Abstracts From the National Perinatal Association's 2022 Conference Perinatology at the Intersection of Health Equity and Social Justice May 2-4 in Aurora, Colorado

Jerasimos (Jerry) Ballas, MD, MPH

The National Perinatal Association (NPA)is an interdisciplinary organization that strives to be a leading voice for perinatal care in the United States. Our diverse membership is comprised of healthcare providers, parents & caregivers, educators, and service providers, all driven by their desire to give voice to and support babies and families at risk across the country.

Members of the NPA write a regular peer-reviewed column in Neonatology Today.

National Perinatal Association

Educate. Advocate. Integrate.

"Here is the link to the poster page form the NPA 2022 conference website: https://www.npaconference.org/posters"

NPA2022-1

The effects of childhood and adulthood social determinants of health on psychological stress during pregnancy: The role of mindfulness and social support to improve health equity

Alsup, S., * Dugoni, H., * Doyle, O., Mackiewicz Seghete, K. & Graham, A.

**These authors contributed equally to this project.*

Introduction. Pregnant individuals are at heightened risk of experiencing psychological stress,[1-4] which may contribute to long-term adverse health consequences for pregnant and postpartum individuals,[5-6] and their offspring.[7-8] It is well-established that psychological stress is more prevalent in individuals with marginalized identities and contributes to health disparities.[9] Social determinants of health (SDoH), characterized as environmental circumstances that affect health, help explain disparate health outcomes.[10-12] Mindfulness-based interventions are gaining support as effective treatments for reducing psychological stress during pregnancy.[13] Further, social support may also be a protective factor against psychological stress.[14] Interventions are needed to identify how childhood and adulthood SDoH contribute to psychological stress during pregnancy. Our research aims to serve as a foundation for identifying mindfulness and social support practices for pregnant individuals to reduce health disparities across generations. The current study sought to examine if protective practices (mindfulness and social support) improved the prediction of psychological stress during pregnancy. ***Method.*** Participants were pregnant individuals (N= 187) who completed self-report measures at baseline (14-23 weeks gestation) about physical and psychological health, social and demographic factors, and coping behaviors prior to eligibility review for an ongoing longitudinal clinical trial examining the effects of Mindfulness-Based Cognitive Therapy on maternal and offspring health outcomes. ***Results.*** Two hierarchical multiple regressions were run to determine if the addition of mindfulness and social support improved the prediction of maternal psychological stress during pregnancy beyond gestational age, body mass index, and Model 1) childhood SDoH and Model 2) adulthood SDoH. Childhood SDoH included race; childhood public assistance, family finances, and healthcare; and childhood trauma. In Model 1, the addition of mindfulness and social support accounted for 45% of the variance, R^2 = .457, F(9, 130) = 12.160, p < .001; adjusted R^2 = .419, and significantly contributed to the model beyond childhood SDoH. For Model 2, adulthood SDoH included race; objective and subjective income; education level; likelihood of food insecurity; and adulthood trauma. In Model 2, the addition of mindfulness and social support accounted for 45% of the variance, R^2 = .451, F(10, 130) = 10.700, p < .001; adjusted R^2 = .409, and significantly contributed to the model beyond adulthood SDoH. Semi-partial correlations suggested that mindfulness uniquely explained the greatest variance when controlling for all other variables. Interestingly, given the overlap in childhood and adulthood SDoH findings, semi-partial correlations indicated that childhood trauma uniquely explained the greatest variance for childhood SDoH, whereas the likelihood of food insecurity uniquely explained the greatest variance for adulthood SDoH. ***Discussion.*** The addition of mindfulness and social support to the prediction of maternal psychological stress further explained variance in the model, beyond childhood and adulthood SDoH; preliminary findings indicate that as mindfulness and social support increase, maternal psychological stress during pregnancy decreases. Initiatives and policies that promote healthy coping practices may support long-term maternal and offspring health,[15-16] particularly for those with marginalized identities who are at increased risk of psychological stress during pregnancy. Findings should be interpreted with caution, given that they are preliminary in nature. Future analyses will examine mediators and moderators of psychological stress, with the overarching goal of using childhood and adulthood SDoH to inform interventions that improve the health of pregnant individuals and their offspring.

