

FALL 2003

## INSIDE

## PAGES 2 &amp; 3

Incidence of Eating Disorder and Diabetes

California Perinatal Transport System (CPeTS) News & Updates

Kit for New Parents: San Diego Welcome Baby Program Update: April 2003

## PAGE 4

*continuation of*  
Incidence of Eating Disorder and Diabetes

Order Form & Mailing List Update

## Bulletin Board

## SPECIAL ANNOUNCEMENTS on page 4

Maternal & Newborn Nursing Care Summit Session

March of Dimes Magazine "mama" Free to Perinatal Providers

## CRIBSHEET

The Regional Perinatal System Newsletter

## QUALITY IMPROVEMENT IN PERINATAL CARE

by Lisa Cardenas.MHA

**California Perinatal Quality Care Collaborative (CPQCC)**

The California Perinatal Quality Care Collaborative (CPQCC) is an outgrowth of an initiative proposed by the California Association of Neonatologists (CAN) and supported by the David and Lucile Packard Foundation and the State of California Department of Health Services, Maternal and Child Health Branch.

CPQCC was formed in 1997 and brings together a public-private alliance of stakeholders in the care and outcomes of California's mothers and babies. The collaboration exists to improve the health of pregnant women, infants, and children by collecting high-quality information on perinatal outcomes and resource utilization. This information allows for performance improvement and benchmarking processes in perinatal care and neonatal intensive care units throughout California.

**The CPQCC Collaborative Network**

Over the past several years, CPQCC has been very successful in developing a network of stakeholders interested in improving perinatal health care in California. The CPQCC network consists of public and private obstetric and neonatal providers, health care purchasers, public health professionals and private sector health industry specialists. More specifically, these collaborators include:

- California Association of Neonatologists (CAN)
- American College of Obstetricians and Gynecologists (ACOG)
- California Maternal and Child Health Branch(MCH)
- California Children's Services (CCS)
- California Office of Vital Records (OVR)
- Office of Statewide Health Planning and Development (OSHDP)
- Regional Perinatal Programs of California (RPPC)
- Health Insurance Plan of California

- Pacific Business Group on Health
- David and Lucile Packard Foundation
- The Vermont Oxford Network
- UC Berkeley School of Public Health
- Stanford University's Center for Health Policy and Research (HRP)

These distinguished collaborators serve as the CPQCC Executive Committee which meets regularly to debate, review, prioritize, and plan perinatal quality improvement initiatives.

**The CPQCC Data Center**

CPQCC has partnered with the Vermont Oxford Network (VON) and Stanford University's Center for Health Policy and Research (HPR) to collect and analyze perinatal health data. This data is then used to develop and monitor perinatal quality health improvement projects initiated by CPQCC. Much progress has been made in the development of CPQCC's data center. A web-based reporting format has been developed over the last year, which allows hospitals to view multiple outcomes and interventions broken down by various categories, such as, birth weight, gestational age, inborn or outborn status, etc. A menu also enables hospitals to view tables and figures by subgroup.

The CPQCC Data Center currently supports two major projects:

**(1) The Vermont Oxford Network** – a database enrolling VLBW (less than 1500 grams) infants admitted to NICUs worldwide, with 370 member centers and a ten year cohort of clinical data.

**(2) The CPQCC Selected Big Babies Database** – an expanded VON database enrolling infants with birthweights over 1500 grams who meet specific clinical eligibility criteria, with 60+ member centers in California.

*continues on page 2*



## QUALITY IMPROVEMENT IN PERINATAL CARE

Information generated from these databases, provides CPQCC member hospitals with valuable information that can be used to compare themselves against other unidentified participating hospitals.

In 2000, CPQCC collaborated with the California Children's Medical Services Branch in producing the CCS reports for 19 CCS hospitals with NICUs. In 2001, CPQCC and CCS finalized the reporting format outlining eligibility requirements for member hospital participation, supplemental information required from participating hospitals, report submission procedures and details for program follow-up and evaluation. Due to the success of the CCS/CPQCC joint reporting program, CPQCC began recruiting hospitals for collection of 2001 data. Twenty-four NICUs participated in the joint CCS/CPQCC reporting project. However, it is expected that there will be a significant increase to the number of NICUs participating in the near future, since CCS is now mandating that all CCS-approved hospitals submit annual morbidity and mortality data through participation in CPQCC beginning in January 2004.

