This *Continuing Education Program* is generously supported by March of Dimes with funding from Proctor & Gamble
Current Updates in Prematurity Prevention 2016

Mary Campbell Bliss, RN, MS, CNS
Best Practice Researcher
Hospital Quality Institute
Learning Objectives

At the end of the presentation, the participants will be able to:

1. Discuss the impact of birth spacing on adverse birth outcomes and the role LARC can play in improving birth spacing.
2. Describe the benefits of 17P for eligible pregnant women.
3. Review the new recommendations for use of antenatal corticosteroids for late preterm deliveries.
4. Identify components of optimal prenatal care along with various resources for consumers and professionals available through the March of Dimes and other agencies.
March of Dimes mission

To improve the health of babies by preventing birth defects, premature birth and infant mortality.

Fund research  Help moms  Support families
Preterm birth rates

*2015 data are preliminary.
LMP=gestational age based on date of mother’s last menstrual period; OE=gestational age based on obstetric estimate.
2020 and 2030 goals based on OE gestational age. Preterm is less than 37 weeks gestation.
Prepared by March of Dimes Perinatal Data Center, June 2016.
5.5% - 2030 U.S. Preterm Birth Rate Goal

Fighting for the Next Generation: US Prematurity in 2030

Edward R.B. McCabe, Gerard E. Carrino, Rebecca B. Russell and Jennifer L. Howse

Pediatrics; originally published online November 2014
Potential impact of interventions and reduction of risk factors on the US preterm birth rate

McCabe ERB, Carrino GE, Russell RB and Howse JL.
Birth Spacing / Interpregnancy Interval (IPI) Overview

• **Definition:** Time between one live birth and *conception* of next pregnancy.

• Pregnancy spacing of less than 18 months increases the risk of preterm birth, low birthweight, and small for gestational age.

• Risks increase as IPI decreases, with pregnancy spacing of less than 6 months having the highest risk.
Birth Spacing in the U.S.

- 33.1% of U.S. births have a short IPI (<18 months)
- 45% of all U.S. pregnancies are unintended (unwanted or mistimed)
- Eliminating excess preterm birth risk associated with IPI <18 months could prevent up to 37,000 preterm births a year


Birth Spacing in the U.S.

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

- < 6 months: 6.4%
- 6 - <12 months: 12.2%
- 12 - <18 months: 14.5%
- 18 - <24 months: 12.2%
- ≥ 24 months: 54.7%

Percent of Women

Birth Spacing and Risk of Adverse Perinatal Outcomes
A Meta-analysis

For each month that birth spacing was less than 18 months,

- Preterm births increased 1.9%
- Low birthweight increased 3.3%
- Poor intrauterine growth increased 1.5%

March of Dimes Prematurity Research Center at Stanford University study, July 2016

Affirms that risks increase as interpregnancy interval decreases below 18 months

Association Between Interpregnancy Interval and Risk of Preterm Birth

<table>
<thead>
<tr>
<th>Interpregnancy interval</th>
<th>PTB 20–36 weeks</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>aOR* (95% CI)</td>
</tr>
<tr>
<td>After live birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;6 months</td>
<td>5414</td>
<td>1.71 (1.65–1.78)</td>
</tr>
<tr>
<td>6–11 months</td>
<td>7781</td>
<td>1.20 (1.16–1.24)</td>
</tr>
<tr>
<td>12–17 months</td>
<td>7771</td>
<td>1.06 (1.02–1.09)</td>
</tr>
<tr>
<td>18–23 months</td>
<td>6236</td>
<td>1.0 (REF)</td>
</tr>
<tr>
<td>24–29 months</td>
<td>5124</td>
<td>1.00 (0.97–1.04)</td>
</tr>
<tr>
<td>30–35 months</td>
<td>4352</td>
<td>1.05 (1.00–1.09)</td>
</tr>
<tr>
<td>36–47 months</td>
<td>6869</td>
<td>1.07 (1.03–1.11)</td>
</tr>
<tr>
<td>48–59 months</td>
<td>5199</td>
<td>1.12 (1.08–1.17)</td>
</tr>
<tr>
<td>≥60 months</td>
<td>17 100</td>
<td>1.28 (1.24–1.32)</td>
</tr>
</tbody>
</table>

Possible reasons short IPI might contribute to adverse outcomes

• Maternal nutritional depletion hypothesis
• Inadequate time to restore folate levels
• Inflammatory mediators / Intrauterine inflammatory milieu – endometritis, PPROM
• Postpartum changes in vaginal microbiome

IPI exercises independent influence on outcomes

Controlling for socioeconomic status, use of health care services, tobacco, alcohol and other exposures does not alter the finding that interpregnancy intervals exercise an independent influence on poor pregnancy outcomes.