Abstract Submission for National Perinatal Association's 42nd Annual Interdisciplinary Conference (Applied or Basic Research)

Shelby Alsup, MS & Hannah Dugoni, MA (alsup@ohsu.edu & dugoni@ohsu.edu)

References

1. *Farias, D. R., Pinto, T. D. J. P., Teofilo, M. M. A., Vilela, A. A. F., dos Santos Vaz, J., Nardi, A. E., & Kac, G. (2013). Prevalence of psychiatric disorders in the first trimester of pregnancy and factors associated with current suicide risk. Psychiatry Research, 210(3), 962-968.*
2. *Goodman, J. H., Chenausky, K. L., & Freeman, M. P. (2014). Anxiety disorders during pregnancy: a systematic review. The Journal of Clinical Psychiatry, 75(10), 1153-1184.*
3. *Rubertsson, C., Hellström, J., Cross, M., & Sydsjö, G. (2014). Anxiety in*

early pregnancy: prevalence and contributing factors. Archives of Women's Mental Health, 17(3), 221-228.
4. *Uguz, F., Yakut, E., Aydogan, S., Bayman, M. G., & Gezginc, K. (2019). Prevalence of mood and anxiety disorders during pregnancy: A case-control study with a large sample size. Psychiatry Research, 272, 316-318.*
5. *Ahmed, A., Bowen, A., Feng, C. X., & Muhajarine, N. (2019). Trajectories of maternal depressive and anxiety symptoms from pregnancy to five years postpartum and their prenatal predictors. BMC Pregnancy and Childbirth, 19(1), 1-10.*
6. *Hasanjanzadeh, P., & Faramarzi, M. (2017). Relationship between maternal general and specific-pregnancy stress, anxiety, and depression symptoms and pregnancy outcome. Journal of Clinical and Diagnostic Research: JCDR, 11(4), VC04.*
7. *Glover, V. (2014). Maternal depression, anxiety and stress during pregnancy and child outcome; what needs to be done. Best Practice & Research Clinical Obstetrics & Gynaecology, 28(1), 25-35.*
8. *Grote, N. K., Bridge, J. A., Gavin, A. R., Melville, J. L., Iyengar, S., & Katon, W. J. (2010). A meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight, and intrauterine growth restriction. Archives of General Psychiatry, 67(10), 1012-1024.*
9. *Schetter, C. D., & Tanner, L. (2012). Anxiety, depression and stress in pregnancy: implications for mothers, children, research, and practice. Current Opinion in Psychiatry, 25(2), 141.*
10. *Satcher, D. (2010). Include a social determinants of health approach to reduce health inequities. Public Health Reports, 125(4_suppl), 6-7.*
11. *Shick, S., Adebambo, I., & Perzynski, A. (2019). Health Disparities and Social Determinants of Health. In Health Disparities (pp. 7-15). Springer, Cham.*
12. *World Health Organization. (n.d.). Mental health: strengthening our response. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.*
13. *Shapero, B. G., Greenberg, J., Pedrelli, P., de Jong, M., & Desbordes, G. (2018). Mindfulness-based interventions in psychiatry. Focus, 16(1), 32-39*
14. *Razurel, C., Kaiser, B., Antonietti, J. P., Epiney, M., & Sellenet, C. (2017). Relationship between perceived perinatal stress and depressive symptoms, anxiety, and parental self-efficacy in primiparous mothers and the role of social support. Women & Health, 57(2), 154-172.*
15. *Bayrampour, H., Tomfohr, L., & Tough, S. (2016). Trajectories of perinatal depressive and anxiety symptoms in a community cohort. The Journal of Clinical Psychiatry, 77(11), 0-0.*
16. *Chojenta, C., Loxton, D., & Lucke, J. (2012). How do previous mental health, social support, and stressful life events contribute to postnatal depr*ession in a representative sample of Australian women?. *Journal of Midwifery & Women's Health*, *57*(2), 145-150.

NPA2022-2

For low-income women receiving prenatal care, race matters

Lindsey Garfield, Dina Tell, Lisa Masinter, Jena Wallander Gemkow, Cara Joyce, Sandi Tenfelde

Abstract

Introduction: In the United States (US), Black women suffer disproportionate poor birth outcomes, including increased morbidity and mortality for mothers and babies. Federally Qualified Health Centers (FQHCs) serve under-resourced populations in the US and these populations are at higher risk for poor birth outcomes. Little is known about how race and ethnicity affect perinatal risk factors for women who receive care at FQHCs. The purpose of this study is to explore racial/ethnic differences in women receiving prenatal care in Federally Qualified Health Centers (FQHCs).

***Methods*:** We conducted a retrospective secondary analysis of 17,086 prenatal women receiving care at FQHCs between 2012–2017.

***Results*:** Compared to both white and Latinx pregnant women, Black women were less likely to initiate prenatal care in the first trimester and less likely to be partnered during their pregnancy. Black women are at greater risk for elevated pre-pregnancy body mass index (BMI) compared to White women and more at risk for hypertension compared to Latinx women.

***Conclusion*:** This study highlights prenatal differences in Black, white and Latinx women. Education on the importance of first trimester entry into prenatal care, adequate social support and healthy nutrition are important to include in the care of Black women of childbearing age.

NPA2022-3

Maternal Perceptions of the Impact of COVID-19 on Visitation Practices in a Level IV Neonatal Intensive Care Unit

Monica Garza Saenz, M.A., Melissa A. Faith, Ph.D., ABBP, Sunita Stewart, Ph.D., ABBP, Dailyn Acosta, Ph.D.

