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TELEMATERNITY PERIPARTUM COLLABORATIVE CARE PROGRAM:
AN INNOVATIVE MODEL OF CARE

A DOCTORAL PROJECT

Submitted in Partial Fulfillment of the Requirements

For the degree of

DOCTOR OF NURSING PRACTICE

By

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ABSTRACT

This Doctor of Nurse Practice project focused on the development of a guideline for the implementation and planned evaluation of a system-wide Telematernity Peripartum Collaborative Care Program (TPCCP) for women veterans (WV) receiving maternity care services in the Veterans Healthcare Administration (VHA). Informed by the Ottawa Model of Research Use Framework, the guideline contents were developed subsequent to a literature review, needs assessment, and input from key stakeholders, including the team members from Maternity Care Coordinators and members of the Women Veterans Health Program.

The new guideline includes the following elements: learning activities on peripartum depression, an algorithm for guiding care, documentation templates, strategies for establishing a collaborative work environment, and a communication network with national groups for women’s health care. Notes and documentation templates are provided for each of the four services. Educational modules were developed to train the staff to perform screening and therapeutic interventions. Metrics are provided for planned program evaluation.
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BACKGROUND

Since the American Revolution, women have fought in battle alongside men. Healthcare for veterans was not standardized as a federal entity until after the Civil War when Abraham Lincoln established the “soldier’s homes,” a promise he made during his Gettysburg Address to provide care for the “soldiers, their widows and their orphans.” However, it was only in the 1920s that women who were veterans or had completed service in the National Guard and militia were eligible for healthcare within the national system, the Veterans Bureau. This system was renamed Veterans Administration in 1930, which subsequently evolved into three entities: the Veterans Healthcare Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery. The VHA is responsible for the healthcare system for veterans; the VBA is responsible for the benefits: education, housing, compensation, and pension. The National Cemetery is responsible for the maintenance of the national cemeteries and the burial of honorable-discharged veterans and their spouses. In 1989, President Reagan elevated the VHA to the Cabinet level ("VA in Brief History," 2014) to emphasize the importance of the healthcare services for the nation’s veterans.

As women veterans (WVs) returned from World War II, Korea, Vietnam, and other military conflicts, they found care in VHA hospitals filled with male patients and in VHA facilities ill-equipped to meet women’s healthcare needs. Many of the WVs were transferred to nearby non-VHA facilities to receive care because the staff and departmental services at VHA facilities were not familiar with women’s health issues. For this reason, many female veterans left the VHA system (Hamilton, Frayne, Cordasco, & Washington, 2013).
In the late 1980s, increased awareness of Military Sexual Trauma (MST) occurred as multiple MST incidences were reported in the media. Women moved forward to voice their stories of sexual trauma during their military tours. To answer the need for women veterans’ health advocacy and service care coordination, the Women’s Health Services (WHS) was created. Consisting of the Chief Consultant for Women’s Health Services who reports directly to the Secretary of the Department of Veterans Administration and Congress, the WHS has many channels of influence that can provide support and assistance to WH champions and facilitators at the local facility, and regional levels (Frayne et al., 2014). A separate Women Veterans Program Manager (WVPM) and a Military Sexual Trauma (MST) coordinator were appointed at each VHA facility. The mission of the WHS is to provide accessible, comprehensive, high quality care to women veterans by proficient and interested providers (Veterans Health Administration [VHA] Publication 1330.01, 2010). The WHS include primary care, reproductive, psychiatric and sexual abuse counseling, inpatient medical and surgical care, rehabilitation care, long term care, quality of care issues, and assistance for homeless WVs.

A Primary Care Mental Health Integration (PCMHI) program was implemented as the need for close collaboration rose between the two services, primary care and mental health. Patients requested to be seen for mental health (MH) issues in the same areas they received their primary care services. Psychiatrist, psychologists, and MH social workers comprised the PCMHI Team. This combination of services in a single location made for easy access and decreased the stigma association with mental health therapy (Dundon, Dollar, Schohn, & Latinga, 2011).
**Problem Statement**

This Doctoral of Nursing Practice project proposed to develop an implementation guideline that offers integrated and collaborative care program for women veterans identified as having peripartum depression. One in seven pregnant females will develop peripartum depression. Pregnant female veterans are more likely to be depressed than pregnant non-veterans (Mattocks et al., 2010). Peripartum Depression is any depression that occurs during and after pregnancy (Uher, Payne, Pavlova, & Perlis, 2013). Peripartum depression (PPD) places women at an increased risk of suicide and infanticide (Di Florio, Smith, & Jones, 2013). Compared to the civilian population, veterans in general have higher rates of suicide, which places a pregnant female veteran with PPD in a vulnerable state requiring attention and intervention throughout the peripartum stage (Mattocks et al., 2010; Williams & Bernstein, 2011).

With the most recent changes in the Department of Defense policies regarding female soldiers and combat, more active duty military females are exposed to combat stressors never experienced in the past. Stressors of family separation, multiple deployments, combat tours, Military Sexual Trauma (MST), and Post-Traumatic Stress Disorder (PTSD) have affected these young women in negative ways making them more vulnerable to depression. When these women seek help, most of them access services at the Veterans Healthcare Administration (Frayne et al., 2014).

Adjusting to the changes can be challenging for those recently discharged, especially the young pregnant female. Starting a family and obtaining maternity care can be overwhelming. The already described mental health stressors predispose this unique group of women to experience depression during their pregnancy (Mattocks et al., 2010;
Williams & Bernstein, 2011). It is the responsibility of the healthcare provider to have the needed resources and services required to assist the peripartum depressive women progress throughout her pregnancy. There is a need to optimize women’s health services for these returning veterans and to develop interventions that will provide quality of care during the peripartum period.

**Women’s Health Care at Veterans Health Administration (VHA)**

The Department of VHA instituted changes in the healthcare system delivery to align with the growing policies in the military. More women’s health clinics (WHC) were established in VHA facilities in the last five years as military service women transitioned to civilian lives. Many VHAs integrated women’s health services with designated women’s health primary care providers (D-WHPCPs) in the primary care and gynecology clinics.

**Health Domains**

The top three physical health domains for reproductive age, 18-44 years old women veterans (WV), are musculoskeletal, mental health (MH), and reproductive health (50%, 46%, and 41%, respectively). Depression and post-traumatic stress disorder (26% and 17%, respectively) are ranked as the top two MH diagnoses for WVs of reproductive age (Frayne et al., 2014). In 2012, 10,568 WVs, 18-44 years of age, were identified with a diagnosis of pregnancy (Frayne et al., 2014).

**Pregnancy and Maternity Care Services**

Maternity care services are covered benefits under VHA services and are provided through non-VHA care coordination (NVCC). Veterans who request maternity care services at the VHA are evaluated by a women’s health registered nurse or a
maternity care coordinator. The maternity care coordination program was formally introduced in 2012 with the release of the VHA Handbook, 1330.03, *Maternity Health Care and Coordination*; this program was created to decrease fragmentation of maternity care services and ensure continuity of care with collaboration and communication among the VHA primary care providers, non-VHA maternity care providers, and local hospital facilities. Many VHAs are in varying stages of maternity care coordination program implementation.

The woman veteran chooses a non-VHA maternity clinic and non-VHA hospital near her home. Once she delivers and completes the six to eight weeks postpartum visit with the non-VHA providers, she contacts the maternity care coordinator to request follow-up care at a VHA clinic. All maternity care services for mothers and the first seven days of infant hospitalization care are paid for by the VHA under the non-VHA care coordination (NVCC) (VHA Handbook Publication 1330.03, 2012).

**Peripartum Depression**

The Diagnostic and Statistical Manual of Mental Disorders, DSM-IV (DSM, 4th edition) was revised to DSM-V (DSM, 5th edition) with a notable change in the major depressive disorder (MDD) timeline for postpartum depression to include the period of pregnancy through postpartum, renaming it as peripartum depression with emphasis on clinical judgment (Uher et al., 2013). This change in language expanded MDD, starting with pregnancy and into postpartum, in alignment with current practice and research. Antenatal, prenatal, and prepartum may be used interchangeably, meaning before delivery. Postnatal and postpartum may be used interchangeably, meaning after delivery.
In alignment with the new DSM-V, both prenatal and postpartum are called the peripartum stage (Uher et al., 2013); this term will be used throughout this paper.

The peripartum stage may be a vulnerable time for the mother, especially new mothers or mothers with multi-births, and mothers with prior history of mental health disorders. One of the most common diagnoses after delivery is postpartum depression (PPD) (Shivakumar, Anderson, & Suris, 2015). A time of great joy is expected; instead a mother may experience sadness from birthing, body image changes, pain from the episiotomy or surgery, lack of sleep, other postpartum stressors, and a shifting of attention to the baby after nine months of maternal attention (Werner, Miller, Osborne, Kuzava, & Monk, 2015).

Although many states have implemented education and awareness of peripartum depression (PPD), only a few have mandatory screenings, which may be related to limited evidence-based studies on the efficacy of PPD screening (Thombs et al., 2014). Underestimated at 10-20% of live births, PPD is inconsistently assessed by providers in maternity care clinics, well-child pediatrician visits, or primary care clinics (Baker-Ericzen et al., 2012; Conard & Sauls, 2014; Werner et al., 2015).

Many Veterans Healthcare Administration (VHA) facilities have implemented the use of the Patient Health Question 2 (PHQ 2) when screening their pregnant female veterans. The PHQ 2 is a short screening tool with two questions administered to the patient: 1) “do you feel little interest or pleasure in doing things?” and 2) “are you feeling down, hopeless, and depressed?” (Department of Veterans Affairs and Department of Defense (VA/DoD), 2009). One local VHA facility reported that the PHQ 2 was not informative in identifying PPD as most of the maternity female veterans
typically do not report depressive symptoms. This is despite the fact that there are a number of patients they serve who have an underlying behavioral health condition or positive screening for Post-Traumatic Stress Disorder and/or a history of depression. This is consistent with the literature, which reported that there is limited specificity of the PHQ 2 in detecting PPD. It is recommended that a more comprehensive Patient Health Questionnaire 9 screening or the Edinburgh Postpartum Depression Scale be used when screening for PPD (VA/DoD, 2009).

According to a study by Mattocks et al. (2010), young women veteran mothers may have more risk factors for PPD because of their prior history of stressors, including Post-Traumatic Stress Disorder (PTSD), homelessness, and/or Military Sexual Trauma (MST). The authors relied on data audit tools using diagnoses, ICD-9 codes for pregnancy, and mental health disorder. They did not report the relationship of combat PTSD and development of PPD. This is in concert with the paucity of literature describing the effects of combat trauma on all aspects of post military life in women.

Because of the higher incidence of mental health issues with women veterans (WV) and the relationship between these mental health issues and PPD, the need for additional screening and support services became evident to healthcare providers caring for WV in the VHA. Because space and time constraints are known problematic issues in VHAs, these barriers mandated that these essential services be delivered in an innovative manner.

There is a need to implement a coordinated and innovative program, such as, the Telematernity Peripartum Collaborative Care Program, which will address the identification of and treatment of at risk women veterans. Therefore, the development of
telehealth programs is a strategy to improve access to WV during the critical peripartum period associated with PPD.

Significance of the Problem

Mattocks et al. (2010) reported that pregnant women veterans (WV) were more likely to be diagnosed with depression, anxiety, bipolar, schizophrenia, or Post-Traumatic Stress Disorder (PTSD) than non-pregnant women veterans. Among the leading predictors for peripartum depression were lack of social support, poor partner relationships, infant or birthing complications, difficulty with breastfeeding, and lack of sleep.

Studies demonstrated that depression screenings in pregnant women were inconsistently performed at maternity care and pediatrician clinics. Many providers used a combination of subjective and objective evaluations, with or without depression screening questionnaires. Many providers were not as familiar with the use of standardized screenings, such as the Edinburgh Postpartum Depression Screening (EPDS) (Baker-Ericzen et al., 2012; Conard & Sauls, 2014; Gaillard, Strat, Manderbrot, & Keita, 2013; Uher et al., 2013).

These reported deficits in care identify a gap in services. Using home telehealth technology, patients can have access to their healthcare team from their home. This technology allows frequent interaction between patient-providers without the physical space constraints that many VHAs are facing. Programs that standardized the screening process through the peripartum stage and utilized a validated tool sensitive to peripartum depression, such as the EPDS, address these deficiencies. In addition, all services should
be systematically redesigned into a collaborative care program (Conard & Sauls, 2014; Gaillard, Strat, Manderbrot, & Keita, 2013; Uher et al., 2013).

**Purpose Statement**

The overarching aim of this Doctor of Nurse Practice project was to develop a guideline for establishing a Telematernity Peripartum Depression Collaborative Care Program within system-wide VHA facilities. This innovative program, utilized a collaborative care model, to optimize coordinated care for women with depression throughout their peripartum stage in the VHA healthcare system. The program consisted of four services, i.e., Maternity Care Coordination, Primary Care Mental Health Integration, Home Base Primary Care, and Telehealth. Early peripartum depression screening, referral, education, and therapeutic interventions are the core services provided.

**Supporting Framework**

A supporting framework provides structure to a process and guides it from initiation to completion. First developed in 1998 and revised in 2004, Graham and Logan devised the Ottawa Model of Research Use (OMRU) (see Appendix A) as an interactive, dynamic model for continuity of care to implement knowledge to practice (Graham & Logan, 2003; Graham, Logan, Davies, & Nimrod, 2004; Logan & Graham, 2012; White & Dudley-Brown, 2012). A systematic theory of planned change with application of knowledge transfer to practice allows managers and facilitators to control elements of change as they occur in the organization. The process consists of three continuous phases, assessment, monitoring, and evaluation (AME) of the knowledge transfer to practice as they apply to the six key elements: 1) evidence-based innovation, 2) potential
adopters, 3) practice environment, 4) implementation strategies, 5) adoption, and 6) outcomes. A continual loop of assessment, monitoring, and evaluation of these six elements allow adjustments to occur for sustained and successful implementation (Graham & Logan, 2004; Logan & Graham 2012). Permission was obtained to use and adapt the OMRU framework from the developers (see Appendix B).

The initial phase of the process is assessment of the first three elements: 1) evidence-based innovation, 2) potential adopters, and 3) practice environment. Logan and Graham (2012) identified that these first three elements are the most important areas for developing the implementation strategies. The second phase of the process monitors the implementation, intervention(s), and adoption [degree of use]. This phase manages the barriers and supports. Diffusion, dissemination, and implementation are strategies that facilitate the adoption of the innovation. With “experience, practice, reflection, discussion, clinical rounds, and conferences,” (Logan & Graham, 2012, p. 85) further refinement of the model is achieved. The third phase of the process is the outcomes evaluation. During the evaluation phase, a process of monitoring and evaluation is instituted. A continuous cycle of assessment, monitoring, and evaluation (AME) is in place to identify the barriers and supports, overcome the challenges, and proceed to achievement, until it becomes routine practice (Graham & Logan, 2004; Logan & Graham, 2012; White & Dudley-Brown, 2012).

Innovation

Innovation is defined as a change, idea, or practice that is new to the organization or potential user (Graham & Logan, 2003; Logan & Graham, 2012; White & Dudley-Brown, 2012). An innovation can be an established practice in one location or unit, yet
new in another area. Development process involves bringing in subject matter experts and clinical champions together to develop objectives and methods to achieve application of innovation or change in practice. Attention to detail and documentation are needed to ensure all brainstorming ideas are captured.

Innovation attributes are the specific characteristics of the innovation that are applied to the change in practice. Key to this innovation is the early adopter who will provide adjustments to the innovation to facilitate its application into practice (Graham & Logan, 2003; Logan & Graham, 2012; White & Dudley-Brown, 2012). Assessment of barriers and supports of the innovation must be explored. Once identified, strategies to address barriers must be developed.