**In response to the anticipated increase in membership and data processing needs, the CPQCC Data Center has been offering data training workshops at various locations throughout the state this year. The training sessions provide introductory information about CPQCC, an overview of the data, how to interpret CPQCC reports, and practice case studies. The next training is scheduled for October 24, 2003 at Children's Hospital in Los Angeles. To register, please contact Ahsia Khan at (650) 723-5763 or [ahsia@cpqcc.org](mailto:ahsia@cpqcc.org). Future trainings will be posted on the CPQCC website at <http://www.cpqcc.org/calendar.htm>.**

### **The Perinatal Quality Improvement Panel (PQIP)**

The Perinatal Quality Improvement Panel (PQIP) is a permanent subcommittee of stakeholders with expertise in the area of quality improvement. Through its efforts, CPQCC is building an effective quality improvement infrastructure at the state, regional, and individual hospital levels. PQIP is responsible for analyzing CPQCC data and reviewing the literature for evidence based best practices in perinatal care. Based on its findings, PQIP defines indicators and benchmarks, recommends quality improvement objectives, provides models for performance improvement, and assists providers in a multi-step transformation of data into improved patient care.

CPQCC Toolkits are one of the quality improvement interventions that have been developed by PQIP. CPQCC Toolkits are designed to promote successful quality improvement activities at the hospital level, based on hospital-specific data. To date, CPQCC has developed a series of toolkits, each focusing on key topics related to perinatal care. These toolkits provide valuable information on the following practices:

- Nosocomial Infection Prevention
- Antenatal Corticosteroid Therapy
- Postnatal Steroid Administration
- Reducing Chronic Lung Disease

CPQCC Toolkits can be downloaded from the CPQCC website at <http://www.cpqcc.org>

Additionally, CPQCC offers workshops throughout California where teams of practitioners from member hospitals can work together to develop improvement aims, select processes to improve, develop methods to overcome barriers, and prepare personal action plans.

**The next workshop being offered, "Successful Strategies for Implementing Neonatal Practice Improvements", will be held on October 21, 2003 at Summit Medical Center in Oakland. The workshop will focus on nosocomial infection prevention through appropriate line management and prevention of chronic lung disease through appropriate ventilation management. For more information please contact Ahsia Khan at (650) 723-5763 or [ahsia@cpqcc.org](mailto:ahsia@cpqcc.org). Registration forms can be downloaded from the CPQCC website, <http://www.cpqcc.org>**



## Postpartum care for new mothers and parents by Cathreena San Juan Kang, MSW

For new mothers and parents, the joy of a newborn baby is quickly followed by the realization of this new 24hr a day/7 days a week responsibility. The postpartum period is a time of significant transformation for the mother and family that includes emotional, physical and psychological changes.

Although prenatal care has often been encouraged and supported in our medical practice, postpartum mental health has not had the same attention. There is no designated professional that looks after the mental health of the woman postpartum (<http://intelihealth.com>). The emotional status of a woman whose pregnancy had an abnormal outcome also should be reviewed (Guidelines for Perinatal Care, 2002).

Assessing the woman's mental health should become part of routine postpartum care because many women are embarrassed or otherwise reluctant to seek help (<http://intelihealth.com>). Like many mental health illnesses, women will often hide any indications they feel depressed due to the stigma of depression and expectations they are doing well (Colino, 2002). Higher depressive symptoms were associated with greater everyday stressors, fewer social resources, and greater use of avoidance coping among low-income, single mothers (Logsdon et al., 1994). Providers can inquire how new mothers are coping with their new babies during the postpartum period and well-baby visits. This is particularly important with mothers who have diabetes (type I & II) to assess their physical and emotional conditions while ensuring they continue to successfully manage their diabetes. Not only are they adapting to their role as mothers, but they are also committed to maintaining their own health. Counseling should also address specific issues regarding her future health and pregnancies (Guidelines for Perinatal Care, 2002).

