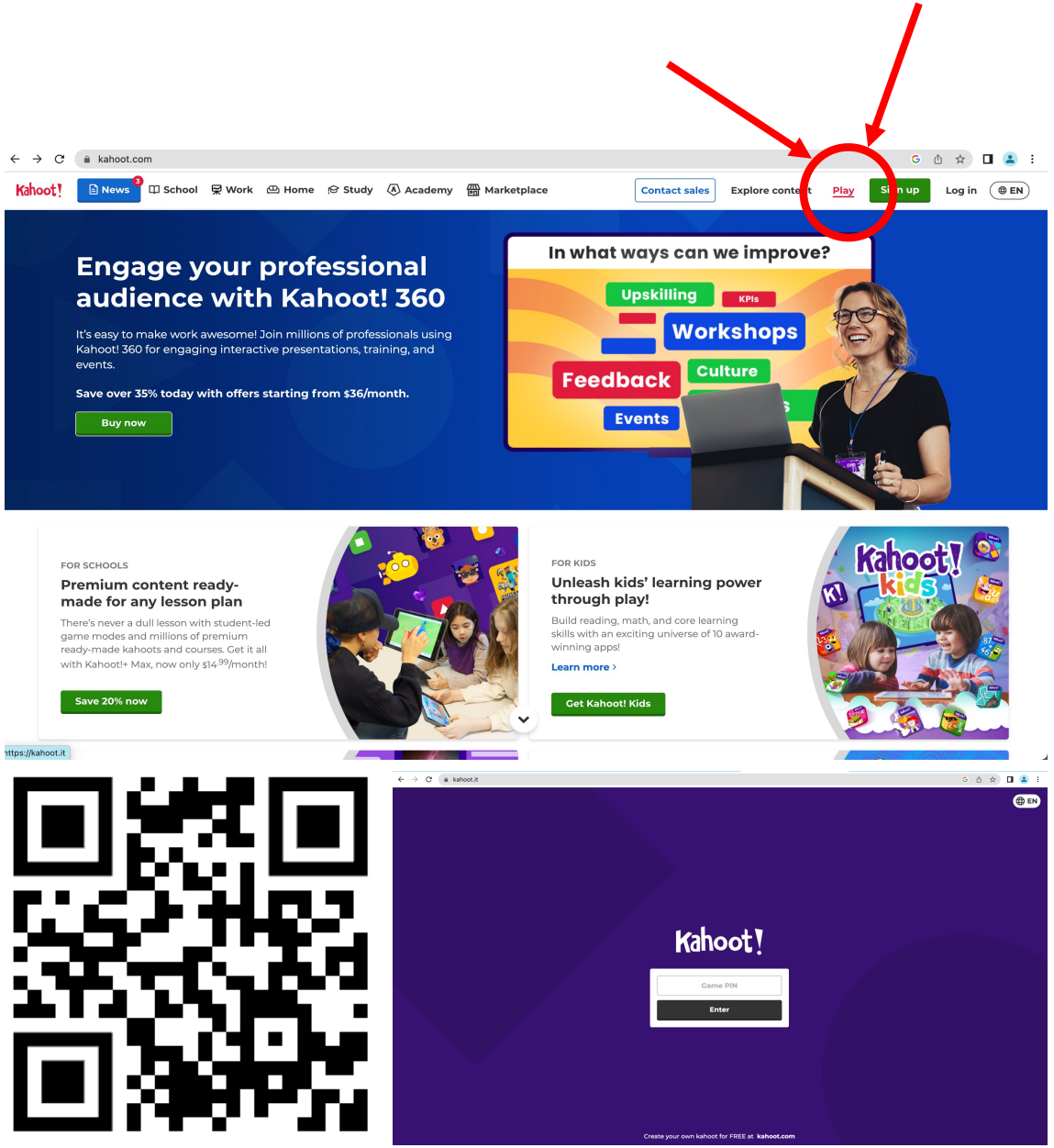
Introducing Kahoot (there is also an app, but they'll want information…)

https://kahoot.com

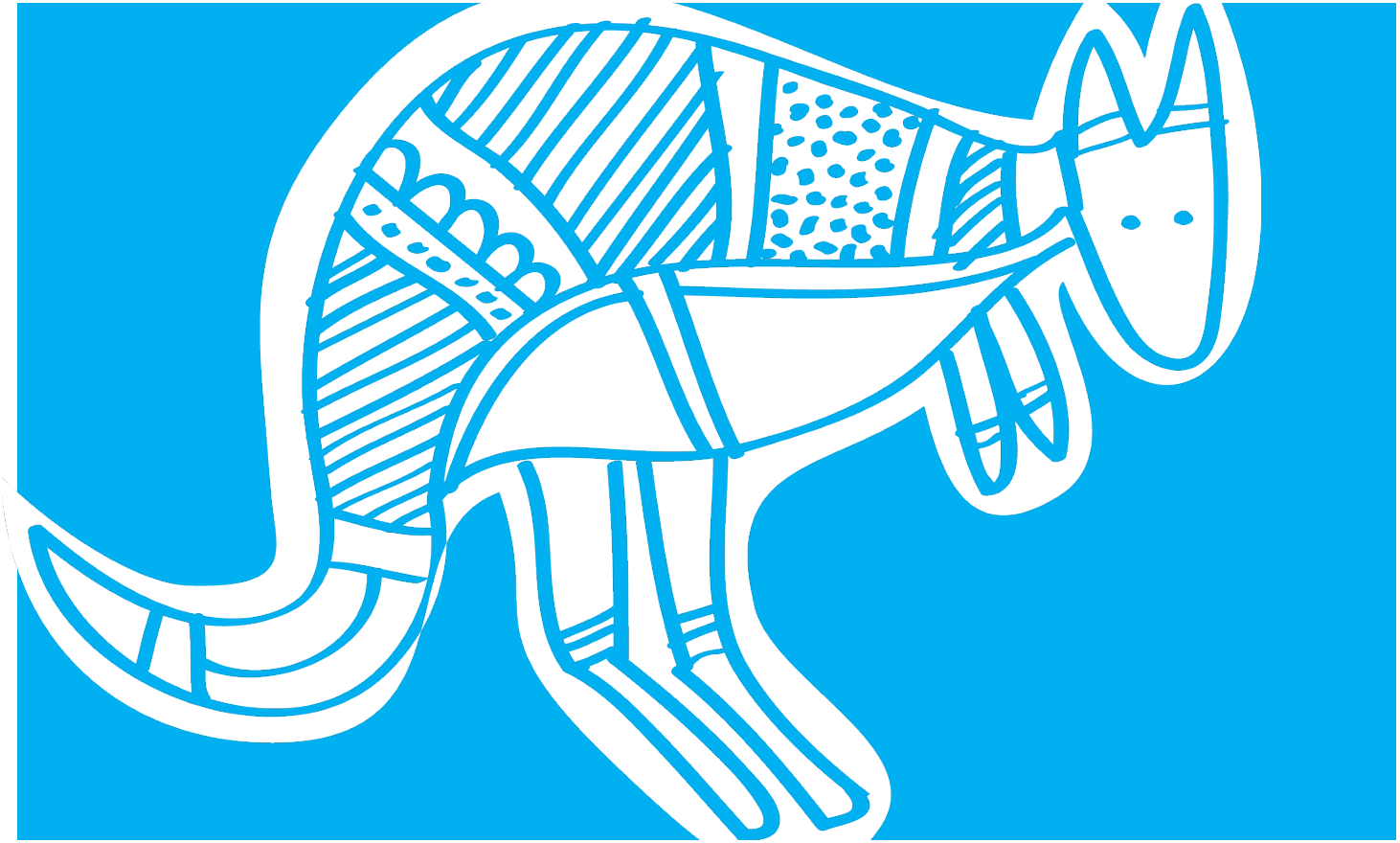
You will be asked what do you *most* want out of today and you have only 20 characters to use! Start thinking….



Mater Mothers' Alignment 1

March 18, 2023

Acknowledgement of Traditional Owners



The Turrbal and Jagera peoples

Acknowledgments

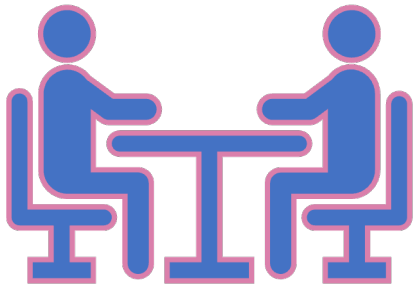
- MMH
- Caroline Nicholson, Maree Reynolds
- Anne Williamson & Erin Hutley GPLM
- The extended MMH GP Shared Care Alignment team
- Mater Education
- BSPHN

Getting the most out of your day

ALL QUESTIONS WELCOME

- Please raise your hand at the relevant time
- You may be asked a question
- We are using QR codes to connect you to resources
- We will be using Kahoot to canvas opinions in the room
- Phone out, but on silent!
  - If you need to take a call, please leave the room

Depending on the ‘depth of the dive’, we may have to take some questions on notice and get back to you with an answer post-program.



SESSION 1:

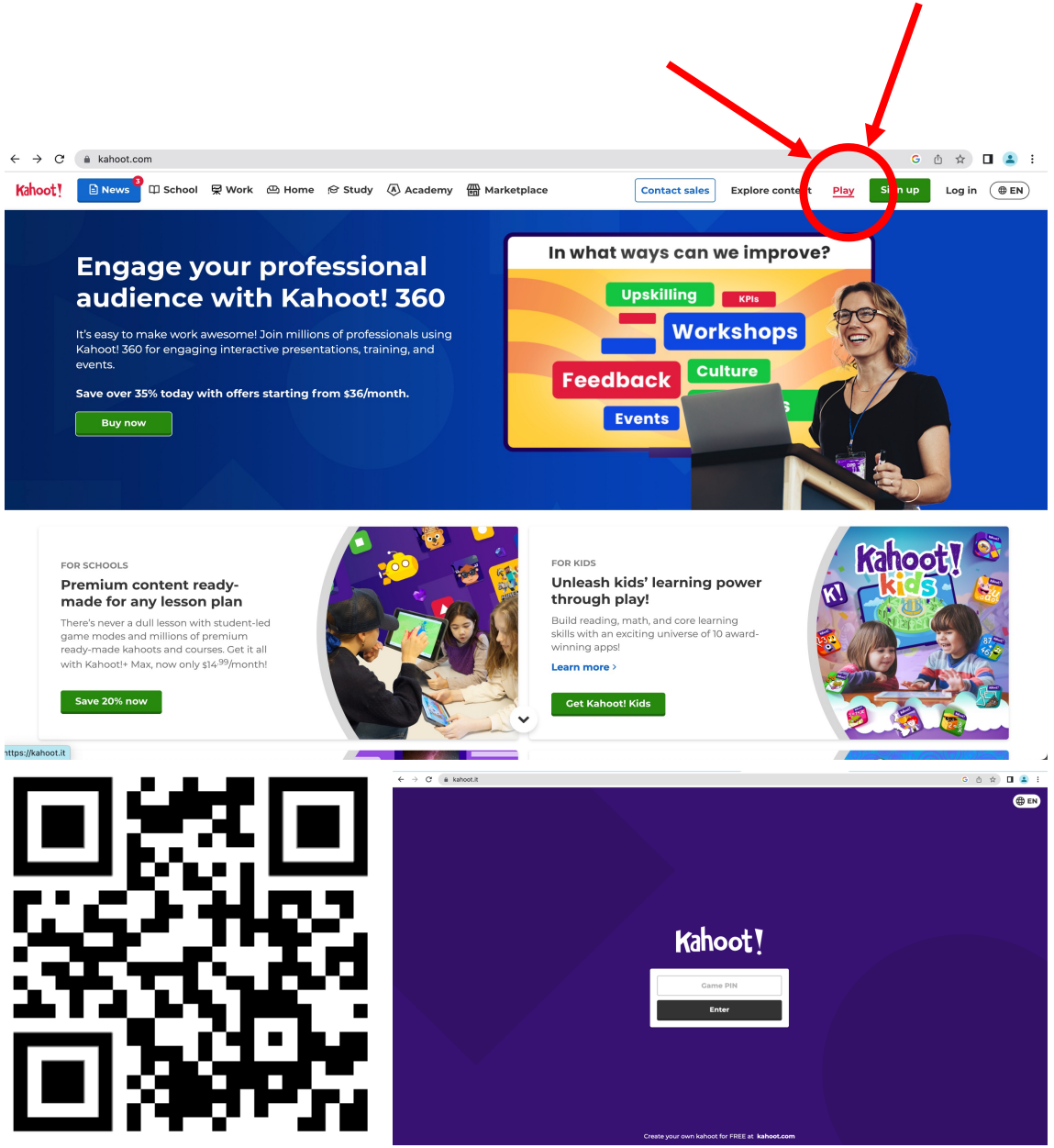
Time	Session	Who
8:00 am	**Welcome:** course expectations, learning objectives, Covid-19 chat	Dr Wendy Burton
8:10	**Models of care:** Understanding Mater maternity care options	Video (16 min) GP Liaison midwife (GPLM) Anne Williamson
8:30	**Referrals:** What, why and how	Dr Wendy Burton
8:45	**Recurrent issues:** GDM, obesity, thyroid disorders, emerging concerns after initial referral	Dr Stephanie Teasdale Obstetric physician Dr Wendy Burton Dietitian (VOPP)
9:30	Aneuploidy screening and diagnosis Carrier Screening	Dr Joseph Thomas
10:00	Morning tea break (videos to play)	Introduction to Mater Maternity support services.

SESSION 2:

Time	Session	Who
10:30	**Physiotherapy**	Megan Newell Physiotherapist
10:40	**Mental health** – general principals	Den Davies-Cotter CNC Perinatal Mental Health Dr Wendy Burton
10:55	**Pharmacology** & pregnancy	Dr Treasure McGuire Pharmacist
11:10	**Case work** All Dr Wendy Burton Facilitator Dr Gabriel James Obstetrician	Anne Williamson (GPLM) Nicola Adams Annette Parry Diabetes Educator/Clinical Midwife Sue Whiteman Gabriela Lacey Louise Duncanson
12:50	**Conclusion**	Dr Wendy Burton

Kahoot poll

https://kahoot.com



Program Goals

Optimal patient experience

- Educate
- Update
- Equip
- Empower

Facilitate

- Innovation
- Integration
- Communication

No one knows everything!

We need to know

- Enough to make it worthwhile people coming to see us (Education)
- Where to look (Showcase resources)
- Who to call (Build relationships, inform, provide contact numbers)
- When and where to refer (Education, PAC, ED, ANC, Birth Suite)

Learning objectives

This program is designed to enhance your understanding of:

1. GP Maternity Shared care guidelines
2. Routine antenatal screening recommendations
3. Models of care and how to access them
4. High risk pregnancy recommendations
5. Medical conditions such as gestational diabetes and thyroid disease in pregnancy

Learning objectives

This program is designed to enhance your understanding of:

6. Appropriate screening options for fetal anomalies in general and specific situations
7. Physiotherapy services available to women and common ailments requiring treatment
8. Screening and management options for mental illness
9. Medications in pregnancy
10. Referral and communication pathways with MMH

Pregnant? Planning pregnancy? Breastfeeding?

Pfizer & Moderna vaccines recommended

Safe. Effective. Protect yourself and your child.

mater

Mater Mothers
Models of care

MMH Models of care

1. **Preconception / Fertility service**
2. **Midwifery Group Practice**
3. **Birthing in Our Community- BIOC**
4. **Refugee Service**
5. **CHAMP service**
6. **Risk Planning service**
7. **Bereavement Service**

Specialised Models of Care (MOC)

Please assist appropriate triage by identifying risk factors such as:

- indigenous status
- refugee background
- social risk
- drug and alcohol use
- previous pregnancy loss

Women may choose to have GP share care, but their booking appointments and assessment will occur in the specialist clinic

Antenatal Clinics, Models of Care

mater

OBSTETRIC

- Obstetrician
- Obstetric registrar
- Midwife
- MMH Monday to Friday

OBSTETRIC MEDICAL

- Midwife and Obstetrician
- Obstetric registrar
- Obstetric physician
- MMH Monday to Friday

GP SHARE CARE

- Midwife history
- Obstetrician/Obstetric registrar at booking appointment
- GP routine visits
- MMH at K36 midwife/obstetrician.Or midwife at Brookwater + obstetrician via telehealth

MIDWIVES CLINIC

- MMH and Inala Monday -Friday
- Coorparoo<21yrs Tuesday+ Wednesday
- Norman Park - Thursday
- Brookwater -Monday
- RPM (Risk Planning Midwife) for women with high psychosocial risk factors MMH Monday and Thursday.

REFUGEE CLINIC

- MMH Tuesday
- Midwife/Obstetrician
  - Obstetric physician
  - Social Worker

BIOC Birthing in Our Community

Midwifery Group Practice for Aboriginal and Torres Strait Islander women or women with partners who identify as ATSI.Midwives + Indigenous health workers Obstetrician/registrar at booking and when required

DIABETIC CLINIC

- MMH Tuesday
  - Obstetrician/Registrar
  - Endocrinologist
  - Diabetes Nurse Educator
  - Midwife
  - Dietician

PREGNANCY AFTER LOSS CLINIC

- MMH early review if last pregnancy IUFD, stillbirth or neonatal death
- **CHAMP**
- Recent or current drug and alcohol use.
- MMH Wednesday

MIDWIFERY GROUP PRACTICE

- Coorparoo +Stones Corner
- Inala + Acacia Ridge
- Coorparoo<21yo
- Refugee background Inala
- Telehealth consult with Obstetrician/ registrar at booking

Early discharge post caesarean section

At Mater public women can transfer home *24 hours post c/s*

Eligibility criteria

- maternal interest
- women who don't need an interpreter
- PHx of previous birth
- no history of diabetes
- BMI < 40
- homecare eligible
- adult support at home.

Routine postpartum care for these women includes **earlier**:

- intake of fluids
- discontinuation of IV
- mobilisation when full return of sensation
- removal of IDC

Communication

The importance of getting it right

Dr Wendy Burton

Linking in to MMH

A safe & optimal patient experience:

Antenatal Clinic (ANC) receives 200-400 referrals *a week*

- ✓ **Information** =
  safe, effective and efficient triage
  - Medical, social risk factors
  - Indications for early appointment
- ✓ Need **advice**? Contact the GPLM
- ✓ The use of the MMH **referral** template is mandatory. Please include ALL patient information requested.
  There is a Mater Health Link option and QHealth have an Antenatal Smart referral
- ✓ cc MMH ANC on *ALL* **investigations**

Mater
Misericordiae Ltd

REFERRAL - ANTENATAL

FAX NUMBER: (07) 3163 8053

MHS Unit Record No.

Patient surname

Patient given names

Patient date of birth

Do not fax from private or business numbers. GP fax only.

Patient details

Residential address:

Suburb: State: Postal code:

Preferred contact: ☐ Home ☎: ☐ Mobile ☎:

Next of kin: ☎:

Please advise all patients to bring their Medicare card when presenting to the Mater. Medicare ineligible patients will incur a fee for appointments/ treatment provided which is payable on presentation. Insurance provider and policy number must be provided before bookings can be processed.

Medicare eligible? ◯ Yes ◯ No Medicare no.: Card ref. no.: Expiry date:

Private health insurance name: Policy number:

Indigenous status? ☐ Aboriginal ☐ Torres Strait Islander ☐ Australian South Sea Islander ☐ Not Indigenous

Does this patient identify as having a refugee background? ◯ Yes ◯ No

Interpreter required? ◯ Yes ◯ No Language: **Special needs** e.g. Carer:

This referral is for an initial consultation with a Doctor for the planning and co-ordination of care for this pregnancy. Women will be subsequently offered a choice of appropriate models of care. To improve efficiency and reduce waiting times, this named referral will be shared with other specialists. The consultation may be bulk-billed to Medicare Australia with NO out of pocket expenses for this patient.

Referral

Referral date:

Dear Dr Michael Beckmann (Director, Mothers Babies and Women's Health Services)

Thank you for seeing this woman whose LNMP was **and whose EDC is**

She is G P **Height** **Weight** **BMI**

This patient is high risk and requires early assessment ? ◯ Yes ◯ No If "Yes", specify details below

Past genetic, medical ,surgical, and obstetric history:

06/16
Ver. 6.00
F1828

Clear form

Continued on page 2 ➔

REFERRAL - ANTENATAL 100

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REFERRAL - ANTENATAL
FAX NUMBER: (07) 3163 8053

MHS Unit Record No.

Patient Surname

Patient Given Names

Patient Date of Birth

Medications: (attach patient summary if necessary)

Allergies:

Models of care

I have discussed models of care and this woman would like:

GP Shared Care? ◯ Yes ◯ No

I have completed the MMH alignment program: ◯ Yes ◯ No.

Midwifery Care? ◯ Yes ◯ No

Midwifery Group Practice? ◯ Yes ◯ No Second choice if **Midwifery Group Practice** full?

