

REGIONS

- 1. North Coast Perinatal Access System**
415/ 476-3868
- 2. Northeastern California Perinatal Outreach Program**
916/ 733-1750
- 3. East Bay Regional Perinatal Program**
510/ 204-3937
- 4. Mid-Coastal California Perinatal Outreach Program**
650/ 723-5763
- 5. San Joaquin/Sierra Regional Perinatal Program**
559/ 221-6315
- 6.1. Perinatal Outreach Education Program**
562/ 595-6459
- 6.2. South Bay Perinatal Access Project**
310/ 222-3651
- 6.3-6.6. PAC/LAC**
818/ 788-6850
- 6.7. Community Perinatal Network**
562/ 945-6484
- 7. Inland Counties Regional Perinatal Program**
909/ 558-3970
- 8. Orange County Regional Perinatal Program**
714/ 456-6706
- 9. San Diego/Imperial Regional Perinatal System**
858/ 536-5090
- 10. Northern Kaiser Permanente Regional Program**
510/ 987-3430
- 11. Southern Kaiser Permanente Regional Program**
626/ 405-6052

IMMUNIZATIONS FOR WOMEN'S HEALTH

For the health-care provider, vaccines are essential tools used to help keep a pregnant woman and her baby healthy before, during and after pregnancy. A woman should be encouraged to consider which adult immunizations are recommended and if possible to obtain these prior to becoming pregnant. It is best when immunizations are given before pregnancy begins, therefore the preconception period offers a window of opportunity for every provider to ensure that a woman planning pregnancy is up-to-date on routine adult immunizations.

It is also important to consider that pregnancy provides many women an opportunity to develop positive health behaviors. The desire to have and raise a healthy child can provide powerful motivation to properly immunize herself, her infant and growing family. It is important for the mother to know that immunizations before pregnancy can increase the chance that a child will be born healthy. The protection gained from some immunizations is passed on to the fetus, protecting the newborn. Therefore, pregnancy is a crucial time at which to provide information and resources. Some vaccines need to be given before or after pregnancy, while some can be given during pregnancy.

While emphasizing that immunizations can protect both mother and child, mothers may also be assured that immunization is recommended and the standard of practice. The majority of vaccines are labeled pregnancy category C. This designation indicates that no adequate and well-controlled studies have been conducted with the vaccine in pregnant women to determine the product's safety. When choosing the immunizations that are right for each patient, any woman who has had a life threatening allergic reaction to a vaccine or who has a severe allergy to any component of a vaccine must be ruled out as a candidate. In general, pregnant women should not be vaccinated with live, attenuated vaccines. Health-care providers should weigh the theoretical risks and benefits before choosing to administer any vaccine to a pregnant woman.

BEFORE OR AFTER PREGNANCY IMMUNIZATIONS

Mumps, Measles and Rubella (MMR): Pregnant women are routinely tested for rubella immunity at an early prenatal visit. If a pregnant woman is not immune, she should not be vaccinated during preg-

nancy. Because a risk to the fetus from administration of these live virus vaccines cannot be excluded, women should be counseled to avoid becoming pregnant for 28 days after vaccination with measles or mumps vaccines or MMR or other rubella-containing vaccines. These women should be advised to avoid exposure to anyone with the illness and get vaccinated soon after delivery so they are immune during any future pregnancies.

Tetanus, Diphtheria, and Acellular Pertussis (Tdap):

Armed with a formulation that combines tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine, Tdap is a powerful weapon against an alarming nation-wide increase of pertussis. Vaccinating parents, including new mothers, can significantly reduce the number of pertussis cases in early infancy, when rates for complications and fatalities are highest. CDC recommendations encourage adult and adolescent women of childbearing age to receive Tdap before conception. For pregnant women, the vaccination should be given in the immediate post-partum period to provide personal protection and reduce the risk for transmitting pertussis to their infants.

Influenza: Almost all women who will be pregnant during the flu season (November through March) or who are at increased risk for severe complications from influenza should receive inactivated influenza vaccine, the "flu shot". The nasal-spray flu vaccine — a vaccine made with live, weakened flu viruses that do not cause the flu (sometimes called LAIV for "live attenuated influenza vaccine" or FluMist®) is approved for use in healthy people 2-49 years of age who are not pregnant. About 2 weeks after vaccination, antibodies that provide protection against influenza virus infection develop in the body.

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IMMUNIZATION DURING PREGNANCY (continued from Page 1)

Varicella (chickenpox): Testing to determine immunity to chickenpox before pregnancy or early in pregnancy is necessary if the patient is not sure if she has had the disease. The effects of the varicella virus vaccine on the fetus are unknown; therefore, pregnant women should not be vaccinated. Women who are not immune, and not yet pregnant, should be immunized. Experts recommend that a newly vaccinated woman wait at least one month before trying to get pregnant. For those in her household who are susceptible to the disease, having a pregnant household member is not a contraindication to vaccination.