It is important for medical providers to be aware of postpartum education and to communicate the same information to patients. Key topics of patient education include the following:

**Emotional Changes** – Speak to new mothers about the emotional changes they might experience after childbirth. Feelings of being overwhelmed, crying, exhaustion, joy and excitement are all part of this new experience. Mothers may experience temporary periods of “baby blues” which may include fear of hurting the baby or anxious over their ability to care for the newborn (<http://askdrsears.com>). This is normal, but encourage patients to seek professional help if these feelings last more than a few hours at a time over the course of a week.

**Physical Changes** – The experience of childbirth is incredibly demanding on a woman's body. New mothers will feel physically exhausted and pain from medical procedures, such as an episiotomy, is expected (AskDrSears, <http://askdrsears.com>; US Healthbenefits <http://ushealthbenefits.com>). Providers will need to monitor a mother's physical recovery and suggest different methods of pain management that include both non-medicinal and pharmacological treatments. Additionally, educate new dads and partners of ways to alleviate mom's discomfort and educate on the types of pain that may require follow-up medical treatment.

**Support Systems** – It is critical medical providers emphasize the importance of seeking assistance from support systems to provide much needed relief to new mothers and parents (US Healthbenefits, <http://ushealthbenefits.com>). Social support has long been associated with health, well-being and counterbalances the effects of life stress (Logsdon, McBride & Birkimer, 1994). Encourage patients to ask friends and family to help in large and small ways if they can. If a family member comes to visit the new baby, they may be willing to stay an extra 30 minutes while the mother rests for a while. Could a friend pick up dry cleaning or walk the dog? Can someone make sure mom has all of her necessary medicines or prescriptions, e.g. a supply of test strips to check her insulin levels? New dads and partners should also note their role is vital as well. Providers could suggest dads and partners give both psychological and physical support. Examples include giving the new mother words of encouragement and tell her she is doing a great job, helping during feeding time, changing diapers, and cuddling and rocking the baby to sleep (March of Dimes, [www.modimes.org](http://www.modimes.org)).

It is critical for medical providers to deliver their postpartum education in a culturally appropriate manner (World Health Organization, [www.who.int](http://www.who.int)). Provide postpartum literature that is linguistically correct and ask the patient if they would prefer a translator to help them understand your postpartum instructions. Providers should also take it upon themselves to become familiar with their patient populations and their cultural practices as it relates to pregnancy and childbirth.

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## Kit for New Parents: San Diego Welcome Baby Program

A Project of First 5 San Diego

Update: July 2003

By A Elizabeth Creer, RN, FNP MPH



## California Perinatal Transport System (CPeTS), Southern Region News & Updates

By Catherina San Juan Kang, MSW

### Kit Distribution

The *Kits for New Parents* became available in San Diego in January 2002. Since then our Distribution Partners have ordered nearly **73,000 Kits** to distribute to new parents. Partners are agencies that serve pregnant families and parents of children less than five years of age. Our Partners have incorporated Kit distribution into their work in creative ways, and we thank them for all they do to get the Kits to San Diego's new parents.

Parents can also order a Kit by calling a toll-free number: **1-800-KIDS-025** or **1-800-5-0-NINOS**. Approximately 5,000 parents have taken advantage of this method. There is no charge for the Kit or for shipping. Our new Welcome Baby Program poster, highlighting the toll-free number, has been disseminated around the county to inform parents to the availability of this free resource. The poster is currently available in English and Spanish.

There had been a third method for receiving a Kit—the prepaid order postcards. After 18 months' experience with this method, the First 5 California has decided to discontinue the postcards. The parents' handwritten addresses were often hard to read, and the Kits were not reaching the correct destination. First 5 California is developing a new card directing the parent to call the toll-free number to order a Kit. Partners who formerly gave out postcards will use the new reminder card instead.

### Evaluation of the Kit

We have evaluated San Diego parents' response to the basic Kit. Over 1,000 parents filled out a baseline survey and over 500 were contacted again after six weeks and asked their opinions. Preliminary data indicate parents are appreciative of the Kit, use it and learn from it. Full analysis of the data will be available in the fall.