**Potential Adopters and Key Stakeholders**

Facilitators, as key stakeholders, are often seen as the ones who have knowledge and insight to move the team to action. Potential adopters provide the fuel to move forward and allow others to see the change in action (Graham & Logan, 2004; Logan & Graham, 2012; White & Dudley-Brown, 2012). Support and buy-in from key executive leaders in the organization brings about allocation of needed resources.

The Ottawa Model for Research Use (OMRU), derived from Roger’s theory of diffusion of innovation, described the five different adopters to innovation. These five adopters are: innovators, early adopters, early majority, late majority, and laggards (Logan & Graham, 2003).

The initial 2.5%, innovators, are the first to try a new idea; 13.5% are early adopters who are opinion leaders; 34% are early majority, who shy away from risks, deliberately relying on what is familiar. Thirty-four percent are the late majority, who
will adopt when the innovation has become routine and part of the norm. The final 16% of the population consists of the laggards, who are traditionalists, and will never be involved in the change. Careful planning is recommended to influence each of these adopters as the research into action is being implemented (Graham, & Logan, 2003; Logan & Graham, 2012; White & Dudley-Brown, 2012). Adjustments to implementation strategies should be incorporated to increase the likelihood of practice adoption.

**Practice Environment**

The practice environment includes culture/social, structural, economic, and uncontrolled events. Organizations have different history, structure, and priorities that are part of their culture. Current practice must be assessed to determine what changes are needed to meet practice goals. The positives and negatives of the practice environment, e.g., the organization, clinic setting, and patient setting, are identified to develop strategies to implement the change (Graham & Logan, 2003; Logan & Graham, 2012; White & Dudley-Brown, 2012).

**Implementation**

There is an introduction of implementation strategies to adopt the innovation by diffusion, dissemination, and implementation. There should be implementation strategies that address all identified barriers.

**Adoption and Degree of Use**

According to Logan and Graham, 2012, adoption is demonstrated by degree of use. The initial use of new knowledge (innovation) is measured by the extent that the adopters will participate in the activities. Staff participation with the activities and education, use of innovation, and allocation of resources by leaders will be the foundation
of how this change in practice will be sustained. Strategies applied for initial implementation may be different from strategies for sustained use. Having a timeline for the project will provide urgency and focused effort for the initial implementation.

**Outcomes**

The outcome evaluates the impact of the practice change. These metrics will have target goals. Provider, patient, and systems evaluation reflect outcomes from the change in practice.

**An Ottawa Model of Research Use Exemplar**

In a study by Fisher (2014), an expert panel [innovators] met to review and synthesize a comprehensive literature review of clinical practice guidelines (CPG) [innovation] on urinary continence care and bladder training in stroke survivors. After choosing select clinical practice guidelines (CPG) to pilot, they invited a focus group of staff: nursing, physicians, and occupational therapists [potential adopters, key stakeholders], who are experts in continence care at acute and rehabilitation settings. With this focus group, the research team solicited the staff’s input with these three questions: 1) what are the barriers, 2) what are the supports, and 3) what are the strategies that will promote implementation of the CPG for continence care in stroke survivors. The pilot study CPG [innovation] included an educational program [transfer of knowledge and follow up strategy], chart audit tool [adoption/degree of use], and knowledge, skills, and attitude tool survey [outcome evaluation].

The research team first met with administrators [facilitators/ key stakeholders] to secure the full support of the organization and determine their priorities [barriers and
supports in the practice environment]. Subsequently, they met with the nursing administrators and managers [potential adopters] to facilitate meeting with the staff.

Implementation of intervention strategies includes barrier management, transfer, and follow up. To enhance the transfer of knowledge and follow up, the expert panel provided educational interactive learning modules [implementation strategies] with “1) evidence-based recommendations, 2) instructional videos, 3) interactive care, 4) scenarios, 5) learning assessments, and 6) supplementary materials, such as assessment tools and clinical algorithms” (Fisher, 2014, p. 20).

Adoption consists of intention and degree of use which show how well the interventions are received by the adopters (end-users). During the scheduled meetings with the nursing staff [degree of use, participation], the research team provided education [transfer of knowledge strategy], with discussion [transfer of knowledge strategy] on the value of the CPGs, and how they can be implemented in their units [intent to use]. The clinical nurses chose three recommendations that they believed could be implemented [degree of use, participation].

The expert panel, used an existing survey, the Knowledge, Attitudes, and Beliefs Survey (KABS), to raise awareness, identify learning needs and knowledge deficits, and determine the nurses’ beliefs and perceptions. This constant feedback [follow-up strategy] allowed a formative evaluation, allowing adaptation and adoption of the change in practice.

During the evaluation phase, Fisher’s (2014) study noted staff turnover, conflicting priorities, and patient workload [barriers] that may have negatively impacted the study. The research team was able to revise the CPG to individualize [follow-up
strategy] the guideline for each of the units. This evidence-based innovation was successfully implemented during the three month pilot program, improving the nursing knowledge on continence care. A process of monitoring and evaluation was instituted to ensure the projects’ continuing success.
LITERATURE REVIEW

To identify key components essential for the success of the Telematernity Peripartum Depression Collaborative Care Program (TPDCCP), a literature search was conducted from December 2014-March 2015, utilizing the databases: PubMed, CINAHL, EBSCO, and Government Publication Office publications with clinical data support systems. Search terms included: women veteran, combat veteran, Edinburgh Postpartum Depression Scale (EPDS), maternal care, motherhood, postpartum depression, postpartum and primary care, postpartum home visits, Post-Traumatic Stress Disorder (PTSD), peripartum depression, telehealth, and telehome care. Further delineation of the search included combat female veterans, primary care mental health integration, and women veterans health. Limited to journals and books published from 2006 to 2014, in the English language only, the search was restricted to studies on adults defined as those 18 years of age and older. No literature was found using the terms women veterans or Telehealth and postpartum depression in PubMed.

A second literature search was conducted, in January 2015-March 2015, to evaluate research articles from 2009-2015. This search was conducted utilizing the databases: TRIPBASE, PubMed, CINAHL, TRIP, and EBSCO. Included were publications in English, available through California State University of Fullerton and Veterans Affairs Library Network. Key search terms were the same as above. Excluded were articles and topics on ostomy, diabetes, and those studies that did not expand on pre- and postnatal care. The literature review demonstrated limited research focusing on combat women veterans.
**Post-Traumatic Stress Disorder (PTSD) and Combat Women Veterans**

Post-Traumatic Stress Disorder is an anxiety disorder manifested by “intrusive thoughts, nightmares and flashbacks, avoidance of stimuli, persistent negative cognitions and numbing of responses, symptoms of anxiety, hypervigilance, difficulty concentrating, irritability, and sleep disturbance,” (Rowe, Sperlich, Cameron, & Seng, 2014, p. 282). Peripartum depression may be manifested as intrusion, avoidance, and hyperarousal.

Multiple traumas may solidify fear conditioning as the unconditioned stimulus; trauma increases stress hormones and neuromodulators in the body (Inslicht et al., 2013). A systematic review by Conard and Sauls (2014) investigated the association of deployment and Post-Traumatic Stress Disorder (PTSD) experienced by women. The authors identified relevant research published in a 10-year period; multiple quantitative and one qualitative studies were included in the review. Results indicated that PTSD was one of the common mental health diagnoses among veterans. This was more pronounced among female veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom Gulf War II. Prolonged and multiple deployments, especially in blurred war zones, where women soldiers served as non-combat staff (e.g., logistics, civilian affairs, transport drivers, and nursing staff) in a combat zone, caused fear conditioning with repeated traumatic events, contributing to PTSD (Conrad & Sauls, 2014; Inslicht et al., 2013; Wells et al., 2010).

Other traumatic events responsible for PTSD can be Military Sexual Trauma, exposure to enemy fire, explosions from improvised explosive devices, and motor vehicle accidents. In addition to compromised privacy and safety issues using shared bathrooms and sleeping quarters with men, uncertain deployments, and family separation, women
with past childhood history of abuse prior to their military duty are most vulnerable to developing PTSD (Conard & Sauls, 2013; Frayne, et al., 2014; Seng et al., 2011).

**Depression and Pregnancy**

Peripartum depression is an umbrella term that encompasses depression experience related to pregnancy. Antepartum, intrapartum, and postpartum stages are a part of the continuum of peripartum depression.

**Postpartum Depression**

Under-diagnosed, postpartum depression is a major depressive disorder, occurring within the first six weeks to 18 months of delivery. Eighty-five percent of women are affected by a mood disorder after childbirth (Baker-Ericzen et al., 2012; Conard & Sauls, 2014; Gaillard et al., 2013; Gjerdingen & Yawn, 2007; Uher et al., 2013). Mood disorders, baby blues, postpartum depression, postpartum psychosis, and PTSD are along the continuum of conditions that affects women after childbirth. Multiple studies of the deleterious effects on infant survival, growth and development, disrupted child-mother bonding, well-being of the mother and the family, and worst case, infanticide and/or suicide, are documented if postpartum depression is left undetected and untreated (Baker-Ericzen et al., 2012; Giannandrea, Cerulli, Anson, & Chaudron, 2013; Thombs et al., 2014; Thompson & Fox, 2010).

Manifestations of postpartum depression are eating disorders, moodiness, weeping, sleep disturbances, and irritability. The risks for developing postpartum depression include single-parenthood, marital discord, domestic violence, stressors of childcare, past and present traumatic life events, complications of pregnancy and delivery, lack of social support, low self-esteem, prior history of fetal loss, mental health
disorders, prenatal and postpartum depression, baby blues, and cessation of mental health medications and therapy (Baker-Ericzen et al., 2012; Giannandrea, et al., 2013; Howard, Oram, Galley, Trevillion, & Feder, 2013; Hung, Lin, Stocker, & Yu, 2011; Xie, He, Koszycki, Walker, & Wen, 2009; Zauderer, 2009).

**Baby Blues**

Baby blues normally occur during the first three to four weeks of delivery, attributable to stressors prior to childbirth, sleeplessness, thyroid or parathyroid disturbances, hormonal, and biological changes. The woman’s body must readjust to the pre-pregnant state after labor and delivery. Attention to the woman during her pregnancy shifts to the child after birth. These physical and psychological changes may present as “mood swings, weepiness, mild anxiety, low energy, worry, and mild sleep disturbances” (Zauderer, 2009, p. 29). When baby blues extend for more than three to six weeks, it is called postpartum depression (Zauderer, 2009).

The systematic review by Thombs et al. (2014) revealed that out of 9,242 abstracts and titles, and 15 full-text articles, only one postpartum screening randomized controlled trial (RCT) was included. Because of the insufficient scientific evidence available, the authors concluded that screening may not be warranted when services are not accessible for the patients. Instead, the authors recommended that healthcare workers be cognizant of the patient’s individual risk factors and symptoms of depression to assist with the assessment and referral process. Education of family and patients about the prevalence of depression during this stage may allay the anxiety of labeling, normalize feelings of depression, and decrease the stigma of mental health (Thombs et al., 2014).
Postpartum Psychosis

Postpartum psychosis, also known as puerperal psychosis, is the most extreme psychological disorder during the peripartum period, manifested by hallucinations, delusions, confusion, abnormal, irrational, and unrealistic disconnected thought processes. Occurring in one to two mothers per 1000 immediately after childbirth, with a high concurrent bipolar disorder diagnosis, puerperal psychosis is considered very dangerous because suicide and infanticide can occur, at 3% and 4%, respectively (Di Florio, Smith, & Jones, 2013).

Peripartum Depression (PPD)

Studies and recommendations vary on when peripartum depression screening should be performed. In the prospective longitudinal study by Onoye et al. (2013), the authors explored varying degrees of Post-Traumatic Stress Disorder (PTSD) and other mental health symptoms during the pregnancy and postpartum period in 119 women in Oahu, Hawaii, from 2002-2006. Although stable at varying degrees from pregnancy to postpartum there is a rise of PTSD and other mental health symptoms occurring during the last weeks prior to delivery. A possible reduction of social support, hormonal changes, and re-experiencing trauma with fear of childbirth may contribute to the rise of PTSD symptoms before giving birth. Onoye et al. (2013) recommended the initiation and continuation of screening patients throughout the peripartum period, with appropriate referral and early intervention.

Telehealth

Telehealth has been widely used and researched as an effective medium to deliver care. Telemedicine, a form of telehealth, may include telephone, secure
messaging and emails, clinical video telecommunication (CVT), or use of computer and medical equipment that can transmit information to the healthcare staff or providers for clinical decisions. In rural areas where there is a lack of specialty care services, telemedicine has been beneficial in providing consultations and feedback to remote primary care providers (VA Telehealth Services, 2015). There is limited evidence-based literature on telehealth maternity collaborative care, and even less on telehealth maternity care for women veterans.

Yuen et al. (2015) performed a randomized controlled trial using home-based telehealth and face-to-face modalities to deliver prolonged exposure therapy and imaginal exposure. A study was conducted at Tampa, Florida Veterans Health Administration with fifty-two white and black veterans with combat Post-Traumatic Stress Disorder (PTSD). They completed 8-12 weeks of prolonged exposure therapy; of these, 23 participated in home base telehealth and 29 participated in face-to-face therapy. This study was smaller in size compared to previous studies, which showed the same effect of no significant difference between the two modalities of care, face-to-face versus telehealth.

Frequent engagement in patient-nurse interactions, during telehealth sessions for screening and education resulted in increased feelings of social support and patient self-management activities. Increased social support, communication, and shared decision-making impacts patient and provider satisfaction.
METHODS

The Ottawa Model of Research Use (OMRU) fulfills a two-fold purpose for the project. Primarily, it served as the framework for guideline development. However, it is uniquely positioned to serve as the framework for local sites as they implement the Telematernity program.

Ethical Considerations

This project had no human subjects. The project was submitted to the California State University, Los Angeles Institutional Review Board (IRB) for review. A determination was made that the project did not meet the definition of research according to Federal Regulation 45 CFR 46 (Appendix D).

Development Process: Conceptual Framework

The aim of this project was to develop a guideline to implement a Telematernity Peripartum Depression Collaborative Care Program for women veterans throughout their peripartum stage. The Ottawa Model of Research Use (OMRU) served as a framework for program development. The six elements of the OMRU were used as a structure for each step of development. Although non-linear, the model was sequentially utilized beginning with assessment, progressing through monitoring and, finally, to evaluation of outcomes. When the guideline is implemented into practice, the continuous cycle of assessment, monitoring, and evaluation recommended by the developers should be employed (Graham & Logan, 2003; Logan & Graham, 2012).

As identified by the developers, the most important model elements are the first three: innovation, potential adopters, and practice environment; these are crucial factors that can determine successful adoption and sustained use (Graham & Logan, 2003;
Logan & Graham, 2012; White & Dudley, 2012). Practice environment includes the physical setting, the culture of the environment, history, organization, and priorities, both at the patient’s home and the institution. Preparations for unusual events are also included in the plan. These factors will ensure sustainability. Formative evaluation will be used to adjust the process.

**Characteristics of Innovation**

There are four innovations that are explored: 1) Edinburgh Postpartum Depression Scale, 2) Telehealth, 3) Primary Care Mental Health Integration, and 4) Home Base Primary Care. Veterans Health Administration Women’s Health staff and Mental Health providers explored treatment modalities for female veterans with peripartum depression during a collaborative meeting across the facilities. Most VHAs agreed that PHQ 2 was not adequately identifying peripartum depression (PPD). However, the Edinburgh Postpartum Depression Scale (EPDS), an evidence-based tool [innovation], that is easily administered and scored, provides reliable information upon which to make decisions regarding risk assessment and needed care. This instrument has reported reliability and validity across the entire peripartum period (Baker-Ericzen et al., 2012; Conard & Sauls, 2014; Gaillard et al., 2013; Uher et al., 2013; VA/DoD, 2009).

