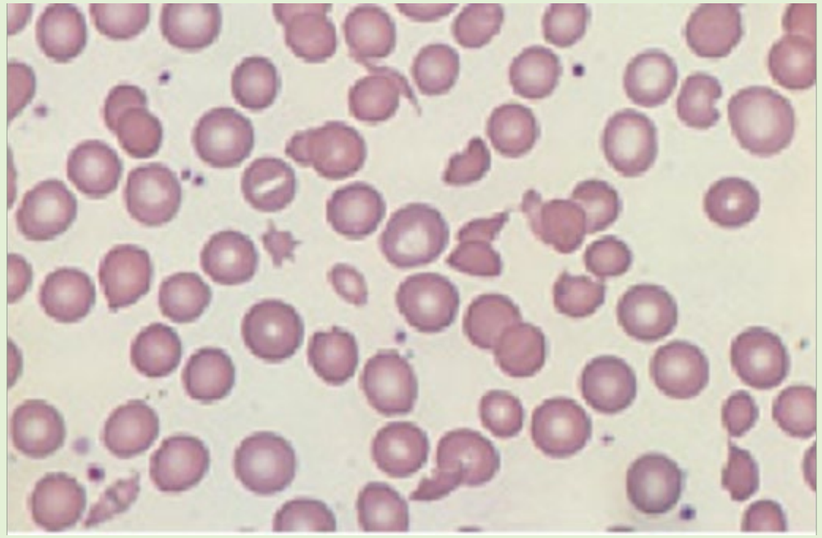
Organ and System Involvement

Hematologic Changes

- Hemolysis
- Thrombocytopenia



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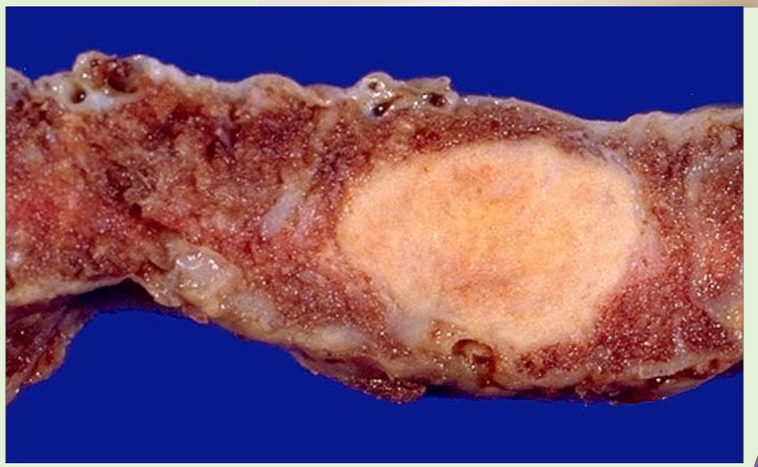
Organ and System Involvement

Fetal

- **IUGR**
- **Fetal loss**

Placental

- **Infarction**
- **Abruption**



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Risk Factors

- Primigravidity/Nulliparity
- Multiple Gestation
- History of Preeclampsia
- Chronic Hypertension
- Pregestational Diabetes/Gestational Diabetes
- Systemic Lupus Erythematosus
- Nephropathy
- Antiphospholipid Antibody Syndrome
- Obesity (Prepregnancy BMI > 30)
- Extremes of Age
- Inherited Thrombophilias
- Assisted Reproductive Technology
- Obstructive Sleep Apnea