Relevant investigations (attach investigations or results)

Pathology service provider: ☐ Mater ☐ S & N ☐ QML

1. **Pap smear up to date?** ◯ Yes ◯ No
   Result: ◯ Normal ◯ Abnormal
2. **Down Syndrome screening discussed?** ◯ Yes ◯ No
   Testing accepted? ◯ Yes ◯ No
   Referral given? ◯ Yes ◯ No
3. **First trimester HbA1c for BMI > 30, previous GDM, maternal age ≥ 40, or previous macrosomic baby?** ◯ Yes ◯ No
4. **18/40 morphology ultrasound ordered?** ◯ Yes ◯ No
6. **FBC?** ◯ Yes ◯ No
7. **Rubella serology?** ◯ Yes ◯ No
8. **Urine M/C/S?** ◯ Yes ◯ No
9. **HIV?** ◯ Yes ◯ No
10. **Syphilis serology?** ◯ Yes ◯ No
12. **Blood group & antibody?** ◯ Yes ◯ No
13. **Hepatitis B serology?** ◯ Yes ◯ No
14. **Hepatitis C serology:** ◯ Yes ◯ No

Referring clinician (Please complete all fields clearly or affix stamp)

Referring clinician name: Provider number:

Address:

Phone number: Fax number:

Signature: Email address:

Mater staff use only

Date received:

☐ **Referral accepted** Age: EDC: Current gestation:

☐ **Referral declined** ☐ Out of Area ☐ Other

☐ GP Notified Date sent: ☐ Woman notified Date notified:

☐ **First appointment midwife and obstetrician** ☐ Woman notified of first appointment on

☐ **Medicare eligilbe** ☐ Medicare ineligible AND insured ☐ Medicare ineligible, NOT insured

Sent to billing office date: Sent to billing office date:

Notes:

Midwife name: **Signature:** **Date:**

Print form

Please attach copy AND cc MMH

Relevant investigations (attach investigations or results)

1. **Pap smear up to date?** ◯ Yes ◯ No
   Result: ◯ Normal ◯ Abnormal
2. **Down Syndrome screening discussed?** ◯ Yes ◯ No
   Testing accepted? ◯ Yes ◯ No
   Referral given? ◯ Yes ◯ No
3. **First trimester HbA1c for BMI > 30, previous GDM, maternal age ≥ 40, or previous macrosomic baby?** ◯ Yes ◯ No
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Pathology service provider: ☐ Mater ☐ S & N ☐ QML

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9. **HIV?** ◯ Yes ◯ No
10. **Syphilis serology?** ◯ Yes ◯ No
12. **Blood group & antibody?** ◯ Yes ◯ No
13. **Hepatitis B serology?** ◯ Yes ◯ No
14. **Hepatitis C serology:** ◯ Yes ◯ No

Copy of results in referral = helpful for triage

cc results to MMH

Printed copy of reports in the Pregnancy Health Record OR copied to My Health Record

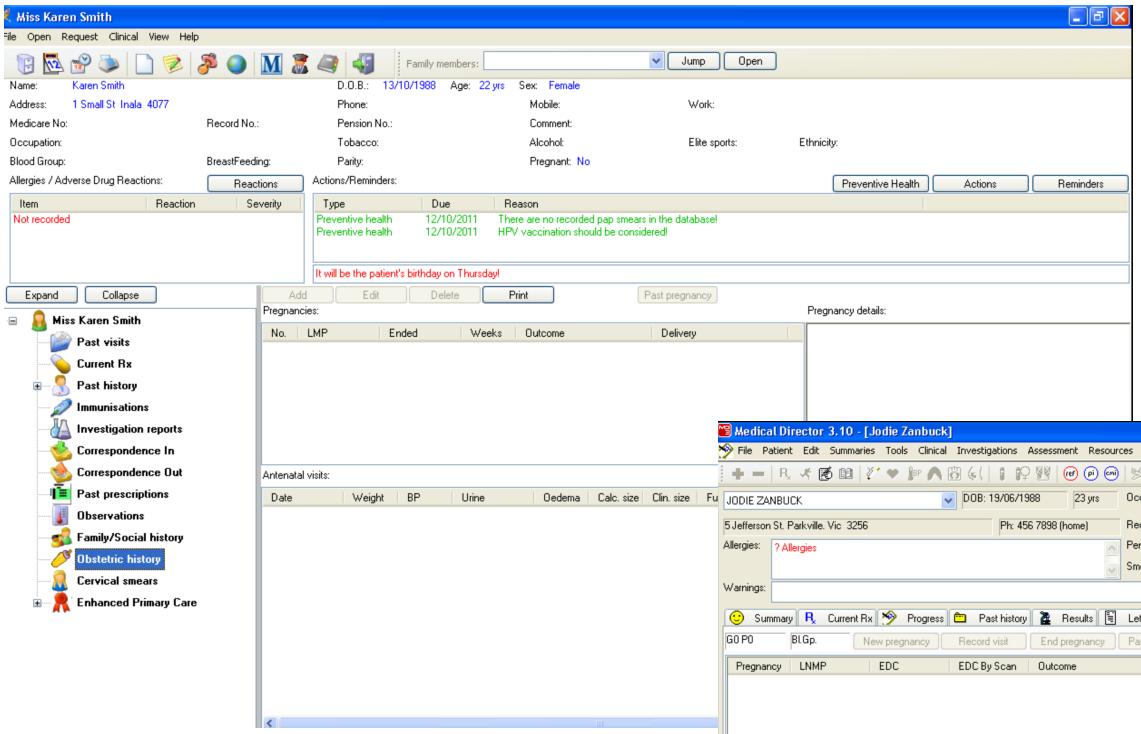
= immediate access to clinical information

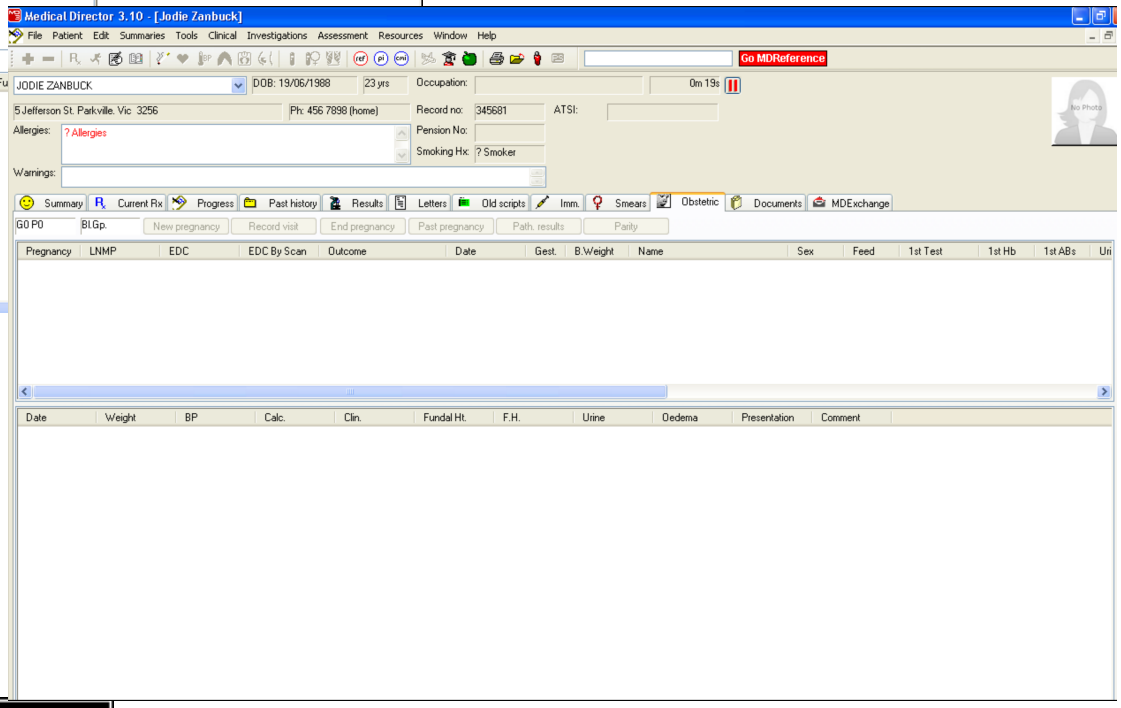
Press print!

Booking In

- Low risk women must complete information online before their antenatal booking appointment or it will be rescheduled
- A **link** is sent via SMS
  mobile phone number must be correct
  (women to notify ANC of any contact changes)
- *If unable to be contacted their booking will be cancelled*
- Women who need an interpreter have a longer booking appointment, not the online version. Identify them!

Where are you entering your observations?

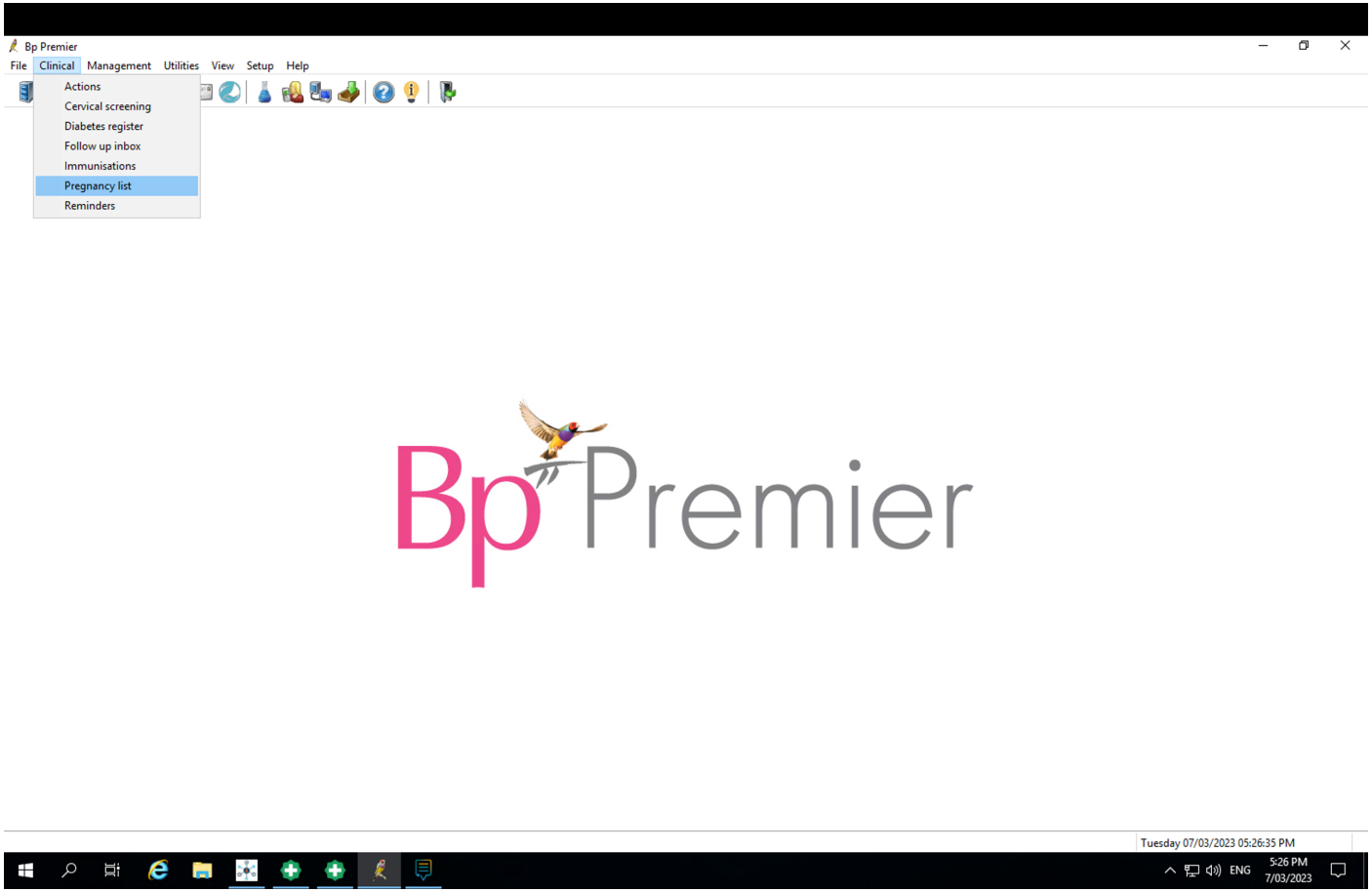




Use the obstetric tabs

- *easy to enter data
- *print a copy for PHR
- *ready for digital PHR
- *easy to see who you are caring for

Clinical audit capacity (MD, go to “search”)



Who is responsible for abnormal results?

You

If you order it, you are responsible for follow up and referrals

- The cc result is not seen by clinicians until contact with the woman is made
- What to you do with what you have found is in the MMH GP Maternity Shared Care Guideline
- Unsure? Who can you call?

Who can you call?

For clinical advice or if a woman requires urgent review:

- Obstetric consultant:

  M-F 8.30-4.30 3163 1330

  24hrs 3163 6612
- Obstetric registrar: 3163 6611 (24hrs)
- Obstetric Medicine registrar via switch 3163 8111

The GP Liaison office

Mon - Fri 0730 - 1600 for all your questions

- Telephone 07 3163 1861
  mobile 0466 205 710
  (you can leave a message) or
- Email GPL@mater.org.au

Referral process

- what to do with what you know
- what to do with what you find

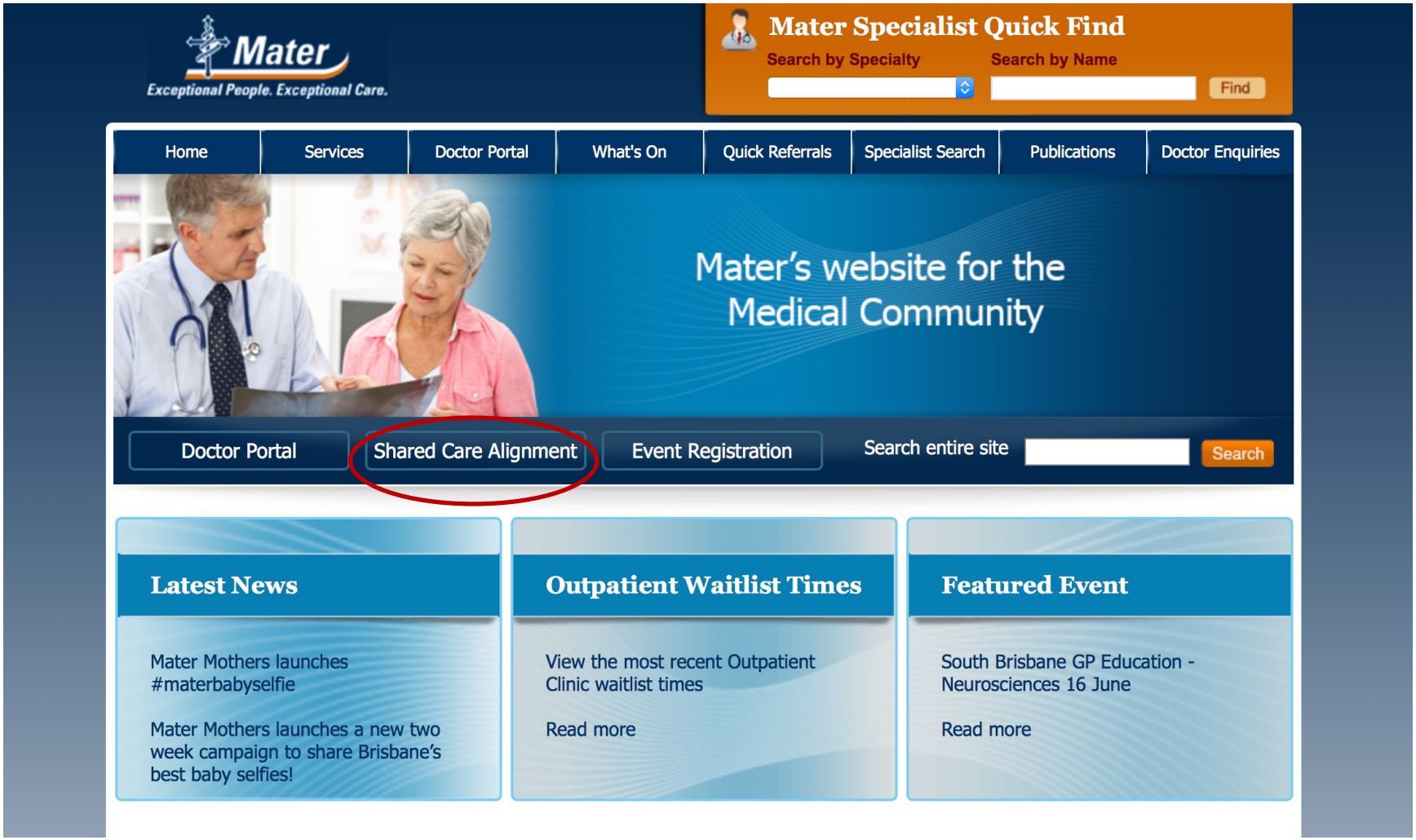
- Women with ***pre-existing*** **medical conditions** identified in the antenatal referral don't need separate referrals to specialist clinics. The obstetrician will sort it out at the first visit
- If a woman develops a complication *after* referral, notify ANC with correspondence and results (Fax 3163 8053 or send electonically) a new referral is not required
- OGTT positive? REFER her into ANC

If immediate referral is needed, refer the woman to PAC (24/7)

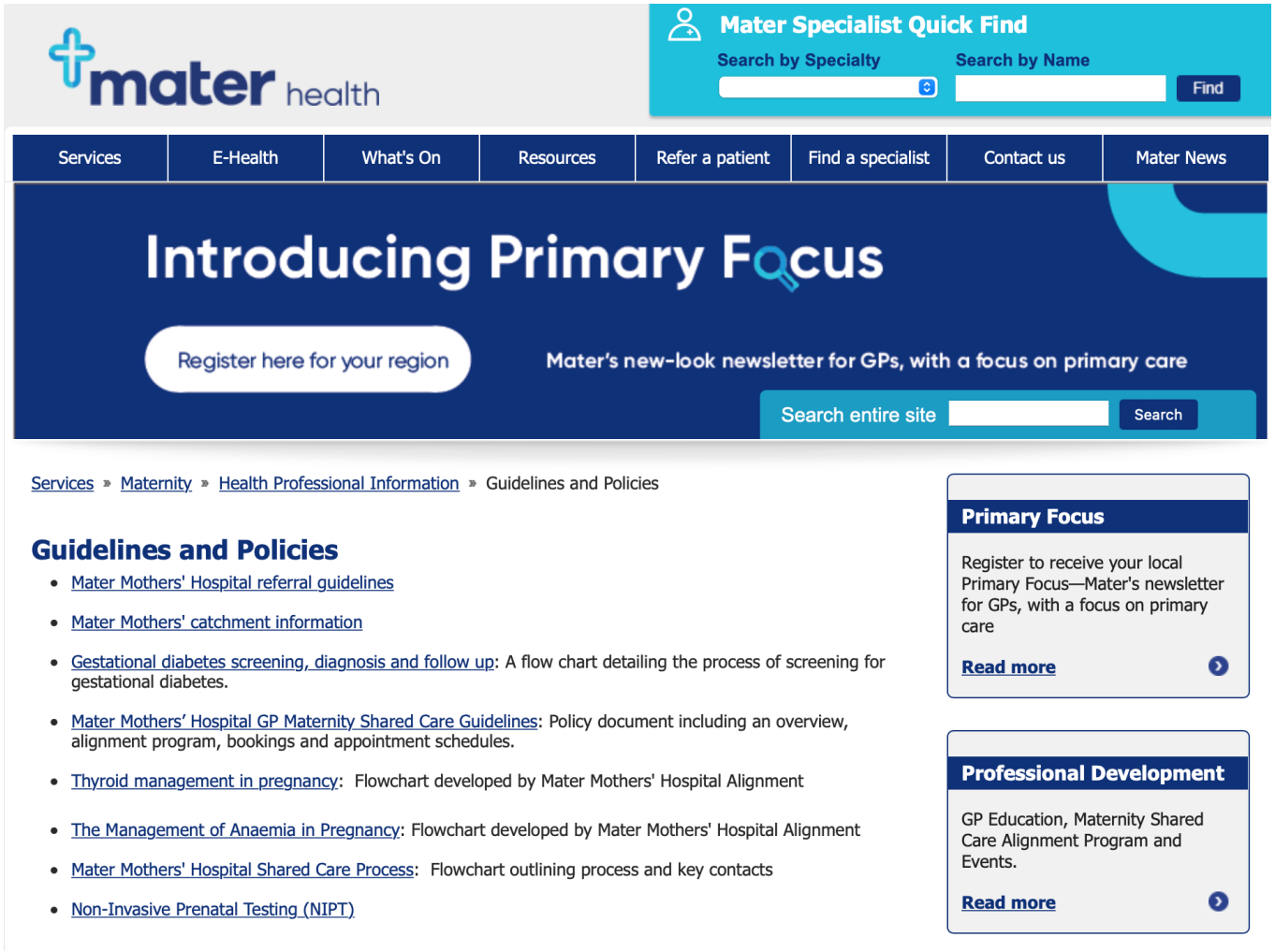
The referral pathway

- All women should be referred to their local obstetric hospital
- A comprehensive referral ensures appropriate triage
- Local obstetricians will liaise with or refer women onto MMH prn
- If complications arise, contact her *local* obstetric service, they can sort it out

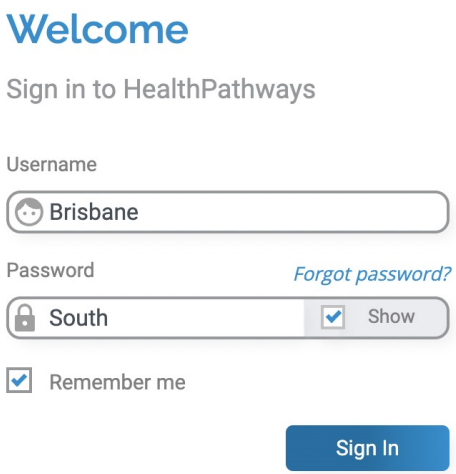
www.materonline.org.au



www.materonline.org.au/services/maternity/health-professional-information/guidelines-and-policies



Spot on Health Pathway (MSHHS)



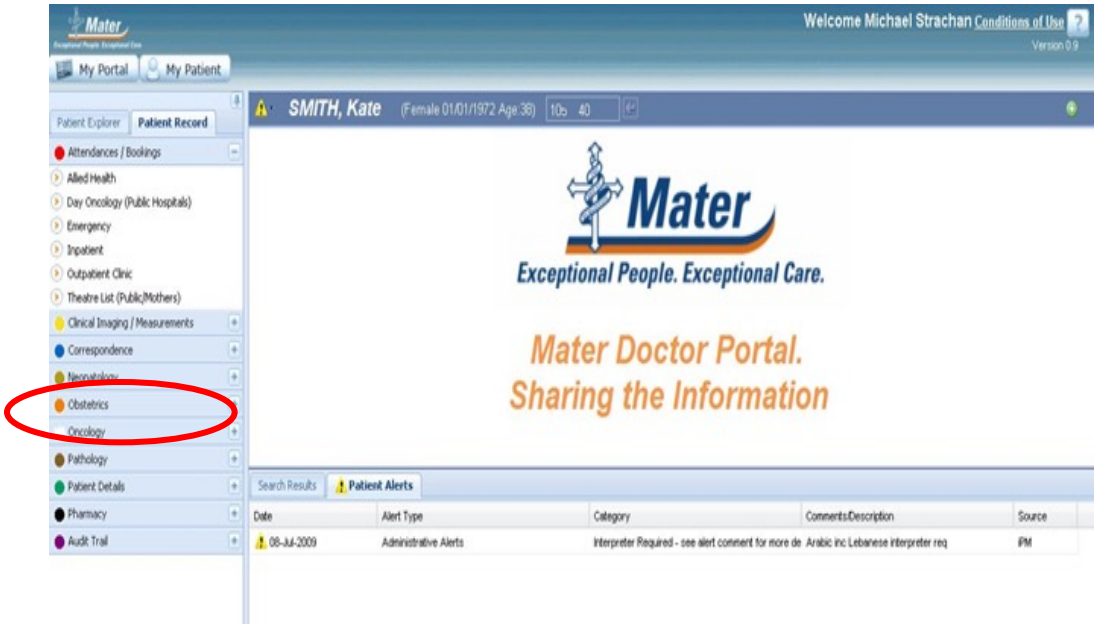
54 RESULTS FOUND FOR 'antenatal'

- (•) Web pages
- ( ) PDFs/forms/documents
- ( ) All

- **Antenatal** Care - Routine
- **Antenatal** Care - Initial
- Maternity Models of Care
- **Antenatal** Care
- Bleeding in RhD Negative Women
- Venous Thromboembolism (VTE) Risk in Pregnancy
- Perinatal Mental Illness
- Acute Obstetric and Maternity Assessment
- Pregnancy Planning
- Sexual Health Check
- Plagiocephaly
- Acute Paediatric Surgery Assessment
- Mater Doctor Portal

Mater Doctor Portal

Mater's version of the Health Provider Portal



Interested? Indicate on the feedback form for this session

MMH catchment area

- Refer all women to their local service. If you are uncertain, or if time is critical = contact GPLM

- **Private** hospital, **public** births
- **Local** hospital, **tertiary** referral centre