Hepatitis B (HBV): The HBV virus can cause severe illness, liver damage, and even death. Many women do not know that they are infected with the HBV virus and are unaware that they may transmit the disease at birth to the infant. Therefore, educating every mother on the rationale for, and importance of testing for her own safety as well as granting her consent for the newborn hepatitis B vaccine for her infant is a key component of prenatal care. Prenatal providers should test every woman for hepatic B surface antigen (HBsAg), preferably in the first trimester, even if a woman has been previously vaccinated or tested. If the mother tests positive to HBV, it is vital that the baby receives hepatitis B vaccine and the antibody preparation hepatitis B immune globulin (HBIG) immediately after delivery, which would most likely prevent him or her from becoming infected. Even if prior testing shows negative results, repeat HBsAg testing upon admission to labor and delivery should be offered to women who are at risk for HBV infection during pregnancy, or who have had clinical hepatitis since previous testing.

Human Papillomavirus (HPV). Recombinant Human Papillomavirus Quadrivalent Vaccine (Gardasil) is not recommended for use in pregnant women. This vaccine offers protection against four common HPV types associated with the development of genital warts and cervical and anogenital carcinomas. The vaccine is given in a series of three injections over a six-month period. The second and third doses should be given at two and six months (respectively) after the first dose. If a woman becomes pregnant after starting the injections, she should complete the pregnancy before finishing the series. Gardasil has received FDA approval for use in females between 9 and 26 years of age and confers immunity against HPV types 6, 11, 16 and 18.

DURING PREGNANCY IMMUNIZATIONS INCLUDE

Tetanus and Diphtheria (Td): Before becoming pregnant, women with uncertain histories of a complete primary vaccination series with diphtheria and tetanus toxoid-containing vaccines should complete a primary vaccination series and be up-to-date on their tetanus-diphtheria booster. If the woman is pregnant and received the last Td vaccination more than ten years previously, Td should be administered during the second or third trimester. If the last Td vaccination was received in less than ten years, Tdap may be given post-partum. The CDC recommends a one-time administration of one dose of Tdap with an interval as short as two years from a previous Td vaccination for post-partum women.

Influenza: Flu shots are generally considered safe at any stage of pregnancy. During pregnancy, influenza can cause serious health problems for mother and baby that may require hospitalization. Women who are pregnant during flu season should receive the inactivated flu vaccine. The only exception is pregnant women who are allergic to eggs. Egg products are used to make the vaccine. Pregnant women should avoid the nasal flu mist vaccine (LAIV). It is not approved for use by pregnant women. No adverse fetal effects are known to be

associated with influenza vaccine and new findings from a study conducted by the National Women's Health Resource Center found that receiving the flu vaccine during pregnancy may also protect the child against the flu, from birth to the age of 6 months. In California, preservative-free influenza vaccine is available for pregnant women.

Pneumococcal: If a woman is considered high-risk for pneumococcal disease, she should get this vaccine. High-risk conditions include chronic disorders of the pulmonary system (but not asthma), cardiovascular disease, diabetes mellitus, chronic liver diseases, chronic renal failure, asplenia (including sickle cell disease), immunosuppressive conditions (e.g., HIV, leukemia, lymphoma, multiple myeloma, Hodgkins disease, generalized malignancy, or organ or bone marrow transplantation), treatment with certain medications, or cochlear implants. Pneumococcal vaccine can be given at the same time as a flu shot (by separate injection in the other arm).

AFTER PREGNANCY

Some immunizations should be given in the hospital before discharge to protect the new mother from diseases that can be dangerous if spread to her newborn or to future babies. It is safe for a woman to receive most vaccines right after giving birth, even while she is breastfeeding.

TRAVEL

Women contemplating travel, particularly outside the United States, should first consult with their health care provider about the safest time to travel. Caution may be advised and specific information provided about immunizations given when traveling to a developing country. Many vaccine-preventable diseases are still common in other parts of the world. Information about travel vaccines can be found at the Center for Disease Control traveler's health website.

REFERENCES

Women Health Immunizations At A Glance please refer to text for specifics and cautions.			
	Before Pregnancy	During Pregnancy	After Pregnancy
MMR	X		X
Tdap	X		X
TD	X	X	
Influenza	X	X	X
Varicella	X		
HepB	X		
HPV	X		
Pneumococcal		X	

<http://www.cdc.gov/vaccines/recs/ACIP>
www.cdph.ca.gov/programs/immunize;
<http://www.healthwomen.org/> . www.pregnancyshotsCA.org
 MMWR 2006; 55 (No. RR-10): 11-12.
 MMWR 2007; 56 (No. RR-4): 16, 24-26, 29-32. Updated 3/2008
 MMWR 2008; 57 (No. RR-4): 1-47,51.