Support for IPI>18 Months:
HP 2020 Goal and ACOG Recommendation

Healthy People 2020 birth spacing goal: reduce the proportion of pregnancies conceived within 18 months of a previous birth by 10%, to 29.8%.

ACOG recommends that “women wait at least 18 months after having a baby before trying to get pregnant again in order to have the best health outcomes for both mom and baby.”

healthypeople.gov/2020
Current System is Not Working

• 45% of pregnancies are unintended

• 41% of unintended pregnancies are to women who inconsistently and/or incorrectly use birth control

• Women often do not seek care for themselves OR have no insurance coverage until they are already pregnant
Strategies to Improve Birth Spacing

1. Provider education and engagement.
2. Increase the rate of postpartum visits among women.
3. Home visiting programs.
4. Utilize established initiatives to reach women
   - One Key Question®
   - Every Woman, Every Time
   - IMPLICIT Interconception Care Model
   - CDC “Show Your Love” Consumer Campaign
5. Increase access to highly effective birth control (Long Acting Reversible Contraception).
ACOG Committee Opinion 654 on Reproductive Life Planning

ACOG “encourages obstetrician-gynecologists and other health care providers to use every patient encounter as an opportunity to talk with patients about their pregnancy intentions and to support initiatives that promote access to and availability of all effective contraceptive methods.”
One Key Question® Initiative:
Recommended in ACOG Committee Opinion

This campaign promotes direct screening for women’s pregnancy intentions by asking the following question ……

“Would you like to become pregnant in the next year?”

If the answer is “no,” discuss pregnancy prevention, including education and counseling on all available contraceptive options.

If the response is “yes,” provide preconception counseling and discuss evidence-based lifestyle modifications to optimize health status in preparation for future pregnancies.

ACOG Committee Opinion 654, Reproductive Life Planning to Reduce Unintended Pregnancy, February 2016
Every Woman, Every Time Initiative

“It is not a question of whether you provide preconception care, rather it’s a kind of preconception care you are providing.”

Joseph Stanford and Debra Hobbins
Family Practice Obstetrics, 2nd ed. 2001

- Providers see women every day in multiple settings
- Need to take the opportunity when we can—when she is in front of us, for whatever reason....
  - Primary care providers should be leaders in this effort
  - Need to change our paradigm
  - Preconception Care IS Primary Care
Interconception Care Toolkit utilizing IMPLICIT ICC Model

Incorporates maternal assessments into well-child visits with pediatric and family medicine providers, focusing on: birth spacing and contraception, depression screening, smoking cessation, and folic acid intake.

IMPLICIT (“Interventions to Minimize Preterm and Low birth weight Infants through Continuous Improvement Techniques”):

- a set of program models developed by the Family Medicine Education Consortium, funded in part by the March of Dimes.
- IMPLICIT has both a prenatal care model and an interconception care model.
IMPLICIT interconception care toolkit

Incorporating maternal risk assessment into well-child visits to improve birth outcomes

Planned release in 4th Quarter 2016 from March of Dimes
Show Your Love Campaign
Engaging Consumers...

Show Your LOVE! Steps to a Healthier me

Life offers many opportunities. Take time to think about your goals for school, for your job or career and for your health. Your physical and mental health are important in helping you achieve the goals you set for yourself. This is a tool to help you set your goals and make a plan.

Start by choosing your goals for this year. It is easier to focus on 2 – 3 goals. Then use the checklist below to set your plan into motion.

Date plan made or revised:

My top 3 goals for this year are
1.
2.
3.