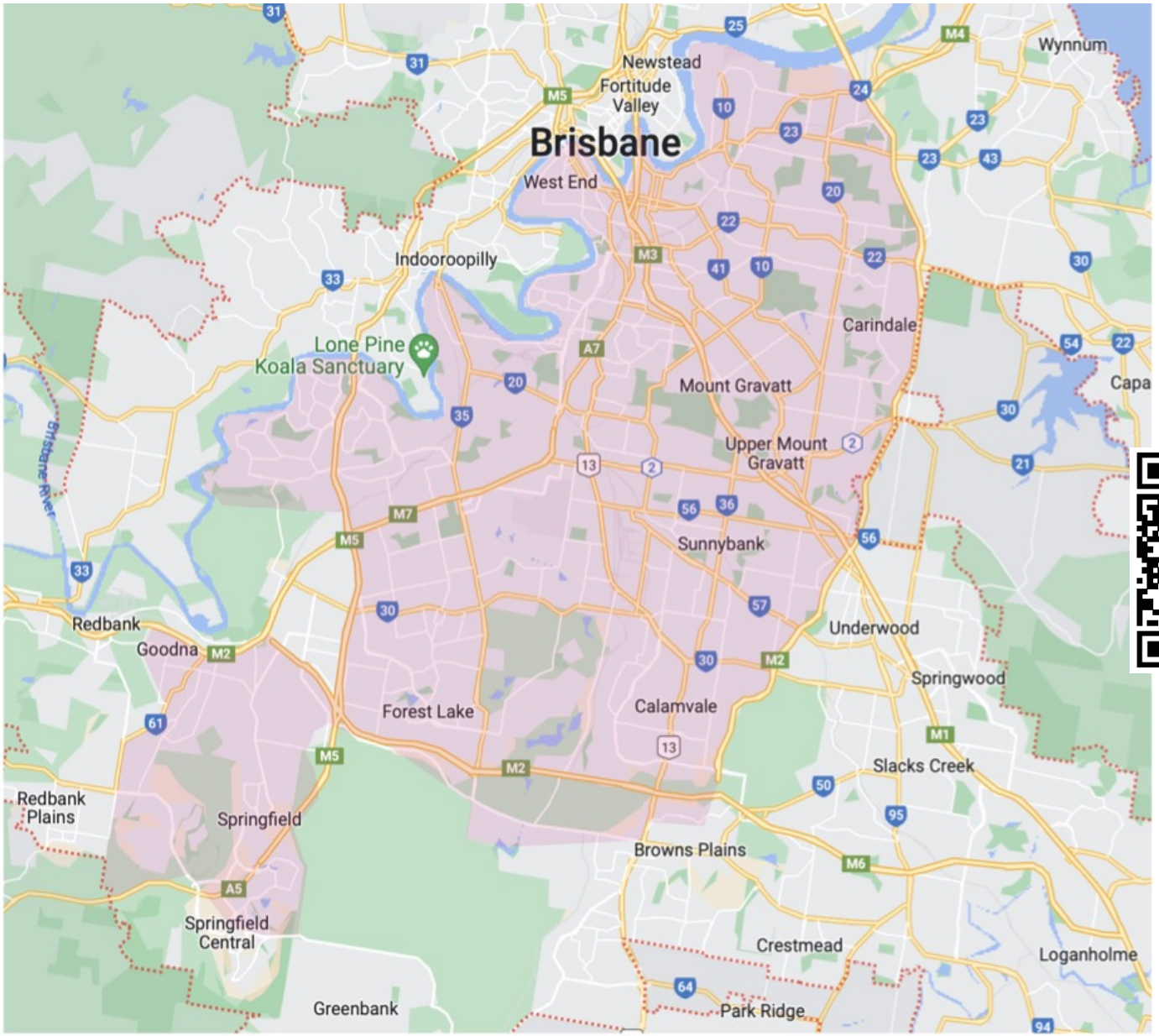
- **High demand =** no routine low risk referrals outside catchment
  - Except indigenous women
  - Perhaps women requiring a specialist drug and alcohol service

Proof of address is required

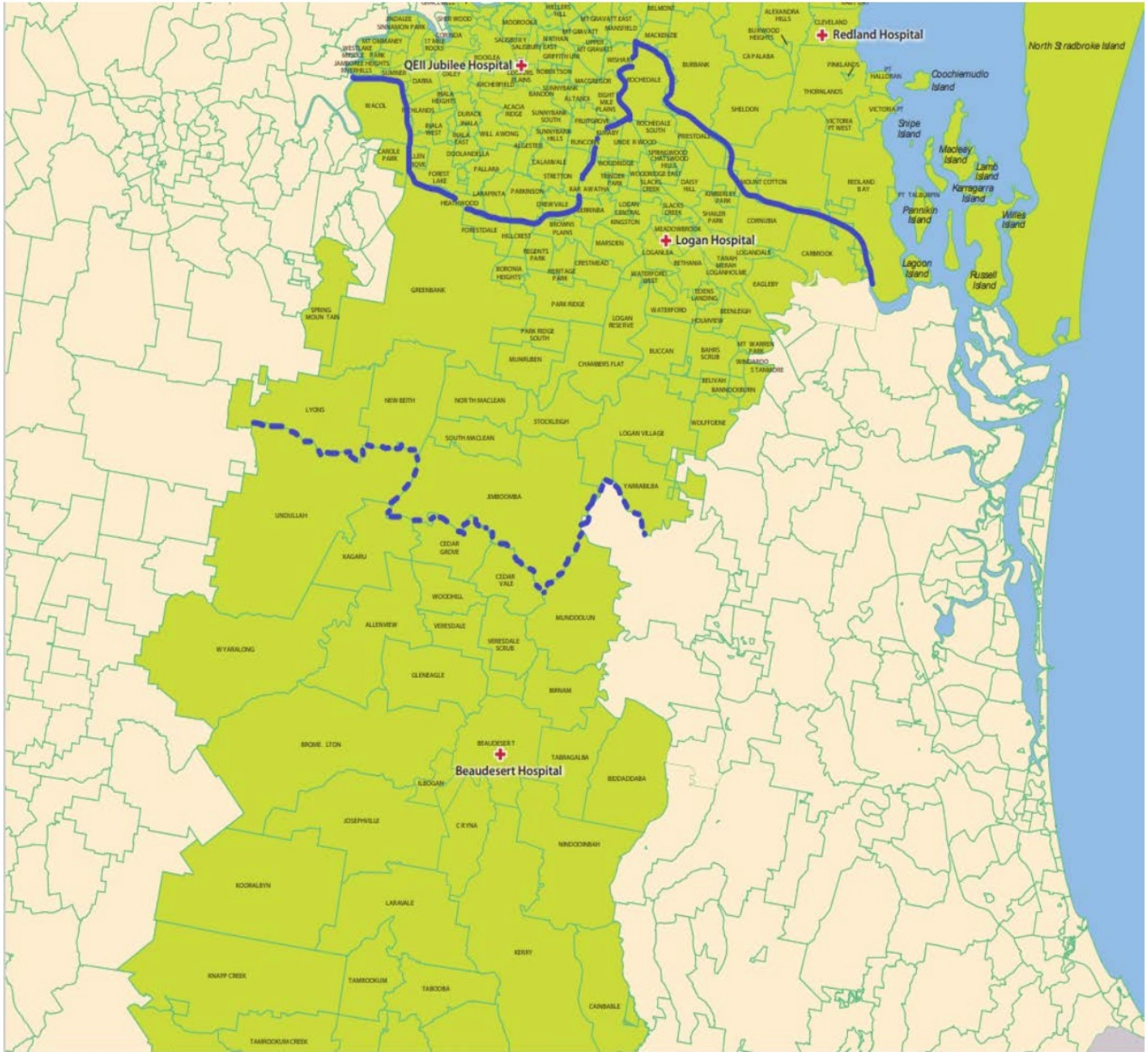
Catchment Map & Postcode List

Mater Mothers Private has no catchment restrictions

Mater Mother's Catchment map



Logan & Beaudesert Catchment



Please consider signing up

Mater has a consumer website
www.matermothers.org.au
with models of care information

Women who do not have a GP can use this list to locate an aligned GP

Indicate your interest and consent on the feedback form

- Yeronga
- Wynnum
- Wishart
- West End
- Waterford West
- Underwood
- Toombul
- The Gap
- Sunnybank Hills
- Stones Corner
- Springwood
- Spring Hill
- Slacks Creek
- Seven Hills
- Runcorn
- Rocklea
- Redbank Plains
- Purga
- Paddington
- Norman Park
- Nathan
- Mount Warren Park
- Morningside
- Meadowbrook
- Mansfield
- Macleay Island
- Laidley
- Keperra
- Jindalee
- Indooroopilly
- Holland Park
- Heritage Park
- Greenslopes
- Goodna
- Fernvale
- Eight Mile Plains
- Eagle Heights
- Darra
- Cornubia
- Cleveland
- Capalaba
- Calamvale
- Buranda
- Brookwater
- Bracken Ridge
- Belmont
- Bardon
- Auchenflower
- Annerley
- Acacia Ridge
- Yeppoon
- Woolloongabba
- Windsor
- Wellington Point
- Victoria Point
- Toowoomba
- Tingalpa
- Tenneriffe
- Sunnybank
- Stafford
- Springfield Lakes
- Southport
- Sinnamon Park
- Samford
- Rochedale
- Richlands
- Redbank
- Parkinson
- Oxley
- Newmarket
- Murrumba Downs
- Mount Ommaney
- Moorooka
- McDowall
- Manly West
- Loganlea
- Kuraby
- Kenmore
- Jimboomba
- Inala
- Hillcrest
- Hawthorne
- Greenbank
- Fortitude Valley
- Fairfield
- East Brisbane
- Durack
- Daisy Hill
- Coorparoo
- Carindale
- Cannon Hill
- Burpengary
- Bulimba
- Brookfield
- Bowen Hills
- Beenleigh
- Balmoral
- Ashgrove
- Algester
- Yarrabilba
- Woodridge
- Windaroo
- Wellers Hill
- Upper Mt Gravatt
- Toowong
- Thornlands
- Taringa
- Sumner Park
- St Lucia
- Springfield
- South Brisbane
- Sherwood
- Salisbury
- Robertson
- Redland Bay
- Red Hill
- Park Ridge
- Nundah
- New Farm
- Mt Gravatt
- Mount Cotton
- Middle Park
- Marsden
- Manly
- Loganholme
- Kingston
- Kangaroo Point
- Ipswich
- Holmview
- Highgate Hill
- Gumdale
- Graceville
- Forest Lake
- Everton Hills
- Eagleby
- Dunwich
- Crestmead
- Collingwood Park
- Carina
- Camp Hill
- Burleigh Waters
- Browns Plains
- Brisbane CBD
- Birkdale
- Beaudesert
- Bald Hills
- Ascot
- Albany Creek

Recurrent issues:

GDM
Obesity
Thyroid disorders

Dr Stephanie Teasdale
Endocrinologist

Dr Stephanie Teasdale

Adult endocrinologist

Her interests and professional knowledge span all areas of diabetes and general endocrinology including pregnancy, and she has a special interest in adrenal and gonadal problems

Testing for Diabetes in Pregnancy

- First trimester **HbA1c** for women at high risk of GDM
- **No** glucose challenge testing
- Routine OGTT (24 – 28 weeks) for all women not previously noted as abnormal (HbA1c NOT suitable)
- OGTT diagnostic criteria changed in 2015
- MMH and QHealth follow the ADIPS, not the RACGP, diagnostic criteria

Let's revisit

HbA1c

- HbA1c can be used as a diagnostic test for diabetes in *first trimester*
- HbA1c of **≥5.9%** (41mmol/mol) required for a diagnosis of GDM
- **>6.5%** (48mmol/mol) to diagnose type 2 diabetes
- This DOES NOT replace the GTT for women after first trimester, or in the 6-8 weeks postpartum
- HbA1c can be used for **long term follow** up of women with a past history of GDM, for early pregnancy or preconception testing in a high risk woman.

Screening and diagnosis gestational diabetes mellitus[1] (Revised February 2019)

Risk factors for GDM

- **BMI greater than 30 kg/m2** (pre-pregnancy or on entry to care) **Ethnicity** (Asian, Indian subcontinent, Aboriginal, Torres Strait Islander, Pacific Islander, Maori, Middle Eastern, non-white African)
- **Previous GDM**
- **Previous elevated BGL**
- **Maternal age 40 years or older**
- **Family history DM** (1st degree relative or sister with GDM)
- **Previous macrosomia** (birth weight Greater than 4500 g or greater than 90th percentile
- **Previous perinatal loss**
- **Polycystic Ovarian Syndrome**
- **Medications** (corticosteroids, antipsychotics)
- **Multiple pregnancy**

GDM diagnosis

At MMH, HbA1c is the preferred test in the first trimester

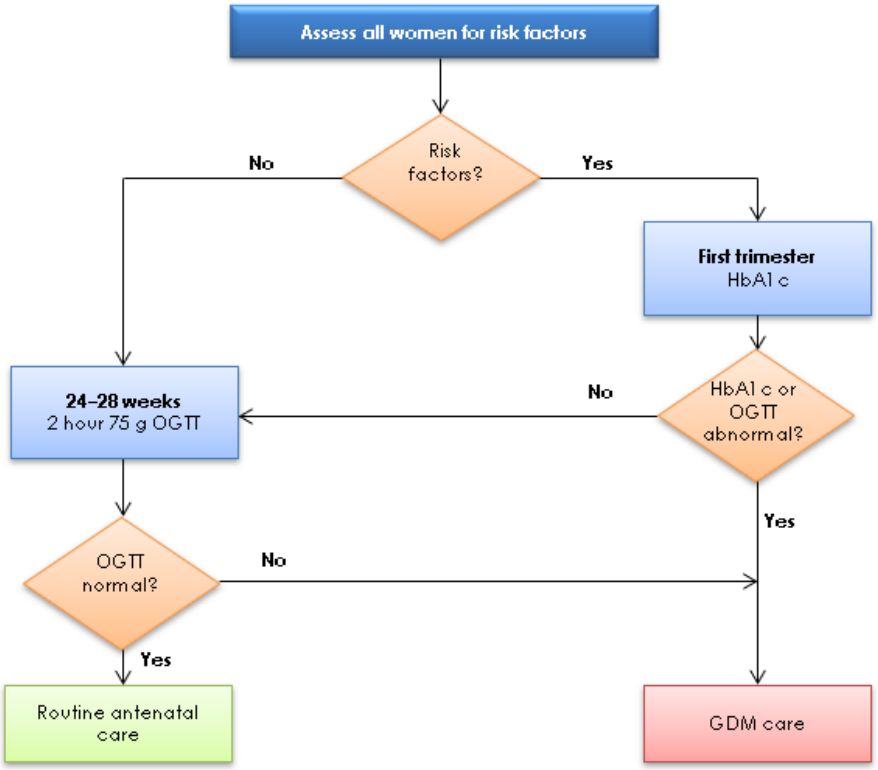
HbA1c

- First trimester only
- Result equal to or greater than 41 mmol/mol (or 5.9%)

OGTT (after 12 weeks)
One or more of:

- Fasting BGL equal to or greater than 5.1 mmol/L
- 1 hour BGL equal to or greater than 10 mmol/L
- 2 hour BGL equal to or greater than 8.5 mmol/L

Note: a single elevated fasting BGL of 5.1–5.5 mmol/L in the first trimester does not constitute a diagnosis of GDM; these women will be recommended to have an HbA1c (if still first trimester) or 2 hour OGTT



MMH Clinical Guidelines GDM Flowchart

(page 43 MMH MSC Guideline)

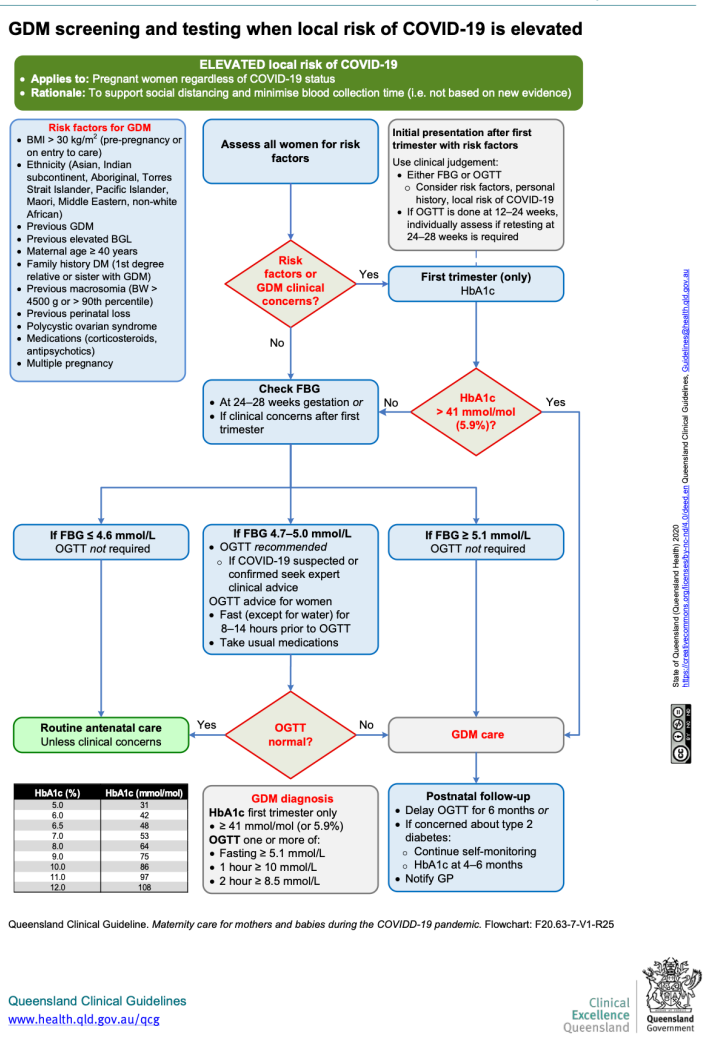
Testing for Diabetes in Pregnancy during Covid-19

Low numbers: usual pathway

Moderate to high numbers: modified pathway

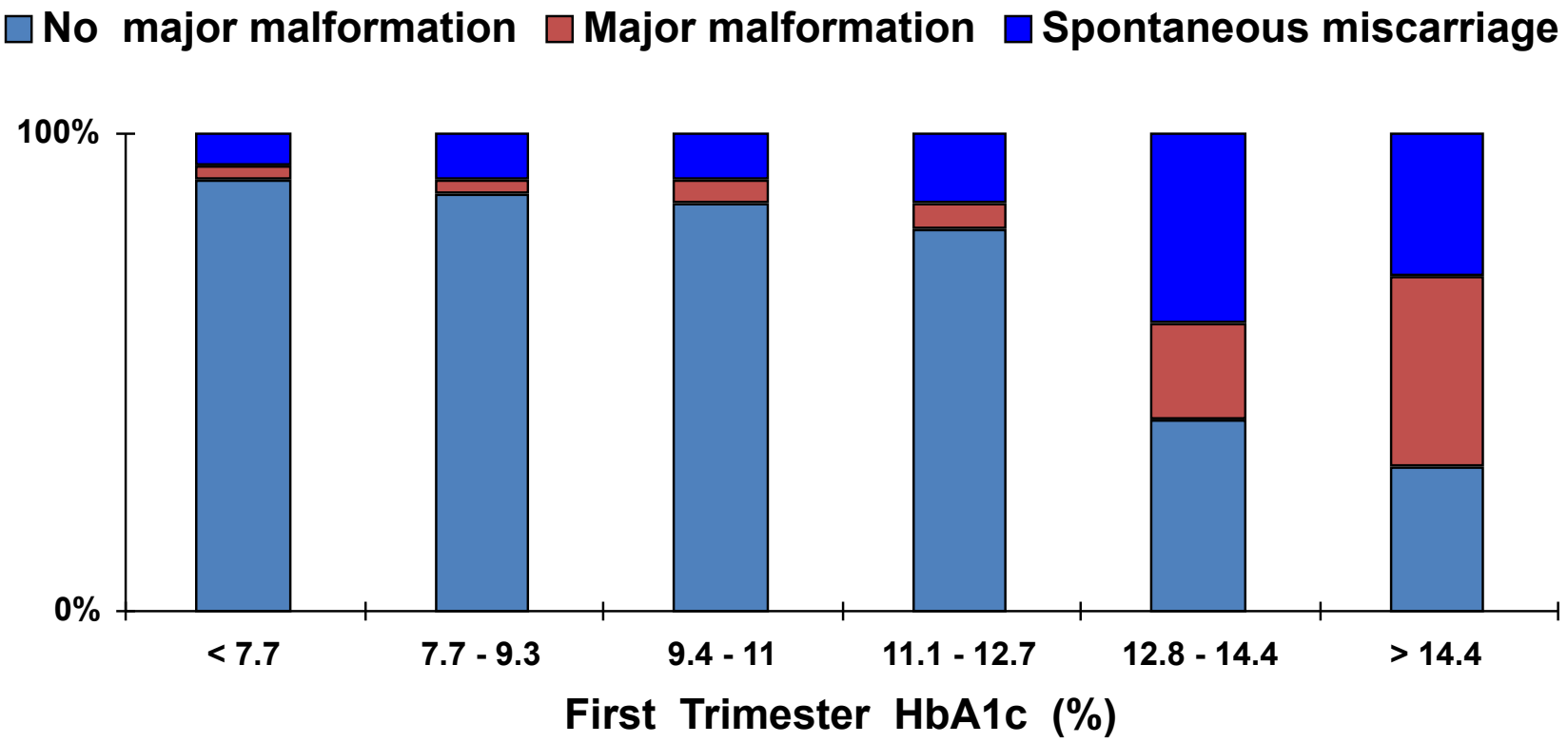
Fasting BSL at 26-28 weeks

- BSL ≤ 4.6 no GTT, normal
- BSL ≥ 5.1 GDM, no GTT
- BSL 4.7-5.0, GTT recommended (glucometer option prn)



Why test?
Pre-gestational Diabetes

Fetal / Neonatal Considerations Greene MF et al Teratology 1989: 39; 224-231
Major Malformations / Spontaneous miscarriage



Potential Adverse Pregnancy Outcomes

- Congenital Malformations
- Miscarriage
- Macrosomia (birth weight > 4500g)
- Shoulder dystocia
- Preterm birth
- Respiratory distress
- Hypoglycaemia of neonate
- Polycythemia
- Hyperbilirubinemia
- Cardiomyopathy

GDM care in evolution

MMH in partnership with CSIRO are trialing a smartphone app to healthcare portal for remote management of GDM

This means we can see ALL the self monitored BGLs ALL the time!

Women can remain in their chosen model of care with remote monitoring

- From GDM diagnosis (and notification to ANC by usual processes) all public women will receive a GDM education video, a blood glucose meter, 2 fetal scans and access to the app
- All women will have two F2F appointments with the diabetes educators and dietitians for individualized management
- All women requiring insulin will receive F2F education, but titration will be done via the app
- New SMBGL targets < or equal to 5 fasting, and < or equal to 7.4 at one hour from the first bite of food

Concerns about GDM

(or anything obs med related)

GDM:

- Email: diabetesmmh@mater.org.au
- Phone: 07 3163 1988

Other issues:

- Daytime senior obs med registrar available 0800 – 1630: via switch
- Afterhours full consultant cover available
- If you have concerns/questions about the app/GDM care in the community, please call

Why is thyroid disease important in pregnancy?