### Local Resource List

The Welcome Baby Program, with the assistance of a community Advisory Group, is developing a list of local resources for parents of children ages 0-5 years. The document will be field tested with local parents, translated into Spanish, and inserted into the San Diego Kits by January 2004.

### Partner Support

We conducted our second Regional Training session in June. Over 40 participants from our Partner agencies attended to review strategies for helping parents use the Kit. The next training session is planned for later this fall.

We have stepped up the number of site visits to assist Partners with Kit ordering and distribution. This is a wonderful opportunity for an individualized discussion with a Welcome Baby Program representative. The Kit is presented to parents in a variety of ways, and we look forward to sharing information among our Partners.

### Promotion

The Kit has been exhibited at various community events such as parent conferences, Philippine Independence Day, and the Women's Resource Fair. Please contact us if you would like to help publicize the Kit's availability through brochures, posters, other promotional items such as bookmarks.

As part of our efforts to increase the quality of health services to mothers and infants, a component of California Perinatal Transport System (CPeTS) activities includes data collection of maternal and neonatal transfers with regard to the appropriate level of care received at medical facilities in Southern California. With the advent of the Health Insurance Portability and Accountability Act (HIPAA), there is a great need to clarify the status of CPeTS as a covered entity to ensure data collection continues among it California Children's Services (CCS) approved neonatal intensive care units (NICUs).

The Southern California Dispatch Center, now referred to as the "California Perinatal Transport System (CPeTS)," was established in 1976 pursuant to the enactment of California Assembly Bill 4439. This act appropriated funds for the development of a dispatch service to address the need for facilitating transports of critically ill infants and mothers with high risk conditions to regional Neonatal Intensive Care Units (NICUs) and Perinatal High Risk Units (PHRUs).

In an effort to improve maternal and neonatal outcomes, CPeTS collects and analyzes transport data which is used for regional planning and outreach program development. This information is reported back to participating hospitals and the Maternal and Child Health Branch of the California Department of Health Services.

Based on consultation with the University of California San Diego (UCSD) Healthcare Corporate Compliance Office, it has determined that CPeTS is considered a covered entity as required by law (AB 4439). Under the HIPAA Privacy Rule, a covered entity is permitted to use and disclose protected health information (PHI). Therefore, CPeTS will continue to request that hospitals complete and submit all Infant Transport Record (ITR) forms and monthly logs for all infants transported. This information is sent to the CPeTS office in San Diego.

Lastly, CPeTS is in the process of formalizing HIPAA policies and procedures. This information will be available to CCS approved NICUs as soon as that is approved by appropriate entities.

For more information on CPeTS activities, please contact Cathreena San Juan Kang, Southern Region Program Coordinator at [csanjuankang@ucsd.edu](mailto:csanjuankang@ucsd.edu) or call (858) 467-4990 ext. 113.

## Doula Support during Childbirth

by Jessica Gorman, MPH

What is a doula? Until recently, very few people would be able to answer that question. "Doula", pronounced doo-la, comes from the Greek meaning "woman's servant" and has come to mean a woman who is experienced helping other women through childbirth. A doula is trained and experienced in childbirth and provides continuous emotional, physical and informational support to a woman before, during and immediately after childbirth. Doulas are becoming increasingly popular as more and more couples hire doulas and the mainstream medical community becomes more accepting and familiar with the role of doulas. Doulas are also becoming more common and easier to find in many geographic areas. Doulas of North America (DONA), the premier organization providing training and certification to doulas, has over 4700 members in all 50 U.S. states as well as other countries.

A key difference between a doula, who has no clinical responsibilities, and medical providers such as nurses, midwives and doctors, is that a doula is able to give her full attention to the laboring woman and does not have other demands on her time. While healthcare providers may want to spend more personal time with each woman, they are often pressed for time, have multiple patients to attend to and may have shift changes during a woman's labor. A doula provides uninterrupted support, staying with the woman for her entire labor and delivery.

There are many reasons women or couples choose to have a doula. Many women feel the need for additional emotional and physical support during labor. Some might lack a supportive partner, friend or family member who can attend the birth. Others may just want to have an objective, trained support person by their side.