Check Lists:

- [Link](http://www.cdc.gov/preconception/showyourlove/documents/Healthier_Me_NonPlan.pdf)
- [Link](http://www.cdc.gov/preconception/showyourlove/documents/Healthier_Baby_Me_Plan.pdf)
Increase Access to Highly Effective Contraception: LARC

- Long Acting Reversible Contraception (LARC) includes intrauterine devices (IUDs) and contraceptive implants that prevent ovulation.

- Highly effective in preventing unintended pregnancy:
  - <1 pregnancy per 100 women in a year, compared to oral contraceptive pills (6-12 pregnancies per 100 women in a year) and condoms (>18 pregnancies per 100 woman in a year).

- LARC requires no user intervention, works long term, and can be reversed.

- Increased access to and knowledge of LARC methods helps to decrease unintended pregnancy and improve birth outcomes.
ACOG on Immediate Postpartum LARC

ACOG Committee Opinion 642, October 2015:

“Unintended pregnancy persists as a major public health problem in the United States. Although lowering unintended pregnancy rates requires multiple approaches, individual obstetrician-gynecologists may contribute by increasing access to contraceptive implants and intrauterine devices.”

ACOG Committee Opinion 670, August, 2016

“Immediate postpartum LARC should be offered as an effective option for postpartum contraception; there are few contraindications to postpartum IUDs and implants”. Ob/GYNs and institutions “should develop the resources, processes and infrastructure, including stocking LARC devices in L&D and coding and reimbursement strategies, to support immediate LARC placement after vaginal and cesarean births.”
Barriers to LARC Use

Despite advances in safety and effectiveness of IUDs and implants, and their very low failure rates, LARC use among U.S. women remains relatively low (7.2% in 2011-2013).  

- **Patient Barriers**
  - Low awareness about safety and effectiveness of LARC
  - Upfront, out-of-pocket costs ($500-1,000) can be prohibitive for women who are uninsured/underinsured

- **Provider Barriers**
  - ~50% of OB/GYNs offer LARC in their clinic settings, most commonly due to low patient interest, lack of provider training, and reimbursement issues
  - Providers may use overly restrictive criteria to identify candidates for LARC

- **System Barriers**
  - Costs to women are high and often not fully covered by insurance
  - Inadequate procedures for reimbursement to providers

---

2. ASTHO Fact Sheet: Long-Acting Reversible Contraception (LARC), Association of State and Territorial Health Officials 2014.
LARC: Proven Models

Colorado Initiative to Reduce Unintended Pregnancy
Aimed to reduce unplanned pregnancies by providing intrauterine devices and implants at no cost to young, low income women.

- Birth rate decreased 48% in women ages 15-19 and 19.4% in women ages 20-24
- Repeat teen births dropped by 58%
- 12% decreased risk of preterm birth
- The state estimates that every dollar spent on this initiative saved $5.85 for the state’s Medicaid program due to improved birth outcomes

LARC: Proven models

Contraceptive CHOICE Project (St. Louis)
Examined effect of removing most common barriers to contraception (cost, patient knowledge, access) on reducing unintended pregnancy in a diverse group of ~9,000 women ages 14-45

- 75% chose LARC after receiving counseling about all methods of contraception
- Three-year continuation rates: ~70% among LARC users vs. 31% among non-LARC users
- Non-LARC users were more than 22 times as likely to experience an unintended pregnancy compared to their LARC counterparts
Factors to consider when discussing IPIs with women

Some pregnancies with short IPIs could, in fact, be very intended. Here are some reasons:

- Last pregnancy ended with a tragic or poor outcome such as fetal death, infant death, malformations, prematurity
- Cultural/social familial expectations about how close in age children should be
- Advancing maternal age
- Lack of awareness of the risks

We have not done a good job educating women, but we can change that!
Links to Resources

- **One Key Question®**
  onekeyquestion.org
- **Every Woman, Every Time**
  cdc.gov/preconception/careforwomen/
- **Every Woman California**
  everywomancalifornia.org
- **IMPLICIT Interconception Care Model**
  www.fmec.net/implicitnetwork.htm
- **CDC “Show Your Love” Consumer Campaign**
  ShowYourLoveToday.com
- **March of Dimes**
  marchofdimes.org/catalog
How long should I wait before getting pregnant again?