Hyperthyroidism

Fetal / neonatal hyperthyroidism

Increased perinatal mortality

Pulmonary Hypertension (uncontrolled)

Preeclampsia

Miscarriage

Premature labour

Placental abruption

Infection

Hypothyroidism

Infertility

Risk miscarriage

Reduced IQ children

Increased risk of hypertensive disorders of pregnancy

Placental abruption

Preterm delivery

Perinatal morbidity and mortality

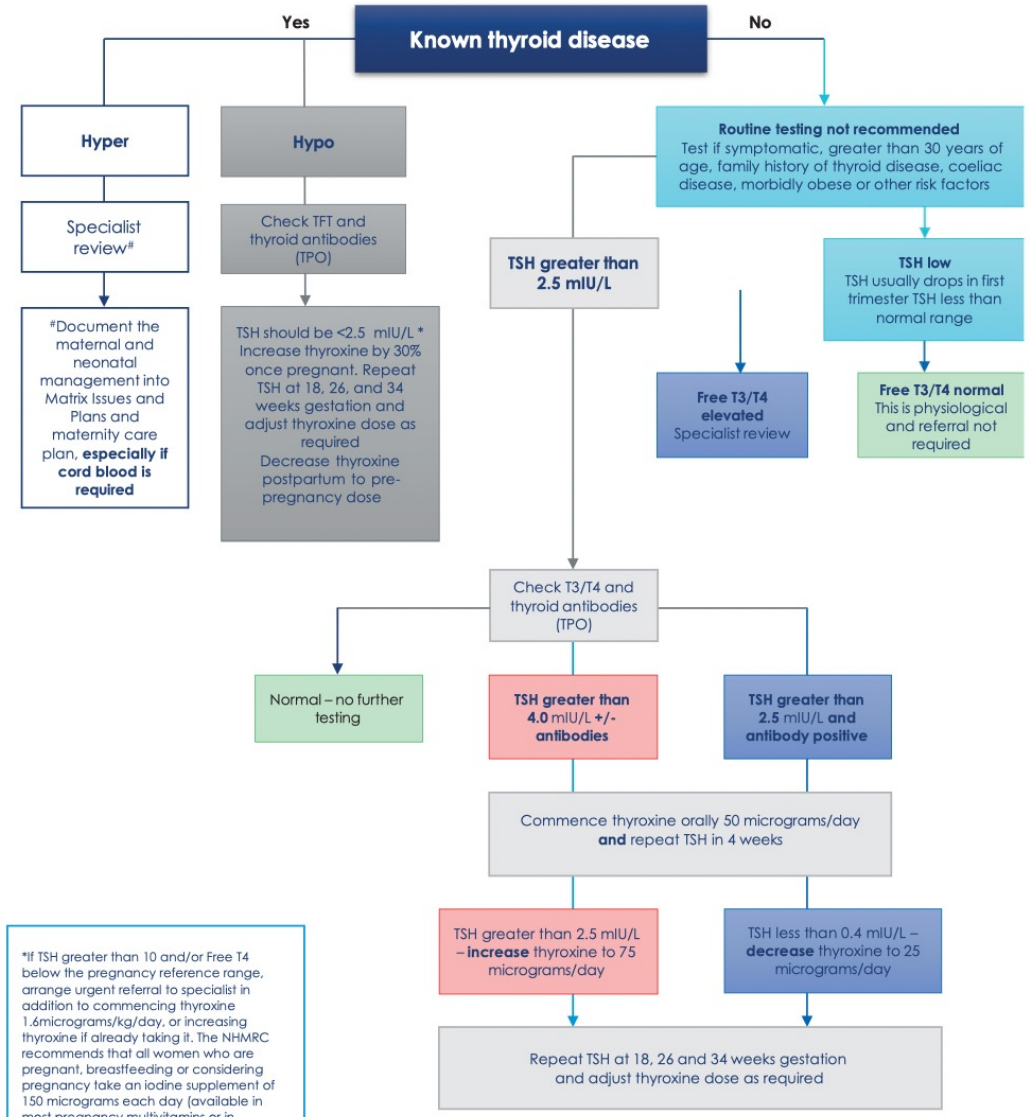
PPH

Let's revisit

Hypothyroidism

- Overt hypothyroidism – increase thyroxine dose by 30% at conception. TSH >10? Commence thyroxine & refer urgently
- Measure TSH at first visit; 6/52 later; then end 2nd and 3rd trimester if normal
- **Reduce** back to preconception dose postpartum
- Aiming for TSH < 2.5-1st trimester, < 3 - 2nd-trimester, < 3.5 -3rd trimester
- 24 % of Australian women are positive for thyroid antibodies
- Studies regarding treatment of euthyroid anti-TPO antibody women with thyroxine are inconclusive with respect to reduction in miscarriage and adverse pregnancy outcomes – so don't routinely test!

Thyroid management in pregnancy March 2022



*If TSH greater than 10 and/or Free T4 below the pregnancy reference range, arrange urgent referral to specialist in addition to commencing thyroxine 1.6micrograms/kg/day, or increasing thyroxine if already taking it. The NHMRC recommends that all women who are pregnant, breastfeeding or considering pregnancy take an iodine supplement of 150 micrograms each day (available in most pregnancy multivitamins or in combination with folate)

Ensure pregnancy specific ranges as determined by your local laboratory are used.

Page 33 of the Mater Guideline

A real-life example….

G2P1

Fit in telephone consultation to organise bloods prior to F2F visit

Age > 30

TSH included

Saturday remoting in from home, TSH 27, T4 normal

Open record, note she is already on levothyroxine for hypothyroidism

WWYD? - Kahoot

Managing Thyroid issues- tips

- *Don't* routinely test for TFT in pregnancy in low-risk women!
- Ensure those on thyroxine are taking it first thing in the morning on an empty stomach and NOT with pregnancy vitamin or iron
- Most common cause suppressed TSH in first trimester is hCG mediated hyperthyroidism ~ 10% women
- Occasionally Free T4 and Free T3 mildly elevated
- Is differentiated from Grave's disease by the presence of TSH receptor antibody and increased colour flow Doppler sonography on US
- Don't treat – will resolve in 2nd trimester RANZCOG guideline

Hyperthyroidism

- Graves most common cause throughout pregnancy
- Rx with propylthiouracil 1st trimester; carbimazole 2nd and 3rd trimester
- ~ 60 % women able to have medications weaned by end 2nd trimester – need to watch for postpartum flare
- Check TFTs every 4-6 weeks
- TSH receptor antibody titre predicts risk fetal / neonatal thyrotoxicosis
- Our Obstetric Physicians will sort this out!

Let's revisit

Obesity in pregnancy

BMI is important for triage. For women with a BMI > 30

- **Routine** scheduled bloods are recommended *plus* E/LFT, HbA1c (or early OGTT if k>12), and urine protein/creatinine ratio.
- Advise women to take **5 mg of Folate** daily preconception and in the first trimester as they have a higher risk of impaired glucose tolerance.
- **Advise the hospital** so they can organise appropriate internal referrals, eg: anaesthetist; consider her suitability for a modified model of care.
- **BMI 40 +** seen at k13-14 Obstetric care or modified GP shared care. Not suitable for MGP or outreach. Need bariatric furniture
- U/A with **each visit** and BP with extra large cuff
- If the first trimester diabetes testing is negative, an **OGTT** is to be performed at 26-28 weeks

Obesity in pregnancy

- It is recommended that all women are weighed each visit
- Advise women of their target weight gain (see page 6 PHR) or use the MMH weight tracker or online weight gain tracker

Target Weight Gains

*Calculations assume a 0.5–2kg weight gain in the first trimester for single babies.
Refer to dietitian if multiple pregnancies, as different goals required. Dietary and physical activity requirements discussed (refer to page b2).
Refer to Queensland Clinical Guideline: *Obesity in pregnancy* for further information.

Pre-pregnancy BMI (kg/m^2)	Rate of gain 2nd and 3rd trimester (kg/week)*	Recommended total gain range (kg)
Less than 18.5	0.45	12.5 to 18
18.5 to 24.9	0.45	11.5 to 16
25.0 to 29.9	0.28	7 to 11.5
≥30.0	0.22	5 to 9

Obesity guidelines

http://www.health.qld.gov.au/qcg/

Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Obesity in pregnancy

Mater's changing maternity population

BMI ≥ 35 is considered high risk

	Overweight	Obese 1	Obese 2	Obese 3
BMI	25-29.9	30-34.9	35-39.9	≥ 40
2000	16.5%	6%	2%	1.1%
2012	19.7%	7.6%	3.1%	1.9%

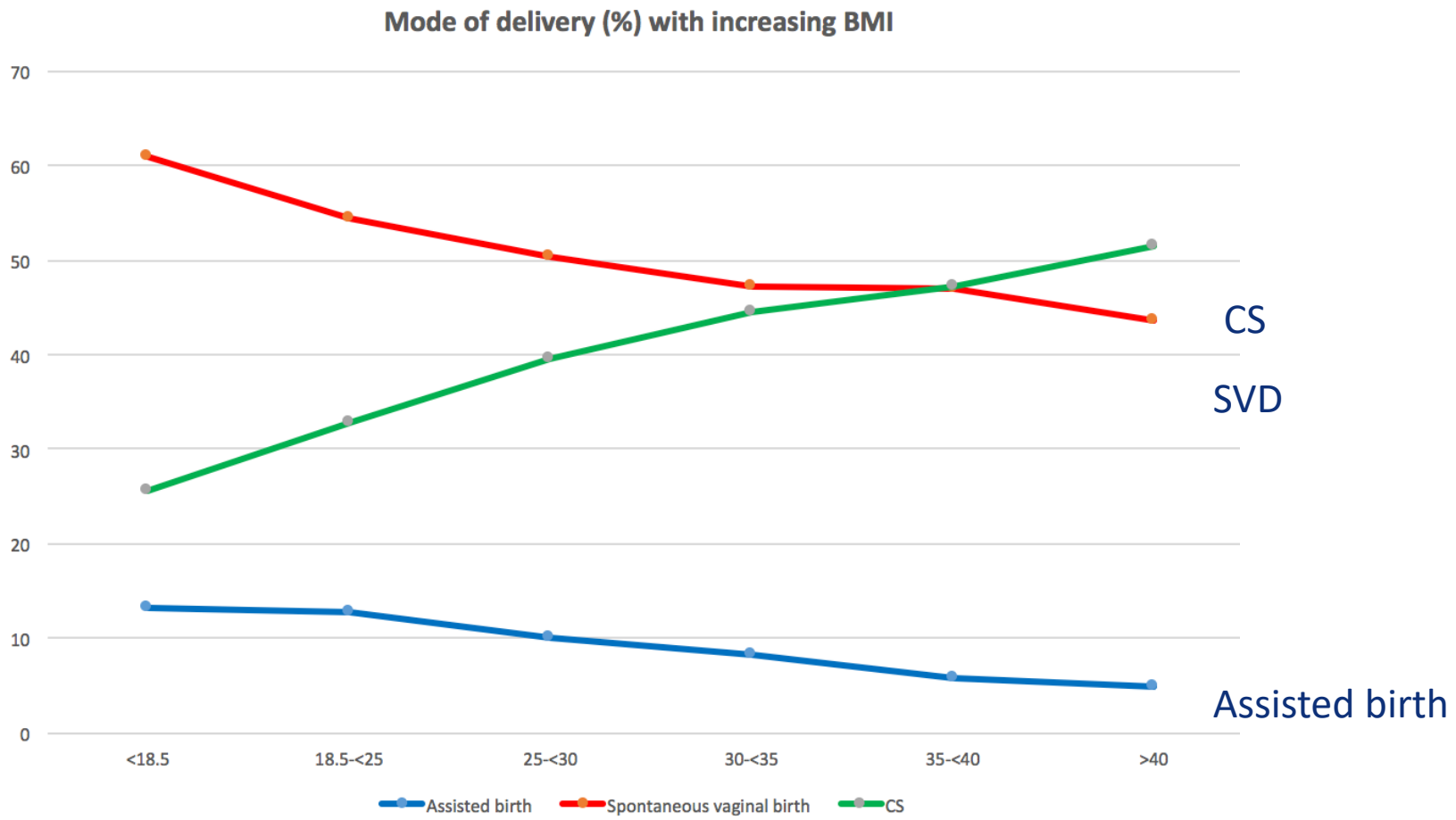
Percentage overweight or obese in
2000 was 25%
2012 was 32.3%
accounted for 2/3 of bookings in 2019

Maternal Obesity Risks

- Type 2 diabetes and it's associated sequelae
- Hypertensive related disorders
- Thromboembolism
- Obstructive sleep apnoea
- Conditions which lead to induction of labour
- Complications in labour resulting in operative birth
- Anaesthetic complications
- Post operative complications
- Postnatal complications i.e. lactation, thromboembolism

The frequency of adverse outcome increases with increasing BMI. The following charts are based on analysis of 75,432 women birthing at Mater Mothers Hospital Brisbane 1998-2009

McIntyre HD, Gibbons KS, Flenady VJ, Callaway LK. Overweight and obesity in Australian mothers: epidemic or endemic? Med J Aust. 2012; 196(3):184-8.



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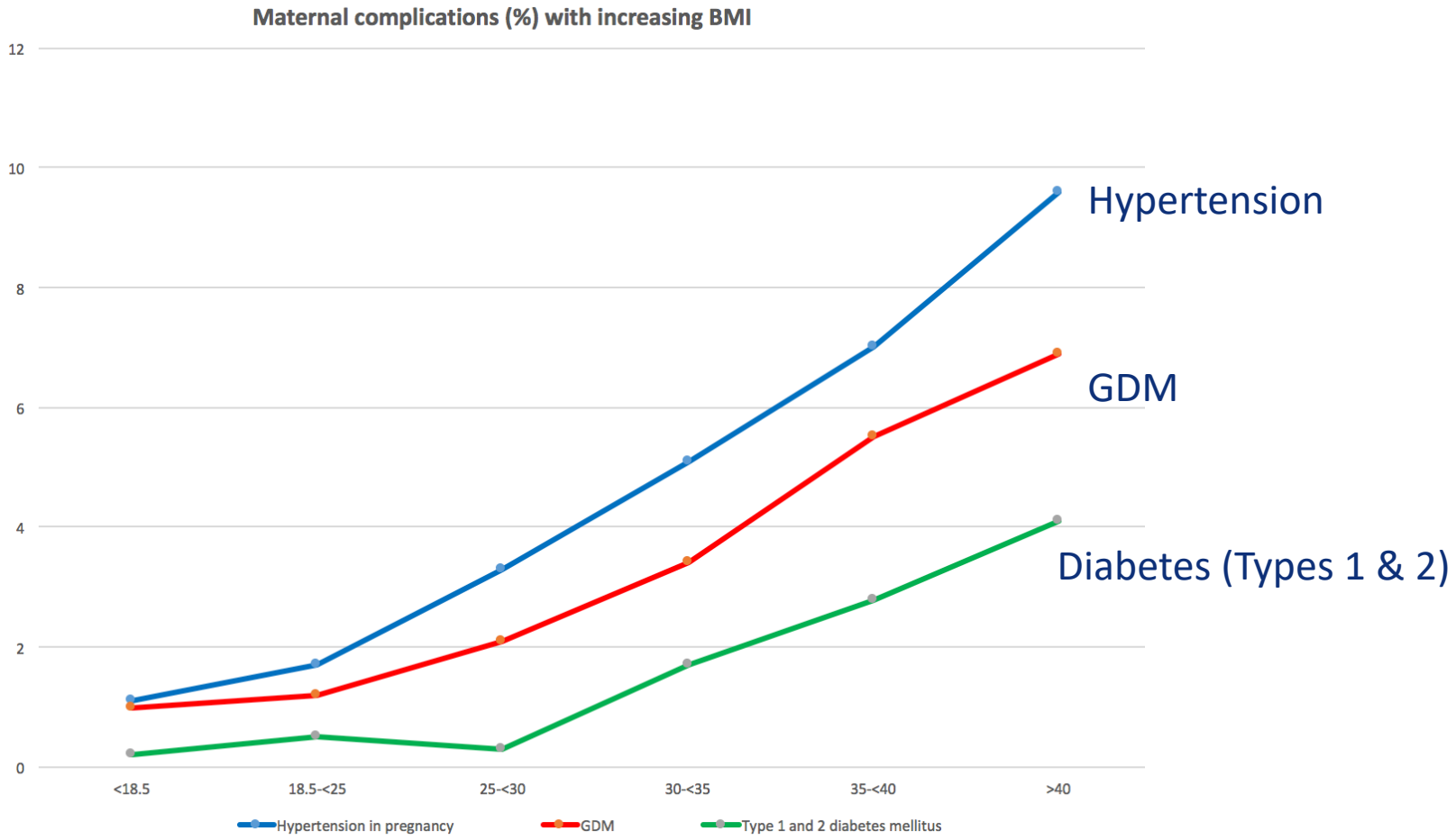

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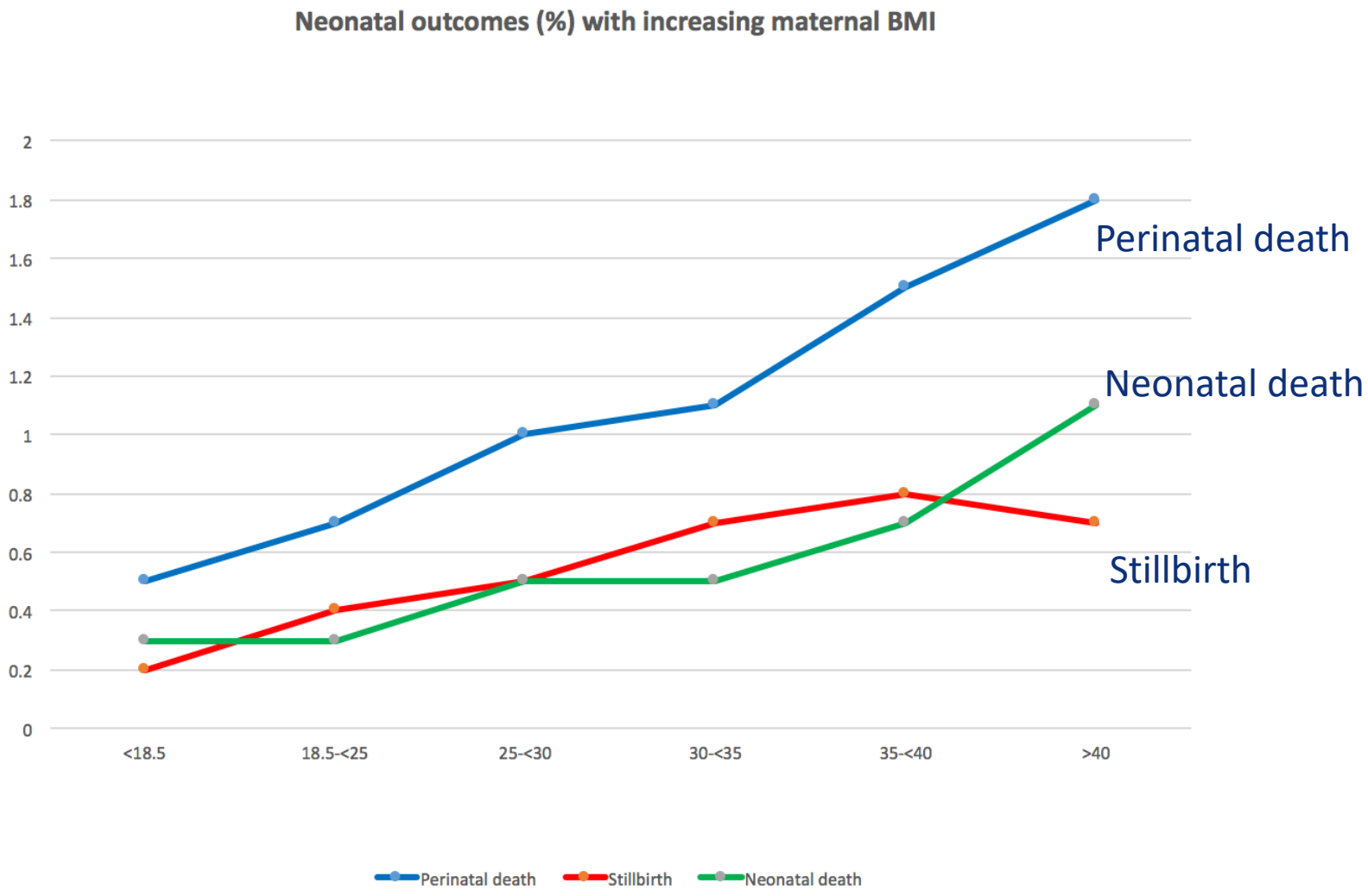

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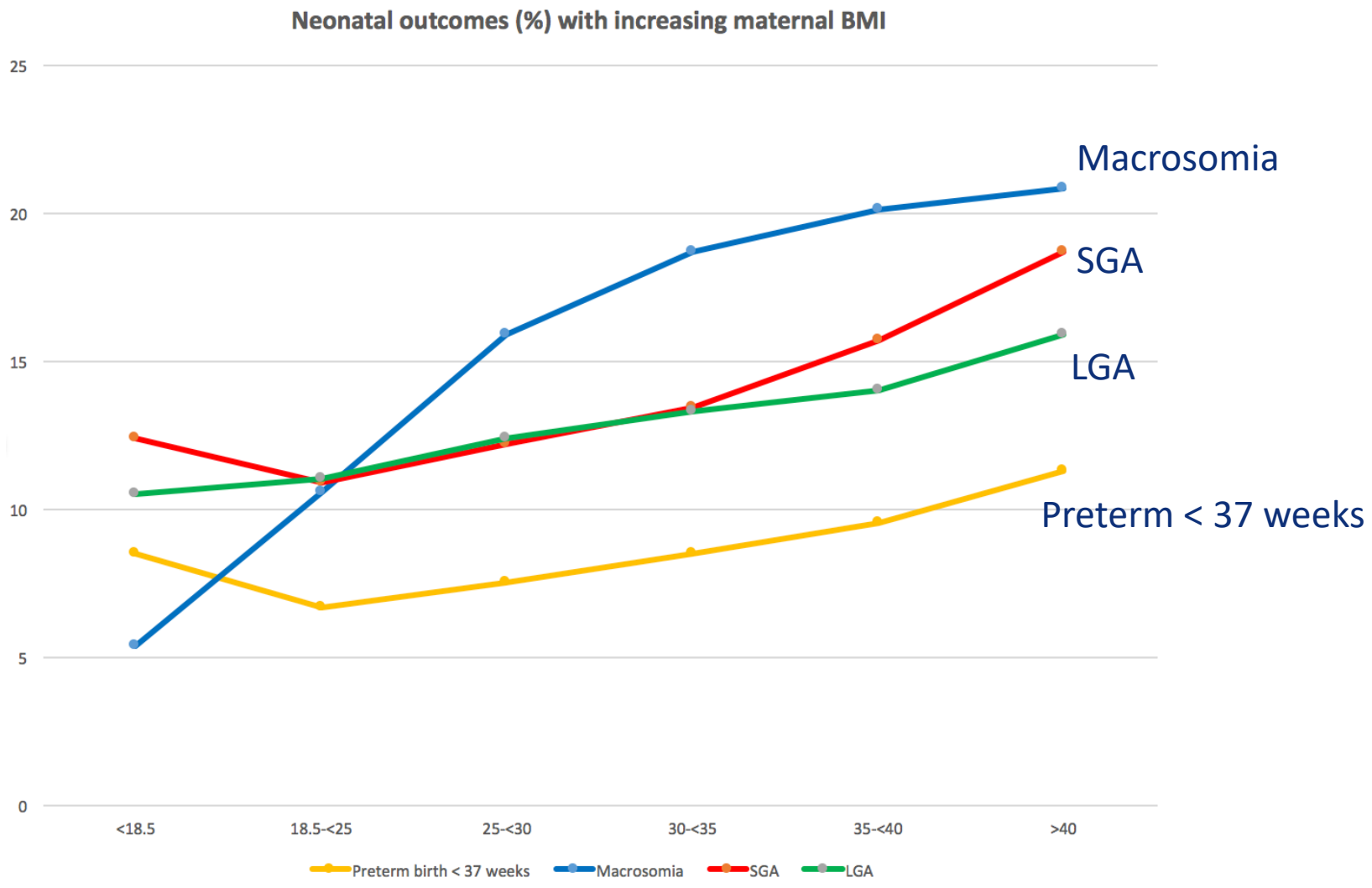