Introduction: Maternal neonatal intensive care unit (NICU) presence is critical for infants' medical recovery and overall neurodevelopmental trajectory (Reynolds et al., 2013). Yet, studies conducted in the United States suggest that caregivers' NICU presence vary significantly (Greene et al., 2015). Since March 2020, many NICUs have enacted policies that restrict caregiver visitation because of COVID-19. This study evaluates mothers' perceptions of COVID-19 impact on their NICU presence.

Methods: Data were collected as part of a larger, funded, ongoing study evaluating a motivational interviewing intervention to increase maternal NICU presence. We enrolled a diverse and representative sample of 62 NICU mothers (age *M*(*SD*)=28(7.6), 46% Hispanic, 20% Spanish-speaking, 80% government subsidized insurance), 8% of whom reported testing COVID-19 positive at the time of their infant's admission. Participants were recruited if 1) their infant's initial treatment plan included ≥2 weeks of NICU hospitalization, and 2) the mother's preferred language was English or Spanish. Exclusion criteria included active Child Protective Services involvement, the biological mother not having custody, and/or maternal cognitive impairment. As part of the larger study, participants were randomized into the motivational interviewing intervention (MI) group (*N* = 29) or a treatment-as-usual control (TAU) group (*N* = 33). Prior to randomization, participants completed an assessment battery that included whether they tested COVID-19 positive during or after pregnancy. At the time of their infant's NICU discharge, participants completed the COVID-19 NICU Visitation Impact scale, a 20-item self-report measure developed in English and Spanish for this study. Themes included understanding visitation restrictions and guidelines, availability and engagement at bedside, perceived distress, and socioeconomic resources. Participants reported the impact of COVID-19 visitation restrictions on a 4-point Likert-type scale (1=*Not true at all*, 4=*Very true*), with higher scores indicating greater impact. We determined maternal visitation rate using concierge electronic visitation data as well as electronic medical record flowsheets where

nursing staff document visitation information.

Results: For participants who completed discharge measures (*N*=53), the most commonly endorsed COVID-19 NICU visitation barrier was having other children in the home. Mothers tended to rate the hospital's COVID-19 policies as a minimal barrier to NICU presence. A subset of mothers reported that COVID-19-related stressors caused them to visit the NICU more than they may have otherwise visited.

Discussion: To our knowledge, this is one of the first studies to develop a self-report measure to assess maternally reported COVID-19 impact on NICU presence. We suspect the hospital's 'one visitor only' policy during COVID-19 may have introduced a barrier particularly for parents of multiple children. Preliminary findings suggest mothers may continue to benefit from additional resources during the COVID-19 pandemic, especially related to childcare, COVID-19 related stress, and finances.

NPA2022-4

Introducing Drexel University's NPASS: The First Psychology Student-Led Chapter of the National Perinatal Association Student Society

Alison R. Hartman, M.S.[1], Ariana Albanese, M.S. [1], Leah B. Sodowick, B.A. [1], Chavis Patterson, Ph.D.[2], & Pamela A. Geller, Ph.D. [1,3]

[1]Department of Psychological and Brain Sciences, Drexel University, Philadelphia, PA

[2]Division of Neonatology, The Children's Hospital of Philadelphia, Philadelphia, PA

[3]Department of Obstetrics and Gynecology, Drexel University, Philadelphia, PA

Introduction:

The National Perinatal Association's Student Society (NPASS) is the student arm of NPA that seeks to advance NPA's mission of improving perinatal care in the United States through student education, advocacy, and collaborative integration across healthcare disciplines. The newly-formed Drexel NPASS is the first and only chapter of this national society that is based in a psychology department rather than a medical school. Led by psychology graduate students and faculty advisors, this new chapter shares leadership with and aims to be the student voice of the National Network of NICU Psychologists (NNNP), whose mission is improving psychosocial outcomes across neonatal settings. The Drexel NPASS chapter will function as part of the Maternal and Child Health Student Organization at Drexel's Dornsife School of Public Health, further extending opportunities for interdisciplinary student collaboration and exchange of ideas.

Content:

The Drexel NPASS seeks to further the goals and mission of NPA by bringing together an interdisciplinary group of students interested in perinatal and neonatal care to learn from and collaborate with one another, creating mentorship and networking opportunities for these students with established professionals, promoting the best evidence-based practices through research, education, and outreach, and supporting and advocating for perinatal individuals, infants, their families, and their healthcare providers across the country. This poster will present programming and other initiatives of the Drexel NPASS based on NPA's three pillars: education, advocacy, and integration. We plan to further NPA's dedication to *education* through quarterly journal clubs (presenting and discussing recent relevant literature as a group), preparation of conference submissions, webinars, position statements, guidelines, and publications, and presentation of community talks through our connections with local experts, including members of the NNNP. In alignment with NPA's dedication to *advocacy*, the Drexel NPASS will work collaboratively with NNNP to promote awareness and evidence-based policy recommendations in our home city of Philadelphia, our home state of Pennsylvania, and beyond. Though our collaborations with students in the Drexel Maternal and Child Health Student Organization and NICU psychologists in NNNP, we will *integrate* interdisciplinary perspectives through social events, research projects, networking and mentorship opportunities, and practice application.