It's best to wait at least 18 months between giving birth and getting pregnant again. This means your baby will be at least 18 years old before you get pregnant.

Too little time between pregnancies increases your risk of preterm birth. For some women, especially those with a history of preterm birth, waiting longer seems to help. Preterm babies are more likely to have health problems than babies born on time. The shorter the time between pregnancies, the higher your risk for premature birth.

Year body needs time to fully recover from your last pregnancy before it's ready for your next pregnancy.

What you can do:

- Wait 18 months or more after having a baby before getting pregnant again.
- Use effective birth control until you're ready to get pregnant.
- Talk to your health care provider about birth control options.
- Talk to your provider about how long to wait between pregnancies if:
  - You're older than 35.
  - You've had a miscarriage or stillbirth.

Watch videos about having a healthy pregnancy at: marchofdimes.org/videos

march of dimes
A FIGHTING CHANGE FOR EVERY BABY

march of dimes
A FIGHTING CHANGE FOR EVERY BABY
17 alpha-hydroxyprogesterone caproate (17P)

ACOG Practice Bulletin 171, Management of Preterm Labor, October 2016

- One of the strongest clinical risk factors for preterm birth is a prior preterm birth.
- Maternal history of preterm birth confers a 1.5-fold to 2.0-fold increased risk in a subsequent pregnancy

17P

- Synthetic form of progesterone given by injection in the gluteus muscle or anterior thigh
- Reduces a woman’s risk of recurrent preterm birth by 33%

Progesterone trial for the prevention of preterm delivery in high-risk women

NICHD Maternal Fetal Medicine Units (MFMU) Network

NICHD: MFMU Progesterone Trial

- **Aim:** To establish if weekly progesterone injections in women with prior spontaneous preterm delivery (sPTD) reduces the risk of PTD
- **Design:** double-masked, placebo-controlled trial
- **Eligibility criteria:** singleton pregnancy 16-20 wks with documented previous sPTD
- **Intervention:** progesterone or placebo
- **Primary outcome:** delivery at < 37 weeks
- **Sample:** 463 pregnant women

Progesterone: Rates of Preterm Birth

Progesterone Results: Ethnic Group

Progesterone prevents neonatal complications

Progesterone prevents recurrent preterm delivery

- Weekly injections of progesterone prevented recurrent preterm birth and improved the neonatal outcome for pregnancies at risk
- Effective in preventing very early as well as later preterm birth
- Effective in both African American and Non-African American women

Protocol for 17P Use

- History of a previous singleton spontaneous preterm birth (20 to 36 weeks)
- Current singleton pregnancy
- Initiate treatment between 16 - 21 weeks gestation*
- Receive 17P injections weekly until 36 weeks gestation or she delivers

Women who delivered multiple infants preterm and/or who are pregnant with multiples are not eligible for treatment
Contraindications to 17p use

• Current or history of thrombosis or thromboembolic disorders
• Known or suspected breast cancer, other hormone-sensitive cancer, or history of these conditions
• Undiagnosed abnormal vaginal bleeding unrelated to pregnancy
• Cholestatic jaundice of pregnancy
• Liver tumors, benign or malignant, or active liver disease
• Uncontrolled hypertension
Underutilization of 17P

What do we know?
What are the barriers?
North Carolina retrospective cohort study - July 2016

• Only 47% of eligible women received 17P

• This in a state that has had a strong statewide 17P access initiative for 9 years!

• “Many women at risk for preterm birth are not accessing 17P, despite its almost universal availability in our state through both public and private payers.”

• “North Carolina was an early adopter of 17P, with Medicaid paying for the drug as early as 2008.”

Critical path that must be negotiated by eligible women in order to receive 17P: North Carolina study, July 2016

65% of eligible women are offered 17P
74% of women offered 17P accept it

Coverage: 0.47 (95%CI: 0.43, 0.51)

Factors associated with not receiving 17P: NC Study

- Dose-response relationship with severity of the prior preterm birth. The earlier the prior birth, the more likely a woman was to be both offered and accept 17P.
- Women who began prenatal care at more than 20 weeks gestation were less likely to be offered and accept 17P.
- Women who attended less than 4 prenatal visits, or between 4 and 10, were less likely to be offered and accept 17P (compared to women who attended more than 10 prenatal visits).
- Women in rural areas less likely to be offered 17P
- Women whose prior preterm birth was late preterm were more likely to refuse 17P.
- Women were also more likely to refuse 17P if their most recent pregnancy was a term delivery (after having a previous preterm delivery).
North Carolina findings in perspective...