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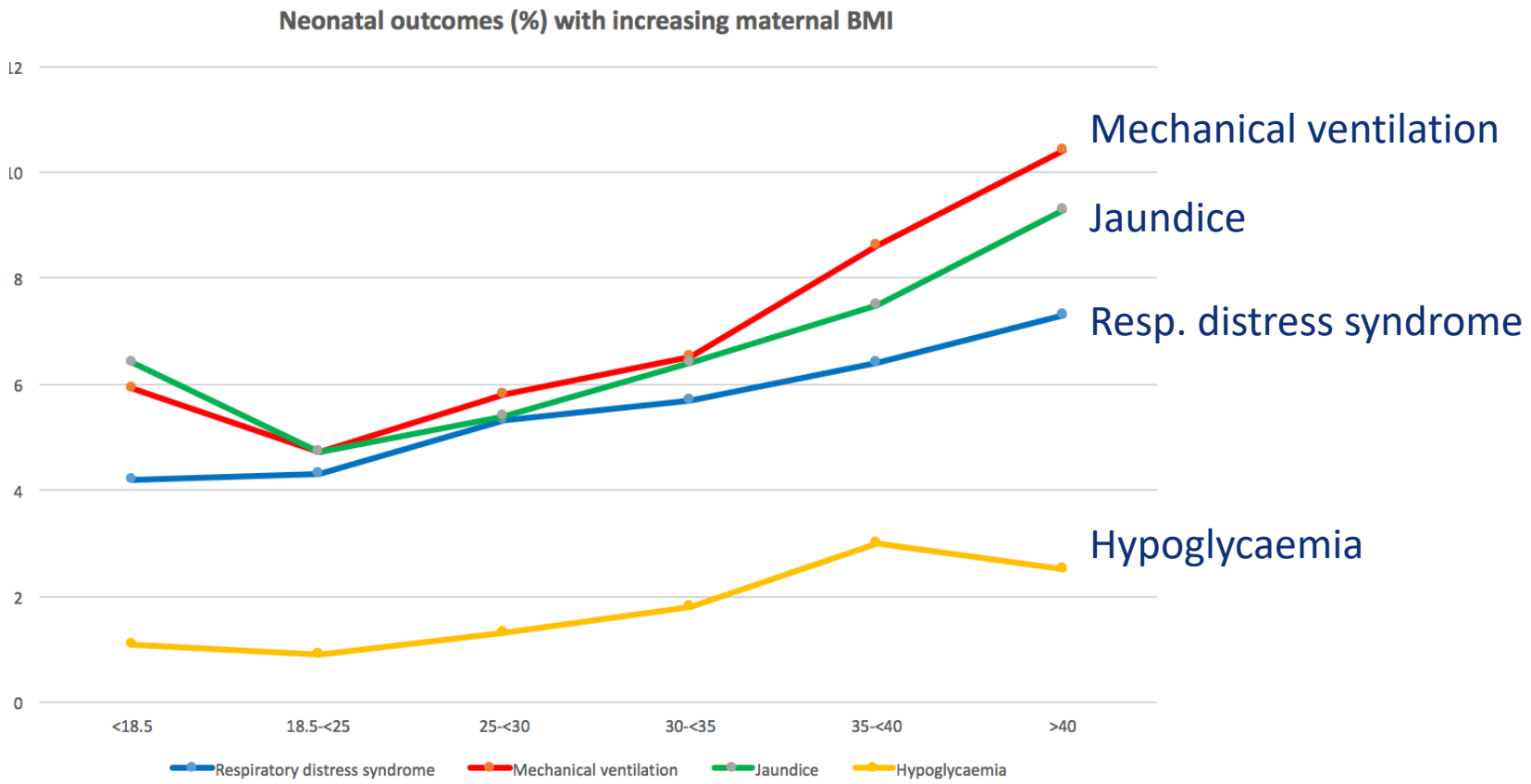


Talk to women about the risks

Antenatally

- Limitations on ultrasound screening for fetal anomaly and growth
- Reduced accuracy of NIPT
- "Fetal anomaly screening is incomplete due to maternal body habitus"
- Increased risk of diabetes, hypertension

Intrapartum

- Difficulty with monitoring fetal wellbeing in labour
- Increased likelihood operative birth
- Increased risk of anaesthetic difficulties

Postpartum

- Increased risk of thromboembolism
- Problems with establishing effective lactation

Treat as an opportunity for long term behaviour modification and offer dietitian referral

First visit with GP should include

General Practitioner can initiate the following:

- HbA1c in first trimester ? Type 2 DM
- High dose folic acid 5 mg daily
- Screen for cardiovascular disease
- Early dating scan is important to confirm EDC as post dates pregnancy is more common
- Anomaly scan screening for congenital anomaly

Consider the following if obese with additional risk factors for:

- Hypertension - Low dose aspirin 150 mg/day,
- DVT - Antenatal thromboprophylaxis

Prophylactic aspirin use in pregnancy to reduce pre-eclampsia (PE) and intrauterine growth restriction (IUGR)

150 mg aspirin nocte
BEFORE 16 weeks gestation,
ideally from 12 weeks, until birth

Source: AJGP October 2022

High Risk Factors

Women with any of the following:

- Hypertension
- Renal disease
- Auto-immune diseases such as SLE or anti-phospholipid syndrome
- Diabetes (Type 1 or Type 2)
- Past history of pre-eclampsia
- Assisted conception with oocyte donation

Moderate Risk Factors

Women with two or more of the following:

- Primiparous
- BMI > 35
- Age > 40
- Multiple pregnancy
- Low socioeconomic status
- Personal history of low birth weight
- Previous adverse pregnancy outcomes
- Family history of pre-eclampsia (mother or sister)

What about calcium?

Calcium has been shown to reduce BP, relax smooth muscle, lower resistance in uterine and umbilical arteries. If a woman has deficient intake, **≥ 0.5 g/day is recommended**

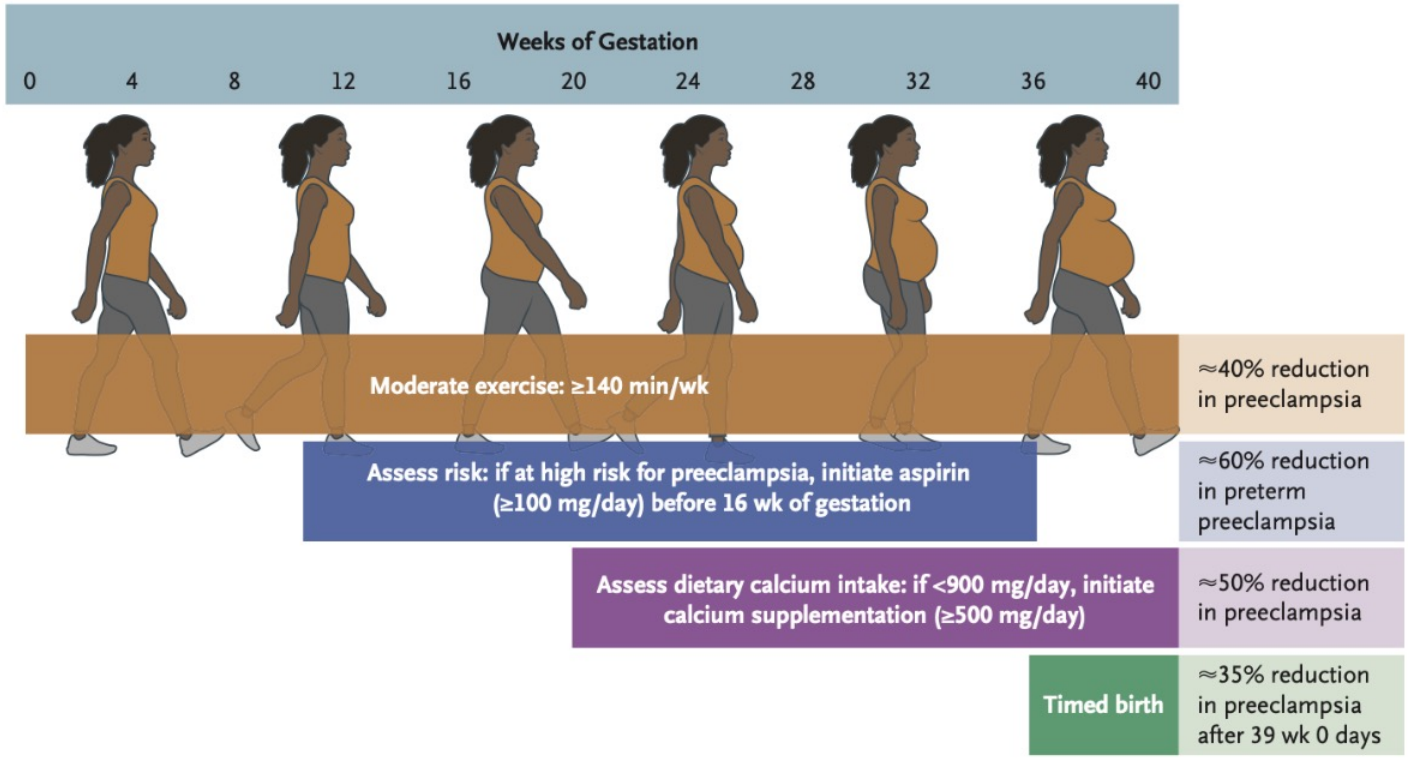


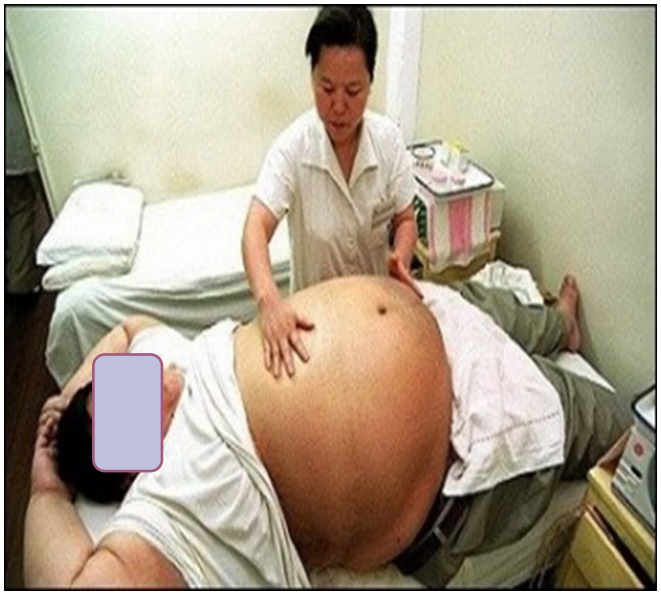
Figure 2. Prevention of Preeclampsia.

Pregnant women should be encouraged to exercise to reduce the risk of preeclampsia and for general health. Before 16 weeks' gestation, women at high risk for preeclampsia should be identified and offered aspirin (≥100 mg per day). Women in low-calcium-intake populations should be offered supplemental calcium, at a dose of at least 500 mg per day, in the second half of pregnancy. Low-risk nulliparous women benefit from labor induction during the 39th week of gestation, between 39 weeks 0 days and 39 weeks 4 days of gestation.

Prevention of Preeclampsia

Source: N Engl J Med 2022;386:1817-32.
DOI: 10.1056/NEJMra2109523

SFH? Lie, presentation?



Practical Issues

- BP measurement
- Bed weight capacity
- Theatre trolley movement & patient shifting
- Ultrasonography – less reliable and risk of wrist/upper limb injuries for sonographers
- Listening to fetal heart/CTG
- Venous access

What will the Obstetrician be doing?

Shared antenatal visits with GP if otherwise low risk

Recommend

- GTT repeat at 28 weeks if early screening negative
- Anaesthetic referral BMI >40
- Serial scans if required (BMI > 40) to monitor fetal growth
  - Risk unrecognised IUGR
- Facilitate discussion about timing and mode of birth
  - VBAC/IOL/anaesthetic risks in labour

Nutrition and Dietetics advice

Nutrition and Dietetics

Healthy eating when you are pregnant is important—a nourishing diet (plus a supplement that contains folic acid and iodine) is essential for good health for you and your growing baby.

Early in pregnancy, the quality of your diet can influence how your baby's organs develop. Later in pregnancy, your diet influences baby's growth and brain development.

The information in these webpages will hopefully inspire and motivate you to eat well during your pregnancy, but sometimes balancing things like weight gain, food preferences, and nutritional needs can be a juggle. Mater Mothers' Hospitals has dietitians available to talk to if you would like more information or help with your diet during this time.

Healthy gut diet

Can we prevent GDM by changing the gut microbiome in high-risk women?

Who is eligible?

- Pregnant women with a history of GDM (but no current diagnosis)
- Enrolled prior to 18 weeks gestation
- Birthing at a Queensland Hospital

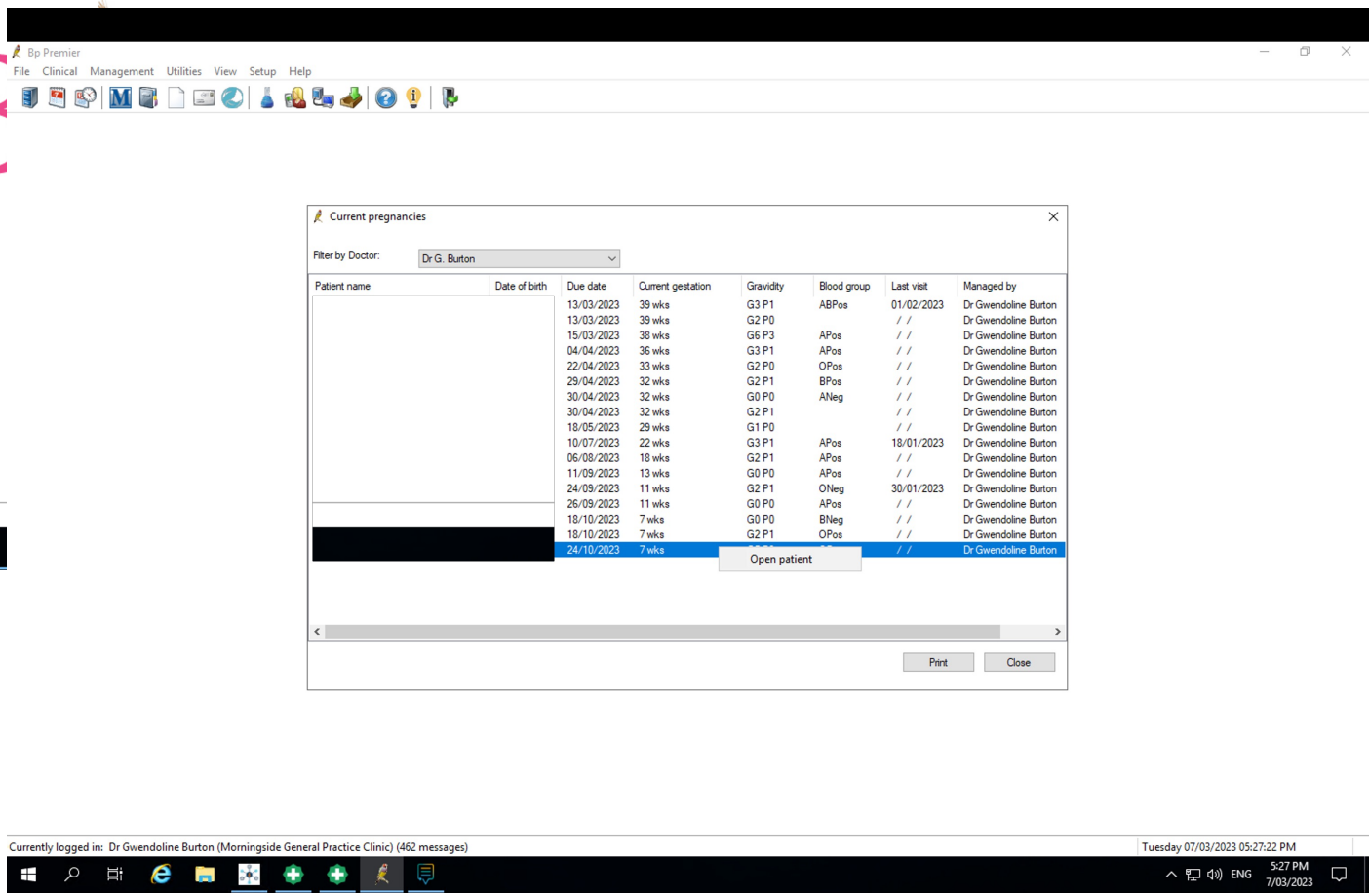
Why should you care?

GDM is the most common disorder a woman can experience during pregnancy. More than 1 in 7 pregnant women will be diagnosed with GDM. There are short and long term risks of GDM to mother and child. About 50% of women with GDM will go on to develop type 2 diabetes within 10 years! Preventing or improving the management of GDM can have intergenerational impacts.

Women can register their interest via www.redcap.link/HGD This will trigger a phone call from the research team where they will learn all about the study and decide if it's something they'd like to participate in.

The Healthy Gut Diet
for preventing gestational diabetes
Study


Bp Premier
File
Clinical
Management
Utilities
View
Setup
Help
Actions
Cervical screening
Diabetes register
Follow up inbox
Immunisations
Pregnancy list
Reminders


Bp Premier
File
Clinical
Management
Utilities
View
Setup
Help
Current pregnancies
Filter by Doctor:
Dr G. Burton
Patient name
Date of birth
Due date
Current gestation
Gravidity
Blood group
Last visit
Managed by
13/03/2023 39 wks G3 P1 ABPos 01/02/2023 Dr Gwendoline Burton
13/03/2023 39 wks G2 P0 / / Dr Gwendoline Burton
15/03/2023 38 wks G6 P3 APos / / Dr Gwendoline Burton
04/04/2023 36 wks G3 P1 APos / / Dr Gwendoline Burton
22/04/2023 33 wks G2 P0 OPos / / Dr Gwendoline Burton
29/04/2023 32 wks G2 P1 BPos / / Dr Gwendoline Burton
30/04/2023 32 wks G0 P0 ANeg / / Dr Gwendoline Burton
30/04/2023 32 wks G2 P1 / / Dr Gwendoline Burton
18/05/2023 29 wks G1 P0 / / Dr Gwendoline Burton
10/07/2023 22 wks G3 P1 APos 18/01/2023 Dr Gwendoline Burton
06/08/2023 18 wks G2 P1 APos / / Dr Gwendoline Burton
11/09/2023 13 wks G0 P0 APos / / Dr Gwendoline Burton
24/09/2023 11 wks G2 P1 ONeg 30/01/2023 Dr Gwendoline Burton
26/09/2023 11 wks G0 P0 APos / / Dr Gwendoline Burton
18/10/2023 7 wks G0 P0 BNeg / / Dr Gwendoline Burton
18/10/2023 7 wks G2 P1 OPos / / Dr Gwendoline Burton
24/10/2023 7 wks / / Dr Gwendoline Burton
Open patient
Print
Close
Currently logged in: Dr Gwendoline Burton (Morningside General Practice Clinic) (462 messages)
Tuesday 07/03/2023 05:27:22 PM
ENG
5:27 PM
7/03/2023

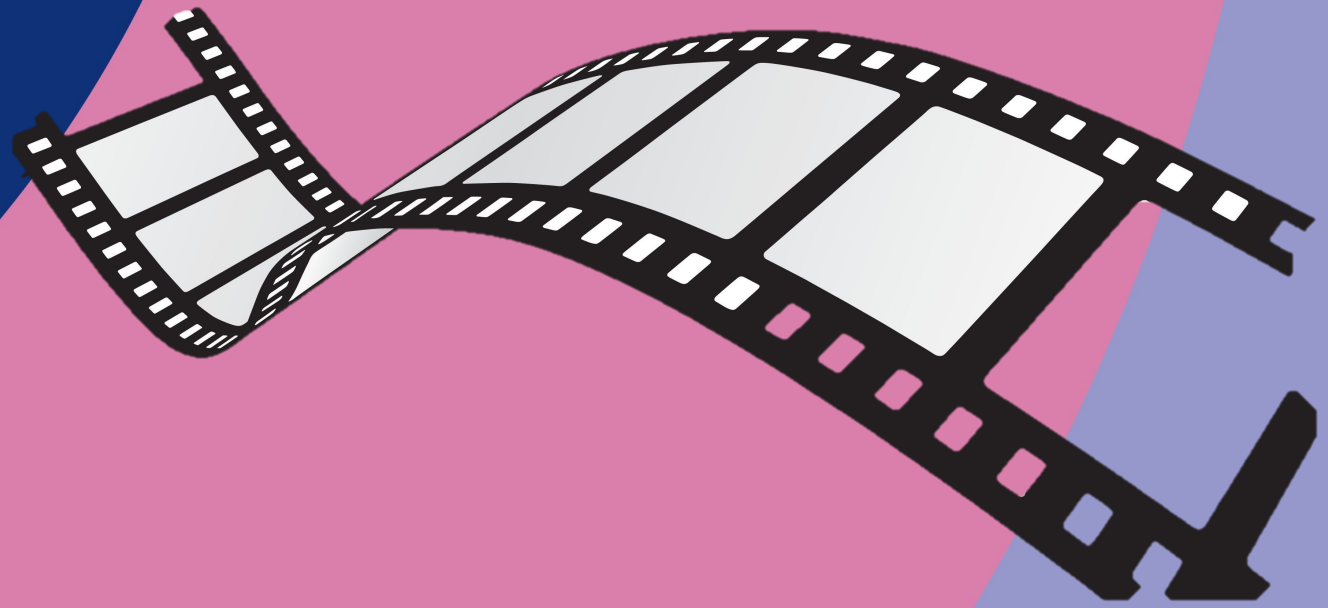
US/S costs—clinics compared
Not an exhaustive list, not Mater endorsed!

Costs correct as of March 14, 2023, for singleton pregnancies with a valid referral.

Not all services are available at all locations, especially the Nuchal Translucency Scan (NTS).