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Risk Factors

- Primigravidity/Nulliparity
- Multiple Gestation
- History of Preeclampsia ★
- Chronic Hypertension ★
- Pregestational Diabetes/Gestational Diabetes ★
- Systemic Lupus Erythematosus ★
- Nephropathy ★
- Antiphospholipid Antibody Syndrome
- Obesity (Prepregnancy BMI > 30) ★
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- Inherited Thrombophilias
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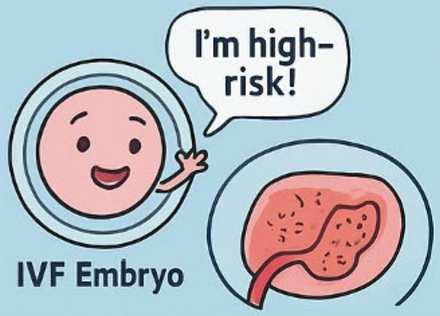
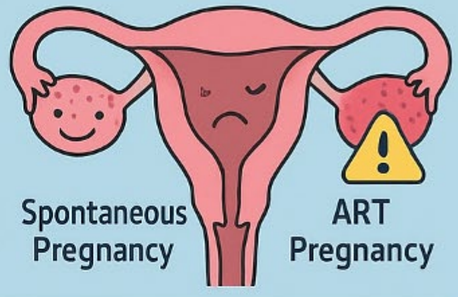
- Obstructive Sleep Apnea ★

★ Preexisting Vascular Damage

Robert K. Creasy M, Robert Resnik M, Jay D I, MD, eds. Creasy and Resnik's Maternal-Fetal Medicine: Principles and Practice. Sixth ed. Philadelphia, PA: Saunders/Elsevier; 2009.

WHY ART INCREASES THE RISK OF PREECLAMPSIA





Mechanism	Explanation
Altered Immune Tolerance	Maternal immune system may respond differently to non-self (donor) antigens.
Hormonal Manipulation	ART involves high estrogen/ progesterone → affects vascurlr remodelling
Multiple Gestation	Higher chance of twins/triplets increases uterine stress and placentatio load
Placental Abnormalities	ART may lead to poor trophoblastic invasion or abnormal placentation
Epigenetic/ Genetic Factors	Some infertility causes and ART itself may affect gene expression related to BP
Advanced Maternal Age	Many ART patients are older, compounding risk

Be on the lookout for high BP and proteinuria in ART pregnancy!
Clinical vigilance = safer outcomes!

ACOG Practice Balletin No. 222 - ASRM Committee Opinion 2021 Ananth eTail,. Obstet Synceol, 2013 - Conde-Agudeloet AlB.

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WHY ARE THROMBOPHILIAS A RISK FACTOR FOR PREECLAMPSIA?

Pathophysiologic Mechanism

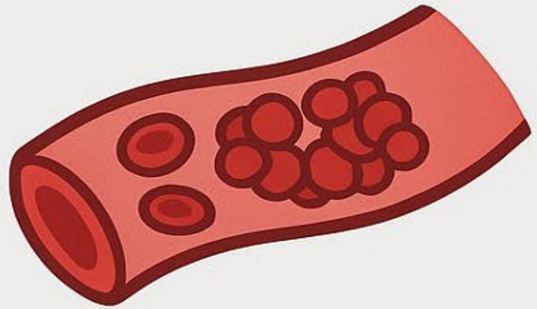
Abnormal Placental Implantation

- Microvascular thrombosis
- Poor placental perfusion

Endothelial Dysfunction

- Systemic endothelial damage
- Inflammatory cytokines

Hypercoagulability



- Procoagulant factors
- Placental infarction

ACOG Practice Bulletin No. 197 (2023): “Inherited thrombophilias are associated with increased risk of preeclampsia, particularly early-onset disease.”
SMFM Consult Series #52 (2020): APS and inherited thrombophilias increase risk of preeclampsia through mechanisms involving abnormal placentation and inflammation.
Kupferminc MJ, *et al.* (2000): “Increased frequency of inherited thrombophilia in women with complications of pregnancy.” *NEJM*.

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Thrombophilias Associated with Preeclampsia Risk

Thrombophilia Type	Increased Risk of Preeclampsia?
Factor V Leiden	Yes – associated with early-onset and severe forms
Prothrombin G20210A Mutation	Yes – especially with other risk factors
Protein C or S Deficiency	Yes
Antithrombin Deficiency	Yes
Antiphospholipid Antibody Syndrome (APS)	Strong association – especially with severe or recurrent preeclampsia

Why Are Extremes of Age Risk Factors for Preeclampsia?

