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July/August 2004

SPECIAL
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Regional Perinatal
System is moving
Effective **July 1, 2004**
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Available June 2004
Standards of Care for
the Prevention of
Perinatal HIV
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CRIBSHEET

The Regional Perinatal System Newsletter

COMMUNITY PRACTICE GUIDELINES

Standards for OB PACU

Contributed by Christine Giese, RNC, BSN * Paradise Valley Hospital, National City, CA
April 2004

Perinatal nurses have a unique role in providing family-centered care and labor support for the parturient. The perinatal nurse is skilled in many dimensions of care, notably in two specialties: obstetrics and operating room nursing.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandate that the same standard of care be provided to all post anesthesia patients, whether these are general surgical patients or those who have received regional or general anesthesia associated with vaginal or cesarean birth. It is generally thought that the perinatal nurse must have advanced cardiac life support (ACLS) licensure to be considered competent to provide care in the post anesthesia care unit setting.

The Association of Women's Health, Obstetrics and Neonatal Nursing (AWHONN) 5th Edition standards and guidelines state; "successful completion of ACLS is not required for the perinatal nurse providing postanesthesia care". However, all nurses should have basic cardiac life support training (BCLS) and follow the requirements and policies of their respective facility.

The education sub-committee of the Perinatal Nurse Leaders Council (PNLC) recommends a multidisciplinary educational approach and competency validation course become the standard of care in this community. The PNLC has come together to facilitate a comprehensive Obstetric Post Anesthesia Care Unit (OB PACU) training course for perinatal nurses in this area. The OB PACU course is designed to increase the knowledge base and skills of the perinatal nurse who provides post-operative care to the obstetrical patient. This two day course includes a 12-hour didactic component as well as a 4-hour skill/competency validation lab. Local anesthesiologists, perinatal clinical nurse specialists and nurse educators participate as speakers and instructors to provide a well-rounded educational experience for the participant.

The OB PACU course outline consists of 1) Guidelines for Obstetric Anesthesia - which focuses on the most critical guidelines for OB PACU care 2) Surgical Anesthesia Complications - including but not limited to; airway management, hemorrhage and code blue procedures and 3) EKG Interpretation/ Arrhythmia Recognition. Competency validation occurs after the participant has successfully completed a mock hemorrhage skill station, a mock code blue skill station, and a competency exam inclusive of EKG interpretation with arrhythmia recognition.

The OB PACU course in conjunction with complete orientation to one's own facilities' policies and procedures as well as hands-on experience will provide a solid foundation for the perinatal nurse to meet the standard of care in the OB PACU.

In addition to clinical experience, the OB PACU course (or its competency equivalent) is recommended to be taken every two years.

References:

Association of Women's Health, Obstetric and Neonatal Nurses. Position Statement: Post Anesthesia Nursing for Obstetric Patients. Washington, DC: Association of Women's Health, Obstetric and Neonatal Nurses: 5th Edition
Burke ME. ECG interpretation for obstetric nurses. J Perinat Neonat Nurs. 1991;5:25-37

O'Brien-Abel, N. Reinke, C. Warner, P., Nelson, C., Obstetric postanesthesia nursing: A staff education program. J Perinat Neonat Nurs 1994;8: 17-32

Tighe D, Sweezy SR. The perioperative experience of cesarean birth: preparation, considerations, and complications. J Perinat Neonat Nurs. 1990;3:14-30.



AWHONN'S FETAL HEART RATE PRINCIPLES & PRACTICES (FHMPP)

Contributed by Luann Beacom FNP, CNS, MPH, MSN

Revised by Eileen Vido RN, BSN

Scripps-Mercy Hospital, San Diego, CA

April 2004

Intrapartum fetal heart rate monitoring has become increasingly visible due to its significant implications for quality of care and legal risk management. There continues to be a great deal of diversity across the country in the emphasis, style, and content of FHM education, and mechanisms for validating competencies. These inconsistencies leave nurses and hospitals at risk for legal "interpretation" of appropriateness of training.

As the focus on skills validation has increased, newer models of continuing nursing education have been developed which provide standardized review and validation of central concepts and skills in specialty practice areas. Examples include the Trauma Core Curriculum Course, Advanced Cardiovascular Life Support (ACLS), and Neonatal Resuscitation Program (NRP). The Association of Women's Health, Obstetric and Neonatal Nurses' (AWHONN) FHMPP courses provide nationally standardized fetal monitoring education that reviews core concepts in the use of both auscultation and electronic monitoring. The program provides a unique format in that it integrates psychomotor skills with an in-depth knowledge of maternal and fetal physiology, as well as specific interpretive and decision-making skills.