SUBMITTED BY: SHIRLEY SMITH, MPA DIRECTOR, RPPC REGION 6.2

THE ROLE OF SELF-EFFICACY IN IMPROVING IN-HOSPITAL BREASTFEEDING RATES

INTRODUCTION

Self-efficacy is the perception of one's own ability to perform certain actions or behaviors (Bandura, 1997). It influences individuals' willingness to participate in activities and tasks, and it helps to establish their level of commitment to goal achievement (Bandura, 1997; Berarducci & Lengacher, 1998). Self-efficacy is recognized as an essential component of health education and promotion programs because it determines the ability of participants to put into practice what they've learned (Bandura, 1997; Berarducci & Lengacher, 1998).

Hospital environments that empower nurses and other direct patient care staff to participate in decision-making and allows them to have some control over both the content and the context of their practice, increase their feelings of self-efficacy and help to create more collaborative relationships with physicians and other healthcare staff (Alexander, 1982; Bandura, 1997; Manojlovich, 2005a). Manojlovich (2005b) also believes that both health care environments and nurses benefit from increased levels of nurse self-efficacy because nurses are able to more strategically utilize their professional training creating job satisfaction. Other studies of self-efficacy and health behavior argue that self-efficacy helps individuals to continue to work towards goals even when confronted with obstacles that hamper motivation (Schwarzer, 1992; [DeVellis & DeVellis, 2000](#)^{xClose}, DeVellis, B. M., & DeVellis, R. F. (2000). Self-efficacy and health. In: A. Baum, T. A. Revenson, & J. E. Singer (Eds.), *Handbook of Health Psychology* (pp. 235-247). Mahwah, NJ: Erlbaum.).

Recognizing the important role that maternal and child healthcare staff play in encouraging and supporting mothers to breastfeed, the Birth and Beyond California: Breastfeeding Training and Quality Improvement Demonstration Project (BBCP) seeks to empower physicians, nurses, and other maternal and child healthcare staff in hospitals to implement breastfeeding quality improvement policies and practices. To determine the impact of education activities on the empowerment of participants to implement quality breastfeeding practices and policies, BBCP will collect and analyze the self-efficacy of participants.

BACKGROUND

BBCP promotes breastfeeding quality improvement practices and policies in hospitals by providing education and training to nurses, physicians, lactation consultants and other maternal and child healthcare staff. It is a four year funded project by the California Department of Public Health (CDPH) Maternal, Child and Adolescent Health (MCAH) Program and administered through the Regional Perinatal Programs of California (RPPC). It targets hospitals and medical centers in RPPC Region 5 counties (Fresno, Kern & Kings, Madera, Mariposa, Merce, Stanislaus, Tuolumne, Tulare), Region 6 (Los Angeles, Santa Barbara, Ventura), and Region 8 (Orange) that have labor and delivery units.

The BBCP is a response to California's low exclusive in-hospital breastfeeding rates. The benefits of exclusive breastfeeding for babies, mothers, and communities include decreased incidence and severity of diseases such as bacterial meningitis and respiratory tract infections (American Academy of Pediatrics (AAP), 2005). However, in California, only about 43% of mothers exclusively breastfed their babies during their hospital

stay in 2007 (CDPH, 2008). In the RPPC regions targeted for the project, the 2007 average exclusive in-hospital breastfeeding rate was about 33% with some counties in regions as low as 25% (CDPH, 2008).

Successful breastfeeding initiation and experiences at birth and during the hospital stay are strong determinants of a mother's decision to continue breastfeeding after discharge. A recent study of the success of breastfeeding after hospital discharge found that hospitals that initiate breastfeeding during the first hour after birth, keep mothers and babies together in the room, do not use supplements of water or formula or pacifiers, and that provide breastfeeding follow-up assistance to breastfeeding mothers after discharge help to increase the duration and exclusivity of breastfeeding (Blackwell Publishing Ltd., 2007, August 30). Therefore, increasing in-hospital exclusive breastfeeding rates promotes long-term breastfeeding and its benefits. Increasing the self-efficacy of maternal and child healthcare staff in hospitals may improve their ability to achieve quality breastfeeding outcomes and increase staff satisfaction and the quality of patient care (Manojlovich, 2005b).



INSTRUMENT DESIGN

BBCP self-efficacy is the perceived ability of participants to implement breastfeeding quality improvement practices and policies in their respective hospitals. BBCP developed a *BBCP Participant Self-Efficacy Scale* to gain a better understanding of the perceptions of nurses, physicians, and other maternal and child healthcare staff about their own abilities to implement and sustain Model Hospital Breastfeeding Policy Recommendations and best practices to improve exclusive in-hospital breastfeeding rates. The *BBCP Participant Self-Efficacy Scale* is composed of items that reflect breastfeeding best practices and policies.

To create an instrument that was both reliable and valid, the BBCP project utilized a rigorous design methodology. Although there are several examples of self-efficacy scales in the field and literature, self-efficacy items should reflect the particular construct of concern (Bandura, 1997). Therefore, the instrument design methodology focused on in-hospital breastfeeding best practices and policies.