Adolescents
(<20 years)

- Immature vascular adaptation
- Nutritional deficiencies
- First exposure to paternal antigens
- Limited prenatal care

Advanced Maternal Age
(≥35 or ≥40 years)

- Vascular aging
- Higher chronic disease burden
- Decreased immune tolerance
- Increased assisted reproduction use

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Clinical Manifestations

Cerebral
- **Headache**
- Dizziness
- Tinnitus
- Drowsiness
- Change in respiratory rate
- Tachycardia
- Fever

Gastrointestinal
- Nausea
- Vomiting
- **Epigastric pain and RUQ pain**
- Hematemesis

Visual
- Diplopia
- **Scotomata**
- **Blurred vision**
- Amaurosis

Renal
- Oliguria
- Anuria
- Hematuria
- Hemoglobinuria

Robert K. Creasy M, Robert Resnik M, Jay D I, MD, eds. Creasy and Resnik's Maternal-Fetal Medicine: Principles and Practice. Sixth ed. Philadelphia, PA: Saunders/Elsevier; 2009.

Diagnosis

Classification

Gestational Hypertension

Preeclampsia-Eclampsia

Chronic hypertension with Superimposed Preeclampsia

Classification

Preeclampsia

- **Without severe features**
- **With severe features**

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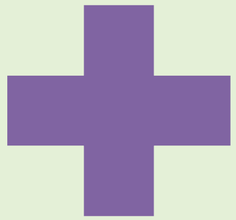
Diagnosis: Gestational Hypertension

Diagnostic Criteria

Blood Pressure

- **> or = 140 mmHg systolic or >/= 90 mmHg diastolic on two occasions at least 4 hours apart after 20 weeks of gestation with a previously normal blood pressure**



Proteinuria

- **< 300 mg per 24-hour urine collection**
- **Protein/creatinine ratio < 0.3**
- **Dipstick reading of < 1+ (used** only if other methods not available)

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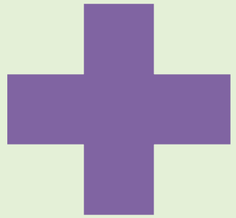
Diagnosis: Preeclampsia-Eclampsia

Diagnostic Criteria

Blood Pressure

- **> or = 140 mmHg systolic or >/= 90 mmHg diastolic on two occasions at least 4 hours apart after 20 weeks of gestation with a previously normal blood pressure**



Proteinuria

- **> or = 300 mg per 24-hour urine collection**
- **Protein/creatinine ratio > or = 0.3**
- **Dipstick reading of 1+ (used** only if other methods not available)

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Diagnosis: Severe Features

In the absence of proteinuria, new-onset hypertension onset of any of:

- Systolic blood pressure of **160** mm Hg or more, or diastolic blood pressure of **110** mm Hg or more on two occasions **at least 4 hours** apart (unless **antihypertensive therapy** is initiated before this time)

- Thrombocytopenia (platelet count **less than 100,000**)

- Impaired liver function:
  - Abnormally elevated liver enzymes (to more than **twice** the upper limit normal)

  or
  - Severe persistent right upper quadrant or epigastric pain unresponsive to medications

Diagnosis: Severe Features

In the absence of proteinuria, new-onset hypertension onset of any of:

- Renal insufficiency
  - Creatinine more than **1.1 mg/dL** or
  - Doubling of Creatinine concentration in the absence of other renal disease (if baseline is elevated)

- Pulmonary Edema

- New-onset headache unresponsive to medication and not accounted for by alternative diagnoses

- Visual Disturbances

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Management

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DELIVERY IS THE CURE FOR PREECLAMPSIA

But timing is everything

WHY DELIVERY IS THE CURE

- Preeclampsia originates from the placenta
- The disease resolves only when the placenta is removed

BUT... WHEN SHOULD WE DELIVER?