Although knowledge of the tool, EPDS, was limited to a few nursing and other health professional members of the team, the training was easily accomplished. The face-to-face and telephonic administration of EPDS has become the standard screening for most VHA facilities. The EPDS questionnaire is shown in Appendix A of the Implementation Guideline.
Because of family responsibilities and infant care during the first few months of postpartum and lack of social support, many mothers are not able to attend their healthcare clinic visits. Distance, lack of social support, and lack of transportation contribute to missed or not scheduled appointments. These issues are magnified in those suffering from Post-Traumatic Stress Disorder (VA/DoD, 2009; Werner et al., 2010; Xie, et al., 2009). The high risk for peripartum depression in this group of women combined with their difficulty in accessing traditional services and therapy lead to a collaborative meeting to determine the optimal method to deliver safe care.

A Telematernity Peripartum Depression Collaborative Care Program [innovation] is an interdisciplinary team consisting of Women’s Health Clinic (WHC), Primary Care Mental Health Integration (PCMHI), Home Base Primary Care (HBPC), and Telehealth staff. These services are available in all the VHA and when combined, it was determined to be an innovative way of delivering coordinated, collaborative maternity care.

Across the country, PCMHI provides mental health therapy within primary care clinics. In this program, by having mental health services in the same suite as the women’s health clinic, the stigma patients often feel with having mental health appointments was reduced [innovation]. Primary Care Mental Health Integration consisted of psychiatrists, psychologist, and mental health social workers who delivered mental health care where patients received their primary care. Traditional HBPC is in-person services for homebound patients. It can provide primary care for greater than six months at the patient’s residence. Specific to patient’s needs, staff includes nurses, nurse practitioners, social workers, psychologists, physical therapists, and physicians.
A care delivery model being piloted by some Veterans Health Administration facilities is a short-term (less than 6 months) program for homebound patients in transition [innovation]. A service provided by this program, ‘Home Based Transition Care,’ includes medication management, education, and simple wound care. It was determined in discussions with key stakeholders that the telematernity program would meet criteria for inclusion into the Home Base Transition Care. The telehealth technician would be dispatched to the patient’s home to facilitate a telehealth visit. During this visit, the healthcare provider would be able to evaluate the mother and/or provide therapy using telehealth communication [innovation].

Additional services that will be available under the telematernity include home visitation appointments to establish initial telehealth visits, maternal social support, and education linking the patient to the VHA services and community resources [innovation]. This personal and frequent interaction promotes trust, rapport, and telehealth use. An added benefit is a predicted increase in the number of patients treated by a specialty provider, such as, a psychologist. Because patients are seen at home, there is no wait while rooms are being cleaned and new patients brought in for care. Lack of transportation or difficulty of finding parking space challenges are removed. Telehealth has the potential to improve access, coordination of care, and space utilization.

Characteristics of Potential Adopters and Key Stakeholders

Stakeholders, potential adopters, champions, and facilitators are the people who are supporters of this project. Key stakeholders are administrators and leaders who can provide support and facilitate implementation. Resources are allocated according to priorities and initiatives presented during leadership meetings. These priorities are
dependent on directives and initiatives from Veterans Administration Central Office. A close collaborative work environment between the Women Veteran Program Manager and the Executive Leadership (Director, Chief of Staff, Associate Chief of Patient Care Services, and Associate Chief of Finance and Resources) is essential to implement change and facilitate program functioning.

Potential adopters are the end-users who will implement the innovation.

- Women Veterans Program Managers, Women’s Health Registered Nurses, Maternity Care Coordinators, and Mental Health providers are subject matter experts (SMEs) and champions; they are the innovators and early adopters. They selected the objectives and target goals during the guideline development process. These SMEs determined the Edinburgh Postpartum Depression Scale (EPDS) instrument implementation and diagnostic parameters. They will become the role models to support implementation of the change into practice.

- Telehealth staff [early adopters], selected because of their familiarity with the technology, will provide training, equipment procurement, and use. In their current practice, they are responsible for obtaining service agreements among the various specialty telehealth participants within the VA. These roles will be continued through the initiation of telematernity program. A reproduced Telehealth service agreement is shown in Appendix I of the Implementation Guideline.

- Primary care nurses [adopters] will screen maternity patients using EPDS instrument by telehealth; in some circumstances, the assessment can be done
in person or by telephone. Nurses can use this time to build rapport and gather additional data. Clinical symptoms and EPDS scores will be communicated with the mental health provider. In the event that the woman is determined to be at risk for suicide or homicide, protocols will be activated and additional actions are implemented. Examples of the Peripartum Depression Algorithm, Primary Care Mental Health Integration, and the Maternity Care Coordination consults are shown in Appendices 3, 4, and 5, respectively, of the Implementation Guideline.

- Patients and families [*potential adopters*] are at the center of this program as they come to the VHA for needed services. This population’s acceptance of this program is essential for its success and sustainability.

**Characteristics of Practice Environment**

Practice environment are the organization’s priorities, demands, initiatives, history, and culture. In order to determine the feasibility of this program, the organization’s mission and priorities [*practice environment*] must be evaluated. A needs assessment of the Women Veterans Program (WVP), specific to the existing maternity care services, and how it is aligned with the organization should be included. Many Veterans Health Administration (VHA) facilities have successfully implemented an integrated Women’s Health Care using the VHA 1330.01, *Women’s Health Services* policy. A Women Veterans Program Manager (WVPM) is appointed at each VHA facility to ensure that quality healthcare services are in place for women veterans [*support*]. The WVPM reports directly to the Chief of Staff or Director; this supports a positive environment for the Women’s Health Services. Each VHA requires a Women
Veterans Health Committee (WVHC) to support the WVPM in her role in implementing programmatic changes at the facility level. A member of the Executive Leadership is highly recommended to be a member of the WVHC. Quarterly updates on women’s health population trends, problems, and progress are formally submitted to the WVHC. These quarterly updates are submitted to the Executive Leadership through an executive-level committee. Advocacy for the growing needs for maternal health is one of the priorities for the women’s health program.

Outreach opportunities can be a forum to provide education and conduct needs assessments. During these events, veterans are asked for their input on needed services. Opportunities to dialogue between patients/families, executive leaders, and care providers support and strengthen the Women’s Health Program.

Access to care was identified as a priority during a needs assessment of peripartum women veterans conducted by a multidisciplinary team of key stakeholders, subject matter experts, and potential adopters. With the increasing demands to have scheduled appointments, the lack of space for physical exam rooms, telehealth was identified as an innovative method to meet the demands to deliver healthcare in a non-traditional way.

Telematernity requires specialized equipment both at the healthcare provider’s location and at the patient’s home. Equipment and procedures currently used by the VHA for other telehealth functions, e.g., tele-neurology or tele-ophthalmology, can be adapted for use in this proposed telematernity program.

A necessary support for the patient is the requirement of an established network connection. Depending on the patient’s preference, a phone contact with the registered
nurse or a telehealth technician-assisted home teleconsultation may be made to ensure that connectivity is possible. A secure software program, such as, Cisco Jabber, will be emailed and downloaded on the patient’s computer. The telehealth technician will provide assistance in set-up and connectivity until the patient is proficient.

**Implementation: Barrier Management**

Management of *barriers and supports, transfer strategies, and follow up* interventions will be explored at each stage of implementation in the next 12 months. Additional workload, unknown, and unchartered practices are *barriers* to implementing an innovation. Staff may perceive multiple services with different innovative tools as too complicated [*barriers*]. Changes of personnel in any of the core services may delay implementation [*barriers*]. Facilitators and champions [*supports*] in each service will be identified with the leaders of the departments. This strategy will promote resource allocation.

Careful assessment of the strengths, weaknesses, opportunities, and threats (SWOT) of the innovation, adopters, and practice environment should be developed before proceeding with program development. There are positive and negative internal factors (strengths and weaknesses, respectively), and external factors (opportunities and threats, respectively). Strengths are the strong facets (internal and positive factors) of the organization, such as, finance, resources, infrastructure, people, and staff experiences. Weaknesses are the organization’s (internal and negative factors) weak areas that “do not meet the standards” (Antony, 2012, p. 691). Opportunities (positive factors) and threats (negative factors) are external factors that are outside of the organization’s control but can be used as advantages or disadvantages (Antony, 2012). Examples of external
factors in this project proposal are community image of VHA, disaster/emergency situations, changes in information technology, and disruption of network connection.

Each quadrant of the SWOT analysis has different factors to be considered so that intervention strategies are developed to overcome the barriers and reinforce supports. The SWOT analysis aids in risk analysis and assists with determining the programs that will provide a better return on investment (American Telemedicine Association Business and Finance SIG Work Group, 2011). This tool will help explore challenges, potential problems, and weaknesses. Each facility must develop its own SWOT analysis. A blank SWOT analysis is shown in Figure 2 of the Implementation Guideline. An example of a SWOT analysis is shown in Figure 3 of the Implementation Guideline.

Many VHA facilities have implemented telehealth since 2003. Other facilities are in varying stages of implementation. Although staff may perceive telehealth as difficult to implement, synchronous videoconferencing telehealth has gained popularity with patients in rural areas. This modality has been highly effective with Mental Health. Telehealth equipment expenses are included in the budget for the expansion of telehealth access in local facilities (VA Telehealth Services, 2015).

Veterans Equitable Resource Allocation (VERA) is one of the methodologies that the VHA uses to reimburse facilities for veterans’ patient care. The methodology was designed in 1997 to provide funding based on the complexity of the patient care needs. Patients with basic care needs are reimbursed at a significantly lower rate compared to those with complex care needs. For example, reimbursement for a patient receiving care for a serious mental illness is approximately $30,000 per fiscal year. Reimbursement for
a patient receiving basic primary care for a comprehensive evaluation and management by a provider is approximately $3,000 per fiscal year. Potential allocated funding for patients under Home Base Primary Care is approximately $25,000 (Allocation Resource Center, 2013). Home Base Transition Care, part of the Home Base Primary Care, may have a high potential return of investment [supports]. With the focus on innovative care delivery, telehealth has gained popularity with allocated funding for expansion [supports]. An example of a start-up financial plan is shown in Table 3 of the Implementation Guideline.

**Implementation: Intervention, Transfer of Strategies, and Follow up**

The three strategies of transferring innovation to practice are *diffusion*, *dissemination*, and *implementation* (Graham & Logan, 2003; Logan & Graham, 2012; White & Dudley-Brown, 2012). *Diffusion*, a passive transfer of knowledge, is slow and may start with awareness. The innovation will be incrementally introduced. A marketing plan should be developed to promote adoption and use of the innovation. An example of a marketing plan is shown in Table 2 of the Implementation Guideline. Written marketing strategies promoting *diffusion* include brochures, posters, and articles in the employee newsletter. *Dissemination* is communicating a specific message to the target audience. Dissemination of information in incremental doses to staff increases the likelihood for providers to understand the services and how to use the referrals.

The VHA has a learning forum that can monitor employees’ participation with learning activities [supports]. The VHA Talent Management System (TMS) [transfer of knowledge intervention strategy] offers available and up-to-date education on healthcare and technology. This web-based educational forum will assist in *disseminating* training.
education on maternity care, peripartum depression, and telehealth. The TMS telehealth learning modules are shown in Appendix E of the Implementation Guideline.

Although labor intensive, using one-on-one meetings [intervention strategy] with the Executive Leadership and Chiefs (key stakeholders) of healthcare groups/product lines/services can build rapport, trust, and open communication. Weekly group meetings [intervention strategy] with the early adopters allow the staff to voice their concerns and issues on the application of EPDS screening, algorithm, consults, and telehealth (innovation). Evidence-base literature regarding each innovation and their attributes will be shared and discussed [intervention strategy] weekly with the staff to promote understanding of the attributes, pros, and cons of the innovation. Inclusion of staff from all services allows input [intervention strategy] to changing the process; the disadvantage to this is that not all feedback can be captured. Active learning and problem-based learning will be used as strategies to promote change in practice. Learning activities are presented during monthly lunch and learn, in-services, staff meetings, and journal club presentations [transfer of knowledge strategy] to overcome barriers to implementation. Case study presentations lead to vibrant active discussion (transfer of knowledge strategy) from the staff as they share their experiences and previous knowledge, with specific cases from their patient panel or personal experience [degree of use/participation]. Discussion on the value of using Edinburgh Postpartum Depression Scale (EPDS) questionnaire versus Patient Health Questionnaire 2 can elicit the staff’s intention to use the innovation during these learning activities. Peripartum webinars and videos will be used to intensify the value of screening for peripartum depression. Examples of a learning course curriculum on Peripartum Depression and Competency
Based Orientation Checklist is shown in Appendices 1 and 9, respectively, in the Implementation Guideline.

Implementation of several innovations and change of practice at the same time will be challenging because of the different services, different leaders, and staff involved. Each innovation needs to be introduced slowly, according to how the staff can understand and are willing to accept. Intervention strategies will be formulated to manage these barriers and strengthen supports, such as, education, meetings, and open house. Strategies to implementation are discussed after a full assessment of the barriers and supports for innovation.

Negative attitudes, lack of skills, and lack of experience are concerns of the key team members of the Telematernity Peripartum Depression Collaborative Care Program (TPDCCP) related to the implementation of the model. These will be explored during the staff weekly meetings [follow up strategy]. Formative evaluation provides development of strategies to overcome challenges and barriers received from the group member’s feedback.

In the past, many members of the Women’s Health Clinic have been acknowledged [follow up strategy] for their contributions to changing their facilities to be more women-centric. Using this strategy, the facilitators can submit commendations in collaboration with the chiefs and supervisors to acknowledge the staff involved in the implementation change. As the Telematernity Peripartum Depression Collaborative Care Program team becomes proficient in meeting the needs of the mothers with these services, they can answer inquiry from other departments on how to manage their patients using innovative tools. The early adopters are now seen as proficient and experts in care
coordination of maternal patients using telehealth. This sense of pride and accomplishment will motivate the staff to assume accountability of the project implementation and sustained use.

Collaborative care programs are opportunities [supports] for services to share their experience and expertise. With services co-located in the same suite, opportunities to exchange ideas, knowledge, and specialties lead to collaboration. With frequent communication and opportunities to partner with patients in outreach events, rapport and trust can be strengthened [strategy].

**Adoption and Degree of Use**

Practice change is an indicator to the *degree of use*. At the center of this project is the patient. The *degree of use* depends on the patient and staff acceptance and willingness to utilize the innovation. The ease of implementation is dependent on the complexity of the innovation, the support of leadership, and commitment of the adopters. Having a committed and caring champion [supports] in each of the coordinated services will facilitate and encourage the staff to adopt the innovation, which contributes to the success of the project. By having participants review the Patient Health Questionnaire 2 and Edinburgh Postpartum Depression Scale screening during the learning activities, they can discuss and reflect [*intent of use*] on the value of the questionnaires. Staff participation in the educational activity and feedback surveys will be used to measure their *intent to use* the innovation.

With the use of the screening tool, clinical reminders and templates for electronic records will need to be redesigned. Involving the staff to update these tools, promotes ownership of the process. Use of referrals and consultations [*degree of use*] for the
maternity and Primary Care Mental Health Integration services will be used to measure how well it is accepted. An example of a Primary Care Mental Health Integration consult is shown on Appendix C of the Implementation Guideline.