Practice Application:

We hope to inspire other students, particularly in the field of psychology, who are dedicated to pursuing careers aimed at improving mental health and psychosocial aspects of perinatal care in the U.S. We also hope to serve as a model for other NPASS chapters operating within psychology departments across the country. As one of the first chapters of its kind, Drexel NPASS hopes to give student voice to efforts that will pave the way for improving perinatal mental health and wellbeing. By harnessing the power of multiple disciplines and perspectives, we hope to create a warm community of future professionals who feel empowered to pursue careers dedicated to making a real difference in the lives of perinatal individuals and their families.

NPA2022-5

A Needs Assessment for Recently Incarcerated Birthing People

Sydney Morris, BS, Reilly Gallin, BA, Alinne Z. Barrera, PhD

The number of birthing people who are incarcerated has increased significantly over the years, with about 6-10% of birthing

people in the legal system being pregnant at the time they enter correctional facilities. (Kelsey et al., 2017). Young, low-income, birthing people are disproportionately incarcerated, and the majority endorse a history of physical or sexual abuse (Richie, 2001). Consequently, birthing people may enter and exit the legal system with a unique set of concerns that impact their mental health. It is estimated that anywhere from 17-48% of incarcerated birthing people currently have PTSD (Harner et al., 2013). Harner et al. (2013) found that over half of participants experienced assault (sexual and nonsexual) or sexual contact before the age of 18. The authors also reported that participants who endorsed experiencing more severe symptoms of PTSD used mental health services within prison and took medication for depression or anxiety (Harner et al., 2013).

In addition to the mental health needs of incarcerated birthing people, medical care is not usually sufficient, particularly reproductive health care (Mignon, 2016). Prisons and correctional facilities are not required to follow standards set by the American College of Obstetricians and Gynecologists (ACOG), which has resulted in a decline of adequate reproductive healthcare (Kelsey et al., 2017). Correctional facilities continue to use restraints throughout labor, interfering with the ability to detect complications and other medical issues that may arise due to these kinds of restrictions. (Kelsey et al., 2017). Due to the longer duration of prison sentences compared to jail time, prisons tend to have more of a system in place for birthing folks care, however, Kelsey et al. (2017) highlighted the issues that continue to arise, such as using restraints, for folks in prison as well. During the labor and delivery process, Kelsey et al. (2017) found that the jails reviewed for their study allowed almost half of birthing people to apply for furlough, and of those who are not granted furlough, 10% and 19% were allowed to have the baby's second parent or another family member present, respectively (Kelsey et al., 2017). The restrictions on birthing choices and support may have a negative impact on birthing people in correctional facilities and create unique adverse experiences for them while in the legal system and when they exit.

The impact these issues have may stay with birthing people beyond their time in correctional facilities, which highlights the importance of assessing and creating plans for their needs upon reentry into their communities and homes. Birthing people have additional stressors to manage as they make this transition back into their community due to significant changes physically, mentally, and emotionally, and in their new role as parents. Little attention has been given to the needs of pregnant and birthing people in prison settings as demonstrated by the lack of medical and adequate mental health resources as discussed earlier. This presentation will propose and outline a needs assessment for birthing people and their reintegration into their communities. A reproductive justice and community based participatory framework will be used to examine this issue and think about potential solutions for reducing and treating mental health and other concerns birthing people have. The implications of this research can lead to improved mental health outcomes for birthing people by informing clinicians and healthcare professionals about the support needed and gaps in care to be filled with this specific population. Fully understanding the experience of birthing people in correctional facilities is difficult for those who have not done so themselves, which highlights the importance of having the voices of birthing people, their families, and communities involved in their care.

NPA2022-6

"Me? Am I the Trauma?": Shifting Perinatal Nursing Culture to a New Standard of Advocacy

Amanda Irby, BSN, RNC-OB, C-EFM, LCCE, Paula Richards, MSN, RNC-OB, C-EFM, Margaret Runyon, MSN, RNC-OB, C-EFM, CYT-200

Introduction

Nursing education and professional development about systematically-oppressed groups has historically been dependent on stereotypes and saviorship, which causes considerable harm and perpetuates dismissive and patriarchal attitudes. Nurses are often trained to focus on supporting providers and policies, and a shift in this mindset is necessary for collaborative care founded on patient autonomy. (1) Standard birthcare is inadequate to meet the needs of families and nurses. Current studies indicate birth trauma occurs in an estimated 34% of all births, (2) mistreatment rates are elevated in birthing people of color, (3) and 54% of nurses suffer from moderate burnout. (4) A new framework is necessary that centers nursing around a standard of trauma-informed advocacy for each and every person in their care. Trauma-informed care (TIC) has been heralded nationally by SAMHSA for decades, but application to birthing families' bedsides has been inconsistent.