Note: The AWHONN courses are NOT basic courses. New intrapartum nurses should take a basic fetal monitoring course. RPS offers an 8-hour basic course twice a year taught by community instructors. The Education sub-committee, like AWHONN, recommends that the 2-day course precede the one day Advanced, however it is up to the individual instructor to determine participant readiness for each course.

Two separate courses currently are being offered throughout the community. The 2-day FHMPP course is designed for registered nurses with a minimum of 6 months' of intrapartum experience. Day 1 is didactic, utilizing case studies to present the principles, and includes audiovisual and discussion methodologies. Day 2 includes skills stations in integration (i.e., written testing), auscultation, Leopold's, IUPC/spiral electrode placement, and communication. The 1-day advanced course (AFHMPP) also uses case studies to present concepts in physiology, tracing interpretation, antenatal testing, dysrhythmic patterns, critical patterns, fetal oxygen saturation monitoring, and preventive legal strategies. In addition, the newest National Institute of Child Health and Human Development Findings are discussed.

Recently, the education sub-committee of the Perinatal Nurse Leaders Council (PNLC) met to discuss fetal heart monitoring competency validation. The following recommendations were made:

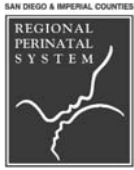
- *AWHONN's fetal heart monitoring courses should become the standard for competency validation for experienced intrapartum nurses throughout the community.
- *The committee recommends that the 2-day FHMPP course be taken initially. Thereafter, either the 2-day or the 1-day AFHMPP can be taken to maintain competency.
- *A minimum of 6 months of intrapartum experience is required prior to taking the initial FHMPP course.
- *In addition to clinical experience, an AWHONN course should be taken every 2 years to maintain competency.
- *A minimum of 2 years of intrapartum experience is recommended prior to enrolling in the AFHMPP course.

References:

Feinstein, N. & McCartney, P. et al (1997). *Fetal Heart Monitoring Principles and Practices, Second Edition*. Washington, DC: Association of Women's Health, Obstetrics, and Neonatal Nurses (AWHONN).

Association of Women's Health, Obstetrics, and Neonatal Nurses, formerly Nurses Association of the American College of Obstetrics and Gynecologists (1998, revised 1992). *NAACOG position statement; Nursing responsibilities in implementing intrapartum fetal heart rate monitoring*. Washington, DC: Author.





STANDARDS FOR UMBILICAL CORD CARE

Contributed by Gina Hoyt, RNC, MS, CNS
Paradise Valley Hospital, National City, CA
April 2004

In the 1940's hospitals began separating newborns from their mothers and utilized nurseries to facilitate care. However, it also facilitated cross-contamination and the risk of nosocomial infection. Thus, the application of antimicrobial agents became a longstanding practice to prevent cord infection. Currently, the risk of cross-contamination and nosocomial infection has been reduced by the practice of newborns "rooming in" with their mothers. However, the practice of applying antimicrobial agents to the cord stump continued. The desired effect was to prevent colonization with microorganisms and to facilitate drying and separation of the cord stump.

However, research has shown that microbial colonization is what facilitates the cord to separate. Separation is a result of the inflammation and leukocyte infiltration which digests the cord. In fact, studies have shown that antimicrobials prolong cord separation time. It disturbs the natural process by destroying the flora and decreasing the number of leukocytes attracted to the cord. In 1999 the World Health Organization (WHO) published a review of the evidence regarding cord care practices and made the following observations:

- *There is not enough evidence to recommend the widespread use of antimicrobial agents on the cord stump.
- *Cleaning the cord with alcohol or other agents is not recommended as it delays healing and drying of the wound.
- *Clean cord care is recommended: washing hands with clean water and soap and keeping the cord stump dry and exposed to air or loosely covered with clean clothes. If soiled, the cord should be washed with clean water and soap.
- *Important measures in preventing cord infections include aseptic technique at delivery, such as using sterile instruments to cut the cord.
- *Other practices that reduce risk of cord infection include: rooming in with mother, skin to skin contact with mother at birth and early and frequent breastfeeding.