Practice	Under 12 weeks (Item 55700, $53.10 rebate)	NTS (Item 55707 $61.95 rebate)	Morphology (Item 55706 $88.45 rebate) Including cervical length – TV-USS if required
Citi Scan	$138.10 HCC BB - viability, dating. GAP: $85.00	$216.00 GAP: $155	$238.45 GAP: $150
Exact Radiology	BB viability, dating scans <16/40	$235 (available at Sunnybank, Inala, Chapel Hill, Ipswich Riverlink and Underwood) GAP: $173.05	$235 morphology - GAP: $146.55 >22/40 $140 (if had Morph scan with Exact, or $235 if not) Further scans > 22/40 are BB if referred by Obstetrician or DRANZCOG – GP (if undertaken by Exact)
I-MED Radiology	$153.10 HCC BB GAP $100	$221.95 HCC BB - GAP: $160 - Only available at Carina	$248.45 HCC BB GAP: $160 for morphology & all 3rd TM scans (Only Carina) GAP: $150
Qld Xray	$213 viability, dating (at some practices GAP: $160	$257 GAP: $195	$283 - morphology GAP: $195 $210 3rd TM scans GAP: $120 BB HCC holders if previous NTS or morphology scan with QXR
Qscan	$123.45 GAP:$70 (Medicare rebate)*BB ALL USS Meadowbrook	$261.95* GAP: $200	$288.56* for morphology GAP: $200 $288.65* 3rd TM scans GAP: $200
Lumus Imaging Formerly QDI	$185 GAP: $132	$231.95* Only at Browns Plains(book well in advance (prefer 12/40); GAP: $170	$208.45 GAP: $120 for morphology (prefer 20-22/40) & 3rd TM scans, GAP: $120
So + Gi (4D)	$243 GAP: $190 $633 for NIPT + dating scan, GAP: $580	$360 GAP: $300 $872 NIPT + NTS rebate $62 GAP: $810	$418 ($88 rebate) GAP: $330 $408 3rd TM scans ($88-$100) GAP: $320-$308

mater



Antenatal screening for fetal chromosome & genetic conditions

Dr Glenn Gardener
Director
Maternal Fetal Medicine
Mater Mothers Hospital
Ph. 3163 8844

The key strategies to **prevent preterm birth**

More than 26,000 Australian babies are born too soon each year.

New research discoveries have led to the development of key strategies to safely lower the rate of preterm birth and are continuing to make pregnancies safer for women and their babies.

1. No pregnancy to be ended until at least 39 weeks unless there is obstetric or medical justification.

2. Measurement of the length of the cervix at all mid-pregnancy scans.

3. Use of natural vaginal progesterone (200mg each evening) if the length of cervix is less than 25mm.

4. If the length of the cervix continues to shorten despite progesterone treatment, consider surgical cerclage.

5. Use of vaginal progesterone if you have a prior history of spontaneous preterm birth.

6. Women who smoke should be identified and offered Quitline support.

7. To access continuity of care from a known midwife during pregnancy where possible.

AUSTRALIAN
Preterm Birth
Prevention
ALLIANCE

These strategies have been approved and endorsed by the Australian Preterm Birth Prevention Alliance.

Cervical length measurement

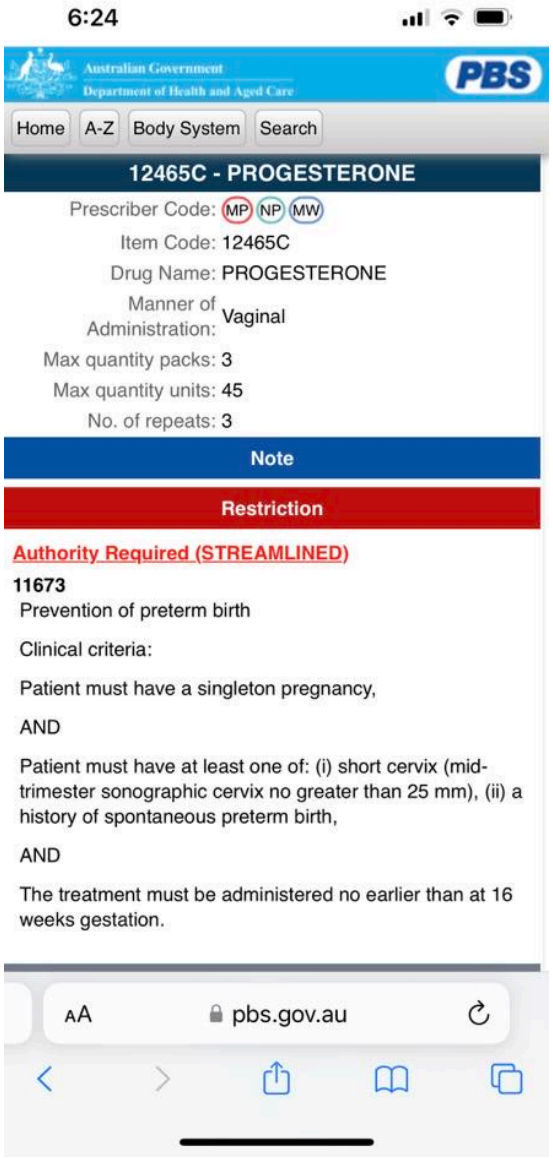
- Best efficacy between 16 and 24 weeks
- Offer transvaginal (TV) if significant Hx PTB/cervical surgery
- Otherwise routine transabdominal (TA) screening at morphology
- Cut off TA: cervical length 35 mm (full bladder)
- TV if < 35 mm TA or cervix cannot be seen across its entire length with certainty
- Cut off TV: 25 mm
- If shorter: urgent referral and commence natural vaginal Progesterone pessaries (200 mg nocte) the same day

Point 3

Use of vaginal progesterone (200mg each evening) if the length of cervix is less than 25mm. This treatment should continue until 36 weeks gestation.

Point 5

Vaginal progesterone 200mg pessaries are also to be prescribed for any case in which there is a history of spontaneous preterm birth in a previous pregnancy between 20 and 34 weeks gestation. The treatment is used each night from 16 to 36 weeks' gestation.



Omega 3's

South Australia has commenced a funded program of testing women for their Omega 3 levels with a view to supplementing those whose levels are low. MMH are awaiting the results of this intervention

Why? A Cochrane systematic review of 70 randomised controlled trials of almost 20,000 women with mainly singleton pregnancies indicated that omega-3 supplementation from early-mid pregnancy until birth reduces the risk of

early preterm birth by 42% (from 46 per 1000 to 27 per 1000 births)
preterm birth by 11% (from 134 per 1000 to 119 per 1000 births)

Other researchers caution that the data is inconclusive, and more research is needed

Universal supplementation is *not* recommended as supplementation of women with high levels of Omega 3 is associated with an *increase* in preterm birth

Some of this research was conducted prior to Omega 3 being added to (some, not all) antenatal supplements

Omega 3's

Testing for Omega 3 is not Medicare funded and costs ~ $265.

- Should be offered before 20 weeks, preferably in the first trimester, however interpretation of results is difficult as there is yet to be standard reporting across the pathology providers in Australia
- Testing is NOT recommended in 2023 outside of the South Australian trial, for the above reason
- A list of supplements and their Omega 3 content are available on the www.sahmri.org.au site (search by Omega 3)

Natural sources of Omega 3 include

- Fish and other seafood (especially cold-water fatty fish, such as salmon, mackerel, tuna, herring, and sardines)
- Nuts and seeds (such as flaxseed, chia seeds, and walnuts)
- Plant oils (such as flaxseed oil, soybean oil, and canola oil)

There are supplements made from algal oil suitable for vegetarians and vegans

Like folic acid, humans absorb Omega 3s differently, making it hard to be confident about serum levels from dietary sources, however deficiency is unlikely if fish is eaten twice weekly

NIPT Vs NTS: order both, or FTCS if $ a barrier

Non-Invasive Prenatal Test (NIPT); Nuchal Translucency Scan (NTS); First Trimester Combined Screen (FTCS) = bloods + Ultrasound scan from 11 weeks to 13 + 6 weeks

NIPT	FTCS
Best screening test for T21	Good screening test T21
Widely available/easy to order	Need access to appropriately trained sonographers
Very low false negative rate, positive predictive value (PPV) varies by age	Higher false positive rate than NIPT, PPV varies by age
Mostly avoids invasive test (CVS, Amnio)	Mostly avoids invasive test (CVS, Amnio)
No fetal anatomy	Identifies twins, miscarriage, major structural anomalies

Cost: $425 Vs $495
with Genome-wide NIPT*

*Pricing confirmed March 14, 2023

SULLIVAN NICOLAIDES PATHOLOGY

INSTRUCTIONS FOR THE PATIENT
To finalise the booking and payment for your NIPT, please visit **sonicgenetics.com.au/bookandpay**
All enquiries, please contact 1800 010 447
(Monday–Friday, 8 am–6 pm AEST).

mater

Non-invasive prenatal test (NIPT) | Request form

FOR THE DOCTOR

This test should be requested by the doctor responsible for medical management of a patient's non-invasive prenatal testing.

Patient details

First name _____
Surname _____
Date of birth ___/___/___ Sex _____ **Female - Pregnant**
Address _____
_____
_____
Phone (mobile) _____

Test(s) requested

NIPT for: Trisomy 21, 18, 13 ☑ Yes

OPTIONS (no charge)
Fetal sex* ☐ Yes
Sex chromosome aneuploidy^ (singleton only) ☐ Yes

*Based on the presence [illegible] chromosome. For [illegible] this could indicate either two females (if absent) or at least one male.
^If sex chromosome aneuploidy is detected, the fetal sex will be revealed.

OPTIONAL SPECIALISED TESTING (additional charge)
Genome-wide NIPT# ☐ Yes

Including screening of autosomal aneuploidies, including gains and losses >7Mb. This option must be requested by the requesting doctor prior to sample collection. This option includes screening for sex chromosome aneuploidy in singleton pregnancies. [illegible] for information before ordering.

Is this a ☐ **RE-COLLECTION?** Previous Lab ID _____

Staff ID/Location	☐ 1 x NIPT tube	Date re-collected / /	Time re-collected :	Re-collect PAY CAT
				SGUN

Clinical information **REQUIRED**

This section must be completed for testing to proceed.

Please note: The requested clinical information is essential for test accuracy. If any of the clinical information you provide below needs updating, please notify the laboratory immediately.

NUMBER OF FETUSES
(assumed singleton, unless otherwise indicated)
☐ Twin pregnancy

GESTATIONAL INFORMATION
☐ LMP ___/___/___ (date) or ☐ EDC ___/___/___ (date)

The presence of any of the following invalidates the NIPT result; an alternative test should be considered.
- Taken at less than 10 weeks' gestation
- There are three or more fetuses
- There is known presence of a demised fetus
- There is known presence of maternal aneuploidy, maternal transplant or maternal malignancy

NIPT is not a test of fetal viability.

Requesting doctor

Name _____
Address _____
_____
_____
Phone _____ Provider No. _____

I confirm that this patient has been counselled about the purpose, scope and limitations of the test and has given consent.

DOCTOR SIGNATURE
X _____ Date

Copy reports to

Name _____
Address _____
_____
_____

FOR THE PATIENT – Patient and Financial Consent

I consent to the non-invasive prenatal test (NIPT) being performed and confirm that I have been advised about the purpose, scope and limitations of the test. I understand that I can request further information or genetic counselling before or after the test. I understand that NIPT is primarily a screen for an extra copy of chromosomes 21, 18 and 13, and can potentially examine other chromosomes as requested by my doctor on this form.

I understand that the result of this test should be interpreted by my doctor in conjunction with other clinical information and tests, and that it should not be the sole basis for making a decision about my pregnancy. I understand that a second blood collection may be required, that a small percentage of tests do not yield a result due to biological factors, and that I can seek a refund if there is no result for chromosomes 21, 18 and 13. A refund is not available if there is no result for sex chromosome abnormalities/fetal sex/other chromosomes.

☐ I do not agree to the laboratory contacting my treating doctors to obtain information and results regarding this pregnancy for quality assurance purposes.

PATIENT SIGNATURE
X _____ Date

Full payment is required prior to sample collection. Medicare benefits do not apply.
Following payment, you will receive an email and SMS confirmation of your booking.
Please make sure to bring this request form and booking confirmation with you on the day.
To locate a collection centre for your NIPT, please visit sonicgenetics.com.au/locations

FOR THE COLLECTOR

I certify that I established the identity of the patient named on this request, collected and immediately labelled the accompanying specimen(s) with the patient's name, DOB and date/time of collection.

Collector initials	☐ 1 x NIPT tube	Patient initials
Location code	Date collected / /	PAY CAT
Collection type	Time collected :	SGU

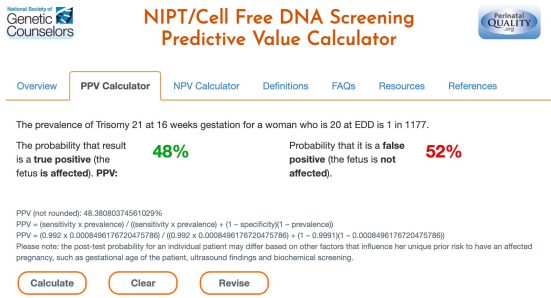
Sullivan Nicolaides Pty Ltd ABN 38 078 202 196,
a subsidiary of Sonic Healthcare Limited ABN 24 004 196 909 APA 906
24 Hurworth Street, Bowen Hills QLD 4006 | **P** (07) 3377 8666 | **E** patientservices@snp.com.au
snp.com.au

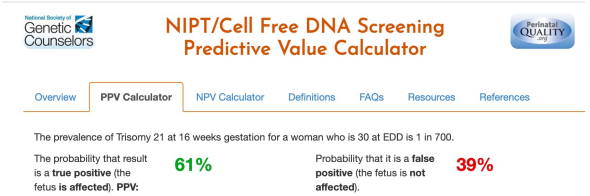
Sonic Genetics

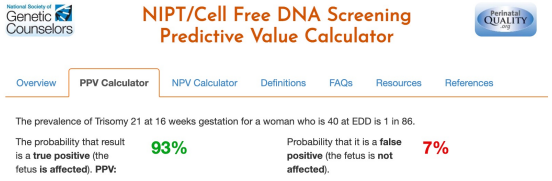
Item 38820 Meridio 426831
ISSUE MAR 2022

NIPT

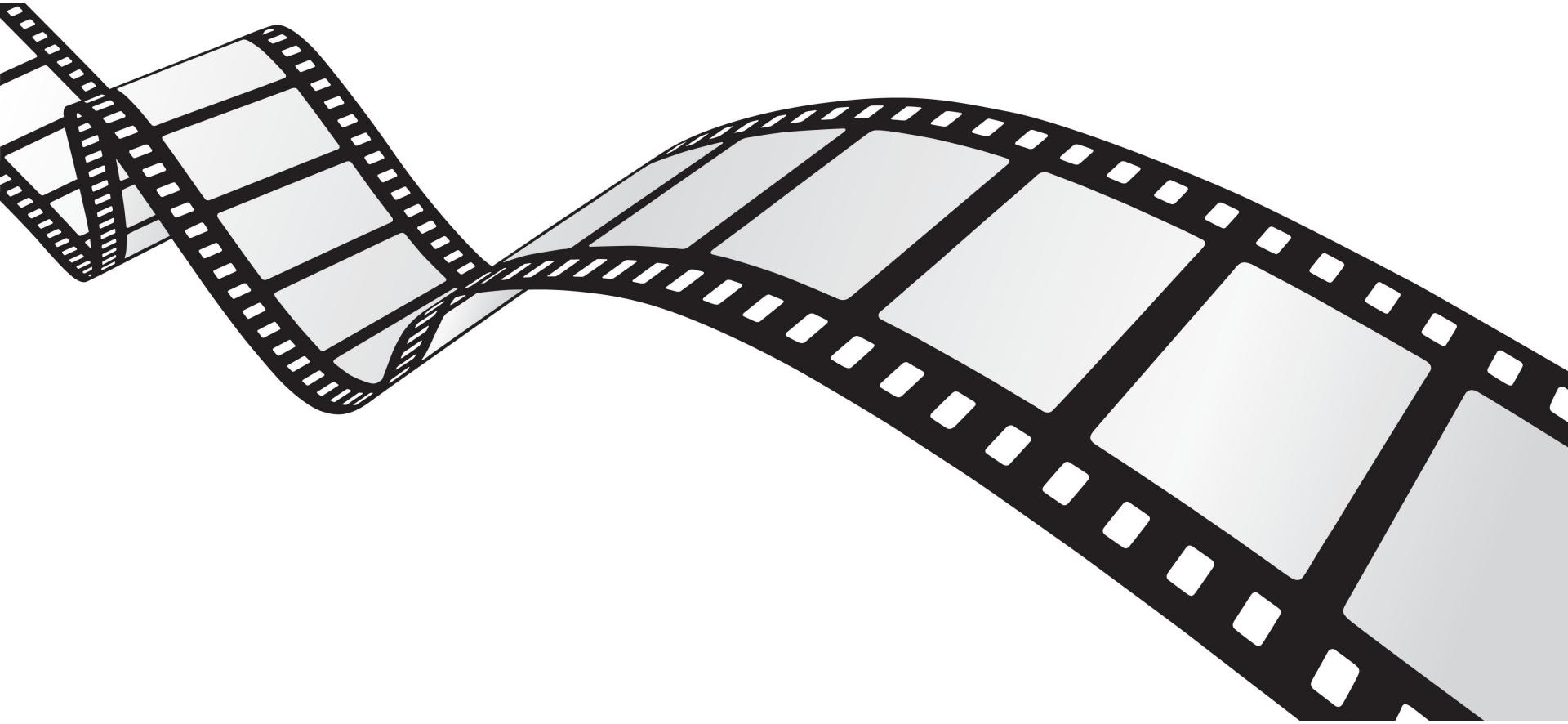
- NIPT is VERY good at excluding a trisomy. If negative, the negative predictive value is >99% at any age
- NIPT's accuracy when it comes to a positive result however depends upon the age of the mother. The younger she is, the lower the pre-test probability and the more likely the positive result is a false positive
- CVS or Amnio is ALWAYS recommended after a high chance NIPT result
- Online calculator https://www.perinatalquality.org/vendors/nsgc/nipt/







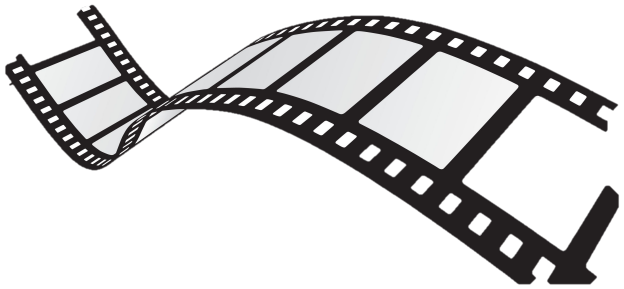
Break - we resume at 10:30



Introducing MMH & Support services

Welcome to **Mater Mother Hospital** Virtual tour

PAC - Pregnancy Assessment Centre



Parenting Support Centre

SESSION 2:

Time	Session	Who
10:30	**Physiotherapy**	Megan Newell Physiotherapist
10:40	**Mental health** – general principals	Den Davies-Cotter (video) CNC Perinatal Mental Health Dr Wendy Burton
10:55	**Pharmacology** & pregnancy	Dr Treasure McGuire Pharmacist
11:10	**Case work** All Dr Wendy Burton Facilitator Dr Gabriel James Obstetrician	Anne Williamson (GPLM) Nicola Adams Annette Parry Diabetes Educator/Clinical Midwife Sue Whiteman Gabriela Lacey Louise Duncanson
12:50	**Conclusion**	Dr Wendy Burton

Physiotherapy in the child-bearing year

“Before & After”

A physiotherapy guide to staying comfortable and healthy before and after childbirth

http://brochures.mater.org.au/brochures/mater-mothers-hospital/before-and-after-a-physiotherapy-guide-to-pregna

Download the booklet to help women learn more about:

- the physical changes in their body
- positions of comfort to use in pregnancy and labour
- strengthening exercises to maintain and regain muscle strength and improve posture
- general guidelines for exercise before and after pregnancy
- how to prevent back pain by taking care of your back in daily life
- relaxation as a skill for life
- baby handling skills to assist your baby’s development

Physiotherapy in child-bearing

How can we help?

Mater Mother's Physiotherapists provide care for all women birthing at Mater, including those cared for through GP Shared care.

This care is provided:

- Antenatally
- During hospital stay post birth
- Postnatally

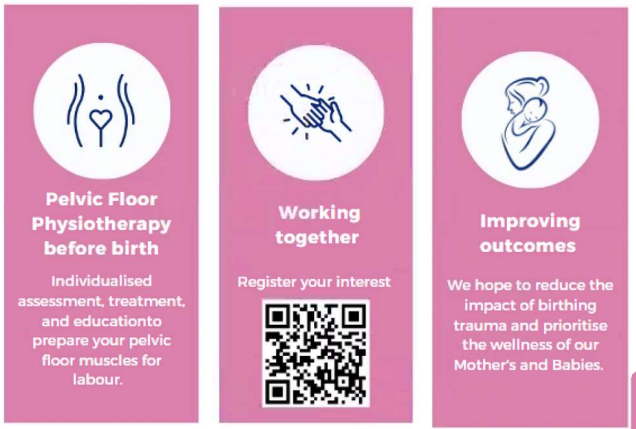
mater mothers

Do you feel prepared to push during labour?

"Prepare to Push" is a Mater Mother's Physiotherapy initiative designed to help women intending vaginal birth, prepare their pelvic floor for birth.

Evidence suggests that 1 in 3 women who 'push' actually activate their pelvic floor muscles instead of relaxing them. This can lead to obstructed labour, prolonged second stage, and greater reports of birthing trauma.

Scan the QR code below to register your interest!



matermothers.org.au

Physiotherapy services

Support for women as they 'prepare to push':

Who is the most at risk?

- A history of painful intercourse or pelvic pain (incl endometriosis)
- History of chronic constipation
- Women <160cm in height and south-east Asian background
  Women with large gestational size relative to their height

What is offered?

Predictive pelvic floor muscle screening and assessment for all antenatal women from 20 – 24 weeks.

- Up to three individualised physiotherapy sessions to 'prepare' the pelvic floor including home exercise program
- Perineal measurements and risk screening in each session
- Communication with care providers if indicated

- **How to refer?**
- Women birthing at the Mater Mothers can self-refer via the patient information QR code
- You can send an email with patient's URN to physio.mmh@mater.org.au

Physiotherapy services

ANTENATAL

Obstetric and Pelvic Floor appointments:

Public Outpatient Physiotherapy for all women booked to birth at Mater Mothers (public)

- **self-referral** (Phone: 3163 6000 select option 2 and 2)
- **GP**s referral (Fax: 3163 1671)

Please contact us if you have any concerns about your patients timely, responsive, Physiotherapy care – we really appreciate your feedback and suggestions.

Private Physiotherapy is also available through Mater Health and Wellness Clinic (Phone 3163 6000 select option 1 and 2)

ANTENATAL

Pelvic and back pain: (pelvic girdle dysfunction, pubic symphysis dysfunction, coccyx pain, lumbar or thoracic spine)

Online resources for patients:
https://matermothers.org.au/journey/pregnancy/moving-and-resting-well-in-pregnancy

Upper limb postural pain and wrist conditions (i.e. Carpal tunnel Syndrome). **Seek advice early**.

See online resources for self management advice:
http://brochures.mater.org.au/brochures/mater-mothers-hospital/pregnancy-carpal-tunnel-syndrome

Physiotherapy services

ANTENATAL

Pelvic Floor dysfunction (incontinence, obstructed defaecation or pelvic pain)

Encourage patients to do pelvic floor exercises and seek Physiotherapy assessment if concerned. Avoid constipation.

Online resources for patient:

Pelvic floor exercises https://youtu.be/OArrUPQqCHM

Exercise in pregnancy

Benefits include better weight control, improved mood and fitness, decreases risk of PIH and pre-eclampsia

Online patient resources:
Being active in pregnancy (https://youtu.be/8A3Eex8l4lg)
Easy exercises to do at home (https://youtu.be/xwFFGfZwizA)

Physiotherapy services

ANTENATAL

Groups:

Pregnancy Birth and Beyond

This session is offered via a video link (from home) or in person and is a part of the antenatal education program.