At the end of the learning activities, the participating staff will develop action plans [follow up strategy] for performance improvement in their clinical areas related to the Telematernity Peripartum Depression Collaborative Care Program. A copy of these action plans will be shared with the Women Veterans Health Committee. Follow up discussion and updates on the performance improvement action plans will be shared during the overall monthly scheduled staff meetings to measure sustained use. Action plans for implementation will be monitored and updated. Champions in each of the services will also update the progress of the teams to the Women Veterans Health Committee [follow up strategy]. Involvement of the decision makers [key stakeholders] is gauged with their recommendations and resource allocation [degree of use].

A timeline should be developed to meet deadlines for implementation. Once education and training are completed, a pilot of the program should be conducted for two to three months to determine the feasibility of the program. During the pilot, a formative evaluation plan which includes, regularly scheduled meetings to address concerns, obtain staff feedback, and adjust the process to accommodate implementation. An example of a timeline is shown in Table 4 of the Implementation Guideline

Outcomes

Meeting minutes provide evidence and metrics for the quality of Women’s Health Services provided to the women veterans. Quarterly reports submitted to the Executive Leadership and Chiefs of the healthcare groups/product lines/services of the collaborative
care will inform the decision makers of the progress. An evaluation plan of the guideline and the implementation plan will be detailed in the Evaluation of Outcomes section.
EVALUATION OF OUTCOMES

Formative and summative evaluation methods are necessary to determine the guideline’s efficacy and feasibility. This culminating Doctor of Nurse Practice project produced a guideline (see Appendix D) that includes: learning activities on peripartum depression, an algorithm for guiding care, documentation templates, a collaborative work environment with notes for each of the four services, and a communication network with the national groups for women’s health care. There are two types of evaluation plan for this project proposal: 1) guideline content evaluation, and 2) program outcome evaluation.

Guideline Content Evaluation

Formative evaluation provided by a team of Veterans Healthcare Administration key stakeholders made the project guideline possible. The early adopters or ‘super end-users’ formed the local team tasked with evaluating the product. These early adopters and key stakeholders discussed content adjustments with the regional and national women’s health subject matter experts, Maternity Care Coordinators, Women Veterans Program Managers, investigators, and researchers. Further modifications to the Implementation Guideline will be made after additional discussion and concurrence. Initial one-to-one meetings with the key stakeholders and the Executive Leadership will be completed to discuss any specific concerns they may have regarding the Implementation Guidelines and program. Committee meetings with supervisors and staff will be conducted.

Consultation with the Women’s Health Services will assist in evaluating the content of the guideline, feasibility, and appropriateness. Adherence to change is an
outcome, which measures the *degree of use*. Early adopters should be encouraged to showcase their involvement in the practice change. Performance improvement fairs are opportunities for early adopters to showcase this innovation as a quality improvement project. Having the early adopters prepare, participate, and present in these activities will be an indicator of how well the change of practice is sustained [*transfer of knowledge, degree of use, follow-up strategy, and evaluation*].

To enhance practice change, the Veterans Administration (VA) Long Beach Healthcare System Women’s Health Program applied and was granted designation to be a member of the VHA Women’s Health Practice Based Research Network (see Appendix C). Data and content evaluation of this project proposal will be submitted to the members of the VHA Women’s Health Practice Based Research Network affiliated with the VHA Women’s Health Research Network to evaluate its efficacy in identifying and treating peripartum depression. The VHA Women’s Health Research Network is a national infrastructure that supports women’s health champions and facilitators by having access to leaders, consultants, subject matter experts, policy makers, investigators, researchers, and providers. It is comprised of the VHA WH Research Consortium and the WH Practice Based Research Network. It was developed as an initiative of the VA Health Services Research & Development (HSR&D) in transforming the VA in support of women’s health research and practice (Frayne et al., 2014).

**Outcome (Program) Evaluation**

Each facility must determine their metrics to monitor program quality and efficacy. Key performance measures are identified and monitored as part of the program evaluation. A suggested set of metrics is included in the guidelines. The purpose of
having a Telematernity Peripartum Depression Collaborative Care Program is to have mechanism to 1) screen, evaluate, and treat women veteran mothers who develop peripartum depression, 2) prevent suicide, and 3) coordinate care.

*Patient, provider, and system outcomes* will be measured. Changes in health-related quality of life scores, such as, Edinburgh Postpartum Depression Scale scores and Suicide Risk scores, will be included in the metrics [outcome evaluation]. Occurrence of unexpected events, such as, suicide and suicide attempts will be monitored and reported through the Women’s Health Practice Based Research Network (WH-PBRN). Patient and provider satisfaction surveys will be included as a measurement of the impact of the practice change [outcome evaluation]. Systems measurement, such as, wait times, access, and reimbursement [outcome evaluation], will be included. Overall, the start-up costs are minimal (less than $20,000) with a potential Veterans Equitable Resource Allocation of approximately, $25,000 per patient (Allocation Resource Center, 2013).

Examples of the provider and patient satisfaction survey questionnaire are shown in Appendix J of the Implementation Guideline. System-wide data collection and evaluation, in collaboration with the system-wide Maternity Care Coordinators (MCC), Women Veterans Program Managers (WVPM), and the Women’s Health Practice-Based Research Network (WH-PBRN), are part of the planned evaluation. The projected program evaluation will be presented quarterly post implementation at the regional and national MCC, WVPM, and WH-PBRN meetings. The feasibility of this program will be based on the results of a pilot program and of competing priorities within the healthcare settings.
Recommendations for Care and Nursing Implications

Nurses in the Women’s Health Clinic, Home Base Primary Care, and Telehealth are able to take on leadership roles in this project. Nurses are able to discuss and disseminate evidence-base innovations that are meaningful to their practice. Appraising and disseminating the latest evidence base innovations, the team was able to make recommendations by adapting a guideline to implement a program for this vulnerable population, the peripartum depressed female veterans. Nurses are able to redesign the healthcare services, allowing patients with peripartum depression to have access to one-stop services instead of having to access multiple departments. Constant discussion with Informatics Technology staff, who designs the Computerized Patient Record System, is necessary to ensure that progress notes, consult notes, and templates are appropriate and operational. Adjustments may need to be made to ensure provider ease of use and appropriate data capture.

Nurses, as leaders, have the opportunities to create partnerships within the system-wide and local VHA sites, the community providers, and hospital facilities in identifying these high-risk women veteran mothers and providing access to services. Awareness of the effects of military duty, PPD, early screening, and interventions, must be shared with non-VHA partners caring for peripartum female veterans. Nurses, as educators, are able to share their knowledge with VHA staff and community partners of the latest evidence base practice, services and programs, including telehealth availability and connectivity. Collaboration with national groups who serve women veterans, such as, the Maternity Care Coordinators, Women Veterans Program Managers, Women’s Health Services, and the Women’s Health Practice Base Research Network, should be part of the
continued plan to ensure that system-wide data collection and evaluation, and generation of new knowledge can be shared across the nation in enhancing the accessibility and quality of care of this unique population.

Nurses, as educators, should train and educate the VHA employees of the growing trends in women’s health care. Sharing success stories and lessons learned are valuable in promoting system-wide changes and sustainability. Using the nursing process, nurses can develop, implement, and evaluate system-wide healthcare programs at their local, regional, and national sites. This project demonstrated the need to provide coordinated care when treating peripartum depression (PPD). The project can provide initial data for the effects of combat and consequential pregnancy-related mental health issues. The program is a good starting point for much needed research in the area of PPD among female veterans.
CONCLUSION

The VHA is the leading healthcare system for mental health concerns and issues of veterans. Many academic affiliations have partnered with the VHA to ensure that healthcare providers are exposed to and are proficient in caring for the United States Veterans. Increasing number of women veterans transitioning to civilian life and the changes implemented by the Department of Defense with opening combat roles to women make the future of our young women veterans as mothers even more challenging. The VHA had expanded the women’s reproductive health services with the increase population of reproductive age women. With issues on infertility, Military Sexual Trauma, Post-Traumatic Stress Disorder, environmental exposures, and service-connected injuries, the VHA will need to be proactive, rather than reactive, when planning for care provision.

Using the Ottawa Model of Research Use as a framework to develop the guideline is an efficient, structured process to achieve this goal. The continuous loop of assessment, monitoring, and evaluation, will assist the facilitator to adjust the process and pace of the guideline development for this project. Involving the end-users with the subject matter experts utilizing evidence supporting the innovations allow for a meaningful application of technology. Management of the barriers and supports for the practice is key to adoption of the evidence base practice. A formative evaluation plan allows adjustment to the implementation process.

By combining current services, Women’s Health Clinic Maternity Care Coordination, Home Base Primary Care, Primary Care Mental Health Integration, and
Telehealth, an innovative model of care for women veterans is possible. This health care delivery may provide strategies to strengthen and support maternity care coordination.

The comprehensive women’s health clinic (WHC), by their nature of integrated and collaborative care with co-located interdisciplinary services for women veterans, is the likely place to implement a Telematernity Peripartum Depression Collaborative Care Program (TPDCCP). Developing a guideline to implement innovation will assist the VHA facilities in successful application of sustainable changes in practice. The recent literature supports the evidence that Edinburgh Postpartum Depression Scale is a valid screening tool to use for women with peripartum depression. Further studies may be needed to know the impact of early intervention with peripartum depression and women veterans.

The VHA Women’s Health Practice Base Research Network (WH-PBRN) will be used as a forum to assist and support VHA facilities to explore application of knowledge transfer into practice in women’s health. The Implementation Guideline for a TPDCCP (see Appendix D) for women Veterans is appropriate and timely, with the changing recommendations by national work groups, such as, the U.S. Preventive Task Force Group, National Rural Health Association, American Telemedicine Association, and California Telehealth Resource Center.
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APPENDIX A

MODIFIED OTTAWA MODEL OF RESEARCH USE

Figure 1. Adapted from Logan and Graham’s “Ottawa Model of Research Use,” p. 85, in J. Rycroft-Malone and T. Bucknall (Eds.), 2012, Evidence-based nursing: Models and frameworks for implementing evidence-based practice action: Linking evidence to action (5th ed., Somerset, NJ: John Wiley & Sons. Adapted with permission.
APPENDIX B

PERMISSION TO ADAPT AND USE
OTTAWA MODEL OF RESEARCH USE

From: Graham, Dr. Ian (OHRI-CEP) [mailto:igraham@ohri.ca]
Sent: Tuesday, June 23, 2015 2:07 PM
To: Rowson, Gina; Jo Logan
Subject: [EXTERNAL] RE: permission to use OMRU in VHA Long Beach Women’s Health

Hi Gina, We are happy for you to use the model. Let us know how it goes. Not sure if you have seen this chapter in Models and frameworks for implementing evidence-based practice by Rycroft Malone and Bucknal. All the best, Ian

Ian D Graham, PhD FCAHS
Professeur titulaire | Professor
École d'épidémiologie, santé publique et médecine préventive
School of Epidemiology, Public Health and Preventive Medicine
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email: igraham@ohri.ca

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From: Rawson, Gina  
Sent: June 23, 2015 13:56  
To: Logan, Jo; Graham, Dr. Ian (OHRI-CEP)  
Subject: permission to use OMRU in VHA Long Beach Women's Health

Hello. I am a DNP student at California State University of Fullerton, Los Angeles and Long Beach, Consortium. My proposal project is on establishing a telehealth maternity perinatal depression collaborative care.

I would like to use your model of change to implement these practices and bring all the services we have together, under the maternity care coordination.

1. Edinburgh Postpartum Depression Screening
2. Telehealth
3. Primary Care/Mental Health Integration
4. Home Base Transition Care

Please advise.

Thank you for supporting our women Veterans
Gina Rawson, MSN, APRN-bc
Women Veterans (VV) Program Manager
VA Long Beach Healthcare System
5901 E. 7th Street
Long Beach, CA 90822
Office: 562-826-5617

Gina Rawson <ggrawson1@csu.fullerton.edu>  
11:45 PM (10 hours ago) ★

to Ian 

Dr. Graham, may I request for your permission to adopt the model with the attached one? I used your model two ways:
1. To guide us with the writing of the implementation guideline, and
2. To guide us to implement the program.
I can send you my proposal to make sure that I am using it correctly.

Graham, Dr. Ian (OHRI-CEP)  
4:35 AM (5 hours ago) ★

to me 

Happy for you to adapt and use the model. Let me know how things go. Have a good weekend. Ian

From: Gina Rawson  
Sent: March 18, 2016 02:45  
To: Graham, Dr. Ian (OHRI-CEP)  
Subject: Re: another illustration - am I still on target?
VA Women’s Health PBRN – VA Long Beach

PBRN Site Lead: Gina Rawson, DNP-c, APRN-bc

PBRN Co-Site Lead: Angela Tan, MD

Dear Dr. Reist,

I am delighted to notify you that Women’s Health Research Network leadership has convened and selected your facility as a VA Women’s Health Practice-Based Research Network Member Site.

We anticipate that we will be sending out formal welcome materials within about a month, but I wanted to alert you of the decision. After we send the welcome package, we will also directly contact the Site Lead for a few additional pieces of information so that we can activate your site.

We are very much looking forward to our relationship with your site!

Best wishes,

Susan Frayne MD, MPH

On behalf of the VA Women’s Health PBRN Leadership Team

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<td>Beverne Bear-Mayberry, MD, MS</td>
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<tr>
<td>636A</td>
<td>IA</td>
<td>Iowa City VA Health Care System*</td>
<td>Anne Sadler, PhD, RN</td>
</tr>
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</table>

* Denotes an inaugural WH-PBRN site.

For more information about the VA Women’s Health Practice-Based Research Network, contact:
Susan Freyne, MD, MPH, PBRN Director (Susan.Freyne@va.gov)
Diane Carney, MA, PBRN Program Manager (Diane.Carney@va.gov)
VA Women’s Health PBRN Coordinating Center, VA HSRR&D Center for Innovation to Implementation (C2I), Palo Alto

For more information about the VA Women’s Health Research Consortium, contact:
Elizabeth Yoon, PhD, MPH, Consortium Director (Elizabeth.Yoon@va.gov)
Ruth Kap, PhD, Consortium Program Manager (Ruth.Kap@va.gov)
VA Women’s Health Research Consortium, VA HSRR&D Center for the Study of Healthcare Innovation, Implementation & Policy (CSHIP), Los Angeles
APPENDIX D
IRB PROJECT SUBMISSION AND APPROVAL

Beth Winokur

From: IRB <irb@calstatela.edu>
Sent: Wednesday, February 24, 2016 4:34 PM
To: Beth Winokur
Subject: RE: IRB NOT HUMAN SUBJECTS

Hi Dr. Winokur,
Based upon the information you have submitted to the IRB, your project does not seem to meet the definition of research according to the federal regulations, 45 CFR 46, as it appears that it is not a systematic investigation, including research development, testing and evaluation, that is designed to develop or contribute to generalizable knowledge. If this differs from your intent, further IRB review will be required.