- Severity of dlsease
- Fetal status
- Gestational age
- Maternal stability

DELIVERY ≠ INSTANT CURE

- Symptoms can worsen before they get better
- Continue magnesium sultate postpartum
- Monitor BP closely for up to 6 weeks

DELIVERY = REMOVAL OF PLACENTA → RESOLUTION OF DISEASE

Continue magnesium sulfate postpartum

1. ACO6 Practice Bulletin No. 222: Gestational Hypertensaion and Presclampssia. Obstet Gynecol, 2020,135 e237–e260.
2. Sibai DM **Gieprosis and management of gestalional hypertension and presclampsia**, Obstet Gynecol, 2002,102-1811–192.
3. American College of Obstetricians and Gynecologists. **Hypertension** in pregnancy. Report of the ACOG Task Force on Hypertension in Pregnancy.
4. Magee LA, et al. The management of hypertensive disorders of pregnancy, executive summary. Pregnancy Hypertens, 2014.4-105–146.

Preeclampsia without Severe Features and Gestational Hypertension

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Management

Antepartum Care

Monitoring of:

- Maternal Symptoms
- Fetal Kick Counts
- Blood Pressure Monitoring Twice Weekly
- Relevant Lab monitoring Weekly
- Antenatal Testing
- Ultrasound for Fetal Growth Assessment
- No antihypertensive medication management
- No strict bed rest

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Management

Timing of delivery → **37 weeks**

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Management

Intrapartum Care

- **Close Blood Pressure Monitoring**
- **No Indication for Magnesium Sulfate for prevention of Eclampsia**

Postpartum Care

- **Monitor Blood Pressure in the hospital or that equivalent outpatient for at least 72 hours**
- **Monitor Blood Pressure 7-10 days after delivery or earlier in women with symptoms**

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Preeclampsia with Severe Features

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Management

Management plans are driven by gestational age at time of diagnosis.

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Management:
Less than 23 weeks

Delivery after maternal stabilization.

Expectant management is not recommended.

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Management: 23.0 to 33.6 weeks

- **Expectant <u>inpatient</u> management**
- **Steroids for fetal lung maturity**
- **Daily fetal monitoring/antenatal testing**
- **Twice weekly lab monitoring**
- **Fetal growth assessment every 2 weeks**
- **Antihypertensive medication if sustained BP ≥160 systolic or ≥110 diastolic**

***Magnesium sulfate during stabilization**

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Medical Management

TABLE 7-1. Antihypertensive Agents Used for Urgent Blood Pressure Control in Pregnancy ⇦

Drug	Dose	Comments
Labetalol	10–20 mg IV, then 20–80 mg every 20–30 min to a maximum dose of 300 mg or Constant infusion 1–2 mg/min IV	Considered a first-line agent Tachycardia is less common and fewer adverse effects Contraindicated in patients with asthma, heart disease, or congestive heart failure
Hydralazine	5 mg IV or IM, then 5–10 mg IV every 20–40 min or Constant infusion 0.5–10 mg/h	Higher or frequent dosage associated with maternal hypotension, headaches, and fetal distress—may be more common than other agents
Nifedipine	10–20 mg orally, repeat in 30 minutes if needed; then 10–20 mg every 2–6 hours	May observe reflex tachycardia and headaches

Abbreviations: IM, intramuscularly; IV, intravenously.

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Management

Timing of delivery → **34 weeks**

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Conditions Precluding Expectant Management

- Uncontrolled blood pressures not responsive to antihypertensive medication
- Persistent symptoms unresponsive to medication
- Stroke, Myocardial Infarction, Aneurysm
- HELLP syndrome
- New or worsening renal dysfunction
- Pulmonary edema
- Eclampsia
- Placental abruption or vaginal bleeding in the absence of placenta previa
- Abnormal fetal testing
- Fetal death
- Fetus without expectation for survival (ex. lethal anomaly, extreme prematurity)
- Persistent reversed end-diastolic flow in the Umbilical Artery

Management:
34 weeks or greater

Delivery after maternal stabilization.