The Cochrane Data Base, a comprehensive international review of current medical practices, published the following statements in 2002:

- *A clean technique for cutting the umbilical cord is recognized as an important principle.
- *Cord treatment may alter the time of separation of the cord, and delays may risk bacterial entry.
- *Cord and other skin infections were not affected by use of antiseptics.

*Simply keeping the cord clean appears to be as effective and safe as using antibiotics or antiseptics.

In 2001, The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) and the National Association of Neonatal Nurses (NANN) collaborated to develop an evidence-based guideline on neonatal skin care, including umbilical cord care. They published the following Clinical Practice Guideline:

*Immediate care: Clean the cord and surrounding skin surface as needed with cleanser used for initial or routine bathing and rinse thoroughly or cleanse with sterile water.

*Ongoing care: Keep the cord area clean and dry. If the cord becomes soiled with urine or stool, cleanse the area with water.

This AWHONN/NANN Guideline promotes evidence-based care. The education sub-committee of the Perinatal Nurse Leaders Council recommends that this guideline become the community standard of care.

References

1. AWHONN/NANN (2001) Evidence-Based Clinical Practice Guideline: Neonatal Skin Care.
2. Cochrane Review (2002) Zupan J, Garner, P. Routine topical umbilical cord care at birth.
3. World Health Organization (1999) Care of the umbilical cord: A review of the evidence.



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**Kit for New Parents: San Diego
Welcome Baby Program**
A Project of First 5 San Diego

News & Updates

by A. Elizabeth Creer, RN, FNP, MPH

Since January 2002, we have ordered over 95,000 Kits for our Partners to distribute to new parents. The Welcome Baby Program continues to support more than 500 Distribution Partners in the following ways:

☞ Partners can place an order for Kits or poster pads on the RPS web site (www.regionalperinatalsystem.org). From the Welcome Baby Program tab, Partners can type directly onto the pdf Order Form on the "Request a Kit" section and email it to: contact@r-p-s.org Kits are now arriving within 1-2 weeks of placing the order.

☞ Visits to Partner sites are continuing, thanks to the help of our new outreach worker, Arinda Gonzalez. She and Beverly Brashear, Outreach Specialist, are working hard to contact Partners to provide program information and support for Kit distribution.

☞ More than 160 Partners recently participated in a "Partner Satisfaction" telephone survey conducted by an outside evaluator. The survey results will give us feedback on our services and contribute to future planning.

☞ The training session, "Creating Teachable Moments with the Kit for New Parents" has been prepared for presentation in Spanish. We have requested feedback from our Partners regarding the best time and place to hold sessions in Spanish, and the number of participants we may expect. Training sessions will be planned accordingly.

☞ The Kits prepared for distribution in SD County now contain an extra packet of items that will be useful to our new parents: a local resource brochure, a magnetic clip (to attach the resource brochure to the refrigerator, if the parent desires), a refrigerator magnet containing emergency numbers, and a growth chart with developmental milestones that will help parents track their child's progress.

☞ A general Distribution Partner meeting was held May 14 to preview the new items and to present Kit and program updates

☞ First 5 California is preparing new language versions of the Kit: Chinese, Korean, and Vietnamese. They should be ready in fall 2004. They are being produced in DVD format, and the Kit box will be smaller. Transitioning these changes to the English & Spanish versions will follow, but the timeline has not been determined.

For additional information about the Welcome Baby Program, please contact us.



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THE CALIFORNIA DIABETES AND PREGNANCY PROGRAM: SUMMARY OF 2003 STATE-WIDE DATA by Elaine R. Simon, RN, MSN, FNP, CDE

During the calendar year 2003, 9687 women received services from Sweet Success providers throughout California. The outcomes of the data reflect that the Sweet Success program is meeting many of the Sweet Success program outcome goals. These goals include low incidence of: prenatal maternal hospitalization for diabetes related care, neonatal congenital anomalies and neonatal hospitalization. This statewide summary reflects data collected during 2003, and submitted by January 31, 2004.

Deliveries Reported:

Of the 9647 patients who were received Sweet Success services, 9711 deliveries were reported. These deliveries included 181 sets of twins, 6 sets of triplets and one set of quadruplets!

Patient Characteristics

The average age of the Sweet Success patient was 32. Of the 9687 maternal patients reported, 1.0 % were 15-19 years of age, 29.3% were 20-29 years of age, 58% were between 30 and 39 years of age, and 12% were over 40 years of age. The CDC recently reported a 33% increase in type 2 diabetes among all people in the US ages 30 to 39, and a 29% increase in those 40 to 49 years of age, thus **70% of our Sweet Success** patients were in the high risk age group to develop type 2 diabetes.