- **47%** of eligible women in North Carolina received 17P
- **7%** of eligible women received 17P in Louisiana in 2013
- Nationwide, an estimate is that approximately **70%** of eligible women receive branded or compounded 17P
  - This is an estimate by AMAG, the manufacturer of branded 17P, based on distributed units of branded 17P and physician market research data on compounded 17P

AMAG Pharmaceuticals (2014). Transformative Acquisition of Lumara Health [Powerpoint Slides].
Barriers to 17P

Identified by Medicaid Health Plans of America and Association of State and Territorial Health Officials (ASTHO)

- Patient cost
- Ease of acquiring the medication
- Late enrollment in coverage and care

“Medicaid health plans have covered 17P for many years. However, under-utilization is still broadly acknowledged.”

Medicaid Health Plans of America Report, 2014
Barriers: Qualitative research
with eligible women and case managers in NC

- Transportation, especially long distances or across counties
- Lack of perceived risk of preterm birth among women
- Competing stressors and priorities (no child care; not able to leave work for weekly appointments)
- Injection site discomforts and inconsistencies in injection administration
- Costs of 17P and payer billing issues
- Lack of provider buy-in toward the treatment

UNC Center for Maternal and Infant Health website, downloaded 7/16
Factors that facilitated access
from NC qualitative research

- Care managers’ praise, encouragement, counseling and continued education about 17P benefits aided treatment compliance.
- Adoption of best practices in care management aided treatment compliance.
March of Dimes 17P Patient Education

Pregnancy after a premature birth: Treatment with progesterone shots (17P)

Because you’ve had a premature birth in the past, you’re more likely to have one in your next pregnancy. But progesterone shots (17P) may help you stay pregnant longer next time.

Taking 17P increases your chances of having a full-term baby in your next pregnancy by one-third (about 33 percent).

Progesterone is a hormone that can help you stay pregnant. You start getting shots between 16 and 24 weeks of pregnancy, and you get a shot each week until 37 weeks.

marchofdimes.org/progesterone

Progesterone shots (17P) to prevent another premature birth

If premature birth is a birth that happens too early (before 37 weeks of pregnancy), your baby is more likely to have health problems than babies born full-term. But the earlier your baby is born, the longer it may stay in the hospital, and the higher your baby’s risk of death or disability is. So, progesterone may help prevent another birth.

What is progesterone?

Progesterone is a hormone that helps your body develop and support the uterus during pregnancy. It helps your uterus attach and support the developing fetus. If you have enough progesterone, the fetus will continue to develop. But if you don’t have enough progesterone, the fetus may not develop properly. This is especially true if you have a history of premature birth or miscarriage.

What are progesterone shots?

Progesterone shots are a kind of hormone called 17 alpha hydroxyprogesterone caproate (also called 17P). It is usually given into your arm or buttocks by a health care provider.

The shots are available in two ways:

Do you need these shots?

Progesterone shots are usually given to women who have a history of premature birth or miscarriage. If you have a history of premature birth, you may need to take these shots if you are pregnant again.

These shots are also given to women who have had a premature birth and have a history of premature birth or miscarriage. These shots may help prevent another premature birth.