The first step in the design was to gather general feedback from BBCP participants about expectations of breastfeeding quality improvement performance upon completion of training. BBCP participants included representatives from hospital administrative staff, maternal and child healthcare staff, and the RPPC directors from targeted regions. This feedback helped to define the context of the project and to identify the goals and objectives of project participants. The next step involved a literature review of self-efficacy theory and a meta-analysis of self-efficacy instruments currently being utilized in health education and promotion to generate ideas for appropriate items to include on the *BBCP Participant Self-Efficacy Scale*. Self-efficacy tools reviewed included examples from nutrition, exercise, smoking cessation, alcohol abstinence, condom use, hypertension, and nursing (Anderson, Winnett, & Wojcik, 2000; DeVellis & DeVellis, 2000; Dijkstra & De Vries, 2000; Gbenga, et al., 2003; and Watson, 2001).

THE ROLE OF SELF-EFFICACY IN IMPROVING IN-HOSPITAL BREASTFEEDING RATE (continued from page 3)

Experts in breastfeeding best practices and policies identified from hospitals in RPPC regions were asked to generate items they felt were appropriate to measure the capacity of individuals involved in BBCP education and training. Experts included nurses, lactation consultants, and hospital administrators who had many years of maternal and child healthcare and breastfeeding experience. Expert feedback and research findings generated potential self-efficacy items to be included on the scale. The self-efficacy items were then analyzed to identify common themes and patterns. This process established content validity for the items. Content validity refers to the extent that the self-efficacy items actually represent the domain of the construct being measured (Key, 1997).

The next step involved establishing construct validity for the scale. Construct validity refers to the degree that the self-efficacy items accurately reflect the concept being measured (Key, 1997). An inter-rater reliability approach that measured the consistency of responses from experts in hospital and nurse management, hospital policies, quality improvement, education and training, and breastfeeding was employed to establish construct validity. This process was repeated twice to help experts focus on the most important and meaningful themes and appropriate items to include on the scale.

Five (5) dominant themes and twenty (20) items emerged from a two-step inter-rater process. The themes are: breastfeeding quality improvement; communication with healthcare professionals; communication with patients; access to resources, and overall empowerment. More than 15 of the items and all of the themes enjoyed an inter-rater consistency of at least 80%. The remaining items all enjoyed consistencies of at least 60%. To create a manageable instrument, experts decided not to include items and themes with consistencies less than 60% on the final scale. These findings indicate that the self-efficacy items accurately reflect breastfeeding best practices and policies.

The final step in the instrument design is to pilot the instrument. The instrument will be administered to a sample of hospitals between July and December 2008. The results will be utilized to establish a self-efficacy baseline for the project, and to determine the usefulness of the instrument.

CONCLUSION

The *BBCP Participant Self-Efficacy Scale* captures key stakeholders' perceptions of their abilities to actually implement Model Hospital Breastfeeding Policies and best practices. One of the guiding principles of the project is to increase the self-efficacy of maternal and child healthcare staff so they are both willing and able to exert greater efforts and time to overcome barriers to breastfeeding quality improvement. In the end, the self-efficacy of BBCP participants may determine the hospitals that are able to successfully overcome barriers and challenges to quality breastfeeding practices and policies and those that are not.

Submitted by: PAC/LAC, RPPC Region 6.3-6.6

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REFERENCES

- Alexander, J. A. (1982). *Nursing unit organization: Its effects on staff professionalism* (Vol. 4). Ann Arbor, MI: UMI Research Press.
- American Academy of Pediatrics (AAP), 2005. Policy statement: Breastfeeding and the use of human milk. *Pediatrics*. 115(2): 496-506.
- Anderson, E. S., Winett, R. A., & Wojcik, J. R. (2000). Social-cognitive determinants of nutrition behavior among supermarket food shoppers: A structural equation analysis. *Health Psychology*, 19(5), 479-486.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.
- Berarducci, A. & Lengacher, C. A. (1998). Self-efficacy: An essential component of advanced-practice nursing. *Nursing Connections*. Spring: 11(1), 55-67.
- Blackwell Publishing Ltd. (2007, August 30). Hospital Practices Affect Long-term Breastfeeding Success. *ScienceDaily*. Retrieved October 31, 2008, from <http://www.sciencedaily.com/releases/2007/08/070828154929.htm>.
- California Department of Public Health (CDPH) (2008). *California in-hospital breastfeeding as indicated on the newborn screening test form: Statewide, county and hospital of occurrence, 2007*. State of California: Author.
- DeVellis, B. M., & DeVellis, R. F. (2000). Self-efficacy and health. In: A. Baum, T. A. Revenson, & J. E. Singer (Eds.), *Handbook of Health Psychology* (pp. 235-247). Mahwah, NJ: Erlbaum.
- Dijkstra, A., & De Vries, H. (2000). Self-efficacy expectations with regard to different tasks in smoking cessation. *Psychology & Health*, 15(4), 501-511.
- Gbenga, O., Mancuso, C. A., Allegrante, J. P., & Charlson, M. E. (2003). Development and evaluation of a medication adherence self-efficacy scale in hypertensive African-American patients. *Journal of Clinical Epidemiology*, 56, 520-524.
- Key, J. P. (1997). *Research design in occupational education: Module R10: Reliability and validity*. Retrieved June 26, 2008, from Oklahoma State University Web site: <http://www.okstate.edu/ag/agedcm4h/academic/aged5980a/5980/newpage18.htm>
- Manojlovich, M. (2005a). Predictors of professional nursing practice behaviors in hospital settings. *Nursing Research*. 54 (1), 41-47.
- Manojlovich, M. (2005b). Promoting nurses' self-efficacy: A leadership strategy to improve practice. *Journal of Nursing Administration*. 33(5), 271-278.
- Schwarzer, R. (1992). Self-efficacy in the adoption and maintenance of health behaviors: Theoretical approaches and a new model. In R. Schwarzer (Ed.), *Self-efficacy: Thought control of action* (pp. 217-243). Washington, DC: Hemisphere.