Of the women who participated in the Sweet Success Program 52.8% were Hispanic, 22.2% Caucasian, and 15.6 % were of Asian origin. Only 3.% of our population was African-American despite strong outreach to the African-American community. An astounding 92.8% of our patient population is of ethnicity that has a high predisposition for type 2 diabetes.

23.5% of the maternal patients were considered overweight using the current body mass index (BMI) value of 24.9. Moreover, another 43.6% of the patients were found to be obese with a pregravid BMI greater than 30. Therefore, a total of **67% of the patients served were overweight or obese** based on their pre-pregnancy weight.

The characteristics of our patient population therefore include advanced maternal age, obesity, and ethnicities which have significant predisposition for developing type 2 diabetes. Postpartum follow-up includes emphasizing the need for 2 hour oral glucose tolerance test, annual fasting blood glucose measurements, and healthy lifestyle choices which are essential to decreasing the epidemic of type 2 diabetes in our patient population.

Prompt Education and Management

Education and management was provided in a timely fashion; approximately 55.4% of the patients were seen by a local Sweet Success Affiliate within 5 days of the initial referral; and 28% of the patients were seen between 6 and 15 days after the initial referral. Thus 70% of patients received education and management within 15 days of diagnosis, the majority seen within 5 days of diagnosis.

Rate of Maternal Prenatal Hospitalization:

Maternal prenatal hospitalization due to diabetes was only 3.3 %. 96.7 % of the patients did not require prenatal hospitalization for diabetes and were able to manage their diabetes successfully on an outpatient basis.

Pregnancy Outcome

Of the patients, 97.9 % of the pregnancies resulted in a live birth, while only 0.5% resulted in a fetal death, and 1.5% resulted in a spontaneous abortion. The majority of the patients (59.5%) had vaginal deliveries. 39.6% of all patients required a Cesarean section. Of those Cesarean sections, 21.1% were primary Cesarean sections and 14.9% were repeat Cesarean sections. The overall rate of Cesarean section for all births in California in 2002 was 26.8% according to the National Vital Statistics Report released on June 25, 2003. The National Statistic Reports on Birth data also noted a 26.1% rate of cesarean section nationwide. It further emphasized the current rate of Cesarean section nationwide is "the highest rate of cesarean section ever reported in the United States". This is consistent with the national trend away from vaginal births after Cesareans (VBAC) In fact, the rate of VBAC decreased 23% from 2001 to a rate 12.7% of overall births. Only 0.8 of the Sweet Success patients had a VBAC. Thus, not all cesarean- sections are due to poor diabetes control or macrosomia.

NICU Observation and Admission: 84.3% the infants of diabetic mothers did not require observation or admission into the neonatal care unit: 15.6% of the infants required either admission or observation in the neonatal intensive care unit. Data was not collected on the causes for NICU observation or admission, however this information is being collected as of January 2004 and will be reported in the summary of the 2004 data.

Congenital Anomalies: The rate of known congenital abnormalities in our patients was 2%. Of the infants with anomalies, 1% of the GDM/IGT patients and infants with anomalies versus 5% of the infant of pre-existing diabetes. However, there was a 23% unknown rate which could significantly affect these statistics. From this information,

two issues need to be addressed. The first is that many of these women with gestational diabetes may have had preexisting type 2 diabetes and were not aware of this at the time of conception; this could account for some of the anomalies in the GDM population. Secondly, the high rate of anomalies in the pre-existing diabetic population also needs to be addressed. Emphasis on preconception care for women with a history of GDM or overt diabetes needs to continue be emphasized with further education and outreach. In addition educating health insurance companies regarding the value of preconception care should be continued to be pursued to help eliminate cost as a barrier to adequate preconception care.

Birthweight

Of the infants born to Sweet Success patients, most infants were not macrosomic. 80.3% weighed between 2500 and 3999 grams. However, macrosomia remains a significant issue as 8.7 % were macrosomic weighing between 4000 and 4499 grams and another 3% weighing over 4500 grams. Thus, greater than 11% of the infants weighed 4000 grams or above. To help address this issue, several methods of intervention are required. Emphasis regarding early entry into care after GDM diagnosis, more aggressive treatment with medication for those with blood glucose values outside of the target range and earlier screening of women at high risk may help decrease the rate of macrosomia. The long-term implications of macrosomia are significant. These infants are twice as likely to develop obesity and type 2 diabetes during childhood and adolescence than the infants of non-diabetic mothers. Thus, macrosomia has long-term public health implications for our youth.