If you have any questions about your progesterone shots, talk to your health care provider.

marchofdimes.org/progesterone
The Big 5 Perinatal Collaborative

A Shared Common Vision
March of Dimes Big 5 State Perinatal Collaborative Success

2010- Launched the first Big 5 State initiative - Elimination of Non-medically Indicated < 39 Week Gestational Age Deliveries initiative

2013- Published work of the Big 5 State Initiative
   - Obstetrics and Gynecology
     Vol. 121, No. 5, May 2013

2016- New Big 5 State initiative: Antenatal Corticosteroid Treatment (ACT)
   - Using ACT results in a proven reduction in neonatal morbidity and mortality.
   - New evidence and recommendations are slow to be adopted so best practices are not followed.
   - Some institutions have no protocols and practitioners do not have consistent practice patterns.
   - Poor documentation also contributes to confusion in patient care and inaccurate reporting
Proven Benefits of Antenatal Corticosteroid Therapy (ACT) Between 24 and 34 Weeks

<table>
<thead>
<tr>
<th>Antenatal corticosteroids led to reduction in:</th>
<th>~</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal death (NND)</td>
<td>30%</td>
</tr>
<tr>
<td>Respiratory distress syndrome (RDS)</td>
<td>35%</td>
</tr>
<tr>
<td>Intraventricular hemorrhage (IVH)</td>
<td>50%</td>
</tr>
<tr>
<td>Cerebroventricular hemorrhage</td>
<td>50%</td>
</tr>
<tr>
<td>Necrotizing enterocolitis (NEC)</td>
<td>55%</td>
</tr>
<tr>
<td>NICU admissions</td>
<td>20%</td>
</tr>
<tr>
<td>Early systemic infections</td>
<td>50%</td>
</tr>
</tbody>
</table>

Roberts D, Dalziel S. Cochrane Database of Systematic Reviews 2006; Issue 3
ACOG ACT Recommendations

“The most beneficial intervention for improvement of neonatal outcomes among patients who give birth preterm is the administration of antenatal corticosteroids.

• Give one course of ACT to a women likely to deliver viable preterm infant (24-33\textsuperscript{6} weeks) \leq 7 days
  • Two 12 mg. doses Betamethasone IM 24 hrs. apart \textbf{OR}
  • Four 6 mg. doses of Dexamethasone IM 12 hrs. apart
• Is not indicated if delivery is imminent (< 2 hrs. per TJC)
• May consider at 23 weeks gestation, if expecting delivery \leq 7 days with resuscitation
• May give Betamethasone to women 34-36\textsuperscript{6} at risk of delivery \leq 7 days and who have not previously received ACT.
• May safely consider giving 2\textsuperscript{nd} rescue course to women meeting these criteria:
  • Received 1\textsuperscript{st} ACT course > 14 days earlier
  • Remain at risk of PTB before 34 weeks gestation

ACOG Practice Bulletin #171, Management of Preterm Labor, October, 2016
ACOG Committee Opinion #677, Antenatal Corticosteroid Therapy for Fetal Maturation, October, 2016
Antenatal Late Preterm Steroids trial:

- Eunice Kennedy Shriver NICHD, Maternal-Fetal Medicine Units Network
- Double-blind, placebo-controlled randomized controlled trial.
- 17 Maternal-Fetal Medicine Units across USA 2010-2015
- Women with singleton fetus 34 – 36 weeks, if in PTL at ≥ 3 cm dilation or 75% effaced, if PROM, or if planned delivery in late preterm time period per provider discretion (N=2831)
- Betamethasone 12 mg IM X 2 24 hours apart vs placebo; no tocolysis
- Results showed a significant decrease in:
  - Need for respiratory support in first 72 hrs. (primary trial outcome)
  - Rates of severe respiratory morbidity
  - Bronchopulmonary dysplasia
  - Transient tachypnea of the newborn
  - Resuscitation at birth
  - Need for postnatal surfactant

Recommendations for women 34-36\textsuperscript{6} Singleton fetus:

1. Treat with 2 doses of Betamethasone 12 mg IM 24 hrs. apart for high risk of delivery ≤7 days, but before 37 weeks.
2. Wait until evidence of PTL (3 cm or 75% effaced) before Betamethasone is given.
3. Do not use tocolysis to delay delivery or to complete ACT course as unclear whether benefits of ACT outweigh risks of delaying delivery.
4. Do not give ACT to women with a potential medical indication for delivery, unless there is a definitive plan for late preterm delivery.
6. Do not use this protocol for conditions not studied in this trial, unless performed as part of research or quality improvement.