Expectant management is not recommended.

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Management

Intrapartum Care

- Magnesium Sulfate for seizure prophylaxis is recommended
- Antihypertensive medication as needed
- Mode of Delivery:
  - Should be determined by gestational age, presentation, cervical status, maternal and fetal conditions
  - Need not be Cesarean Section
    - Continue Magnesium during Cesarean Section

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Management

Postpartum Care

- **Monitor Blood Pressure in the hospital or that equivalent outpatient for at least 72 hours**

- **Monitor Blood Pressure 7-10 days after delivery or earlier in women with symptoms**

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Superimposed Preeclampsia

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Management

- Defined the same as Preeclampsia:
  - *No mention to superimposed preeclampsia with or without severe features*
  - *Diagnosis based on hypertension or proteinuria alone may prove challenging*

- Approach to antepartum and intrapartum care the same as preeclampsia
  - Includes conditions precluding expectant management

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Postpartum Preeclampsia

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Management

New onset or persistence of hypertensive disorders in the postpartum period

Diagnosis and management mirrors antepartum protocols.

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Management

- **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 follow up**
  - 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**

Prevention of Preeclampsia

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Prevention

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

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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

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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.**

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Cardiovascular Disease Later in Life

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Later in Life CV Disease

- **2-fold increase in all cases of Preeclampsia**
- **8 to 9-fold with Preeclampsia delivered before 34 weeks**
- **Lifestyle modification recommendations:**
  - **Healthy Weight, Increased Physical Activity, and No Tobacco Use**
  - **Early Evaluation**

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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.

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.

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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.

May 2025

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

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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

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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

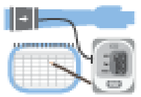
go to the bathroom

sit quietly 3-5 minutes

Within 30 minutes DO NOT

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

brought to you by PREECLAMPSIA FOUNDATION

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.

HEALTH CARE DISCLAIMER: This program, related materials and services do not constitute the practice of medical advice, diagnosis or treatment. The quality of an at home reading is dependent on both the method and equipment. Always talk to your health care provider for diagnosis and treatment, including your specific medical needs. If you have or suspect that you have a medical problem or condition, please contact a qualified healthcare professional immediately. If you are in the United States and experiencing a medical emergency, call 911 or call for emergency medical help immediately.

PREECLAMPSIA FOUNDATION

www.preeclampsia.org

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POSTBIRTH Warning Signs & Resources

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EMERGENCY SIGNS…Call 911

- **P**ain in The Chest → **May Signal Heart or Lung Emergency**
- **O**bstructed Breathing → **Shortness of Breath is Serious**
- **S**eizures → **May be Postpartum Preeclampsia**
- **T**houghts 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**
- **Fever ≥ 100.4°F** → **May indicated Infection**
- **Headache with Vision Changes** → **Possible Preeclampsia**

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POST-BIRTH

Warning Signs for New Mothers

P  Pain in chest

O  Obstructed breathing or shortness of breath

S  Seizures

T  Thoughts of hurting yourself or someone else

B  Bleeding that soaks through one pad/hour or clots larger than an egg

I  Incision that is not healing or smells bad

R  Red or swollon leg, painful to touch

T  Temperature of 100,4°F (38°C) or higher

H  Headache that won't go away or causes vision changes

Sources: AWHONN POST-BIRTH Education | CDC Hear Her Campaign | ACOG Committee Opinion No. 736 | CDC MMRC Report 2017–2019 | Lows JM et al., *Obstet Gynecol*, 2019

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Doula's Role

- Stay calm, provide reassurance
- Encourage timely medical care
- Help prepare a postpartum emergency plan
- Remind clients about follow-up visits
- Advocate if clients feel dismissed