Preconception Counseling:

Only 21% of the women with overt diabetes received preconception counseling. Unfortunately there was a large unknown rate (43%), so that actual preconception counseling accomplished in California is difficult to determine. However, preconception counseling is an essential component of prevention of congenital anomalies. Although preconception counseling remains a required educational content area for all American Diabetes Association Recognized Programs; it still remains a non-covered service by many insurance companies. Lack of medical coverage is a significant barrier to women accessing healthcare prior to pregnancy. To tackle this issue, a more comprehensive approach for women with pre-existing diabetes or a history of GDM needs to be addressed. Each visit to a primary care provider should be used as an opportunity for preconception counseling.

Postpartum Follow-up Testing

Less than half of the participants with GDM or IGT had documentation on the data that they had received postpartum testing. If the women who data was available; 91.7 % were reclassified as having no diabetes, 3.3 % were reclassified as type 2 diabetes and 5.0% were reclassified with IGT. Further emphasis is needed on postpartum follow-up data regarding this issue.

Further Implications

The National Vital Statistics Report released the preliminary birth data for 2002 on June 25, 2003. This report states that the birth rate for teens 15-19 years has decreased. In addition the birth rate for women age 20-24 years of age has declined by 3%. However, the birth rates for women from 30-39 years of age and 40 -44 years of age continues to rise- increasing 2% in both of these age groups. Women in both these age groups are at increased risk for developing Gestational Diabetes. Moreover, the American Diabetes Association reports a 33% increase in type 2 diabetes in the 30-39 year old age group and a 29% increase in type 2 diabetes in the 40-44 year old age group. (Clinical Practice Recommendations, 2003) Thus, an increase for Sweet Success Services would be anticipated for these age groups.

Lastly, the epidemic of childhood obesity contributing to increased childhood type 2 diabetes further highlights the need for Sweet Success Services. Female children with obesity and type 2 diabetes will bring a unique complexity to the future management of their pregnancies. This is a result of potential diabetes-related complications which can result as consequence of a 4 to 20 year history type 2 diabetes, and related complications, in these young women prior to conception.

To truly improve outcomes of pregnancy complicated by diabetes, a healthy lifestyle must be emphasized beginning in elementary school and continuing throughout adulthood.





Pregnancy Passport Pilot Program Summary of Results by Jessica Gorman, MPH

In June 2003, the Regional Perinatal System of San Diego and Imperial Counties, funded by the March of Dimes, introduced the *Pregnancy Passport*. The program was pilot tested at five University of California San Diego (UCSD) prenatal clinics. The *Pregnancy Passport* is a condensed, bilingual handheld medical record that also includes critical information on signs and symptoms of premature labor, important prenatal health information and encourages women to become more involved in their prenatal care. Researchers worldwide have documented the importance of empowering pregnant women to recognize danger signs and symptoms during pregnancy. Recognition of these signs is a critical first step in seeking timely emergency care.

The *Pregnancy Passport* is based on a validated and widely used model of care involving a "pregnancy cooperation card" in Australia, the UK and other European countries as well as a similar program in Northern California. The research on handheld records has yielded a positive response from women in terms of an increased sense of involvement in their care and improved perceptions of communication with care providers.

The program goals were to: (1) increase screening for risk factors and awareness of warning signs for premature labor and high-risk pregnancy complications; (2) empower women through increased involvement in their own prenatal care; (3) improve the quality of patient services aimed at reducing preterm labor, prolonging weeks' gestation and providing medical interventions; and (4) enhance access to crucial prenatal medical information through the use of a handheld medical record, the *Pregnancy Passport*.

Between June 2003 and February 2004, 550 women received a *Pregnancy Passport*. The UCSD pilot sites that participated serve a socio-economically, racially and ethnically diverse client population. Most participants received prenatal care from UCSD's Nurse-Midwives. Women received *Passports* between <10 and 36 weeks of pregnancy. The average gestational age of women receiving a *Passport* was 20 weeks. Some women were enrolled later in pregnancy to increase the number of women eligible to participate in focus groups during the nine month project period. The evaluation goals were to: (1) learn more about the value and use of the *Passport* among women and prenatal providers; (2) determine the feasibility, benefits and barriers of implementing the program in an existing healthcare system; and (3) identify improvements to the *Pregnancy Passport* and its implementation.