Thank you,
Elia

ELIA AMARQ, MSA
Research Support Services Coordinator
Office of Research and Development
California State University, Los Angeles
5161 State University Drive
Los Angeles, CA 90032
T 323.343.3758
calstatela.edu | Pushing Boundaries

From: Beth Winokur [mailto:Elizabeth.Winokur@stjoe.org]
Sent: Wednesday, February 24, 2016 7:52 AM
To: IRB <irb@calstatela.edu>
Subject: IRB NOT HUMAN SUBJECTS

Thank you,
Elizabeth Winokur, PhD, RN, CEN
714-402-4270
Ewinoku2@exchange.calstatela.edu

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Please note that the information contained in this message may be privileged and confidential and protected from disclosure.
APPENDIX E

PUBLISHABLE MANUSCRIPT: IMPLEMENTATION GUIDELINE BOOKLET

“IMPLEMENTATION GUIDELINE FOR A TELEMATERNITY PERIPARTUM DEPRESSION COLLABORATIVE CARE”

This appendix includes a prototype of a soon-to-be published booklet entitled,

“Implementation Guideline For A Telematernity Peripartum Depression Collaborative Care,” by the project author Gina Rawson, and project chair Elizabeth Winokur. This guideline will be provided to the Maternity Care Coordinators who will be implementing the Telematernity Peripartum Depression Collaborative Care Program.
Implementation Guideline

For A

Telematernity Peripartum Depression

Collaborative Care Program

By

Gina Gutierrez Rawson, MSN

Elizabeth Winokur, PhD
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EXECUTIVE SUMMARY

With the changes in the Department of Defense policies in regard to women soldiers and combat engagement, active duty military women will continue to be exposed to traumatic events. Stressors will affect these women soldiers, whether from family separation, Military Sexual Trauma, and/or Post-Traumatic Stress Disorder. Some will remain in the military; others will opt to be discharged and transition to civilian life. Adjusting to the changes can be challenging for those recently discharged, especially the young women. Starting a family and obtaining maternity care can be overwhelming. Those who are honorably discharged from military service are eligible to receive healthcare at the Veterans Healthcare Administration (VHA).

A Telematernity Peripartum Collaborative Care Program for women veterans (WV) receiving maternity care services in the VHA healthcare is critical because of the higher incidence of mental health issues. Implementation of this program will improve care coordination with the mother during her peripartum stage. This collaborative care program will consist of four services that are:

Maternity Care Coordination (MCC),

Primary Care Mental Health Integration (PCMHI),

Home Base Primary Care (HBPC), and

Telehealth.

Maternity Care Coordination, PCMHI, and Telehealth were initiatives that were previously introduced at all the VHAs. Extensive processes were set in place to implement them. Many VHAs are at varying stages of adoption.

Early peripartum depression screening, referral, education, therapeutic interventions, social support, and outreach to these women veterans will be the core services provided. Using
telehealth technology from a patient’s home computer or the telehealth technician’s computer will enable the patient and the provider to communicate
INTRODUCTION

The Department of Veterans Health Administration (VHA) instituted changes in the healthcare system delivery to align with the growing changes of the military. Women’s health clinics (WHCs) were established in VHA facilities in the last five years. As young female military personnel from Army, Air Force, Navy, Marines, and Coast Guards complete their military service and transition to other careers as women Veterans, the VHA facilities are compelled to review a changing healthcare structure to address the needs of the women veterans. The top three physical health domains for reproductive age women veterans are musculoskeletal, mental health, and reproductive health. Depression and Post Traumatic Stress Disorder rank as the top two mental health diagnoses for women veterans (WV) of reproductive age (Frayne et al., 2014). One of the most common diagnoses throughout pregnancy and postpartum is peripartum depression. The peripartum stage may be a vulnerable time for the mother, especially new mothers, mothers with multi-births, or mothers with prior history of mental health disorders (Werner et al., 2015).

This guideline provides the information necessary to implement a Telehealth Peripartum Depression Program for eligible women Veterans during their peripartum stage. The four aims of this project are: 1) to reach out to women Veterans during their peripartum stage, 2) to implement use of a validated, sensitive tool to evaluate peripartum depression, 3) to provide access to care using non-traditional delivery of care, telehealth, and 4) to share the knowledge of healthcare delivery of WV to other VHA facilities.
BACKGROUND

Four services will provide the staff and resources to deliver this care model to patients covered by the maternity care services. The four services are:

Maternity Care Coordination,
Primary Care Mental Health Integration,
Home Base Primary Care, and
Telehealth.

The four evidence-based innovations are the core existing services to be implemented in a Telematernity Peripartum Depression Collaborative Care are:

Use of Edinburgh Postpartum Depression Scale (EPDS) screening throughout the peripartum stage until 12 months postpartum
Women’s Health collaboration with Primary Care Mental Health Integration
Home Base Primary Care (Home Base Transition Care)
Telehealth

The Ottawa Model of Research Use framework was used as a structure for each step of program development (see Figure 1). The six elements of the Ottawa Model of Research Use are:

Evidence-based innovation
Potential adopters
Practice environment
Barrier management, implementation, and interventions
Degree of use and adoption
Evaluation of patient, practice, and provider (Logan & Graham, 2012).
Although non-linear, the model will be sequentially utilized beginning with assessment, progressing through monitoring and, finally, to evaluation where an evaluation plan will be developed. Logan and Graham (2012) recommended that the first three elements are the most important areas to concentrate to develop the strategies for implementation. As the guideline is implemented into practice, the continuous cycle of assessment, monitoring, and evaluation will be employed.
STRENGTHS, WEAKNESS, OPPORTUNITIES AND THREATS (SWOT) ANALYSIS

Careful assessment of the strengths, weaknesses, opportunities, and threats (SWOT) of the innovation, adopters, and practice environment should be developed before proceeding with program development. There are positive and negative internal factors (strengths and weaknesses, respectively), and external factors (opportunities and threats, respectively). Strengths are the strong facets of the organization, such as, finance, resources, people, infrastructure, and staff experiences. Weaknesses are the organization’s weak areas that “do not meet the standards,” (Antony, 2012, p. 691). Opportunities and threats are external factors that are outside of the organization’s control but can be used for an advantage or disadvantage (Antony, 2012).

Each quadrant of the SWOT analysis will have different factors to be considered so that intervention strategies are developed to overcome the barriers and reinforce supports. The SWOT analysis aids in risk analysis and assists with determining the programs that will provide a better return on investment (American Telemedicine Association Business and Finance SIG Work Group, 2011). This tool will help explore challenges, potential problems, and weaknesses. Each facility must develop its own SWOT analysis (see Figure 2 for Blank SWOT). An example of a completed SWOT analysis is shown in Table 1.
Figure 2. Blank Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis
Table 1. Example of Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

<table>
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<tr>
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<th>POSITIVE</th>
<th>NEGATIVE</th>
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<td><strong>STRENGTHS</strong></td>
<td>Improve access to care</td>
<td>Lack of staff and patient knowledge</td>
</tr>
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<td></td>
<td>Improve patient safety</td>
<td>Change of leadership and staff</td>
</tr>
<tr>
<td></td>
<td>Improve follow up care and care coordination</td>
<td>Challenge to attract staff to utilize telehealth modalities</td>
</tr>
<tr>
<td></td>
<td>Reduce/eliminate travel time for patients</td>
<td>Challenge with scheduling</td>
</tr>
<tr>
<td></td>
<td>Reduce/eliminate stigma for patients waiting in mental health clinics</td>
<td>Coordinate with departments</td>
</tr>
<tr>
<td></td>
<td>Decrease use of “outsourcing” of patients to community providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Utilize new technology</td>
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<td><strong>OPPORTUNITIES</strong></td>
<td>Re-design templates</td>
<td>Unexpected patient events</td>
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<td></td>
<td>Education of staff and patients</td>
<td>Disruption of network connection</td>
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<tr>
<td></td>
<td>Obtain resources from VHA</td>
<td>Rise in costs of technology</td>
</tr>
<tr>
<td></td>
<td>Access to the VA Women’s Health Research Network</td>
<td>Changes in regulations related to telehealth</td>
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<tr>
<td></td>
<td>Enhance community image of VHA</td>
<td>Decrease in patient satisfaction</td>
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<tr>
<td></td>
<td>Improve patient satisfaction</td>
<td>Changes in information technology (IT)</td>
</tr>
<tr>
<td></td>
<td>Use during disaster/ emergency situations</td>
<td>Decrease in IT support</td>
</tr>
<tr>
<td></td>
<td>Use staff for cross coverage</td>
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INTERNAL

EXTERNAL
MARKETING PLAN

The goal of the marketing plan is to increase the adoption and use of Telematernity Peripartum Depression Collaborative Care Program (TPDCCP). This will be accomplished by identifying the target market, objectives, activities, and evaluation outcomes (Desai, n.d.). Effective communication among the innovators, facilitators, subject matter experts, key stakeholders, end-users, and early adopters is crucial to successful promotion of the change in practice.

Opportunities for communication must be encouraged. The initial target market is the key stakeholders and early adopters. This includes the following:

- Executive Leadership,
- Primary Care leaders,
- Nursing supervisors,
- Women’s Health staff, including the Maternity Care Coordinators, and
- Women Veteran patients and families.

Once support is obtained from the key stakeholders, the target market will be expanded to include the staff who will be actively involved in the program. Staff and patients will provide feedback and promote the marketing efforts. The success of this program is dependent on the patient’s acceptance of the innovation (California Telehealth Network, 2015).
Marketing Objectives

The marketing objectives are to:

- Increase awareness of the Telematernity Peripartum Depression Collaborative Care (TPDCCP)
- Obtain support from leadership to fund and support the program
- Increase adoption and use of TPDCCP by patients and staff
- Communicate successes of the TPDCCP

Marketing Activities

The marketing activities that will be used to increase awareness and adoption are:

- One-on-One Meetings – a facilitator will meet with a key individual to gain support for the program. The benefits to this type of meeting are personalized discussion, immediate feedback, opportunities to address concerns, and facilitate open communication. This type of marketing activity is labor-intensive
- Group Meetings – meetings with Executive Leadership, supervisors, clinic staff, and others involved. These meetings allow information to be communicated to a larger audience. Feedback from all participants may not be captured as easily as in one-on-one meetings
- VA Women’s Health Research Network (WHRN) – a national infrastructure that will assist women’s health champions and facilitators in having access to leaders, consultants, subject matter experts, policy makers, investigators, researchers, and providers. It is comprised of the WH Research Consortium and the WH Practice Based Research Network. It was developed as an initiative of the VA Health Services Research & Development Service (HSR&D) in transforming the VA in support of women’s health
research and practice (VA Women’s Health Research Network, 2016). Consultation with this group will assist in evaluating the content of the guideline

VA Women’s Health Services – regularly schedule meetings with this national group of women’s health consultants, policy makers, leaders, subject matter experts, and advocates will assist in promoting Women’s Health research and evidence-based practice

Consisting of the Chief Consultant for Women’s Health Services who reports directly to the (WHS) of the Department of Veterans Administration and Congress, the WHS has many channels of influence that can provide support and assistance to WH champions and facilitators at the local facility and regional levels (Frayne et al., 2014)

Electronic Communication – electronic messages can be sent to individuals and groups using emails, e-newsletters, and social media. This type of marketing is free, easy to use, and able to reach a large audience. The concerns with electronic communication are information overload, misunderstanding, lack of personal touch, and difficult to track.

Additional written marketing materials should serve to clarify and correct any misunderstandings.

Lunch-and-Learn Seminars – lectures are held during lunchtime to encourage maximum participation. Although seminars are well attended, some staff may be reluctant to attend during their lunch

Journal Club Meetings – regularly scheduled meetings by specific disciplines to discuss evidence-based practice. The Telematernity Peripartum Depression Collaborative Care program is an additional agenda item for discussion. The advantage of this type of marketing is the staff are in attendance for the journal club
Talent Management Systems – the VHA uses these web-based learning resources for VHA employees. This system records training completed by employees and reports are easily generated by employees and training activities. Evaluation outcomes of the marketing activities will be measured by how well the objectives are met. The marketing plan also includes resources needed, start-up costs, and ongoing costs of marketing. An example of a marketing plan is shown on Table 2.
### Table 2. Example of a Marketing Plan

<table>
<thead>
<tr>
<th>Marketing Objectives</th>
<th>Marketing Activities</th>
<th>Method of Evaluating Marketing Activity</th>
<th>Resources Involved</th>
<th>Budget Start-up costs</th>
<th>Budget On-going costs</th>
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<tr>
<td>Increase awareness of the TPDCCP</td>
<td>1:1, GM, EC, L&amp;L, JC, TMS</td>
<td>Sign-in sheets, Confirmation of email “Read receipts,” tracking of website visitors, TMS reports</td>
<td>Facilitator</td>
<td>$0 collateral duty If printed brochures utilized, cost will be $20 - $500 depending on quantity and quality</td>
<td>$0</td>
</tr>
<tr>
<td>Obtains support from leadership to fund and support program</td>
<td>1:1, GM, EC</td>
<td>Meeting minutes supporting funding and program</td>
<td>Lead Facilitator</td>
<td>$0 collateral duty</td>
<td>$0 collateral duty</td>
</tr>
<tr>
<td>Increase adoption and use of TPDCCP by patients and staff</td>
<td>1:1, GM, EC, L&amp;L, JC, TMS (Staff only)</td>
<td>Patient referrals and enrollment</td>
<td>Facilitator, key stakeholders, and early adopters</td>
<td>$0 collateral duty If printed brochures utilized, cost will be $20 - $500 depending on quantity and quality</td>
<td>$0 collateral duty</td>
</tr>
<tr>
<td>Communicate successes of the TPDCCP</td>
<td>GM, EC, L&amp;L, JC,</td>
<td>Sign-in sheets, tracking of website visitors</td>
<td>Facilitator, key stakeholders, early adopters, and public affairs officer</td>
<td>$0 collateral duty If video production, cost to be determined</td>
<td>$0 collateral duty</td>
</tr>
</tbody>
</table>

Legend:
1:1 (one-on-one)  
GM (group meetings)  
EC (electronic communication)  
L&L (Lunch and Learn)  
JC (Journal Club)  
TMS (Talent Management Systems)
FINANCIAL PLAN

Because the Women Veterans Health Program is integrated throughout the healthcare system, the specific leaders, chiefs, and supervisors of each service, i.e., Primary Care, Mental Health, Telehealth, Women’s Health, Primary Care Mental Health Integration, and Home Base Primary Care are consulted for a series of meetings to discuss staffing and core services that will be required for a Telematernity Collaborative Care. The budget proposal will be developed in collaboration with the Chiefs of Resources and Finance once the leaders of the health care group or service line concur.

Costs of technology (equipment, software, network), training, education, supplies, and space will be requested under each of the patient care health care groups, service line, or departments. The Women’s Health Clinic will provide the physical space for these various services. All services will be located in the same geographic area to support coordination of care. The funding control point for allocated resources from VA Central Office (headquarters) will be under the healthcare group, service line, or department in which the Women’s Health Clinic resides within the organization. Staffing, salary, and benefit expenses are absorbed by the four services. Telehealth delivery of care will be a collateral duty, as the telehealth visit will replace the in-person clinic visits. Initially, there will be no additional expenses for clinical staff salary and benefits (see Table 3). Expenses and time allocation are projected to increase with program growth.