NATIONAL QUALITY FORUM ENDORSES NATIONAL CONSENSUS STANDARDS FOR PERINATAL CARE

Recognizing the importance of quality healthcare for mothers and newborns the National Quality Forum (NQF) endorsed 17 perinatal standards to measure and thereby improve care received by mothers and babies during the third trimester of pregnancy through hospital discharge. Consensus standards improve quality of care by standardizing measurement in care settings and encouraging accountability and public reporting. NQF was guided in its endorsement of these perinatal care measures by comments from NQF members and the public.

Pregnancy, childbirth and care for newborns is the most common reason for hospital admission, and childbirth-related procedures account for the five most common procedures in patients aged 18-44. Poor quality care during the third trimester, labor and delivery, and during the post-partum period can translate into unnecessary complications, prolonged hospital stays, and costly intensive care admissions.

“Without appropriate information about hospital performance at a national level, perinatal quality improvement efforts have been unfocused and incentives for improvement limited,” said NQF president and CEO Janet Corrigan. “There have been relatively few standardized measures in the field of perinatal care to assess and publicly report on the safety and quality of care. As evidenced by the record-breaking number of comments NQF received during the endorsement process, there was an enormous need for more standardized consensus standards in this area. A more complete set of NQF-endorsed™ perinatal performance measures will provide the necessary tools for a unified national approach to quality improvement for mothers and babies.”

The newly NQF-endorsed measures are patient-focused and address care provided by individual clinicians such as nurses, doctors, and midwives, both in hospitals and in free-standing birth centers. The perinatal standards fill gaps in quality measurement and measure care at critical points for the mother and baby from the third trimester through hospital discharge and reflect aspects of care that can be substantially influenced by provider performance. Ultimately, through public reporting and accountability, the measures - birth trauma rate for the mother and baby, and relevant vaccinations for newborns - increase patient safety and decrease serious complications from childbirth.

Laura Riley, MD, medical director for labor and delivery at Massachusetts General Hospital, and Maureen Corry, MPH, executive director of Childbirth Connection, co-chaired NQF's steering committee on perinatal care. “This is a huge step forward for the medical community and for women as we all strive to improve obstetrical and neonatal care,” said Riley. “Meaningful improvements cannot be made until we have a common set of goals which encompass prenatal, intrapartum, postpartum, and early newborn care. Constant assessment of the care measures endorsed by NQF will allow us to address areas of weakness and reallocate resources where needed to provide babies with the best possible start to life.”

In NQF's effort to endorse a set of measures for perinatal care that are relevant, feasible, usable, scientifically acceptable, and will drive toward higher performance, several previously endorsed perinatal measures were retired from endorsement.

“The new perinatal care measure set takes a big leap forward for maternity care quality improvement,” said Corry. “With more than a

million births per year in the United States, these measures will impact a large number of mothers and babies and provide consumers and purchasers with essential information to make informed decisions on maternity care quality and value.”

In its ongoing work to improve quality in healthcare, NQF will continue to look at measures addressing vaginal birth after cesarean section (VBAC) to add to this set of measures.

NQF is a voluntary consensus standards-setting organization. Any party may request reconsideration of the recommendations, in whole or in part, by notifying NQF in writing via e-mail (appeals@qualityforum.org). For an appeal to be considered, the notification e-mail must include information clearly demonstrating that the appellant has interests that are directly and materially affected by the NQF-endorsed recommendations and that the NQF decision has had (or will have) an adverse effect on those interests. This work was funded by the Hospital Corporation of America.

MEASURES ENDORSED BY NQF

Please visit the NQF website at www.qualityforum.org to read the full specifications for all NQF-endorsed voluntary consensus standards and read NQF's research recommendations.