Evaluation methods included tracking the number of *Passports* given, conducting focus groups and interviews with program participants and conducting surveys with healthcare providers and program participants. Analysis of focus groups and interviews data, the primary evaluation method, revealed four main themes: the *Pregnancy Passport* contains valuable information related to pregnancy and prenatal care; the *Pregnancy Passport* helped increase women's involvement and communication with providers; the *Pregnancy Passport* is convenient, organized and easy for women to use; and the *Pregnancy Passport* gives women a way to share information about their pregnancy and prenatal care with others.

Because of the small size and scope of this evaluation, we were not able to draw definitive conclusions about the effects of the *Pregnancy Passport* on knowledge, behavior or birth outcomes. We were, however, able to detail the experiences, use and opinions about the program from the perspective of women who received a *Passport* as well as their prenatal providers. Evaluation resulted in many suggestions from women and their providers that will be used to improve the *Passport* and the program overall. These results guided the revision of the *Passport* in April 2004. Other recommendations for improving the program include: obtaining support from upper level management and administration, providing training for clinical and administrative clinic staff at all levels, incorporating patient-provider communication skills training, and increasing community outreach efforts. If you would like more information, please contact Jessica Gorman at **858-467-4990** or jgorman@ucsd.edu.



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SAVE THE DATES!

OB Stat, Inc. presents:
Advanced Concepts of OB Transport
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Call Pam Adams, RN to register at
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The San Diego & Imperial Counties Regional
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Council & Paradise Valley Hospital presents:
**The Fundamentals of
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July 15, 2004 - August 20, 2004
&
**Basic Fetal Heart Monitoring Principles &
Practices**
July 23, 2004

For more information call (858) 467-4990

Illustrations

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UPCOMING CONFERENCES

Scripps Memorial Hospital, La Jolla presents:
Infertility Surrogacy & Adoption
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For more information, contact Carol Brown at
(858) 541-4185 or by email at
carol.brown@sharp.com

“ dedicated to quality perinatal care for mothers and newborns in San Diego and Imperial Counties.”



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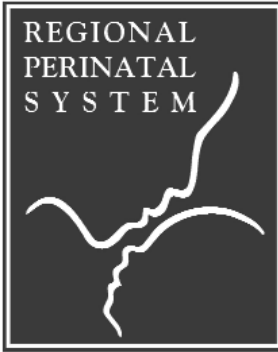
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AVAILABLE JUNE 2004

**Standards of Care for the
Prevention of Perinatal HIV Transmission in
San Diego County**

Although perinatal HIV transmission in the U.S. has been reduced from 25% to 2% as a result of increased HIV testing and advances in care, mother-to-child HIV transmission can still be reduced to the lowest possible level through routine HIV counseling and testing, rapid testing of women presenting for delivery with no prior prenatal care, HIV treatment and obstetric interventions at the time of delivery.

To be released in June, 2004 is a summary of the current guidelines adapted from the US Public Health Service HIV Testing and Treatment Recommendations. In preparing this Summary, representatives from the County of San Diego Health and Human Services Agency, University of California San Diego, Regional Perinatal System of San Diego and Imperial Counties, and clinicians reviewed federal and state guidelines to assist you in the provision of HIV testing, treatment and care during delivery. List of references, community resources and websites are included.

California Assembly Bill 1676, (Dutra) requires prenatal providers to provide HIV counseling and testing as a routine part of prenatal care. All prenatal care providers should offer HIV testing and encourage all women to obtain an HIV test with each pregnancy. The US Department of Health Services Centers for Disease Control and Prevention, American College of Obstetricians and Gynecology and American Academy of Pediatrics recommend HIV testing for pregnant women. In addition, HIV infection is a reportable disease and providers are required to report positive HIV tests to the County of San Diego Health and Human Services Agency. Please call 619.515.6672 to report or if you need any additional information or copies of the standards.

We're moving!!

After 11 years in the Kearny Mesa area, Regional Perinatal System is moving. Our new address is:

**9170 Camino Santa Fe
San Diego, CA 92121-2254**

**WATCH FOR MORE
INFORMATION!**