Health Equity and Advocacy

- Recognize higher risks for Black, Indigenous, and Hispanic families
- Speak up for clients if concerns are ignored
- Support respectful, timely, and culturally aware care

Sources: AWHONN POST-BIRTH Education | CDC Hear Her Campaign | ACOG Committee Opinion No. 736 | CDC MMRC Report 2017–2019 | Lows JM et al., *Obstet Gynecol*, 2019

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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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Trauma Informed Care for Clients

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THE PREVALENCE OF TRAUMA

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.

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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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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

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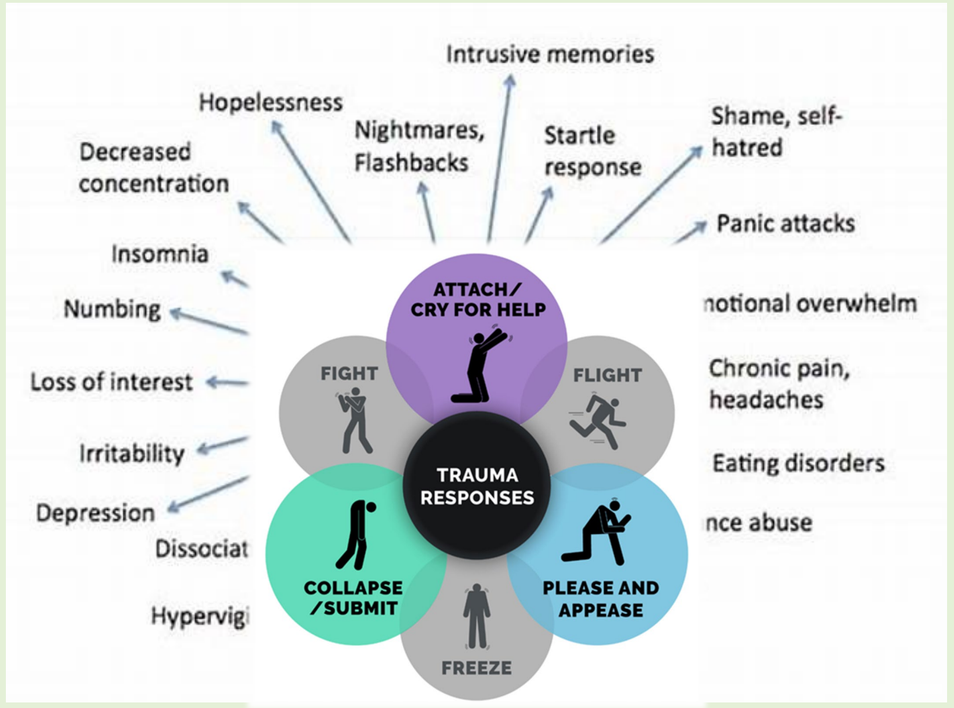
Effects of Trauma on Behavior