- **Elective Delivery Prior to 39 Completed Weeks Gestation:** All singletons delivered at ≥ 37 completed weeks gestation that are electively delivered prior to 39 completed weeks gestation.
- **Incidence of Episiotomy:** Number of vaginal deliveries with episiotomy procedures performed.
- **Cesarean Rate for Low-Risk First Birth Women:** Proportion of livebirths born at or beyond 37.0 weeks gestation to women having their first delivery, that are singleton (no twins or beyond) and vertex presentation (no breech or transverse positions) that had a cesarean birth.
- **Prophylactic Antibiotic in C-Section:** All women undergoing cesarean delivery without evidence of prior infection or already receiving prophylactic antibiotics for other reasons who received prophylactic antibiotics within one hour prior to surgical incision or at the time of delivery.
- **Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery:** Women undergoing cesarean delivery who receive either fractionated or unfractionated heparin or pneumatic compression devices prior to surgery.
- **Birth Trauma Rate measures (harmonized):** Number of infants with specific birth traumas.
- **Hepatitis B Vaccine Administration to All Newborns Prior to Discharge:** Number of live newborns discharged from the hospital who were administered hepatitis B vaccine prior to discharge.
- **Appropriate Use of Antenatal Steroids:** Total number of mothers who delivered preterm infants (24-32 weeks with preterm premature rupture of membranes or 24-34 weeks with intact membranes) who received antenatal steroids at any time prior to delivery.
- **Infants Under 1500g Delivered at Appropriate Site:** The number per 1,000 livebirths over 24 weeks' gestation weighing less than 1500g delivered at hospitals not appropriate for that size infant.
- **Nosocomial Blood Stream Infections in Neonates:** Selected bacterial blood stream infections per 1000 qualifying neonates.

Continued on page 7

PERINATAL HIV TOOLKIT REVISED

Approximately 7,000 women who are Human Immunodeficiency Virus (HIV) positive give birth each year in the United States. While the number of perinatally transmitted cases of HIV has declined in recent years, up to 40% of HIV-infected infants are born to women whose HIV-positive status was unknown prior to delivery of their infants. Prenatal and/or intrapartum treatment with antiviral medications has been shown to significantly decrease the incidence of perinatal transmission of the virus. Since 2004, the California Health and Safety Code (§125085) has required that all perinatal care providers draw blood for HIV testing as part of prenatal and intrapartum care. One important component of this testing is the availability of rapid HIV testing capabilities in Labor and Delivery.

In their efforts to support California's perinatal care providers' achievement of full compliance with this new law, the California Perinatal Quality Care Collaborative (CPQCC) is pleased to announce the release of the 2008 Revision of the **CPQCC Perinatal HIV Prevention Toolkit**. The materials contained in this toolkit have been designed to guide organizations through this process and can be accessed at no cost from the CPQCC website at: http://www.cpqcc.org/quality_improvement/qi_toolkits/prevention_of_perinatal_hiv_toolkit.

KEY POINTS REGARDING CALIFORNIA HEALTH AND SAFETY CODE §125085

AB 682 (chaptered 10/07) simplified the HIV testing and documentation requirements for providers. Earlier legislation had mandated that physician providers assume full responsibility for educating patients about their options regarding HIV testing during pregnancy and documenting that the test was offered, as well as whether or not the patient refused it. Non-physician providers are now permitted to provide this education and to document any refusal of the testing in either the prenatal or hospital setting. Additionally, the State of California has developed HIV education forms in English and eleven other languages, which provide information about pregnancy and HIV testing (<http://www.cdph.ca.gov/pubsforms/forms/Pages/AIDS.aspx>)

HIV post-test counseling for women who test positive must now include information about the availability of highly active antiretroviral therapy (HAART) for treatment of HIV and the prevention of perinatal HIV transmission. All pregnant HIV infected women should be offered HAART to maximally suppress viral replication, reduce the risk of perinatal transmission, and minimize the risk of developing resistant virus. The monotherapy with the three-part zidovudine (ZDV) prophylaxis regimen, previously thought to be acceptable for women with HIV RNA viral load <1,000 copies/mL, is now considered controversial. Specific treatment guidelines are available in the revised Perinatal HIV Prevention Toolkit. Recommendations for resistance testing for HIV infected pregnant women now also apply to those women with a new diagnosis of HIV infection of unknown duration.

Providers caring for the HIV-infected pregnant woman must now provide the most complete and current information regarding use of antiretroviral therapy, mode of delivery, and other clinical issues, including use of an AZT-containing regimen and the avoidance of scalp electrodes, episiotomies and any procedure that may increase risk of fetal contact with maternal blood or vaginal secretions. Consultation with a HIV specialist is *highly* recommended.

Newborn care for infants born to HIV-positive mothers requires consultation with a Pediatric HIV Specialist to insure that appropriate

anti-viral agents are administered in appropriate doses. It is important to note that most of these agents (other than zidovudine) have not been tested in premature infants so the appropriate dosage is unknown.