It includes:

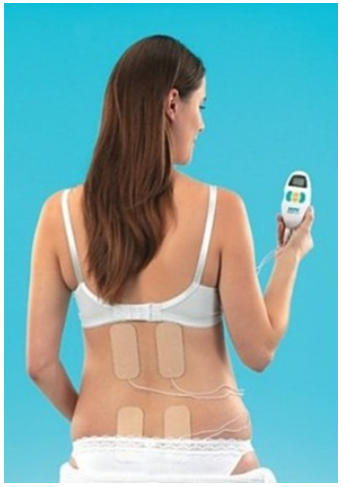
- Body awareness, movement and stretches
- Activating and using your core and preventing strain
- Being active in pregnancy and after birth
- Tool box to reduce pain and tension now, in labour and after birth

Online resources:
https://matermothers.org.au/journey/childbirth/movement-during-labour

Book through Parent Education Phone: 3163 8847

Physiotherapy services

ANTENATAL



Groups:

TENS in Labour (from K37)

This session is for women birthing at the Mater wishing to use TENS as a pain relief option in labour and includes hire of a TENS unit

Self referral Phone: 3163 6000 (select option 2 and 2)

*Please book **EARLY** to attend at K37*

More information:

- http://brochures.mater.org.au/brochures/mater-health-and-wellness/tens-in-labour
- How much does it cost?

  A total of $150 ($100 deposit, $30 hire fee & $20 for gel pads)

  is payable at the class

ACUTE POSTNATAL – HOSPITAL

Physiotherapy review (typically day 2 post birth) provides information and advice to patients assisting:

- Early recovery
  - Acute management of their CS/perineal area (swelling management, wound support)
  - Education on bowel and bladder
  - Discussion around back care and exercises provided
  - Care of abdominal area including how to get in and out of bed
  - Acute pelvic floor exercise
- And recovery post acutely (2-6 weeks)
  - Progressions of pelvic floor exercises
  - Return to exercise guidelines
  - Indications and options for follow up physiotherapy

Physiotherapy services

POSTNATAL

Groups:

Postnatal Review

This session is recommended for **all postnatal women** 4-6 weeks post birth and can be **booked by women directly**. Phone: 3163 6000 (option 2 and 2)

This group session covers:

- Expected physical recovery post birth
- Abdominal wall recovery and exercise progression
- Pelvic floor recovery including pelvic floor exercise, bladder and bowel function
- Returning to activity and/or exercise after birth
- Caring for yourself while caring for your baby
- Where to find more information and individual support from Physiotherapy

Physiotherapy services

POSTNATAL

Groups:

Mother - baby wellness group

This session is for women 6 weeks to 6 months post birth who are seeking support for their emotional wellbeing.

- The series runs for several weeks with a focus on exercise, play and wellbeing for mums and bubs.
- BOOKINGS VIA HCP REFERRAL ONLY
- Please Fax referral to 3163 1671

Physiotherapy services

POSTNATAL

Obstetric and Pelvic Floor appointments:

- **Public Outpatient Physiotherapy** for all women who have birthed at Mater Mothers (public)
    - **self-referral** (Phone: 3163 6000 select option 2 and 2)
    - **GP**s referral (Fax: 3163 1671)
- Please contact us if you have any concerns about your patients timely, responsive, Physiotherapy care – we really appreciate your feedback and suggestions.
- **Private Physiotherapy** is also available through Mater Health and Wellness Clinic (Phone 3163 6000 select option 1 and 2)

Physiotherapy services

POSTNATAL

- **Pelvic floor** (Incontinence, prolapse, obstructed defaecation or pelvic pain)
- **Musculoskeletal concerns** (pelvic, back, wrist, hand)
- For more information on thumb and wrist pain:
- http://brochures.mater.org.au/brochures/mater-mothers-hospital/thumb-and-wrist-pain
- **Third or fourth degree tears**
- Physio assessment by phone at 10 days and face to face at 6 weeks. For more information on acute perineal management:
- http://brochures.mater.org.au/brochures/mater-mothers-hospital/recovering-from-third-and-fourth-degree-perineal-t

Families in Mind

Den Davies-Cotter

CNC Perinatal Mental Health

Catherine's House

Comprehensive, integrated perinatal mental health service

- 10 in-patient beds for public (8) and private (2) patients
- Parent Support Centre for parents and babies up to six months after birth
- home-visiting service to help improve infant-parent relationships
- individual and group therapy treatments and day programs

Families will receive care from a multidisciplinary team of psychiatrists, lactation consultations, allied health practitioners, paediatricians, nurses, and other professionals.

Mental Health – general principals

1. Identify women at high risk and provide personalised, appropriate advice, treatment or referrals
    - Past personal history
    - Family history
    - Psychosocial factors & precursors

1. Screen all women every pregnancy –
    - as a minimum, use a standard screening tool at 28 weeks and again at 6 weeks post partum e.g. EPDS, K10, DASS21, ANRQ

What do you do with what you find? (Poll)

iCOPE

- Screening tool to be rolled out to all women having public maternity care across Qld from Nov 2022
- Women will have access to a consumer report they can share/show their clinicians
  - This includes hyperlinks to information, resources and referral suggestions
- If they have given consent, a clinician report will be viewable in My Health Record

Management of mental illness in the perinatal period

Consider all options including :

- lifestyle
- appropriate supports
- resources

Options include:

Pregnancy support counseling—no Mental Health Plan required, 3 Medicare funded visits

Search for eligible psychologists at www.psychology.org.au

Maternal Mental Health

Management of mental illness in the perinatal period

- Mental health assessment – plan/manage/refer as appropriate
  - medication
  - psychologist
  - psychiatrist
- GP psychiatry support line 1800 16 17 18
- BSPHN has funding for mental health support of at-risk groups, including perinatal presentations 1800 59 52 12
- Mater - public outpatient service for women with complex mental health issues, Catherine's House will be operational in 2023
- Belmont Private Hospital

Management of mental illness in the perinatal period

If public specialist assessment is required:

Metro South Acute Care Services
(1300 MH CALL = 1300 64 22 55)

- Offer initial triage and assessment for severe or complex presentations.
- Provide expert advice on management and medications.

Services provided by Families in Mind (FiM) include:

FiM has capacity to offer a maximum of 6 appointments to each patient. The support offered includes:

- An initial mental health assessment
- Providing information/psychoeducation regarding mental health concerns e.g. postnatal depression, anxiety, attachment and bonding issues, sleep hygiene, adjustment issues, coping with stressful situations, parenting advice, healthy lifestyles, new family dynamics
- Advice on treatment options
- Referrals for specialist support e.g. community psychologists, parent aide, parenting programs, mother-baby in-patient programs
- Co-ordinated care with midwifery/obstetrics/GP and other community stakeholders
- Counselling and brief interventions
- Telephone advice for patients, GPs, and other health care workers

Families in Mind

FiM OUTPATIENT CLINIC FiM also offers a limited number (6) of outpatient sessions for perinatal mothers living within the Mater Hospital catchment area who need 1:1 mental health assessment and treatment.

REFERRAL : Phone 3163 7990 (Monday – Friday 0830 -1700), or email materinmindintake@mater.org.au Please include :

- Patient details, contact information, MMH booking status
- Risk assessment
- current medical issues, past psychiatric history
- reason for referral (clinical question to be answered),
- relevant additional information- whether the request is for the patient to be seen antenatally, postnatally, or during their in-patient stay and that the patient is aware and has consented to the referral.

FAMILIES IN MIND
REFERRAL FORM

MATER PERINATAL MENTAL HEALTH SERVICE

AFFIX PATIENT ID LABEL HERE (if available)

Please email completed form to: materinmindintake@mater.org.au or fax to (07) 3163 1636
Telephone enquiries: 3163 7990

PATIENT DETAILS

Patient Name:	**DOB:**
Patient consents to referral: ☐ Yes ☐ No	**Medicare Number:**
Home Address:	
Email Address:	**Mobile Number:**
Country of Birth:	**Interpreter requirements:**
Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and TSI ☐ Neither Aboriginal nor TSI ☐ Not stated or unknown	
If Antenatal- EDC:	**If Postnatal- number of weeks:**
Baby's Details (if applicable): **Name:** **Date of Birth:** **Gender:**	**Alternative Support Person Details:** **Name:** **Relationship:** **Contact Number:**

REFERRAL DETAILS

Reason for Referral/Presenting Issue:

Relevant clinical background (eg mental health history, current treatment including medication etc):

Other relevant information:

REFERRING CLINICIAN DETAILS

Name:	**Role/Delegation:**
Organisation/Clinic:	**Best Phone Number:**
Email:	**Referring Clinician's Signature:**

Take home message

- Perinatal mental illness is a significant cause of morbidity and mortality, affecting maternal and neonatal outcomes, the health of families and of the community.
- EPDS completed at her booking in appointment. As per the PHR (Pregnancy Health Record) please administer EPDS (or K10 or DASS21 or ANRQ) again by 34 weeks, at 6 weeks post partum and prn
- Identification and appropriate treatment is essential to promote optimal outcomes
- **Suicide** is the leading cause of maternal death in Qld

Every woman, every time….

Are you ok?

COPE:

How do you ask women about DV?

"In addition to the blood tests and ultrasound scans we recommend in pregnancy, we ask every woman questions about how she is feeling and if she is safe. Anxiety, depression and domestic violence are common conditions and they may occur for the first time or get worse in pregnancy."

"Are you safe?"

Domestic and Family Violence (DFV) Local Link

- Brisbane South PHN initiative to help primary health care become part of an integrated system response to domestic & family violence
- The DFV Local Link offers a one-point of referral for patients affected by DFV & can provide advice & support for general practices

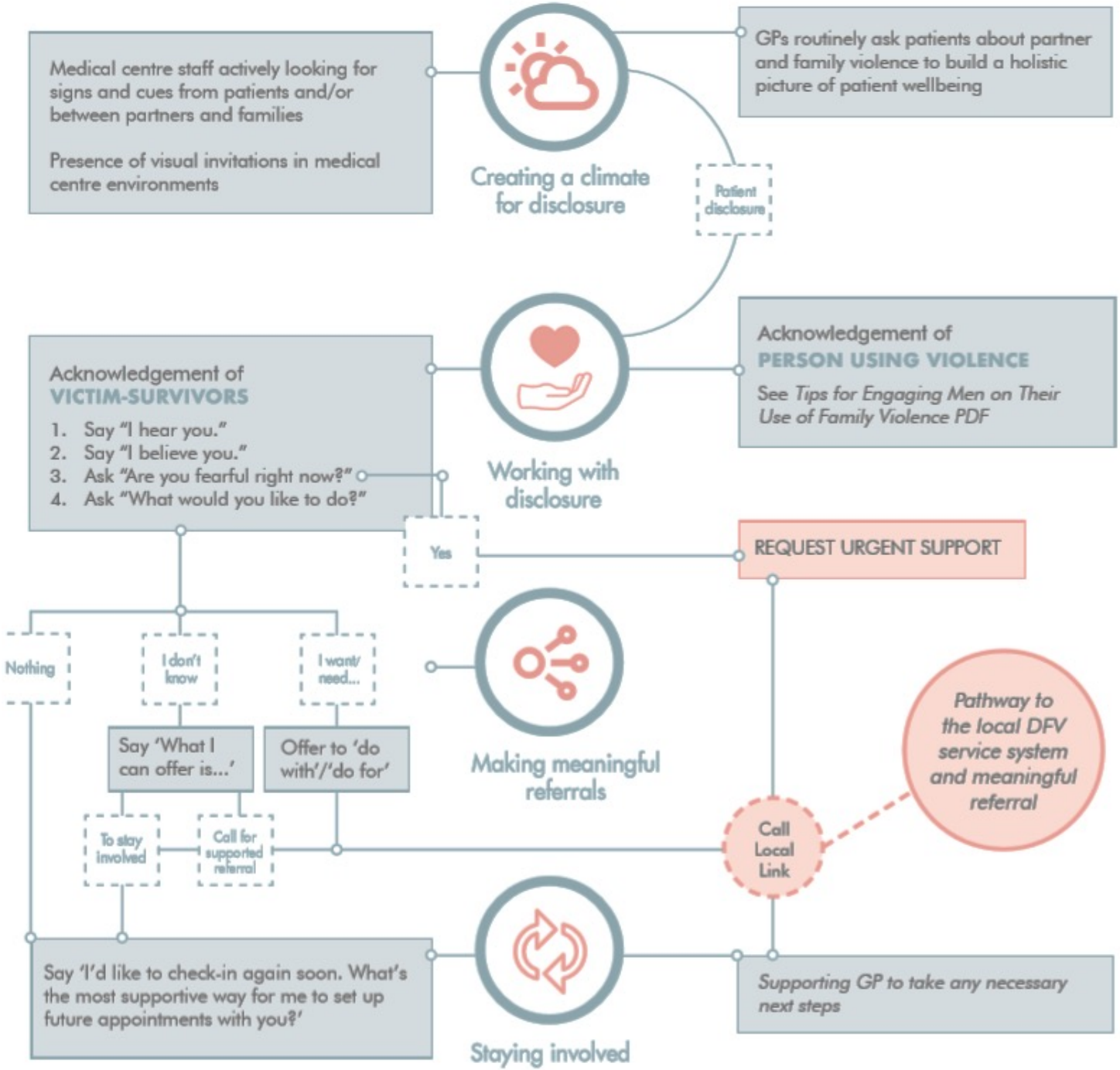
- Patients can be referred to the DFV Local Link if they are affected by DFV and are a patient of a general practice in Brisbane, Logan, Redlands or Beaudesert. More information and contact details for your DFV Local Link are found at https://bsphn.org.au/support/for-your-patients-clients/domestic-and-family-violence/

- The DFV Local Link support referred patients by conducting risk assessments, providing advice on next steps, and connecting them with supports and services. The Brisbane DFV Local Link also provides case work support to patients.

Landline: 3013 6035
Hannah's Mobile: 0488-180-590
Summer's Mobile: 0419-757-257

Contact your Brisbane DFV Local Link:
bdvslocallink@micahprojects.org.au

Recognise
Respond
Refer



mater

DFV Local Link

Management

Organise a 2nd appointment without partner if possible

Resources

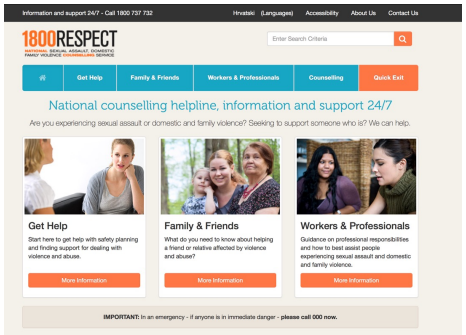
- Domestic Violence Hotline 1800 811 811
- 1800Respect 1800 737 732

Facilitate early referral to hospital

- Flag concerns/suspicions
- Enable social worker support

MMH telehealth appointments

MW unable to ask DV questions due to no assurance of privacy. GP's to ask early please notify concerns



Please use available resources and tools

Notify	Notify the Social Workers
Alert	Alert MMH to the risks so that they can triage most effectively
Communicate	Communicate with other care providers
Screen	On page 3 (QHealth a10) of the Pregnancy Health Record (PHR) is the Tobacco Screening Tool. Use it.
Screen	On page 4 (QHealth a11) of the PHR are the Alcohol and Drug Screening Tools. Use them.

Reducing stillbirth

To register for the Safer Baby Bundle free eLearning, please visit

https://learn.stillbirthcre.org.au

For more information on how to register for the eLearning module, please visit

https://vimeo.com/352404965

Pharmacology and pregnancy

Dr Treasure McGuire, Pharmacologist

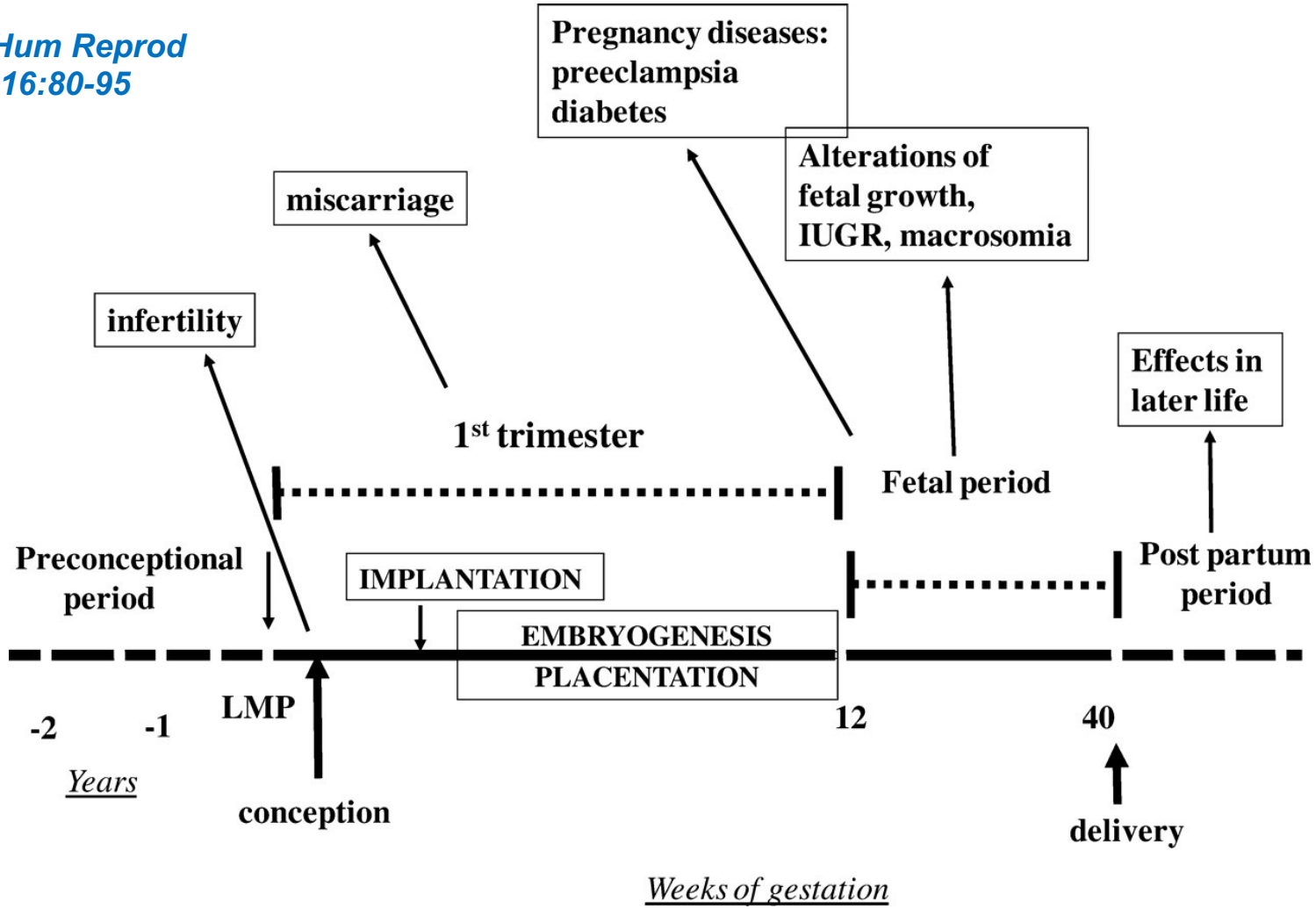
General principles

Introduction - general pharmological principles including supplements and CAMS	Dr Wendy Burton, MBBS Chair, MMH MSC Alignment Committee Maternity Lead, GMSBML & Dr Treasure McGuire, Pharmacist and Pharmacologist Mater, UQ and Bond University	 Video (≈17 mins)
General principles, organogenisis, ADEC categories	Dr Wendy Burton, MBBS Chair, MMH MSC Alignment Committee Maternity Lead, GMSBML & Dr Treasure McGuire, Pharmacist and Pharmacologist Mater, UQ and Bond University	 Video (≈10 mins)

Pregnancy stages:

Represent a continuum, from pre-conception to post-partum

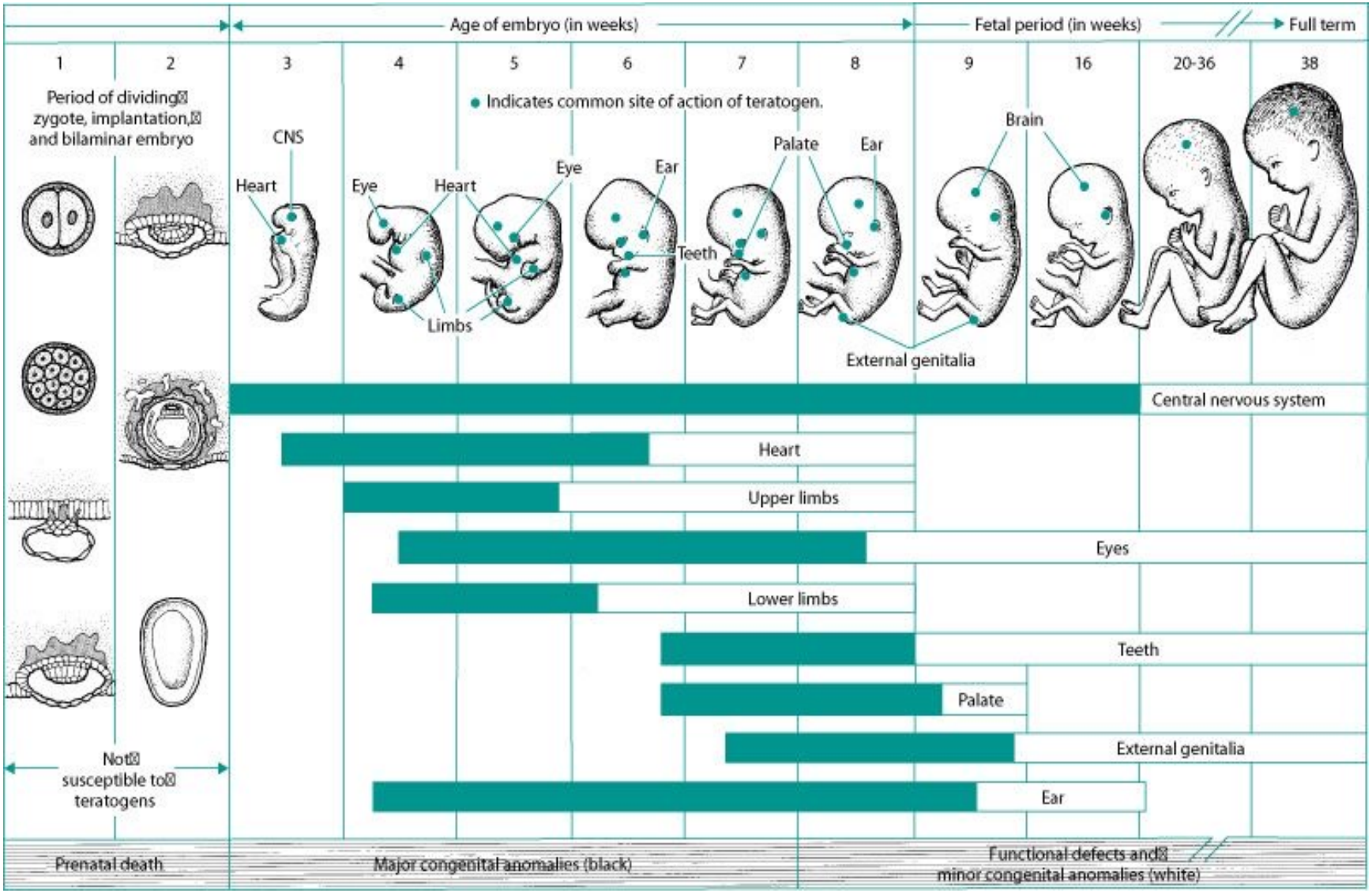
Cetin I et al. Hum Reprod Update 2010;16:80-95



Wk	*Period*	
0-2*	Conception	Nutrients / drugs are transferred into luminal secretions of fallopian tube & uterine cavity through which ovum then blastocyst must pass. Drugs can kill but cannot cause congenital malformations
2	Implantation	Vascular connection between mother & fetus are established
2-8	Embryo-genesis	As now a direct connection between the maternal & fetal circulation, this is the period of organ formation e.g. Heart - days 18 - 40 Brain - days 18 - 60 Eyes - days 25 - 40 Limbs - days 25 - 38^{6} Genitalia - days 40 - 60
8-<22	Organ function	As organs are now formed, the focus is on organ and tissue growth & function
>22	Fetogenesis	Fetus takes on progressively more responsibility for nutrient/drug intake and elimination, but does so less efficiently than the mother → drug accumulation (with chronic use) .. Period of 'fetal toxicity' Histogenesis of CNS continues postnatally -> behavioural development

Organogenesis calendar (from conception) differs from an obstetric calendar (counts from LMP

Drug impact on organogenesis



Tuchmann-Duplessis H. Drug effects on the fetus. New York: ADIS Press; 1977.