- 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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7 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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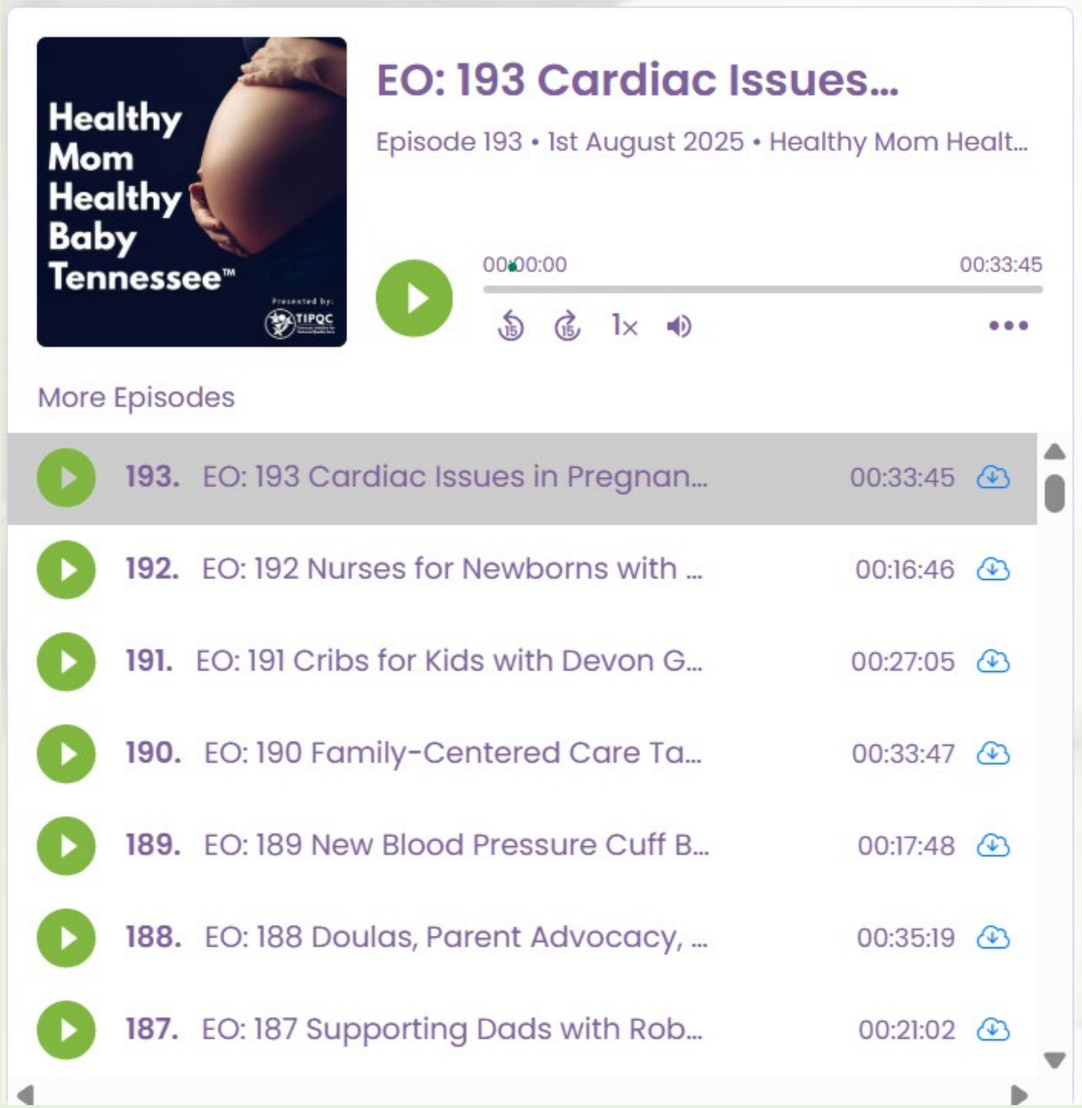
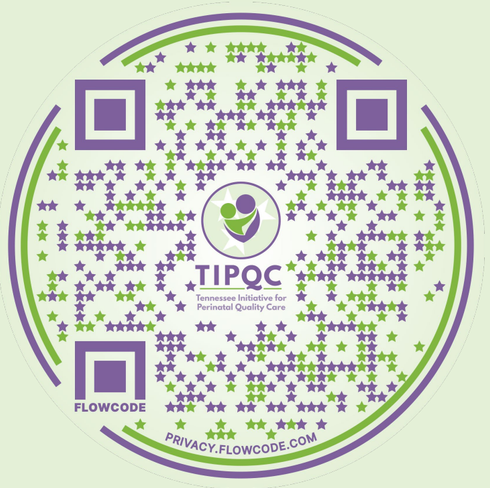
Questions?

Podcast





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Evaluation

Partners


MARCH OF DIMES


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
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