ADDITIONAL NEW REFERENCES

- State of California, Office of Aids Forms, <http://cdph.ca.gov/pubsforms/forms/Pages/AIDS.aspx>
- American College of Obstetricians and Gynecologists (ACOG) (2007). Committee Opinion #389, Human Immunodeficiency Virus.
- Branson, BM, et. al, Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings. MMWR Recommendation Report. 2006; 55(RR-14):1-17; quiz CE 1-4.
- Guidelines for the Use of Antiretroviral Agents in HIV 1 Infected Adults and Adolescents. January 29, 2008. Available at: <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

Questions concerning the CPQCC Perinatal HIV Prevention Toolkit may be addressed to CPQCC, 750 Welch Road, Ste. 224, Palo Alto, CA, 94304, or may be e-mailed to barbar@stanford.edu.

Submitted by Barbara Murphy, RNC, MSN, Director CPQCC

BIRTH CERTIFICATES MATTER

Reorganizing can simplify and improve the quality of birth certificate data collected. After interviewing two birth clerks from a San Bernardino County institution with an outstanding record for "lack of missing data," one notion became quite apparent and helpful in improving quality; the location of where the birth clerk completes work can affect input. Working in a very busy OB department can be quite disruptive, and even though the clerks are part of the medical records staff, these birth clerks have found that being seated away from the mainstream area of the very busy OB department allows for better concentration. The clerks work area is located adjacent to the OB department and benefit greatly from this arrangement as they are free from the frequent interruptions of most hospital unit clerks.

They also found that another key to decreasing missing data is working on a rotating schedule to ensure that coverage is available 7 days a week. They have developed a consistent daily work routine that allows them to interview patients and obtain the answers to the birth certificate on a worksheet. It is a priority for them to start each day early in the morning as they are more likely to have the mother alone without other visitors in the room and with fewer distractions. They have found that being bilingual in Spanish and English also assists in obtain completed information. If there are any questions that seem unclear, or if they do not understand, they do not hesitate to ask questions of the patients, physicians or nurses. When asked what was needed to make their job better, their reply was that they would like help in understanding what many of the medical terms mean that they are asked to enter. This seemed an issue for others as one of the suggested topics for future meetings was medical terminology. The State Office of Vital Records has completed their birth data quality meetings for 2008. The meetings were rated as excellent by the majority of participants and over 80% expressed an interest in attending such trainings each year.

Submitted by: Kathy Bird, RN, RPPC, Region 7

NEW GUIDELINES DOUBLE THE AMOUNT OF RECOMMENDED VITAMIN D

The American Academy of Pediatrics (AAP) is doubling the amount of vitamin D it recommends for infants, children and adolescents. The new clinical report, "[Prevention of Rickets and Vitamin D Deficiency in Infants, Children, and Adolescents](#)," recommends all children receive 400 IU a day of vitamin D, beginning in the first few days of life. The previous recommendation, issued in 2003, called for 200 IU per day beginning in the first two months of life.

CHANGES IN RECOMMENDATIONS

The change in recommendation comes after reviewing new clinical trials on vitamin D and the historical precedence of safely giving 400 IU per day to the pediatric population. Clinical data show that 400 units of vitamin D a day will not only prevent rickets, but treat it. This bone-softening disease is preventable with adequate vitamin D, but dietary sources of vitamin D are limited, and it is difficult to determine a safe amount of sunlight exposure to synthesize vitamin D in a given individual. Rickets continues to be reported in the United States in infants and adolescents. The greatest risk for rickets is in exclusively breastfed infants who are not supplemented with 400 IU of vitamin D a day.

Adequate vitamin D throughout childhood may reduce the risk of osteoporosis. In adults, new evidence suggests that vitamin D plays a role in the immune system and may help prevent infections, autoimmune diseases, cancer and diabetes.

"We are doubling the recommended amount of vitamin D children need each day because evidence has shown this could have life-long health benefits," said Frank Greer, MD, FAAP, chair of the AAP Committee on Nutrition and co-author of the report. "Supplementation is important because most children will not get enough vitamin D through diet alone."

"Breastfeeding is the best source of nutrition for infants. However, because of vitamin D deficiencies in the maternal diet, which affect the vitamin D in a mother's milk, it is important that breastfed infants receive supplements of vitamin D," said Carol Wagner, MD, FAAP, member of the AAP Section on Breastfeeding Executive Committee and co-author of the report. "Until it is determined what the vitamin D requirements of the lactating mother-infant dyad are, we must ensure that the breastfeeding infant receives an adequate supply of vitamin D through a supplement of 400 IU per day."

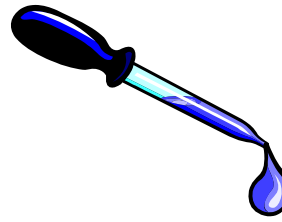
THE NEW RECOMMENDATIONS

- Breastfed and partially breastfed infants should be supplemented with 400 IU a day of vitamin D beginning in the first few days of life.
- All non-breastfed infants, as well as older children, who are consuming less than one quart per day of vitamin D-fortified formula or milk, should receive a vitamin D supplement of 400 IU a day.
- Adolescents who do not obtain 400 IU of vitamin D per day through foods should receive a supplement containing that amount.
- Children with increased risk of vitamin D deficiency, such as those taking certain medications, may need higher doses of vitamin D.