An addendum will be included in each of the job descriptions of the staff member involved with telehealth. Additional duties will reflect timely, coordinated, collaborative, and appropriate patient care, which will include:

- Participation with Telematernity collaborative care implementation
- Completion of required training for telehealth use and maternity care
Review of telehealth service agreement, standardized protocols, and national guidelines

Use of telehealth equipment, network platform (Jabber to Home), and scheduling process

(VA Telehealth Services, 2015).
Table 3. Example of a Start-up Financial Plan

<table>
<thead>
<tr>
<th>EXPENSES</th>
<th>Start-up costs</th>
<th>Recurring Costs</th>
<th>Full time Employee Equivalent</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>$0</td>
<td>$0</td>
<td>0.1</td>
<td>Telehealth visit will replace face-to-face visit with psychiatrist</td>
</tr>
<tr>
<td>Psychologist</td>
<td>$0</td>
<td>$0</td>
<td>0.1</td>
<td>Telehealth visit will replace face-to-face visit with psychologist</td>
</tr>
<tr>
<td>Maternity Care Coordinator/RN</td>
<td>$0</td>
<td>$0</td>
<td>0.1</td>
<td>Telehealth visit will replace face-to-face visit with RN</td>
</tr>
<tr>
<td>Telehealth Technician (HBPC)</td>
<td>$4000</td>
<td>$4000</td>
<td>0.1</td>
<td>Additional workload</td>
</tr>
<tr>
<td>Telehealth Coordinator</td>
<td>$6000</td>
<td>$6000</td>
<td>0.1</td>
<td>Additional workload</td>
</tr>
<tr>
<td>IT technician</td>
<td>$500</td>
<td>$500</td>
<td>As needed</td>
<td>Initial set-up and just-in-time training</td>
</tr>
<tr>
<td>Clinical Applications Coordinator</td>
<td>$300</td>
<td>$300</td>
<td>As needed</td>
<td>Consultation and templates for electronic medical record</td>
</tr>
<tr>
<td>Telehealth Equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camera for staff computers (5)</td>
<td>$300</td>
<td>$0</td>
<td></td>
<td>Cameras to be mounted on existing monitors</td>
</tr>
<tr>
<td>Training Expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 staff members</td>
<td>$6000</td>
<td>$2000</td>
<td>Training of new staff (attrition)</td>
<td>9 hours per staff member comprised of TMS training, maternity screening, and preceptorship</td>
</tr>
<tr>
<td>3 staff members</td>
<td>$2800</td>
<td>$1000</td>
<td></td>
<td>Certification of additional staff</td>
</tr>
<tr>
<td>Certification Peripartum Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marketing Expenses</td>
<td>$0</td>
<td>To be determined</td>
<td></td>
<td>If printed brochures utilized, cost will be $20 - $500 depending on quantity and quality</td>
</tr>
<tr>
<td>Total costs</td>
<td>$19,900</td>
<td>$13,800</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>REVENUE</th>
<th>ACTUAL</th>
<th>POTENTIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran Equitable Resource Allocation Reimbursement*</td>
<td>$0</td>
<td>$25,000 per patient enrolled in HBPC</td>
</tr>
</tbody>
</table>

*Veterans Equitable Resource Allocation (VERA) is one of the methodologies that the VHA uses to reimburse facilities for veterans care. The methodology was designed in 1997 to provide funding based on the complexity of the patient care needs. Patients with basic care needs are reimbursed at a significantly lower rate compared to those with complex care needs. For example, reimbursement for a patient receiving care for a serious mental illness would be approximately $30,000 per fiscal year. Reimbursement for a patient receiving basic primary care for a comprehensive evaluation and management by a provider would be approximately $3,000 per fiscal year (Allocation Resource Center, 2013).
IMPLEMENTATION PLAN

Prior to implementation facilities must determine physical space for the program and equipment must be acquired. Education of staff must occur prior to implementation of the program.

This section of the guideline will outline:

A. Physical Practice Environment
B. Equipment needed
C. Education and training
   1. Edinburgh Postpartum Depression Scale
   2. Peripartum Depression Algorithm
   3. Resources
   4. Telehealth training
      a. Equipment use
      b. Troubleshooting
Physical Practice Environment

Clinic Site

A private and quiet room, with adjustable lighting, and telehealth equipment will be needed. Computer equipment, with secure appropriate telehealth software to access the patient’s chart will be supplied. Because the patient can see the appearance of the physical background of the office during a telehealth session, a professional atmosphere of the workplace environment must be considered.

Patient’s Home

The patient must feel comfortable in the use of telehealth for communication and intervention. The feelings of intrusion that patients may feel using telehealth must be explored during the initial patient assessment for telehealth use. The patient can decline and treatment will be provided face-to-face in clinic sessions. It is recommended that the room that the patient chooses at her house for telehealth should allow maximum patient comfort, privacy, and freedom to speak freely during the therapeutic interventions. Expectations, concerns, and issues on connectivity and interruptions should be discussed and a contingency plan is prepared.

Providing the equipment for telehealth communication via computer, the Home Base Primary Care telepresenter, also known as, telehealth computer technician (TCT), knowledgeable in telehealth communication, will visit the patient to initially interview, screen, and gather information from the patient to establish telehealth connectivity. After the primary care provider completes the assessment and determines the need for medications and supplies, education, and referrals, such as breastfeeding or lactation care needs, the TCT will reinforce the schedule for further care. On subsequent visits, the TCT will go to the patient’s home to connect the visit. This will continue until the patient becomes proficient with telehealth.
Education, Training, and Competency

Edinburgh Postpartum Depression Scale (EPDS)

Education, consisting of an overview of peripartum depression (PPD), depression screening, and evidence-based practice will be presented to the nurses, providers, and social workers. Because the audience is composed of adult learners, content should be delivered in a meaningful way stressing the connection to the providers’ role in care delivery. The curriculum has been developed using active learning and problem-based learning/teaching strategies (Bradshaw & Lowenstein, 2011). The EPDS screening and peripartum collaborative care algorithm will be reviewed and used during this learning session (see Appendix A). Three hours should be allocated for this interactive phase of training.

Telehealth and Equipment Training

Telehealth computer technicians and telehealth coordinators have a separate intensive telehealth training required by the VA Telehealth Services, which will be followed according to VHA policies (VA Telehealth Services, 2015). The telehealth technician will provide assistance in set-up and connectivity until the patient is proficient. Telehealth staff [early adopters], selected because of their familiarity with the technology, will provide training, procurement, and equipment use. In their current practice, they are responsible for obtaining service agreements among the various specialty telehealth participants within the VA. These roles will be continued through the initiation of Telematernity program. Several telehealth training modules are available to the clinical employees in the Talent Management System (TMS), a web-based learning system for VHA employees. All staff (end-users) involved with Telematernity program must be trained on telehealth equipment prior to telehealth visit. All employees will need to complete seven modules for telehealth. This can be delivered at one or multiple sessions. Seven to eight hours should be allocated for module completion (see Appendix F). The modules will
be used as a periodic refresher for staff not frequently providing Telematernity services. The supervisor can monitor the employee’s completion of the training. The staff will provide a certificate of completion to the Telehealth coordinator prior to telehealth equipment use.

**Competency**

Each staff will work to the highest scope of his/her practice. Credentialing and privileging policies will be followed according to the medical by-laws and nursing policies as required by the local VA facility. Quality management and patient safety requirements will be monitored according to the VA Telehealth facility regulations. This competency checklist will be added as an addendum to their files.

A Telematernity competency checklist will be completed prior to the clinical staff members’ first telehealth visit. The competency checklist applies to the nurses, providers, and social workers (see Appendix I).

**Algorithm and Suicide Risk**

The EPDS screening will be administered to the veteran by the registered nurse (see Appendix B). A referral algorithm will be followed (see Appendix C). Question 10 (I have thoughts of harming myself) identifies self-harm response. The total EPDS scores, presence of symptoms, and question 10 response will determine which initial branch of the algorithm will be followed. Symptomatic patients and those with a positive response to question 10 will require additional screening for suicide risk. The suicide risk screening results will determine the plan of treatment and actions according to the VHA policies (see Appendix H).

An EPDS score of greater than ten will be referred to Primary Care Mental Health Integration (PCMHI). An example of a PCMHI consult is shown on Appendix D. A veteran who is actively receiving mental health therapy can continue care with her mental health provider.
All patients will be screened bi-monthly throughout the peripartum stage, until 12 months postpartum. All patients will receive education regarding the possible cause and incidence of peripartum depression, signs and symptoms, resources available, and a list of people to contact for maternity care coordination. The need for social support will be explored. If social support is deemed inadequate, patient will be referred to the social worker for resources available. This patient will be reevaluated in two weeks. Resources for each local site should be prepared, and at a minimum, include:

Maternity Care Coordinator

VHA Crisis Hotline, 1-800-273-8255

Referral for Women’s Health Clinic (WHC)

When a pregnant patient presents to a VA clinic other than the WHC, a pregnancy lab test result will generate a computerized alert to the women’s health pharmacist and maternity care coordinator, who are responsible for documenting and marking the patient’s electronic chart with a pregnancy/lactation flag. This system was implemented for patient safety and to decrease iatrogenic incidences. The pregnancy/lactation flag was also instituted so that the maternity care coordinator will be alerted to contact the patient for a follow-up appointment to determine additional services that the patient may need. Any VHA provider may also generate a WHC consult for maternity care coordination (see Appendix E).

A woman veteran may present herself at the WHC with a positive pregnancy or a request for pregnancy screening. Once the pregnancy is confirmed, the consult for Non-VA Maternity Care services referral will be processed. The maternity care coordinator will discuss several important items with the female veteran. This should include:

Review Non-VA maternity care services

Provide point of contact for maternity care coordinator
Provide patient education, which includes prevalence of peripartum depression (PPD), signs and symptoms, and VHA Crisis Hotline

Provide list of available resources and services in the local VHA facility and community, including availability of PCMHI and Telehealth services,

Discuss prevalence of PPD and schedule of bi-monthly telephone calls

Administer Edinburgh Postpartum Depression Scale screening

**Referral from Non VA Providers**

Once the expectant mother established a schedule of appointments with her OB/GYN or certified midwife, contacting the maternity care coordinator can facilitate maternity services. In the event an OB/GYN identifies risk of peripartum depression (PPD), the provider will contact the maternity care coordinator (MCC). The patient will be contacted by the MCC for immediate PPD screening using the Edinburgh Postpartum Depression Scale and implement appropriate interventions.
Documentation

Limited forms for the Telematernity program are available within the VA Computerized Patient Record System (CPRS). Written service agreements are required to ensure coordination of care, decrease fragmentation and confusion, and delineate the responsibilities of the requesting and consulting providers. Service agreements can be separate forms (see Appendix J) or embedded in the consult (see Appendices D and E). Forms that are recommended include:

Maternity Care Templates: Initial, Bi-monthly, Postpartum (see Appendix G)
Edinburgh Postpartum Depression Scale (see Appendices B and G)
Suicide Risk Screening (see Appendix H)
Nutrition Screening (see Appendix G)
Primary Care Mental Health Integration Consult (see Appendix D).

The Maternity Care templates are examples of documenting the initial, bi-monthly, and postpartum contact with the female veteran. Screening questionnaires, such as, the intimate partner violence, EPDS, and the Nutrition, tobacco, and alcohol use, can be embedded on these templates for ease of use for the end-user (see Appendix G).

Nutrition services are consulted during the initial maternity care visit to establish care and continued consultation. Nutritional screening should be part of the initial maternity care appointment to ensure that the mother receives optimal nutritional intake screening and recommendations for the physical and mental health of the mother and the baby. Nutritional deficits may accompany peripartum depression. Referrals to primary care providers and social services should be made as appropriate.

Multiple meetings with the local facility Clinical Application Coordinator (CAC) will need to be scheduled. The CAC will be able to import the Computerized Patient Record System templates and documentation forms from other VHAs.
Once education and training are completed, a pilot of the program should be conducted for 60 to 90 days to determine the feasibility of the program. During the pilot, regularly scheduled meetings should occur to address concerns, obtain staff feedback, and make changes (American Telemedicine Association Business and Finance SIG Work Group, 2011). A timeline should be developed to meet deadlines. An example of a timeline is shown in Table 4.
Table 4. Example of a Timeline for Implementation

<table>
<thead>
<tr>
<th>Timeline: Month</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate need for program</td>
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<tr>
<td>What problem will Telematernity Peripartum Depression Collaborative Care program improve or solve</td>
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<tr>
<td>Develop a service plan to include service agreements, templates, algorithm</td>
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<tr>
<td>Develop a business plan to include SWOT analysis, marketing, and financial plans</td>
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<tr>
<td>Meet with key stakeholders, executive leadership to gain support and approval</td>
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<tr>
<td>Implement marketing plan</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educate and train staff</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test care and technology plans by Pilot Program</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluate and recommend changes to program</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision to fully implement program</td>
<td></td>
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</tbody>
</table>
**Evaluation of Outcomes**

The feasibility of Telematernity program will be based on the results of each institution’s pilot program, patient and provider satisfaction, and performance measures. Quarterly reports should be presented to the local institution’s Executive Leadership. Each facility should determine which performance measures will be used as metrics for quality of care. Program performance metrics will measure telehealth schedule, no-show rates, wait times, and consent prior to each session. Examples of patient and provider satisfaction survey questions are in Appendix K. Performance Measures will address the following:

**Edinburgh Postpartum Depression Scale (EPDS) screening under maternity care services:**

1. Numerator: Number of EPDS screening
2. Denominator: Number of maternity care patients
3. Target goal = 90%

**Low Risk Screen (Negative Question 10, Scores < 10, and no MH symptoms)**

1. Numerator: Number of patients screened as low risk
2. Denominator: Total screened
3. Target goal = TBD

**Low Risk* Screen and appropriate Algorithm**

1. Numerator: Number of Low Risk screened with appropriate interventions according to the Algorithm
2. Denominator: Number of total Low Risk
3. Target goal: TBD

**High Risk Screen (Positive Question, or Scores > 10, or with MH symptoms)**

1. Numerator: Number of patients screened as high risk
2. Denominator: Number of total screened
3. Target goal: TBD
High Risk** screened and appropriate Algorithm
1. Numerator: Number of High Risk patients screened with appropriate interventions according to the Algorithm
2. Denominator: Number of High Risk patients screened
3. Target goal: TBD

Suicide Risk Screening
1. Numerator: Number of Suicide Risk Screening
2. Denominator: Total of Number of Positive Question 10
3. Target goal: 100%

Suicide Risk Screening Dispositions (according to the institution’s referral services)
Number of Suicide/homicide threats, attempts, and completion
Telehealth Scheduled appointments:
1. Target goal = 12 patients for initial year (increase to 36 patients on second year).

Wait Times:
1. Less than 14 days
No-show rates:
1. Target goal = less than 10%
Consents obtained prior to each sessions:
1. Target goal = 100% (chart review)
Conclusion

Early detection of peripartum depression prepares the patient and family to be aware of the changes that the mother may experience, the value of social support, the women’s health clinic and primary care mental health integration staff as the liaisons for available services and early intervention. Overall, the start-up costs are minimal (less than $20,000); however, the implementation of a complex program may be challenging to sustain.

By combining current services, Women’s Health Clinic, Maternity Care Coordination, Home Base Primary Care, Primary Care Mental Health Integration, and Telehealth, an innovative model of care for women Veterans is possible. This health care delivery may provide strategies to strengthen and support maternity care coordination. Integrating telehealth practices promote awareness and education of peripartum depression, increase access to mental health services, and meet patient care needs.

More evidence-based literature and articles are being published on the recent population of women in combat, validity of Edinburgh Postpartum Depression Scale (EPDS) in peripartum depression screening, and telehealth delivery of care in specialty care services. Developing a guideline to implement Telematernity Peripartum Depression Collaborative Care will assist the VHA facilities in successful application of sustainable changes in practice. The Implementation Guideline for a Telematernity Peripartum Depression Collaborative Care for women Veterans is appropriate and timely, with the changing recommendations by national work groups, such as, the U.S. Preventive Task Force Group, National Rural Health Association, American Telemedicine Association, and California Telehealth Resource Center.