Content

The Trauma-Informed Birth Nurse Program (TIBN) centers nurses' perspectives around the disenfranchised within our birthcare system, and illuminate why TIC is necessary for all patients at all times. We have defined TIC as *"one element of organizational change that prioritizes the individual as the leader of their own health, and recognizes how person-centered care shifts unhealthy power dynamics to mitigate the potential for trauma found in each care interaction."* Nurses are invited to question the foundation and motivation of our healthcare practices, examine their own biases, and reflect upon further resources as they work through the program. Each of the 6 modules in the TIBN Foundations program is anchored by a parent sharing their lived experiences, and content incorporates SAMHSA's 4 Rs of TIC. (5) Nurses are called to journal through the content as they review case studies, create scripts, and apply these concepts to their own practice. This high-touch, asynchronous virtual learning environment is supported through several group live video processing calls with a trauma therapist, and the three labor and birth nurse co-creators.

Practice Application

To date, two cohorts have entered the program, serving a total of 55 nurses. For course preparation, students participated in an in-depth pre-survey to gauge their understanding of trauma-informed care principles and their secondary trauma symptoms. Administration of the Secondary Trauma Stress Scale (STSS) revealed 42% evidenced secondary trauma stress, consistent with recent research. (6)

Results: Preliminary feedback from students has been overwhelmingly positive, with many voicing frustration at lacking this information earlier in their career. Student K.R. reflects *"[Going into this course,] I knew I wanted to be crafting my practice to be trauma-informed but I really didn't know what that would look like. This course has been showing me the full dimensionality of what trauma in our specialty looks like. This is useful both in connecting with our patients and to keep from being complicit in causing harm to these patients who place their trust in us to keep them safe."* Students also share how they translate these concepts into care: A.Q. explains "*I posted a flyer on my unit sharing the TIBN definition of TIC and simple actions individual nurses can take*" and J.V. said "*I've stopped using dark humor; it's insidious and results in us losing sight of centering our patient.*

Opportunities: As students complete the course we are evaluating their STSS scores and their confidence embodying trauma-informed care in their personal practice. Further levels of the TIBN program in development focus on quality improvement projects and nurse leadership at the bedside. Additionally, we are prioritiz-

ing efforts to increase program reach so the voices and experiences of parents inform a broader swath of nurse education and care practices.

References:

1. *Kuzma, E.K., Pardee, M., Morgan, A. (2020). Implementing Patient-Centered Trauma-Informed Care for the Perinatal Nurse*
2. *Simkin, P. (2020). Birth Trauma: Definition and Statistics.*
3. *Vedam, S. Stoll, K., Taiwo, T.K., Rubashkin, N., Cheyney, M. Strauss, N. McLemore, M. Cadena, M., Nethery, E., Rushton, E. Schummers, L., Declercq, E. (2019).The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States*
4. *Kelly, L.A., Gee, P.M., & Butler, R.J. (2021). Impact of nurse burnout on organizational and position turnover.*
5. *SAMHSA. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.*
6. *Nicholls, E.M., Hermann, R.M., Girordano, N.A., & Trotta, R.L. (2021) SECONDARY TRAUMATIC STRESS AMONG LABOR AND DELIVERY NURSES.*

NPA2022-7

The Imperative of Equitable, Accessible Childbirth Education

Denise Bolds, MSW, AdvCD(DONA), CLC, CBE, EBB® Instructor, Michelle Gabriel-Caldwell, PhD, CD, EBB® Instructor, Meredith Strayhorn, M.Ed, CD, Student Midwife, EBB® Instructor, Sasha Sumling, LMT, CD, EBB® Instructor, Margaret Runyon, MSN, RNC-OB, CYT-200

Introduction

The abysmal, worsening perinatal morbidity and mortality rates in the US are fueled by large disparities in the treatment of Black individuals. (1) Black and Brown families deserve equitable access to childbirth classes that prepare them for the realities of birth while bolstering their community connections. It is necessary to prioritize classes that center Black joy, where parents are safely supported in exploring and voicing their goals and desires for birth, and where evidence around typical birthcare interventions is shared. Childbirth education must address the racism-driven disparities in birthcare outcomes, and research demonstrates the importance of cultural-congruence between students and instructors of color with lived experience navigating these issues. (2)

Content

Your BIRTH Partners' (YBP) Evidence Based Birth (EBB®) Childbirth Class Imperative was created in response to the call for accessible childbirth education that meets the needs of Black and Brown families navigating the tremendous inequities in our current birthcare environment. The partnership between YBP, a 501c3 non-profit organization, and the above named EBB® mentors & instructors developed due to our shared interest in cultivating birthcare communities rooted in autonomy, respect, and equity. The EBB® organization prioritizes the provision of accurate childbirth information by synthesizing research findings so families are aware of current evidence-based care and prepared to advocate for themselves. (3) Our mentor partners have been serving birthing families in their communities for decades; their passion and awareness of local birthing places, providers, and policies informs their practice. YBP provides funding for all Imperative class costs; grants are distributed to the mentors to eliminate the financial burden of a reimbursement model on students.

