Defense Health Agency (DHA) Clinical Communities Speaker Series

Feb 2021 CCSS: Challenges in Women's and Infants' Health

S04: Perinatal Loss: Policy Updates and Best Practices

Unanswered Questions from the Session

1. Are we testing for thyroid abnormalities in those who are experiencing pregnancy loss?

   ANSWER: *Yes. The American Society for Reproductive Medicine (ASRM) and the American College of Obstetricians and Gynecologists recommend thyroid screening in patients with recurrent miscarriage (2 or 3 first trimester losses without an identified etiology). In the cases of stillbirth, thyroid testing is not part of the first line testing, however may be considered in clinically appropriate situations (e.g. no clear etiology of the stillbirth, other clinical evidence of thyroid disease, etc.).*

2. Would not sensitivity and sympathy demonstrate the expression of active listening, non-judgmental approach, etc.?

   ANSWER: *I am not sure I completely understand the question, but yes I agree that sensitivity and sympathy are important.*

3. From an emotional perspective, what are some strategies to prevent further trauma to a woman by giving her the option to complete medical follow-up appointments without having to sit in a waiting room with other pregnant women or asking her to return to the same environment where she learned of her miscarriage and/or had a medical procedure completed (e.g., D&C, labor, etc.)?

   ANSWER: *Having these patients come in for the very first or the very last appointment of the day can help avoid them being in waiting room full of other pregnant women. There may also be alternative ways for them to access the clinic (or provider office) without needing to come through the waiting room (i.e. have the patient text or call when they arrive and escort them through a side door). Some visits may also be amenable to virtual modality, allowing the patient to be in her own home/space for the visit. If possible, consideration could also be taken to coordinating seeing the patient in a separate clinic space (i.e. patient checks into primary care clinic and women's health staff sees them there).*

4. Why doesn't the military consider a D&E or covered even if the "patient" or mother isn't at risk, for example, why does some military branches deny a D&E/D&C if the fetus has several fetal abnormalities (Hypoplastic Left Heart Syndrome, CDH, and missing forearm bones) and the baby will not survive after birth, but the mother is healthy? It is painful to know that the military will make a mom carry the baby to term only to prepare for death.

   ANSWER: *Military medical care is limited by federal law when it comes to the provision of pregnancy termination. The only pregnancy terminations that are allowed to be performed under*

TRICARE (and in our MTFs) are those when the pregnancy is a result of incest or rape, or the mother's life is endangered with continuation of the pregnancy. You present a terribly difficult scenario here and I understand your concerns. I think in these scenarios, as military providers we try to provide the most compassionate care possible within the bounds/limitations of the law.

5. With regards to providing support (especially with stillbirth), are patients and families given the option to utilize photography services such as Now I Lay Me Down To Sleep?

   ANSWER: *Yes, absolutely. Patient are encouraged to utilize community resources such as Now I Lay Me Down to Sleep and MTF/clinical staff are encouraged to be familiar with what is available in the community to help support patients experiencing perinatal loss. While there will not be a formal arrangement between an MTF and community organizations such as Now I Lay Me Down To Sleep, these types of resources are certainly an option for patients to pursue and utilize.*

6. Do you recommend the ROSE program for education for nurses? Any other education programs that you recommend?

   ANSWER: *I am not familiar with the ROSE program, however I know there are lots of great training resources out there. Resolve Through Sharing is a great example of perinatal bereavement training. Additionally, the Women and Infant Clinical Community (WICC) Perinatal Loss Working Group is currently working on creating our own perinatal bereavement training that would be available for our Military Health System (MHS) care teams.*

7. Frequently, MTFs rely upon donations for memory boxes and other items to support the after care of a stillbirth. As part of DHAs approach are supplies being added to the logistics ordering system?

   ANSWER: *The WICC Perinatal Loss Working Group is currently working on a Defense Health Agency Procedural Instruction (DHA-PI) surrounding perinatal loss clinical care. Memory boxes are included in this DHA-PI and (if we are successful with our efforts) would become a requirement for care of patients who have perinatal loss. This requirement would help to drive MTF funding for these supplies.*

8. Thank you for this excellent presentation. How can we continue to provide consistent education, support, and resources to our staff and patients across the MTF and New Parent Support Program?

   ANSWER: *That is a great thought, honestly not one I had considered. I would say that collaboration between the perinatal care teams and the New Parent Support Programs would be a mutually beneficial relationship. I would encourage our perinatal care teams to reach out to New Parent Support Program and provide education or share resources in order to help create another platform where families could find support following perinatal loss. This is something we should consider for our perinatal loss DHA-PI!*

9. Not a question, but just to add to the conversation (as a previous Labor and Delivery nurse) it is important to also be sure you have regular gowns to give the patient, rather than a breastfeeding gown. I would also recommend rooming a parent with a fetal demise away from new parent and

newborn rooms. Crying babies can easily upset patients/parents who just lost their baby. Debriefing for staff members who cared for the stillbirth family is also very helpful.

ANSWER: *All great points. Thank you!*

10. What is needed for your policy recommendations to be implemented? Does it take language to be included in the next National Defense Authorization Act? Or, can DHA implemented the policy themselves without Congressional intervention?

    ANSWER: *Once the policy (DHA-PI) is completed it will be adjudicated through the Services and DHA. If concurrence is obtained and DHA leadership also concurs then we should be able to create a policy.*

11. Will there be funding for Memory Making Items (memory boxes, etc)? TAMC has an average of 2 perinatal losses a month with no support outside fundraising by our bereavement team.

    ANSWER: *See question #7 above.*

12. Is perinatal hospice something offered to families?

    ANSWER: *That is a great question. Hospice care is covered by TRICARE for all ages. Perinatal hospice is not explicitly excluded (that I am aware of) but I don't know for sure that it is a covered benefit. I know that I have had patients who have utilized these services before, but I honestly don't know if they paid for them out of pocket. I will have to look into this further.*

13. Are we screening women for depression postpartum or post miscarriage/stillbirth?

    ANSWER: T*he short answer is yes, I think we are most of the time and should continue to strive to do so. Per the VA/DoD Pregnancy Clinical Practice Guidelines, screening for depression is recommended at the first prenatal visit, 28-32 weeks and then at the postpartum f/u visit(s). Patient who f/u for postpartum care following a pregnancy loss should be screened with either the Edinburgh Postpartum Depression Screen or the PHQ-9. It is less likely that women will follow up for postpartum care following an early miscarriage, however screening for depression (PHQ-2) should be occurring in primary care clinics and so patients who return to see their PCM (instead of OB) should still have a touch point for evaluation for depression.*

14. At what point would you clear a patient to return to duty post miscarriage? Including second and third trimester.

    ANSWER: *Our con-leave recommendations are based on gestational age. See chart below.*

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Gestational Age	Leave Recommendations	Profile Recommendations	Comments
First Trimester ≤ 12+0	7 day	60 days no Physical Fitness Testing (PFT)	*With or without surgical intervention
Second Trimester 12+1 – 16+0	14 days	180 days no PFT testing	*With or without surgical intervention
Second Trimester 16+1 – 19+6	21 days	180 days no PFT testing	If neonate has a fetal weight of 350 grams or more, patient should receive 42 days of convalescent leave.
Second Trimester 20+0 – 27+6	42 days	365 days no PFT testing	None
Third Trimester 28+0 – term	42 days	365 days no PFT testing	None