The literature supports the evidence that EPDS is a valid screening tool to use for women with peripartum depression. If the entire program cannot be initially implemented, at a minimum, the EPDS should be implemented for all maternity care patients, as soon as possible
because this will improve patient safety. Content and data from this project has been presented to the members of the VHA Women’s Health Services, Women Veterans Health group, and Maternity Care Coordination, to pursue implementation throughout the VHA facilities. Content and data from this project has been submitted to the VHA Women’s Health Practice Based Research Network (WH-PBRN), affiliated with the VHA Women’s Health Research Network (WHRN) to evaluate its efficacy in identifying and treating PPD.
References


APPENDIX A

EDINBURGH POSTPARTUM DEPRESSION SCALE

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Baby’s Date of Birth:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

Please select the answer that comes closest to how you have felt **in the past 7 days**:

1. I have been able to laugh and see the funny side of things
   a. Yes, most of the time
   b. Yes, sometimes
   c. Not very often
   d. No, not at all
2. I have looked forward with enjoyment to things
   a. Yes, most of the time
   b. Yes, sometimes
   c. Not very often
   d. No, not at all
3. I have blamed myself unnecessarily when things went wrong
   a. Yes, most of the time
   b. Yes, sometimes
   c. Not very often
   d. No, not at all
4. I have been anxious or worried for no good reason
   a. Yes, most of the time
   b. Yes, sometimes
   c. Not very often
   d. No, not at all
5. I have felt scared or panicky for no very good reason
   a. Yes, most of the time
   b. Yes, sometimes
   c. Not very often
   d. No, not at all
6. Things have been getting on top of me
   a. Yes, most of the time
   b. Yes, sometimes
   c. Not very often
   d. No, not at all
7. I have been so unhappy that I have had difficulty sleeping
   a. Yes, most of the time
   b. Yes, sometimes
   c. Not very often
   d. No, not at all
8. I have felt sad or miserable
   a. Yes, most of the time
   b. Yes, sometimes
   c. Not very often
   d. No, not at all

9. I have been so unhappy that I have been crying
   a. Yes, most of the time
   b. Yes, sometimes
   c. Not very often
   d. No, not at all

10. The thought of harming myself has occurred to me
    a. Yes, most of the time
    b. Yes, sometimes
    c. Not very often
    d. No, not at all

Instructions for users: The mother is asked to choose the response that comes closest to how she has been feeling in 7 days. All 10 items must be completed. Care should be taken to avoid the possibility of the mother discussing her answers with others. The mother should complete the scale herself, unless she has limited English or has difficulty reading. The EPDS may be used at 6-8 weeks to screen postpartum.

Guideline for Evaluation: Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptom. Questions 3, 5, 6, 7, 8, 9, 10 are reverse scored (i.e., 3, 2, 1, 0). Individual items are totaled to give an overall score. A score of 10+ indicates the likelihood of depression, but not its severity. If any number other than “0” is picked for Question number 10, further assessment is required right away. The EPDS score is designed to assist, not replace, clinical judgment. Women should be further assessed before deciding on treatment. This scale is reproduced by users without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

Administered/Reviewed by: __________________________ Date: ____________

Source:
APPENDIX B

PERIPARTUM DEPRESSION ALGORITHM

*If social support is inadequate, then, social services referral and increase frequency of screening to bi-weekly.

**Acute symptoms: suicidal, mania, psychosis, delusional.

Telematernity Session: Emergency Medical Response (911) will be activated, as illustrated.
### APPENDIX C

**EXAMPLE OF A PRIMARY CARE MENTAL HEALTH CONSULT WITH SERVICE AGREEMENT**

<table>
<thead>
<tr>
<th>Patient’s Name:</th>
<th>Jane Doe</th>
<th>#1234</th>
<th>Date: FEB 16, 2016</th>
</tr>
</thead>
</table>

**Primary Care Mental Health (PCMH) Consult**

<table>
<thead>
<tr>
<th>Consult to Service Specialty:</th>
<th>Urgency: Routine</th>
<th>Attention: Rawson, Gina</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Psychiatry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Earliest appropriate Date: Feb 18, 2016</th>
<th>Patient was seen as:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[] Inpatient [] Outpatient</td>
</tr>
</tbody>
</table>

**Service Agreement:**
Appropriate patients are those needing mental health evaluation and/or treatment for mild to moderate symptoms, whose conditions could be expected to improve with short-term mental health treatment in the primary care setting.

All PACT providers and team members can refer any non-urgent patient who is declining to go to MHTC but would be receptive to seeing a psychiatrist in the primary care setting (i.e.: Non-compliant schizophrenia).

**Provisional Diagnosis:**
Pregnant

<table>
<thead>
<tr>
<th>Reason for Request: EPDS &gt; 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

| 1.) Has the patient been seen by a psychiatrist in the past 12 months? | [] Yes [x] No |
|-----------------------------------------------------------------------|

| 2.) Walk-in? | [] Yes [x] No |
|--------------|

<table>
<thead>
<tr>
<th>3.) Walk in appointments are available Monday-Friday, first come-first served, with every effort made on behalf of your patient to be seen as quickly as possible. If you would like the patient seen today, please submit this consult and also page:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. GM at (123) 456-7891 on Mon/Thurs/Fri Afternoons</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.) Please provide a brief description of symptoms to be evaluated (required): EPDS = 11, symptomatic</th>
</tr>
</thead>
</table>
## APPENDIX D
### EXAMPLE OF A WOMEN'S HEALTH CONSULT

<table>
<thead>
<tr>
<th>Women’s Health Outpatient Consult</th>
<th>Patient’s Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregnancy/Lactation Flag</th>
<th>Women’s Health Consult: OB/GYN</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Consult to Service Specialty</th>
<th>Urgency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s Health/Maternity Care</td>
<td>Attention: Rawson, Gina</td>
</tr>
<tr>
<td>Early date appropriate</td>
<td>Patient was seen as:</td>
</tr>
<tr>
<td></td>
<td>[ ] Inpatient [ ] Outpatient</td>
</tr>
</tbody>
</table>

**Service Agreement:**

All women veterans must be assigned to a designated women’s health primary care provider (D-WHPCP) who can provide basic gender specific needs such as cervical and breast cancer screening. D-WHPCPs are located in LBVA Primary Care Clinics, CBOCs, and LBVA Women’s Health Clinic. Please be aware that the patients will be charged a specialty clinic co-payment fee, if applicable.

**For pregnant patients, please submit this consult and call Maternity Care Coordinator at (123) 456-7891**

<table>
<thead>
<tr>
<th>Reason for Consult (required):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive pregnancy test. Initiate pregnancy process consult</td>
</tr>
</tbody>
</table>

Provisional Diagnosis: Pregnancy
## APPENDIX E

### SAMPLE OF TALENT MANAGEMENT SYSTEMS (TMS) TELEHEALTH MODULES

<table>
<thead>
<tr>
<th>Teleprovider</th>
<th>TMS ID</th>
<th>Course Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVT Core Competencies</td>
<td>23393</td>
<td>Key components necessary to assure safe and effective care using clinical video telehealth (CVT). Emphasis on re-, intra-, and post-visit processes. For Non-TeleMental Health individuals</td>
</tr>
<tr>
<td>Emergency Procedures</td>
<td>393872</td>
<td>Overview of how to identify and manage suicide prevention and emergency procedures for videoconferencing telehealth program and encounter. This is for Non-TeleMental Health individuals</td>
</tr>
<tr>
<td>CVT Telehealth Skill Assessment</td>
<td>14750</td>
<td>Skill assessment evaluation of the presenter’s ability to use the technology and complete the Teleprovider competency assessment. This is for Non-TeleMental Health individuals</td>
</tr>
<tr>
<td>CVT Operating your Jabber Software</td>
<td>23394</td>
<td>Learn how to request login credentials and operate Jabber software for CVT. Be able to perform all the functions needed to conduct optimal telehealth encounters using Jabber. Explains how to make and end a call, share presentations and use jabber software from a desktop</td>
</tr>
<tr>
<td>TeleMental Health Operations Manual: Videoconferencing</td>
<td>5268</td>
<td>Overview of how to identify and manage suicide prevention and emergency procedures for a videoconferencing TeleMental Health (TMH) Program and encounter</td>
</tr>
<tr>
<td>TeleMental Health Skill Assessment</td>
<td>14900</td>
<td>Skill assessment is an evaluation of the providers’ ability to use the technology and complete the TMH Skill Assessment</td>
</tr>
<tr>
<td>TeleMental Health Suicide Prevention and Emergency Care</td>
<td>6949</td>
<td>Provides an overview of how to identify and manage suicide prevention and emergency procedures for a videoconferencing TeleMental Health Program and encounter</td>
</tr>
</tbody>
</table>
## APPENDIX F

**EXAMPLE OF MATERNITY VISIT TEMPLATES: INITIAL, BI-MONTHLY, AND POSTPARTUM**

<table>
<thead>
<tr>
<th>Name:</th>
<th>ID #</th>
<th>DOB:</th>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Progress Note Properties</th>
<th>Maternity Care Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Progress Note Title:</th>
<th>Initial</th>
<th>Bi-Monthly</th>
<th>Postpartum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date/Time of note:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregnancy confirmed by:</th>
<th>Urine</th>
<th>Beta HCG</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Menstrual Period:</th>
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</thead>
<tbody>
<tr>
<td>Gravida</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated Date of Confinement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pap smear date/results:</td>
</tr>
<tr>
<td>Presence of vaginal bleeding</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Significant abdominal pain/cramping (current)</td>
</tr>
<tr>
<td>Complicated past pregnancy</td>
</tr>
<tr>
<td>Significant co-morbidities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Medications (including OTC):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
</tr>
<tr>
<td>Ordered OB Panel:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Patient given purple maternity book</td>
</tr>
<tr>
<td>Patient signed Release of Information</td>
</tr>
<tr>
<td>Patient given blood pressure machine</td>
</tr>
<tr>
<td>Patient will utilize Maternity Care Coordination NVCC</td>
</tr>
<tr>
<td>Provided patient with list of available maternity care providers</td>
</tr>
<tr>
<td>Placed a maternity NVCC consult</td>
</tr>
<tr>
<td>Provided patient with maternity brochure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nutrition Consult submitted</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>


Please complete the following clinical reminders: (Drop-down menus)
[] Intimate Partner Violence Screening Tool  [] Homelessness  [] Depression Screening

[] Intimate partner Violence Screening Tool:
1. Have you even been emotionally or physically abused by your partner or someone important to you? [ ] Yes  [ ] No
2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? [ ] Yes  [ ] No
3. In the last year, has anyone forced you to participate in sexual activities that you did not want to participate in? [ ] Yes  [ ] No
4. Are you afraid of your partner or anyone you live with? [ ] Yes  [ ] No

[] Depression Screening: Edinburgh Postpartum Depression Scale (EPDS)
As you are pregnant or have recently had a baby, we would like to know how you are feeling.

Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today:

In the past 7 days:
1. I have been able to laugh and see the funny side of things  Response: _____
   Yes, most of the time = 0
   Yes, sometimes = 1
   Not very often = 2
   No, Not at all = 3

2. I have looked forward to enjoyment to things  Response: _____
   Yes, most of the time = 0
   Yes, sometimes = 1
   Not very often = 2
   No, Not at all = 3

3. I have blamed myself unnecessarily when things went wrong* Response: _____
   Yes, most of the time = 3
   Yes, sometimes = 2
   Not very often = 1
   No, Not at all = 0

4. I have been anxious or worried for no good reason  Response: _____
   Yes, most of the time = 0
   Yes, sometimes = 1
   Not very often = 2
   No, Not at all = 3

5. I have felt scared or panicky for no good reason* Response: _____
<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>6. Things have been getting on top of me*</td>
<td>Response: _____</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Yes, most of the time = 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Yes, sometimes = 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Not very often = 1</td>
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<tr>
<td></td>
<td>Not at all = 0</td>
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<tr>
<td>7. I have been so unhappy that I have trouble sleeping*</td>
<td>Response: _____</td>
<td></td>
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<tr>
<td></td>
<td>Yes, most of the time = 3</td>
<td></td>
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<tr>
<td></td>
<td>Yes, sometimes = 2</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Not very often = 1</td>
<td></td>
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<tr>
<td></td>
<td>No, not at all = 0</td>
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<tr>
<td>8. I have felt sad or miserable*</td>
<td>Response: _____</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Yes, most of the time = 3</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Yes, sometimes = 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not very often = 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No, not at all = 0</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>9. I have been so unhappy that I have been crying*</td>
<td>Response: _____</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Yes, most of the time = 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes, sometimes = 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not very often = 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not at all = 0</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Scoring key: EPDS: Questions 1, 2, & 4 without an * are scored 0, 1, 2, or 3 with top box scored as 0 and bottom box scored as 3. Questions 3, 5-10 (marked with an *) are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.  

**Maximum score:** 30  
**Possible Depression:** 10 or greater  
**Always look at item:** 10- suicidal thoughts
## APPENDIX G

**EXAMPLE OF SUICIDE RISK SCREENING**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you currently have thoughts of harming yourself?</td>
<td>If yes, continue with the following questions as indicated.</td>
</tr>
<tr>
<td>2. Do you have a plan to harm yourself?</td>
<td>If yes, what is the plan:</td>
</tr>
<tr>
<td>3. Have you had thoughts of harming yourself in the past?</td>
<td></td>
</tr>
<tr>
<td>4. What stops you from harming yourself?</td>
<td></td>
</tr>
<tr>
<td>5. Do you have access to firearm?</td>
<td></td>
</tr>
<tr>
<td>If yes, location of the firearm, location of ammunition</td>
<td></td>
</tr>
<tr>
<td>6. Is there a family history of suicide attempts/successes?</td>
<td>If Yes: please note family member(s) and attempts/means/successes:</td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
</tr>
</tbody>
</table>

### Continue with SAD PERSONS SCALE

If any questions above is **positive**, the following assessment should be completed with the patient/client by a **RN, MD, NP, PA, MSW, PhD**

| SEX: Male/Female | (More women attempt, more men complete; Male= YES) |
| Age:            | (Age 19 years or younger or 45 years and above)    |
| Depression:     | (especially with hopelessness, does patient have symptoms of depression or diagnosis of depression?) |
| Previous attempt: | (especially if potentially lethal: firearm, hanging) |
| Ethanol Abuse:  | (or other drug use)                                 |
| Rational thinking loss: | (command hallucinations telling patient to kill him/herself, psychosis) |
| Social Support Deficit: | (actual or perceived social isolation, poor support from friends, relatives or community) |
| Organized Plan: | (has specific plan outlining available method)       |
| No spouse:      | (separated, divorced, widowed, or single)           |
| Sickness:       | (chronic or severe illness, such as COPD, cancer)   |

### SCORE:

- **Score**: Potential | Suggested Clinical Action
- **0-2** Little Risk: Patient may be safely treated with follow-up and minimal precautions
- **3-4** Follow Closely: Notify MD/Clinical provider to develop an appropriate treatment plan
- **5-6** High Risk: Escort to Mental Health Treatment Center (MHTC)/ER for immediate psychiatric evaluation
- **7-10** Very High Risk: Patient should be evaluated by psychiatrist for possible hospitalization/commitment

Plan: (based on question 1-5 and SAD PERSONS SCALLED SCORE):
APPENDIX H
EXAMPLE OF A COMPETENCY BASED ORIENTATION CHECKLIST

GENERAL ORIENTATION TO TELEMATERNITY COLLABORATIVE CARE
A COMPETENCY BASED ORIENTATION PROGRAM

NAME: ___________ DATE SENT: _________
UNIT: ___________ DATE DUE: _________

Purpose: The purpose of this checklist is to assist the Telematernity Collaborative Team to
assess the team’s learning needs and to document competent performance.

a. Scope. Demonstrates leadership in delivering and improving holistic care through
   collaborative strategies with others.

b. Complexity. Telematernity Collaborative Care Staff
   Nurse, Provider, Psychologist, Psychiatrist, Social Worker (*additional MH training may
   be required)
   COMPETENCE is defined as having possession of the intellectual, attitudinal, and technical
   ability to independently function as a Staff Level I
   1. Can Perform independently
   2. Need practice or review
   3. Have no experience

Outcome: Completion of this form and a score of 1 in all categories indicate that the individual
is able to practice independently. Form completion time not to exceed six months.