Practice Application

This initiative was piloted with 19 families in 2021 spread out across New Jersey, New York, and Texas. Class sizes ranged from private instruction up to 6 families per class depending on the needs of the family and their anticipated birthing time. The six week class series is offered virtually to account for a shifting pandemic landscape and remain parent-centered with an option for an in-person element dependent on the individual cohort's preferences. Small class instruction encourages deep diving into the topics from each content module with time for application of real-life examples and answering questions pertaining to the individual concerns of each family.

Outcomes: Parent feedback has been very encouraging: A.S. says "*I feel so prepared for birth, I can't thank you enough for being so supportive and informative*," S.G. shares "*you had all the tools to self-advocate*," and K.C. states "*we love the community we created.*" C.P. explains "*As a first time Mom and a Black Woman, Black Maternal Health is super important to me. I wanted to make sure that I understood the birthing process, and was educated on all of the options available to me…I had a few friends ask me if I would take the EBB course again, during my future pregnancies and the answer is "of course!"* This warmth is echoed by instructor Sasha Sumling: "*mentoring Black and Brown Families with EBB Childbirth Classes is gratifying, especially the younger adults 21-25 years of age. They start the classes with so much unknown and end the classes empowered, able to self advocate, and use a voice they never knew they had. The "Comfort Measures Rehearsal" is one of my favorites. I had the opportunity to teach it in-person during the pandemic. The families were engaged and eager to participate. It was almost like a family reunion. We communed virtually for 5 weeks then finally met up with open arms. No more air hugs! Fun fact: I hosted one of my mommas in class despite the fact that she was in early labor. She was determined to get her comfort measures rehearsal in, so she can be well prepared for her birthing time*."

Opportunities: A new survey developed for upcoming cohorts will gain more insights into their education experiences, birth, and postpartum outcomes. YBP has expanded this initiative in 2022 with ambitions of supporting 64 or more families, and is pursuing additional funding.

References:

1. *March of Dimes. (2021). Birthing While Black: Examining America's Black Maternal Health Crisis.*
2. *Taylor, J., Novoa, C., Hamm, K., & Phadke, S. (2019). Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint*
3. *Gluck, O., Pinchas-Cohen, T., Hiaev, Z., Rubinstein, H., Bar, J., Kovo, M. (2020). The impact of childbirth education classes on delivery outcome.*

NPA2022-7

Forging Perinatal Mental Health Support in an Early Pediatric Healthcare System

by Erin M. Sadler, PsyD, PMH-C, Anna Koozmin, LGSW, Caroline Van Buskirk, BA, Sasha Zients, BA

Background

Children's National Hospital (CNH) is a free-standing *pediatric* hospital in Washington, DC providing quality health care for children and families in DC, MD, and VA. In 2020, CNH received a five-year, $36 million philanthropic donation from the A. James & Alice B. Clark Foundation's Parent-Child Health Initiative de-

velop culturally responsive systems of care to advance innovation and reduce health inequities for families living in marginalized DC communities. With this gift, CNH established a Perinatal Mood and Anxiety Disorder Team (PMAD Team) to improve access to quality and equitable care for caregivers at greatest risk of maternal mortality and morbidity, including Black, Indigenous and/or people of color (BIPOC) and families living in rural communities in MD and VA. The PMAD Team secured additional funding during the COVID-19 pandemic to expand the program and make in-house, perinatal psychotherapy more readily accessible by leveraging the use of technology.

Content/Action

The PMAD Team is comprised of trained Family Services Associates (FSAs) and social workers (SW) who lead screening in the NICU and ED, and a dedicated NICU psychologist who provides psychotherapy in-person and via telehealth. The Team is on-site daily from 8am - 11:30pm to reach caregivers who may not otherwise have access to perinatal support. Screening and treatment is offered to *all* newborn (<7 months) caregivers (biological and adoptive caregivers, next of kin, and foster parents), while honoring caregiver choice to opt-in or out. Universal EPDS screening is conveniently administered on a tablet in the caregiver's primary language. Interpreters are also used to administer and review EPDS results. The table below outlines intervention responses for each level of screen result:

EPDS Total Score	Interpretation	Prevention/Intervention
0-9	Negative	Provide Universal Education and Prevention Materials