Meet the MMH midwives

Anne Williamson, GPLM

Nicola Adams, Midwife

Annette Parry, Diabetes Educator/Clinical Midwife

Sue Whiteman, Midwife

Gabriela Lacey, Midwife

Introducing our obstetric subject matter expert: Dr Gabriel James

Specialty: Obstetrics and Gynaecology
Clinical Interests: All risk obstetrics, early pregnancy, reproductive endocrinology, laparoscopic and vaginal surgery, fertility restoring surgery.
Other Languages: Conversational Spanish

Consult Rooms
ObGyn Australia
Suite 7, Level 6, Mater Medical Centre
293 Vulture Street
South Brisbane QLD 4101
Ph 07 3844 9917

Case work :

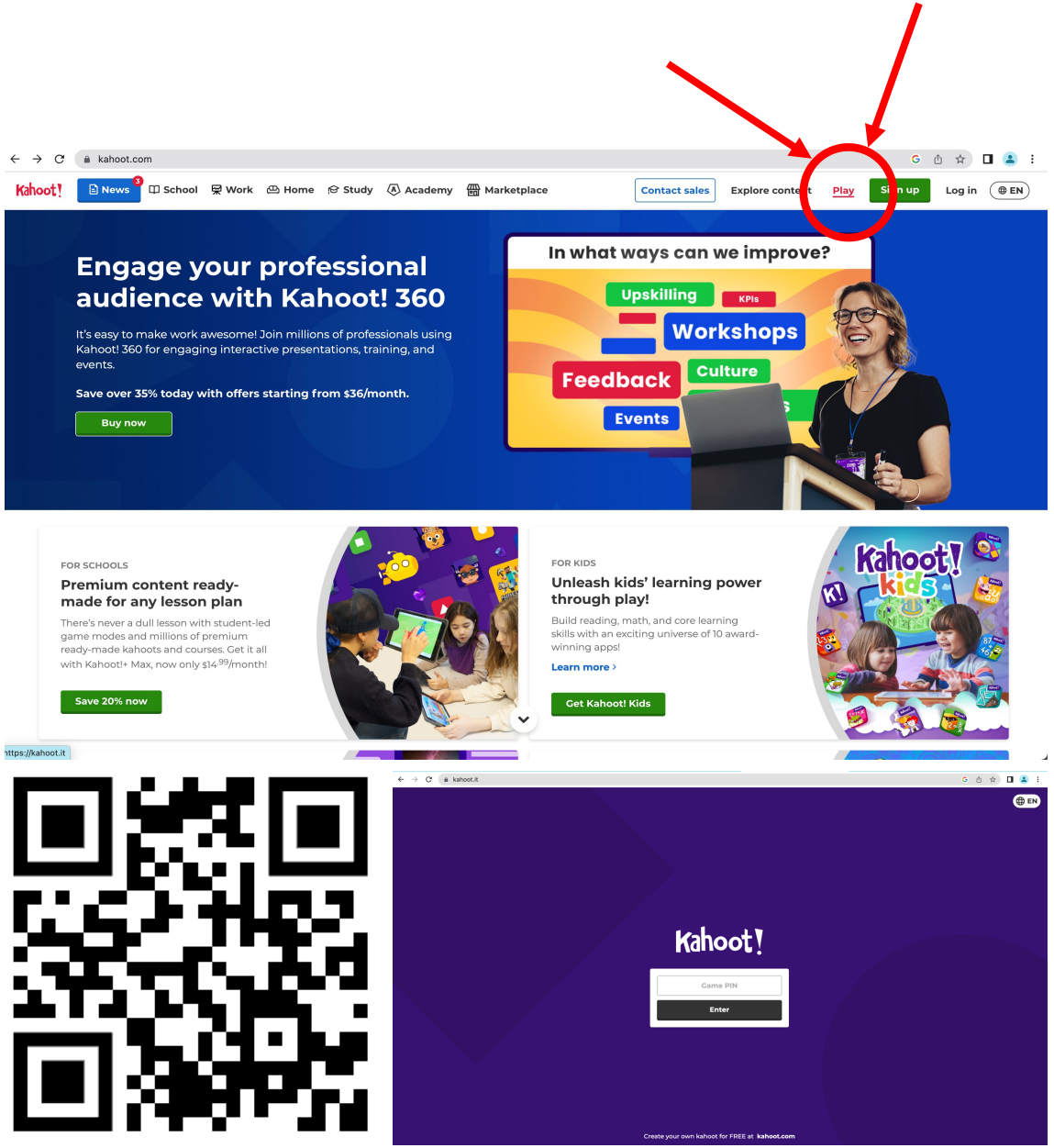
Jodie is a 24yo primip who has come to you to confirm her pregnancy and to find out what she needs to do next.

Identify for Jodie, your individualised PLAN for:

- Assessment
- Screening/investigations
- Ongoing management
- Referrals & resources

Kahoot poll

https://kahoot.com



Summary of key points

Antenatal Appointment Schedule

6-12 week visit

- Confirm pregnancy
- Obtain medical and obstetric history
- Measure BP, record height and weight, and calculate BMI
- Discuss antenatal screening and testing options
  - Ultrasound scans
  - Bloods/urine, depending upon risks
  - Organise CST if due
- Discuss models of care
- Discuss anti-D with Rh negative women
- Review with results and refer to MMH with the information above
- Review post anomaly scan and follow up/referrals prn

Summary of key points

Antenatal Appointment Schedule

18-20 week visit

- Review morphology scan and follow up/referrals prn
- Organise follow up of placental position prn
- Confirm EDC, if not already done

24 weeks

- Routine AN assessment ? Additional care required
- Fundal height and health promotion/parent education

28 weeks

- As above + FBC, Blood group antibodies, Syphilis, GTT +/- Ferritin +/- antiD
- EPDS, DV, drug and alcohol screening
- Discuss infant feeding, Vit K and Hep B
- Discuss and commence birth plan
- When to go to hospital
- Consider discharge planning

Summary of key points

31 weeks

- As above, review results and follow up prn
- Confirm consent for Vit K, Hep B

34 weeks

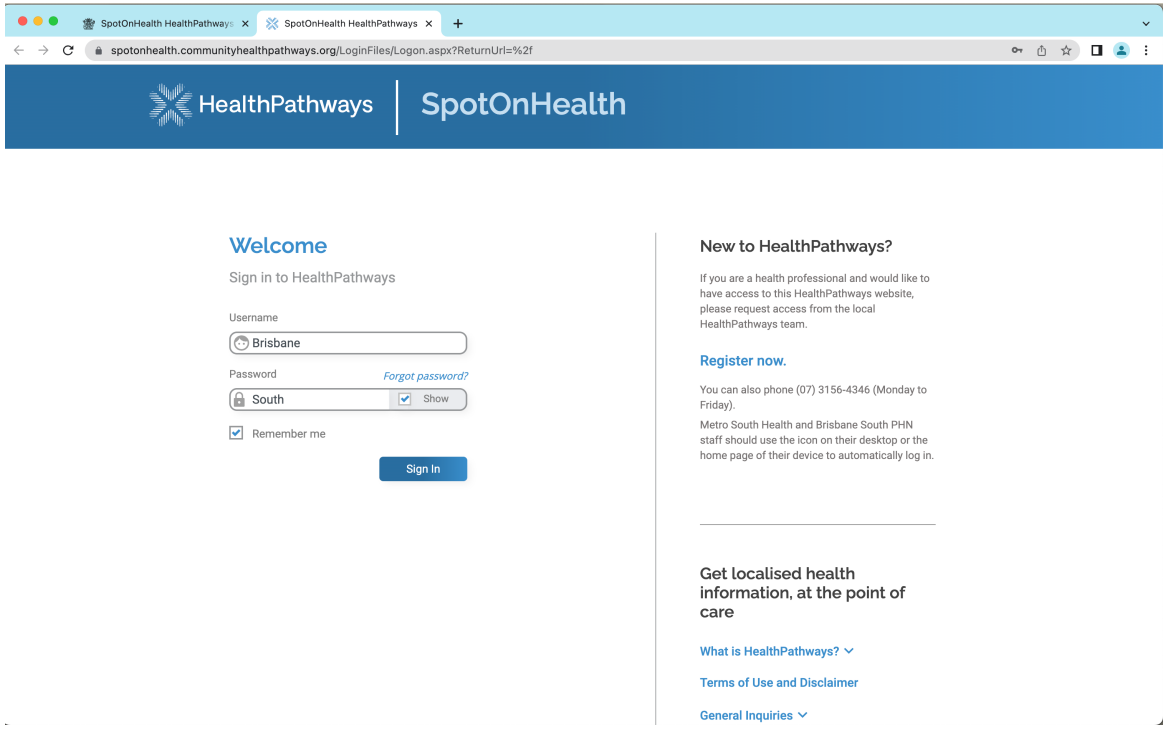
- AntiD prn
- Repeat USS if low lying placenta on morphology scan
- Routine assessment, reassess schedule
- Order 36 week bloods (FBC +/- Ferritin +/- Syphilis)
- Discuss birth preferences

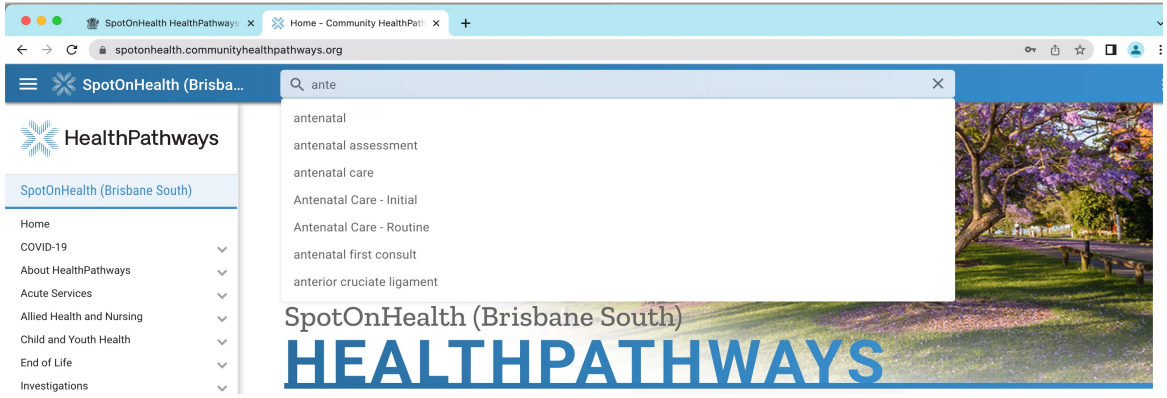
38 & 40 weeks

- Routine assessment
- Confirm understanding of the signs of labour and indications for admission to hospital

Please enquire or inform women about….

- Breastfeeding intentions and availability of support e.g. ABA, Mater Parent Support Centre, brochures
- Vit K
- Hep B
- Birthing preferences
- When to go to hospital
- Post natal checks





Health Pathways can help!

Case work discussions:

- Scenario 1: FADUMA

Faduma is a 25yo Somalian lady.

She has a Hb 104, MCV is low.

She presents with hyperemesis at 10wks.

She reports that a child in her daughter's day care has been diagnosed with chicken pox.

Identify the risks for Faduma, your assessment and management/action plan.

Consider what resources you might utilise

Case work discussions:

Scenario 2:

Sharon is 30yo Torres Straight Islander lady who is newly pregnant.

She has a BMI of 33 and a history of a macrosomic baby

She has essential hypertension treated with ACE inhibitors.

Identify the risks for Sharon and your assessment and management/action plan.

Consider what resources you might utilise

Case work discussions:

Scenario 3: DEVINA

Devina is a 38yo primip, G1P0 who has presented for her routine AN appointment at 28wks.

She is rhesus negative and her BP is 155/95 mmHg
She has rushed to get to her appointment and tells you she has an urgent meeting which she must attend immediately after her appointment. She mentions that she has had a headache all week.

Identify the risks for Devina and your assessment and management/action plan.

Consider what resources you might utilise

Case work discussions:

Scenario 4: KATE

Kate is 34yo lady who presents with an unplanned pregnancy.

She has a history of Depression and is known to DOCS.
She has a history of Lletz x 2 for CIN 3

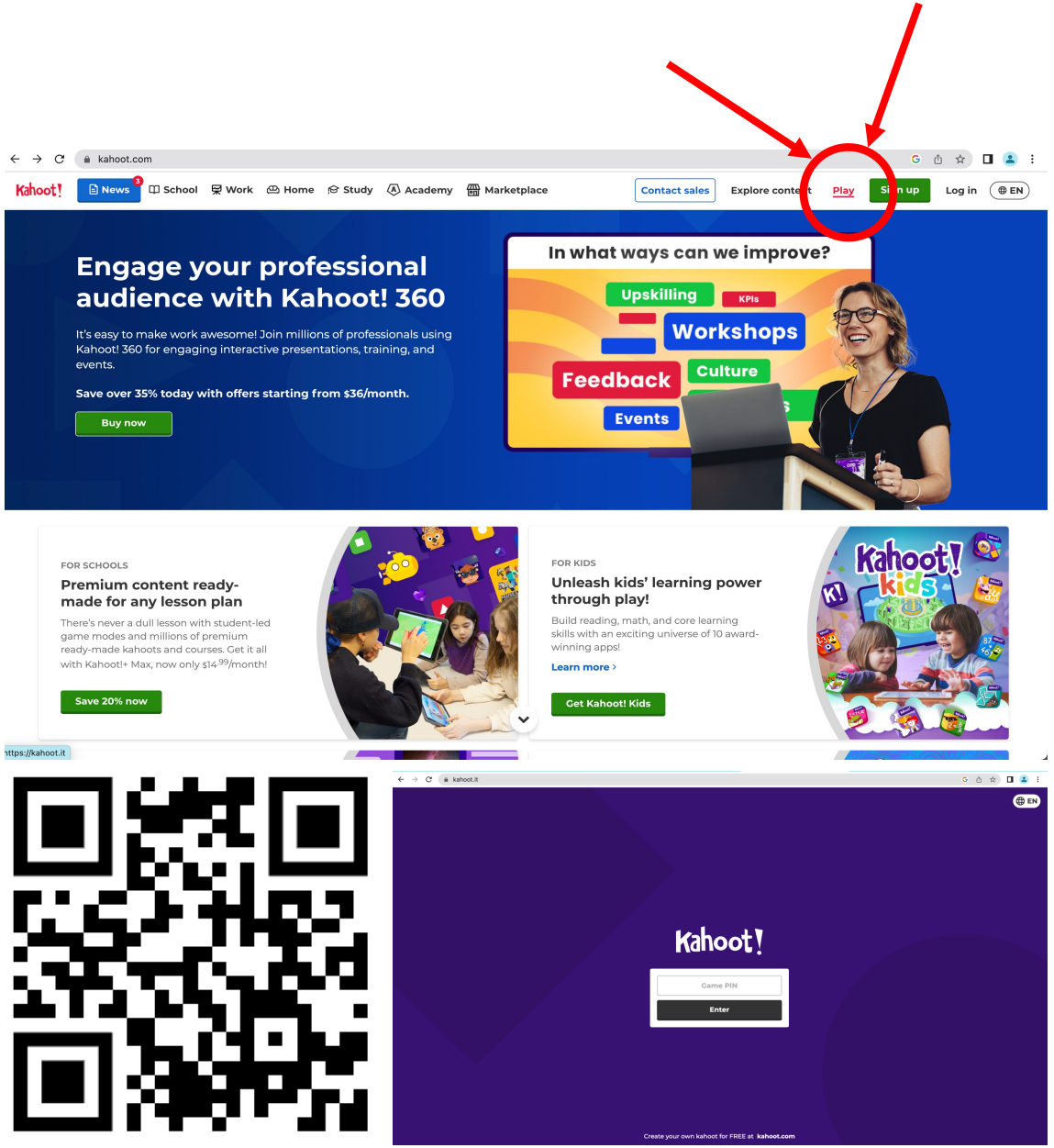
She decided to cease her SSRI medication when she found out she was pregnant

Identify the risks for Kate and your assessment and management/action plan.

Consider what resources you might utilise

Kahoot poll

https://kahoot.com



Please watch out for AOTC

We will keep you updated e.g. about changes to the GDM pathway, guideline changes, immunisations, education events. AOTC, including past editions, is available online

Summary of key points

Routine first trimester Antenatal Screen (ANS)

- FBC, Blood group and antibodies, Rubella, ferritin
- Hep B, Hep C, HIV, syphilis and MSU m/c/s
- CST if due
- Women with BMI > 35 to have first trimester HbA1c or early OGTT if k>12 , E/LFTs urinary protein/creatinine ratio

26-28 week bloods: FBC, OGTT, syphilis and Blood group antibodies (only if Rh –ve) +/- ferritin

36 week bloods: FBC +/- ferritin +/- syphilis

Contact details

Maternity Share Care issues?

- GP Liaison Midwife (GPLM) Phone: 3163 1861
- E-mail: GPL@mater.org.au
- Mobile: 0466 205 710

If you are uncertain about the best approach in caring for or referring a woman, or if she requires urgent review

- on call Obstetric Consultant 3163 1330 (M-F 8.30-4.30)
  3163 6612 (24hrs)
- Obstetric Registrar 3163 6611

Contact details

Alignment status, contact details, evaluation training & RACGP enquiries?

- Phone Mater Education on 3163 1500
- Fax 3163 8344
- Email mscadmin@mater.org.au

Available now!

Online options to realign

- Bridging option (or refresher!) for GPs who complete an Alignment event at an allied hospital

  (Redland, Logan, Beaudesert, RBWH, Ipswich, Nambour!)

- VOPP presentations

- Video clips with Dr Treasure McGuire, pharmacologist

GPs referring to MSHHS?

Dedicated Maternity GP Liaison

Dr Kim Nolan –GPLO General Practitioner – Maternity

Ph: 07 2891 5754 (Tues all day and Friday mornings)

Lisa Miller – GPLM Midwife

Ph. 0428 677 046

Email: GPLO_Maternity_Share_Care@health.qld.gov.au

Their online Bridging Program can be accessed via the GPLM@ GPLO_Maternity_Share_Care@health.qld.gov.au
Please include a copy of your GPs MMH Alignment Certificate

GPs referring to MNHHS?

Contact information for the MNHHS Alignment:

Metro North Maternity GP Alignment Program

Phone: (07) 3646 6852

Email: mngpalign@health.qld.gov.au

Online resources are available under Metro North GP Alignment Program on the Education resources page under "gynaecology resources"

RACGP Events

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27 Apr Webinar

Maternity moments webinar series – First trimester

May Webinar

Maternity moments webinar series – Second trimester

15 Jun Webinar

Maternity moments webinar series – Third trimester

Want to know even more?
Maternity moments, RACGP

Communicate Communicate Communicate

When you have assembled your exhaustive history and have completed your examination and investigations, promptly send your referral to the MMH so the booking can commence and triage can be effectively and efficiently done.

Use the template!

Copy the MMH on ALL investigations.

If an adverse event occurs, such as a miscarriage, let the GPLM know.

If an adverse event occurs at MMH and you are NOT notified, please give this feedback to the GPLM.

Communication is a two way street and gaps can only be closed if they are identified. If MMH contact you about an event, there is contact information – please use it to provide feedback/clarification.

Consultation with women and care givers

We all aim to provide high quality clinical care with ongoing education from us and in seeking advice from others, including:

physiotherapists, dietitians, social workers, pharmacists, lactation consultants, physicians, midwives and obstetricians

USE THEM!

IF IN DOUBT, PHONE A FRIEND!!!

To apply the best practice share care models in antenatal and postnatal care, we all need to be

Clinically competent

Up to date

Following the Guidelines

Thinking

Communicating

Item numbers for MSC

16500 Rebate $42.40 Antenatal Attendance
91853 (video) **91858** (telephone) equivalent of 16500
16591 Rebate $128.15 "Planning and management, by a practitioner, of a pregnancy if:

(a) the pregnancy has progressed beyond 28 weeks gestation; and

*(b) the service includes a **mental health assessment (including screening for drug and alcohol use and domestic violence**) of the patient; and*

(c) a service to which item 16590* applies is not provided in relation to the same pregnancy

Payable once only for a pregnancy"

(16590 = planning to undertake the delivery for a privately admitted patient)

Postnatal item numbers

16407
Postnatal professional attendance (other than a service to which any other item applies) if the attendance:

(a) is by an obstetrician or general practitioner; and

(b) is in hospital or at consulting rooms; and

(c) is between 4 and 8 weeks after the birth; and

(d) lasts at least 20 minutes; and

(e) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and

(f) is for a pregnancy in relation to which a service to which item 82140 applies is not provided (participating RM)
Payable once only for a pregnancy

Fee: $75.80 **Benefit:** 75% = $56.85 85% = $64.45

16408
Home visit for woman who was admitted privately for the birth. Midwife (on behalf of and under the supervision of the medical practitioner who attended the birth) Obstetrician or GP can claim.
1-4 weeks post partum, at least 20 min duration

Fee: $56.45 **Benefit:** 85% = $48

YOU ARE NOT YET ALIGNED!!

You need to :

1. Complete the Questionnaire within 4wks with an 80% pass
   (If not completed in this time frame you will need to submit the points application to the RACGP directly.)

2. Complete your paperwork, this may take up to 8 weeks.

3. Provide evidence of completion of the RACGP ALM

   (Active Learning Module)

4. Please provide your email address

To *maintain* your alignment

By the 3-year mark, you must either:

Do another Alignment:

- at MMH (we have 3 versions) or
- MSHHS or MNHHS and complete an online bridging program + quiz

OR

Complete the MMH online realignment and bridging course (90 minutes) and quiz and complete an attestation form that you have:

a) reviewed the current MMH/GPSC guidelines and/or SpotOnHealth Pathways

b) attended a minimum of 6 hours CPD relevant to Women's Health in the past 3 years. Provide supporting documentation if requested

Conclusion

- Please complete the evaluation and give us feedback
  let us know what we did well and what we could do better
- Let us know if you would be happy to have your contact information available for pregnant women who don't have a regular GP
- Let us know if you would be happy to have MSHHS hold your contact details
- Give us an email address that we will be able to contact/update you on

The End!

GOOD AFTERNOON AND THANK YOU!