<table>
<thead>
<tr>
<th>EMPLOYMENT SELF EVALUATION</th>
<th>PRECEPTOR EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3</td>
<td>DATE SIGNATURE SAT NEEDS DEV METHODS</td>
</tr>
</tbody>
</table>

PROFESSIONAL ACCOUNTABILITY
Competency: Demonstrate professional responsibility in the NP role of management of
patient health/illness.

   Performance Criteria
**EMPLOYMENT SELF EVALUATION**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>DATE</th>
<th>SIGNATURE</th>
<th>SAT</th>
<th>NEEDS DEV</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates critical thinking &amp; diagnostic reasoning skills in clinical decision making. -Appropriate Use of Maternal Depression Screening and Suicide Risk Assessment</td>
<td></td>
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</tr>
<tr>
<td>Assesses, monitors, coordinates, refers &amp; manages the health status of patients in a Telematernity collaborative care: -Appropriate follow up with referrals using PCMHI and other appropriate consults</td>
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<td></td>
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</tr>
<tr>
<td>Communicates with patient/family about health status verbally/writing, using appropriate terminology &amp; format. -Obtains consent for Telematernity session to promote privacy and dignity</td>
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<tr>
<td>Provides anticipatory guidance for expected, potential, &amp; situational changes. -Aware of appropriate action for unexpected events, i.e., suicide threats, emergent situations</td>
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<tr>
<td>Collaborates care coordination with team</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>EMPLOYMENT SELF EVALUATION</td>
<td>PRECEPTOR EVALUATION</td>
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</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DATE</td>
<td>SIGNATURE</td>
<td>SAT</td>
<td>NEEDS DEV</td>
<td>METHODS</td>
</tr>
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</tr>
<tr>
<td>Completion of 7 TMS Modules: CVT Core Competencies 23393</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Procedures 3938872 CVT Telehealth Skills Assessment 14750</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVT Operating your Jabber Software 23394</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Additional Mental Health Training for Mental Health Providers: TeleMental Health Operations Manual: Videoconferencing 5268 TeleMental Health Skill Assessment 14900 TeleMental Health Suicide Prevention and Emergency Care 6949 (Attach certificates to this form)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Skills Assessment Completed with: (Print and signed by Preceptor)</td>
<td></td>
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</tr>
</tbody>
</table>
### APPENDIX I

**TELEHEALTH SERVICE AGREEMENT**

**TELEHEALTH SERVICE AGREEMENT**
**TELEWOMEN’S CARE**

**PURPOSE:** The Telehealth Service Agreement specifies and governs the clinical, business, and technical details of operations of the telehealth services between Receiving and Providing Facilities and defines the responsibilities and procedures involved in establishing and operating a telehealth clinic between the involved medical facilities.

**NOTE:** See Attachment 1 of this agreement for a current listing of privileged providers for this Telehealth Service and Attachment 2 of this agreement for a list of provider performance indicators to be monitored for this Telehealth Service.

**VARIABLES AND RESPONSIBILITIES:**

A. Telehealth Clinical Application/Service to be Provided:

B. Originating (Patient/Receiving) Site – Patients receiving Telehealth Services under this Agreement will be located at: *(Check all that apply and enter address, if applicable)*

- [ ] Home/Alternate Non-VA Site
  
- [ ] Clinic

Primary Contact:

C. Distant (Provider/Providing) Site – Provider(s) providing Telehealth Services under this Agreement will be located at: *(Check all that apply and enter address, if applicable)*

- [ ] Teleworking/Alternate Worksite
  
- [ ] Clinic

Primary Contact:

D. The Following Telehealth Modalities will be Employed under this Agreement: *(Check all that apply)*

- [ ] Clinical Video Telehealth (Synchronous)
<table>
<thead>
<tr>
<th>Store and Forward Telehealth (Asynchronous)</th>
</tr>
</thead>
</table>

**E. Scope of Services to be provided to Patient(s) under this Agreement.** Telehealth providers are credentialed and privileged to provide the below noted clinical service(s) at the Provider Facility and, under the terms of the current Telehealth MOU between the Providing and Receiving Facilities, are permitted to provide this/these clinical service(s) to the Receiving Facility, including satellite clinics, in accordance with the privileges specified in the MOU.

**NOTE:** as defined by VHA Handbook 1100.19, Credentialing and Privileging, October 15, 2012.

<table>
<thead>
<tr>
<th>Teleconsultation Service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[As defined in VHA Handbook 1100.19 teleconsultation occurs when the consultant involved recommends diagnoses, treatments, etc., to the consulting practitioner requesting the consult, but does not actually write orders or assume the care of the patient.]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telemedicine Service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Per VHA Handbook 1100.19, if the consultant diagnoses, writes orders, or assumes care in any way, this constitutes “care” via Telemedicine and requires privileges. Unless noted otherwise in this Handbook, a Medical Staff appointment is required if the practitioner is entering documentation into the medical record, e.g., telecardiology, teledermatology, etc. This requires: 1) direct documentation in the Veteran’s Medical Home CPRS medical record and 2) initial interfacility consult to register patient at provider facility for workload purposes]</td>
</tr>
</tbody>
</table>

**F. Admission Criteria for this Service:**

**G. Discharge Criteria from this Service:**

**H. Methods of Communication (phone, secure e-mail, pager, etc.):**

1. For a questions/issues that may not need an appointment (pre or post telehealth visit):

2. For questions while the visit is in progress about the care or recommendations given by the Provider/Consultant:

3. For immediate needs/urgent care situations pre or post telehealth visit. (e.g., critical lab values or time-dependent diagnoses):

4. For last minute clinic/patient cancellations:

5. Other (Specify):
<table>
<thead>
<tr>
<th>TELEHEALTH SERVICE AGREEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEWOMEN'S CARE</td>
</tr>
</tbody>
</table>

I. Clinical Information Required Prior to the Telehealth Visit:

1. Specific clinical history:
2. Labs:
3. Imaging:
4. Studies:
5. Screenings:
6. Other:

J. Expected Time Frame for a Response to the Consult (Stated in Minutes, Hours, Days, etc.):

1. Simple Questions:
2. Routine Consultations:
3. STAT/Urgent Orders:
4. Store and Forward Telehealth (SFT) consultations:
5. Other (Specify Type):

K. Clinic Scheduling (CVT or SFT, as applicable)

1. Days/times clinic will be held:
2. Length of new (initial) patient appointment (in minutes):
3. Length of established (returning) patient appointment (in minutes):

L. Telehealth Clinical Protocol (if available):

M. Telehealth Technology Requirements at the PATIENT site (Clinic, Non-VA, Home):

1. Clinical Peripherals:
2. Secure HD Video/Audio:
3. Software/VA Computer Imaging:
4. Other:

N. Telepresenter/Telehealth Staff Skill Level and Requirements to Support Clinical Service being Provided:

O. Telehealth Technology Requirements at the PROVIDER Site (Clinic, Non-VA):
### TELEHEALTH SERVICE AGREEMENT
#### TELEWOMEN’S CARE

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<thead>
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<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
<td>Secure HD Video/Audio:</td>
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<td>3.</td>
<td>Software/VA Computer Imaging:</td>
</tr>
<tr>
<td>4.</td>
<td>Other:</td>
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</tbody>
</table>

#### P. Telehealth Technology Requirements at the PROVIDER Site (Teleworking or Alternate Work Station):

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</tr>
<tr>
<td>4.</td>
<td>Other:</td>
</tr>
</tbody>
</table>

#### Q. Indicate when Travel by PROVIDER and/or PATIENT may be required (including determination, communication of need and approval mechanisms, as appropriate): |

#### R. Other Requirements:

#### S. Patient Safety. Requirements for Service-specific emergency and disaster plan (In the event that a patient medical or behavioral emergency occurs during a telehealth visit, list actions/activities are expected to be performed by the provider site staff and by the patient site staff). **NOTE:** Administrative reporting contacts for urgent/emergent events are listed in Attachments 1 and 2. Plan for Management of Urgent/Emergent Events:

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>PROVIDER site staff will:</td>
</tr>
<tr>
<td></td>
<td>Location of Emergency and Disaster Plan/Emergency Procedures at PROVIDER Site:</td>
</tr>
<tr>
<td>2.</td>
<td>PATIENT site staff will:</td>
</tr>
<tr>
<td></td>
<td>Location of Emergency and Disaster Plan/Emergency Procedures at PATIENT Site:</td>
</tr>
</tbody>
</table>

#### T. Quality Management. Indicators to monitor/measure the effectiveness of this specific Telehealth Service Agreement:

#### U. Reimbursement/billing/workload considerations:
<table>
<thead>
<tr>
<th>ORIGINATING (PATIENT) SITE SIGNATURES OF AGREEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Chief (Referring Service):</td>
</tr>
<tr>
<td>Facility Telehealth Coordinator:</td>
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</table>

<table>
<thead>
<tr>
<th>DISTANT (PATIENT) SITE SIGNATURES OF AGREEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Chief (Referring Service):</td>
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<tr>
<td>Date:</td>
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</tbody>
</table>
### APPENDIX J

#### EXAMPLE OF SATISFACTION SURVEY QUESTIONS

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>Question Survey Patient</th>
<th>Strongly Disagree 1</th>
<th>Disagree 2</th>
<th>Neither agree or disagree 3</th>
<th>Agree 4</th>
<th>Strongly Agree 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was able to communicate with my clinician clearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I am satisfied with my telehealth session</td>
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<tr>
<td>I would recommend this type of visit to other veterans</td>
<td></td>
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<tr>
<td>Comments</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>Question Survey Provider</th>
<th>Strongly Disagree 1</th>
<th>Disagree 2</th>
<th>Neither agree or disagree 3</th>
<th>Agree 4</th>
<th>Strongly Agree 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was able to communicate with my patient clearly</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I am satisfied with this type of visit with my patient</td>
<td></td>
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<tr>
<td>I would recommend this type of visit to other clinicians</td>
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<tr>
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</table>
APPENDIX K

EXAMPLE OF A PERIPARTUM DEPRESSION COURSE CURRICULUM

**Purpose Statement:** Up to 15% of women are entering the military as their choice of job and career. As the women who served in the military transition into civilian life, many of them are using their benefits for healthcare at the Veterans Health Administration (VHA) facilities. VHA staff, proficient in caring for a predominantly male patient population, must now address the unique needs of women throughout their lifespan. This learning activity will address the educational needs of the VHA staff caring for maternity women veterans with Peripartum depression.

**Overall description:** During this educational activity, evidence based practice, and overview in providing care for women with peripartum depression will be presented.

**Target Audience:** Nurses, nurse practitioners, physicians, physician assistants, and social workers caring for maternity women veteran patients with peripartum depression.

**Goal:** Participants will acquire skills in assessment and referral of maternity women veteran patients at VHA with Peripartum depression. Three-part series lecture to be delivered one hour each.

**Participation Requirement:**
- Attendance and participation in 100% of the program
- Preparation prior to class attendance: Divide class into 3 groups with assigned diagnoses
- Group Presentation, Group work: discussion and debate. Post-test: completion with a minimum of 80%
- Course Evaluation completion within 30 days of participation
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Outline</th>
<th>Faculty Activity</th>
<th>Participant Activity</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enumerate and discuss three diagnosis of depression during peripartum stage 60 minutes</td>
<td>Significance of the problem</td>
<td>Required Reading prior to class. <a href="http://dx.doi.org/10.1016/j.jpsychres.2013.10.003">http://dx.doi.org/10.1016/j.jpsychres.2013.10.003</a> (Gaillard, Le Strat, Mandelbrot, Keita, Dubertret, 2013). recommended webinars and videos from VHA Talent Management System</td>
<td>Read required reading prior to class. Watch webinar and video on peripartum depression 15 minutes</td>
<td>Group Presentation Reflections and discussions encourage critical thinking and discuss complex patient care plans</td>
</tr>
<tr>
<td>Assessment:</td>
<td>Differentiate the following diagnosis of Depression during the Peripartum stage: Baby Blues Peripartum Depression (PPD) Peripartum Psychosis Implications to care</td>
<td>Short review lecture, bullet point summary format of Baby Blues, Peripartum depression (PPD), and Peripartum Psychosis (PP) Divide class into 3 groups: Facilitate Q&amp;A using meaningful questions. Use cues if participants unable to verbalize responses</td>
<td>Cognitive: 80% accuracy of the test Create matching words for definition of the 3 types of depression in maternity 15 minutes Present to class: Definitions Risk Factors Signs and Symptoms 15 minutes Complete post-test multiple</td>
<td></td>
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<tr>
<td>List and discuss signs and symptoms of peripartum depression (PPD) 60 minutes</td>
<td>Signs and Symptoms (S+S) of PPD: Recognize/List PPD S+S</td>
<td>Lecture/Discussion of signs and symptoms of PPD</td>
<td>Listen to lecture <strong>15 minutes</strong> Short discussion: <strong>5 minutes</strong></td>
<td>Cognitive (remembering), Affective (interaction), Psychomotor (enactment of interview)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risk Assessment for peripartum depression</td>
<td>Interview simulation between participants</td>
<td>Suicide Question #10: If answer is Yes- Did the provider follow up with additional questions: How would you proceed? (2 points if asked) Do you have a plan? (2 points if asked)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide list of PPD S&amp;S for re-enactment to patient participant.</td>
<td>Paired activity: Perform an interview using EPDS questionnaire on each other.</td>
<td>Patient able to articulate S+S (minimum of 3 S+S is passing). Provider able to identify correct S&amp;S and Risk factors (minimum of 3 S+S each is passing) Affective: Self-reflection</td>
</tr>
<tr>
<td></td>
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<td>Provide EPDS and Suicide Risk Screenings for group interaction</td>
<td>One acts as a provider; the other is the patient.</td>
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<td>Provide the participant a template for documentation</td>
<td>20 minutes interview</td>
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<td>Pair participant (provider and patient) together for PPD interview session to identify PPD S&amp;S.</td>
<td>Patient answers Question #10: Suicide with a Yes or No.</td>
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<td>Each participant describes how they feel after the interaction, how comfortable or</td>
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<td>uncomfortable are they in answering each other; how well did they know the</td>
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<td>material prior to the re-enactment; how confident are they with performing a</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Objectives</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Perform test patient interview using appropriate templates and referrals 60 minutes</td>
<td>Provide templates for referrals and documentation in Computerized Patient Record System (CPRS) for review on next lecture. Faculty to log on the test query site to see if providers completed referral forms.</td>
<td>Participants to log onto CPRS with a test patient to access the template and referral for practice. One entry (P/F) <strong>20 minutes</strong>. Participants will be divided into their clinic team/unit. They will discuss and write out 3 goals that they plan to complete from the learning activity. Quarterly updates.</td>
<td>Electronic Test Patient. Faculty will have access to perform chart audit.</td>
<td>from both participants (submission P/F). Self-reflection allows participants a deeper meaning to absorb what is learned. Psychomotor: Interview Recommend to proceed/accompany to the Crisis Clinic or Mental Health Treatment Clinic. Completion or non-completion (Pass/Fail).</td>
</tr>
<tr>
<td>Objectives</td>
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<td>Evaluation</td>
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<td></td>
<td>Provide Action Plan activity template</td>
<td>20 minutes</td>
<td>20 minutes</td>
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<tr>
<td></td>
<td></td>
<td>Faculty to have copy of the activity and to each team members</td>
<td>Present to the group</td>
<td>20 minutes</td>
</tr>
</tbody>
</table>