≥10 to 30	Positive	Provide Universal Education and Prevention Materials + Social Work Consult + Referral
Endorse SI on question #10	Positive	Provide Universal Education and Prevention Materials + Social Work Consult + Risk Assessment, Safety Planning, & Warm Hand-Off to Appropriate Psychiatric Services

Caregivers who score positively or endorse suicidal ideation (SI), receive an immediate SW consultation and referral to community providers or the in-house psychologist. In the event of active SI, a crisis response is initiated with warm hand-offs to the proper psychiatric services. The Team also arranges care coordination by linking families to community resources, helping navigate social service applications, and connecting with local therapists and support groups. Information is also given to caregivers who request to pursue resources independently. Caregivers seen in-house receive psychotherapy during their newborn's NICU admission at bedside or virtually, *and* after discharge through telehealth in an effort to maintain continuity of care while the Team helps parents establish care with a community provider. Most recently, the Team has partnered with a perinatal wellbeing group to pilot a HIPAA-compliant, remote, app-based screening approach, and began a Wi-Fi-enabled iPad Loaner program to ensure low-income families have access to telehealth therapy at no cost to them. The app can send screens via email or SMS, and includes crisis response, wraparound care that is coupled with the Team SW follow-up. Together, these services support and empower caregivers to be self-advocates for their own perinatal mental health and their newborn's care.

Lessons Learned

By using a quality improvement approach, the Team has increased the number of caregivers served by employing feedback from caregivers and staff. Strengthening staff awareness of PMADs and the team's services has been instrumental to the success of this program. Providers have begun to initiate requests for screening and consultation as a direct result of the relationships and training. NICU caregivers prevented from being at bedside due to the pandemic required innovative means of engagement. The integration of remote screening and virtual treatment options was vital to decreasing disparities in access for caregivers. The Team actively engages non-birthing and non-native English-speaking caregivers and thus developed specific educational materials, given the dearth of information available for these populations.

Implications for Practice

The PMAD Team continues to maintain a family-centered approach that is responsive to caregivers' needs and collaborative with hospital staff. The Team will continue to prioritize perinatal services as a standard of care and is working directly with the NICU Parent Advisory Council to elicit feedback and input regarding program initiatives. The Team is developing a robust community-based resource network that can be readily accessible to caregivers in person, remotely via text, email, and on the CNH website. In response to caregivers' requests and to enhance service convenience, the Team is identifying a HIPAA-compliant texting system. To further ensure equitable access to services, the Team is particularly driven to locate and offer in-house services in languages other than English. The Team plans to expand staff education and identify PMAD Champions to serve as liaisons between the Team and the Champion's respective specialty groups (e.g., nursing, child life, nutrition, etc.). Hospital staff will continue to receive additional training on the prevalence of PMADs, which will increase referrals and access to caregivers. Finally, as the nature of the COVID-19 pandemic evolves, remote outreach capacities will continue to grow.

NPA2022-8

Maternal Social Emotional Maturity and Child Development

Morgan A. Staver BSN, RN; Tiffany A. Moore PhD, RN

Introduction: Repeated exposure to adverse childhood events (ACEs), otherwise known as toxic stress, is associated with physical and mental health problems in adulthood. Experiencing toxic stress increases the likelihood for preterm birth and birth complications. Toxic stress can also have downstream effects on adult emotional intelligence, behavior, and judgement.

Emotional abuse in childhood is an ACE of particular interest in the context of adult emotional intelligence due to the developmental processes inherent in achieving emotional maturity in adulthood. The nature of the relationships between maternal emotional abuse in childhood, social emotional intelligence in adulthood, and child social emotional development is currently unknown. Therefore, the current exploratory analysis aimed to examine the relationships between childhood emotional abuse, maternal social emotional intelligence, and social emotional development in early childhood.

Methods: Participants who completed all data collection requirements for the study *Toxic Stress and Social Emotional Maturity at 16 Months* were included in this preliminary analysis (n=21). Study enrollment is ongoing. Participants were recruited from a developmental clinic visit post NICU hospitalization. Instruments used to collect data included in this analysis were the Adverse Childhood Experience Questionnaire, the Emotional Quotient Inventory, and the Survey of Wellbeing of Young Children. Statistical analyses included descriptive statistics, Kruskal-Wallis H tests, Spearman's rho correlations, and Fisher's Exact tests.

Results: There was a statistically significant difference in maternal sociability between infants who met age-specific developmental milestones and those who did not, $\chi^2 = 4.237$, $p = 0.04$, with a mean rank maternal sociability score of 7.07 for infants who did not meet developmental milestones and 12.96 for infants who met developmental milestones. There was also a strong positive linear relationship between maternal sociability and the degree of difference from expected developmental milestones ($r = 0.553$, $p = 0.009$). There was a moderate positive linear.

relationship between maternal wellbeing and the degree of difference from expected milestones that trended towards significance ($r = 0.39$, $p = 0.111$). There were no significant differences found in maternal total trait emotional intelligence, self-control, or emotionality between infants who did and did not meet expected developmental milestones. There were no statistically significant differences found in any domain of emotional intelligence between women who were emotionally abused in childhood and women who were not emotionally abused. There were also no statistically significant differences found in child development between women who were emotionally abused in childhood and women who were not emotionally abused.