So, what exactly does a doula do? A doula is primarily there to offer encouragement, guidance, and nurturing to the mother and her partner during labor and delivery. Doulas are trained in labor support and have many skills and techniques that they can use during a birth, depending on the particular situation. For example, during early labor, a doula can encourage the mother to eat and drink, suggest restful activities such as massage or taking a bath, and help the mother to focus her attention on something other than the contractions. As labor progresses, a doula can offer more ideas for relaxation, suggest comfort measures, such as using a cold compress, breathing patterns to maintain focus or taking a shower, and help the woman move into different positions that are comfortable for her and effective in helping labor to progress. Later, when labor becomes more intense and as the baby descends, a doula can stay by the woman's side, encourage her, listen to her and continue to assist with comfort measures and suggest changes in coping measures or positions if needed. After the baby is born, the doula can stay with the mother during the early postpartum adjustment period and can also assist with initiation of breastfeeding. Throughout this process, the doula can also support (where appropriate) the woman's partner by showing him or her how to assist with different positions and how to become more involved in the birth.

Importantly, a doula can also help the woman and her partner become more actively involved in the birth by teaching them the right questions to ask when medical interventions or medications are offered. Doulas can benefit women and couples who choose medications, such as epidurals, or have medical interventions, such as cesarean sections, as well as those who do not. In these cases, a doula can provide essential emotional and informational support and help ensure that the woman and her partner are part of the decision making process. However, a doula never provides any medical advice and does not speak for the woman or her partner. She also does not replace or take over the role of the partner or assert her personal opinions about what choices should be made during the birth. The doula is there to help ensure that the mother and her partner have the type of birth experience they desire.

Many studies have shown the physical and emotional benefits of doula support for women and children. An analysis of twelve separate clinical trials comparing doula-supported women and women not receiving doula support found consistent benefits of continuous doula support in labor. These studies showed that emotional and physical doula support led to shorter labors, decreased cesarean deliveries by as much as 50% and decreased the use of forceps, the need for pain medication and the use of oxytocin to speed labor. Studies have also show a number of psychological and social benefits of doula support, including reduced anxiety, increased positive feelings about the birth experience, increased rates of breastfeeding, decreased symptoms of depression, improved self-esteem and increased sensitivity of the mother to her child's needs. (Sources: Scott, Klaus and Klaus, 1999; Scott, Berkowitz and Klaus, 1999; <http://www.dona.org>)

Despite this evidence and the increasing demand for doulas, health insurance usually does not cover doula services. Many doulas work in private settings and are hired on a fee-for-service basis by clients. In San Diego County, the average fee for a doula is \$400-\$600 per birth. Some doulas also work for community-based or hospital-based volunteer organizations, such as the UCSD Hearts and Hands Volunteer Doula Program. This innovative program, which began in January 2000, partners volunteer doulas with families who will deliver at UCSD Medical Center. This is the only hospital of 17 area institutions that offers free doula services to its families. Within the past year, volunteer doulas in the program have contributed over 5000 hours of time to mothers and their families. Programs such as this are helping to make doula care available to families who cannot afford one on a fee-for service basis. To learn more about the Hearts and Hands program at UCSD, call 619-543-6269. For more information on doulas, check out the Doulas of North America website at [www.dona.org](http://www.dona.org).

## Order Form and Mailing List Update

Name/Credentials

Agency/Affiliation

Mailing Address

City

State

Zip

Phone

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Email

Please send me RPS information about:

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- Perinatal Nurse Educators
- Maternal & Newborn Nursing Care
- Educational Opportunities
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- Guidelines for Care
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*The Kit for New Parents on:*

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- Ordering Kits
- Other \_\_\_\_\_



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Fax: 858-467-4993  
[www.regionalperinatalsystem.org](http://www.regionalperinatalsystem.org)

## UPCOMING CONFERENCES

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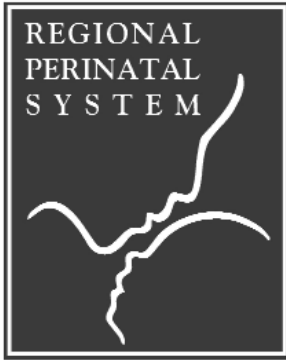
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