Optimal Prenatal Care
Depression Screening and Pregnancy
## Depression in Adults: Screening

**Release Date:** January 2016

### Recommendation Summary

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What’s This?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General adult population, including pregnant and postpartum women</td>
<td>The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.</td>
<td>B</td>
</tr>
</tbody>
</table>

### Grade and Definition

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.</td>
</tr>
</tbody>
</table>

### Suggestions for Practice

- Offer or provide this service.
The totality of the evidence supports the benefits of screening ... pregnant and postpartum and general adult populations.

Although definitive evidence of benefit is limited, the College recommends that clinicians screen at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool.
## Depression Screening Tools

<table>
<thead>
<tr>
<th>Screening Tool</th>
<th>Number of Items</th>
<th>Time to Complete (Minutes)</th>
<th>Sensitivity and Specificity</th>
<th>Spanish Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh Postnatal Depression Scale</td>
<td>10</td>
<td>Less than 5</td>
<td>Sensitivity 59–100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Postpartum Depression Screening Scale</td>
<td>35</td>
<td>5–10</td>
<td>Sensitivity 91–94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient Health Questionnaire 9</td>
<td>9</td>
<td>Less than 5</td>
<td>Sensitivity 75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Beck Depression Inventory</td>
<td>21</td>
<td>5–10</td>
<td>Sensitivity 47.6–82%</td>
<td>Yes</td>
</tr>
<tr>
<td>Beck Depression Inventory-II</td>
<td>21</td>
<td>5–10</td>
<td>Sensitivity 56–57%</td>
<td>Yes</td>
</tr>
<tr>
<td>Center for Epidemiologic Studies Depression Scale</td>
<td>20</td>
<td>5–10</td>
<td>Sensitivity 60%</td>
<td>Yes</td>
</tr>
<tr>
<td>Zung Self-rating Depression Scale</td>
<td>20</td>
<td>5–10</td>
<td>Sensitivity 45–89%</td>
<td>No</td>
</tr>
</tbody>
</table>

ACOG Committee Opinion No. 630, May 2015. Screening for Perinatal Depression
Safer Medication Use
Medication Use in Pregnancy: A Public Health Concern

• Medication use has surged to 9 out of 10 pregnant women. About 7 out of 10 take at least one prescription medicine. Over the last 30 years, use of prescription medicine during the first trimester of pregnancy has increased more than 60%.¹

• Fewer than 10% of medications have enough information to determine their safety for use in pregnancy.²

• Taking certain medications, such as isotretinoin (also known as Accutane®), during pregnancy can cause serious birth defects or poor pregnancy outcomes.


CDC: Treating for Two. Available at:www.cdc.gov/pregnancy/meds/treatingfortwo/facts.html
Some studies have shown an association of opioid use with stillbirth, poor fetal growth, pre-term delivery, and birth defects.

For pregnant women already receiving opioids, avoiding or stopping medication use during pregnancy may be more harmful than taking a medication.

Clinicians should access appropriate expertise if considering tapering opioids because of possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.

For pregnant women with opioid use disorder, medication-assisted therapy with buprenorphine or methadone has been associated with improved maternal outcomes and should be offered.
Pregnancy and Oral Health
ACOG Recommendations

1. Discuss oral health with all patients, including those who are pregnant or in the postpartum period.

2. Advise women that oral health care improves a woman’s general health through her lifespan and may also reduce the transmission of potentially caries-producing oral bacteria from mothers to their infants.

3. Conduct an oral health assessment during the first prenatal visit.

ACOG Recommendations

4. Reassure patients that prevention, diagnosis, and treatment of oral conditions, including dental X-rays (with shielding of the abdomen and thyroid) and local anesthesia (lidocaine with or without epinephrine), are safe during pregnancy.

5. Inform women that conditions that require immediate treatment, such as extractions, root canals, and restoration (amalgam or composite) of untreated caries, may be managed at any time during pregnancy. Delaying treatment may result in more complex problems.

Additional Resources

Depression:

NICHD, NCMHEP
www.nichd.nih.gov/ncmhep

U.S. Preventive Services Task Force:
www.uspreventiveservicestaskforce.org

IMPLICIT Toolkit Coming in Fall 2016
www.prematurityprevention.org

Medication Use
Treating for Two: http://www.cdc.gov/pregnancy/meds/treatingfortwo/

Oral Health
Thank you