Discussion: Children who met age adjusted developmental milestones had mothers who were more sociable upon self-assessment. Maternal sociability in adulthood was also shown to be related to the degree of difference from expected developmental milestones, with higher sociability being associated with higher developmental achievements than expected given the child's age.

The relationship between maternal wellbeing and the degree of difference from expected developmental milestones was not statistically significant, but the data trended towards higher maternal wellbeing being associated with higher developmental achievements than expected given the child's age. The lack of statistical significance may be related to the study's power and the small sample size. Given that no other aspects of maternal emotional intelligence were significantly associated with child development, the exact mechanism of the relationship between maternal sociability and child development should be investigated further. No statistically relevant relationships were found between emotional abuse in childhood and adult emotional intelligence or child development at this time. Further investigation into these relationships is warranted given the small sample size and exploratory nature of this analysis.

NPA2022-9

Essential Care in the NICU: Parent perspectives of neonatal hospitalization during COVID-19

Ashlee J. Vance PhD, MA, RN, RNC-NIC, Henry Ford Health System, Center for Health Policy and Health Services Research, avance2@hfhs.org, Kathryn J. Malin PhD, RN, NNP-BC, APNP, Marquette University, College of Nursing, kathryn.malin@marquette.edu, Clayton J. Shuman PhD, MSN, RN, University of Michigan, School of Nursing, clayshu@umich.edu, Tiffany A. Moore PhD, RN, University of Nebraska Medical Center, College of Nursing tamoore@unmc.edu

Introduction: Parenting and family life were exceptionally susceptible to unanticipated changes during the COVID-19 pandemic. Pandemic-related changes can result in elevated levels of stress and uncertainty especially for families experiencing an infant's admission to the NICU. Prior to the COVID-19 pandemic, parental presence was encouraged through unrestricted visitation and family-centered care practices in neonatal intensive care units (NICU). Parental caregiving is essential to an infant's healthy development, especially during hospitalization. While there is sufficient evidence demonstrating the negative parental outcomes secondary to having an infant hospitalized in the NICU prior to the COVID-19 pandemic, it is unknown how parents experienced neonatal hospitalization during the COVID-19 pandemic. Therefore, the aim of this study was to describe parent perceptions of a neonatal hospitalization during the COVID-19 pandemic.

Methods: We conducted an online survey from May 2020 – July 2020 to investigate parent's experiences of neonatal hospitalization. We invited parents to participate via social media (e.g., Facebook, Instagram, and Twitter). Inclusion criteria required an infant admission to a US NICU between February 1 – July 31, 2020. Free text responses from five open-ended questions covering topics such as visitation experience, transition to home, and clinician interactions were thematically analyzed using NVivo 11 qualitative data analysis software.

Results: Our sample included 169 parent responses on one or more open-ended questions. We focused on examining continuities and discontinuities and shared patterns of experiences among parents. Through this lens, we identified three broad themes: 1) Emotional isolation and exhaustion, 2) Parents desire to be "essential", and 3) NICU providers exacerbated or alleviated distress. To quote a parent, "hospital policies [were] not in touch with the reality of families, making the impossible pain of [having] a baby in the NICU even more impossible." Overall, parents of infants in the NICU experienced and expressed feelings of painful separation, disconnection, isolation, splitting, and alienation. Parents desired more empathy from providers and hospital administrators.

Discussion: This qualitative study included parents of infants admitted to a NICU during the COVID-19 pandemic. The descriptions of parent experiences document the emotional struggle of being separated from support systems, feelings of isolation, lack of family-centered care, and exacerbation of emotional distress already known to be common to the NICU journey. The experience of parents included intense and frequent disappointment at the system level of having their visitation rights restricted and desire for more empathy, validation, and inclusion in decision making. To support families and institutions, a consensus statement entitled "*Essential Care in the NICU during the Covid-19 Pandemic*" was developed in response to these findings and endorsed by the National Association of Neonatal Nurses (NANN), and National Perinatal Association (NPA), and Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN).

Disclosure: The National Perinatal Association www.nationalperinatal.org is a 501c3 organization that provides education and advocacy around issues affecting the health of mothers, babies, and families.

NT

Corresponding Author

Jerry Ballas, MD, MPH
Past-President,
National Perinatal Association
Associate Professor, Maternal-Fetal Medicine
University of California, San Diego
Email: Jerry Ballas <jerry.ballas@nationalperinatal.org>