Given the growing evidence that adequate vitamin D status during pregnancy is important for fetal development, the AAP also recommends that providers who care for pregnant women consider

measuring vitamin D levels in this population. Vitamin D status is evaluated by measurement of serum biomarker 25 dihydroxy vitamin D [25(OH)D]. Optimum levels may be as high as 32-40 ng/mL (80-100 nMol/L).

The American Academy of Pediatrics is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well being of infants, children, adolescents and young adults.



Editor's Note: Also in October, the AAP will publish the sixth edition of its [Pediatric Nutrition Handbook](#), which details the latest evidence-based guidelines on feeding children and adolescents and updates the previous version published in 2004. The new edition covers advances and developments in breastfeeding, fast food, vegetarian diets,

newborn diarrhea, food labeling, preterm infant nutrition, chronic obesity and other topics.

NQF CONSENSUS STANDARDS (continued from page 5)

- **Birth Dose of Hepatitis B Vaccine and Hepatitis Immune Globulin for Newborns of Mothers with Chronic Hepatitis B:** Percentage of neonates born to hepatitis B surface antigen-positive mothers who receive a birth dose of hepatitis B vaccine and hepatitis B immune globulin within 12 hours of birth.
- **Exclusive Breastfeeding at Hospital Discharge:** Livebirths not discharged from the NICU who were fed by "breast only" since birth.
- **First Temperature Within One Hour of Admission to NICU:** Proportion of infants with weights between 501-1500g whose first temperature was measured within one hour of admission to the NICU.
- **First NICU Temperature < 36°C:** Proportion of infants with weights between 501-1500g whose first temperature was taken within one hour of admission to NICU whose first temperature was < 36°C
- **Retinopathy of Prematurity Screening:** Number of infants born at 22 to 29 weeks gestation hospitalized at the postnatal age at which a retinal eye exam is recommended by the AAP who received a retinal exam for retinopathy of prematurity.
- **Timely Surfactant Administration to Premature Neonates:** Number of infants born at 22 to 29 weeks gestation who were treated with surfactant at any time who received the surfactant within 2 hours of birth.
- **Neonatal Immunization:** Neonates with a length of stay greater than 60 days who receive DTaP, Hepatitis B, IPV, Hib, and PCV vaccines according to current AAP guidelines.

The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs. NQF, a non-profit organization (qualityforum.org) with diverse stakeholders across the public and private health sectors, was established in 1999 and is based in Washington, DC.

California Public Policy

Another exciting year of California legislative action has drawn to a close and what a ride it has been! With a budget that was eighty-five days late, the Governor went to work on the numerous bills that had piled up on his desk during that period. A record 415 bills were vetoed this year. Below is a brief summary of important legislation that was chaptered into law, died on the floor or was vetoed by the Governor. This year was the last year of a two year session. Keep an eye out for new bills to be introduced and for old bills to be reintroduced in 2009. For more information on the status of specific bills, visit www.leginfo.ca.gov.

SENATE INITIATIVES

SB 164: Migden – Prenatal Screening - DIED

Changes the name of the Birth Defects Monitoring Program. Requires the Department of Public Health to charge investigators who are approved by the department to use pregnancy blood for research purposes, a fee for costs related to data linkage, storage, retrieval, processing, data entry, reinventory, and shipping of newborn blood samples or their components, and related data management. Protects identifying information. Requires billing of specified entities to cover the costs of confidentiality protection.

SB 840: Keuhl - Single-Payer Health Care Coverage - Vetoed

This bill would establish the California Healthcare System and make all California residents, including those who travel out of state, eligible for specified health care benefits. The California Healthcare System would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. The bill would create the Office of Health Planning to plan for the health care needs of the population, and the Office of Health Care Quality, headed by a chief medical officer, to support the delivery of high quality care and promote provider and patient satisfaction.

SB 825: Padilla – Public Health: Shaken Baby Syndrome – Held in Appropriations

This bill establishes the Shaken Baby Syndrome Education Program. It requires the Department of Health Services to select eligible counties which are designed to provide new parents and other adult caregivers of newborns and young infants with information and education relating to the prevention of shaken baby syndrome. It requires a report on the effectiveness of the program in reducing the number of injuries and infant deaths resulting in shaken baby syndrome. This bill provides that the funding will be from the Children's Trust Fund.

SB 1661: Kuehl – Unemployment Compensation: Family Leave - Vetoed

This bill relates to the family temporary disability insurance program for workers who take time off work to care for a seriously ill family member, or to bond with a new child. This bill provides that an individual shall be deemed to have left his or her most recent work with good cause if individual's employment terminated as a result of the individual's taking a qualifying leave under the family temporary disability insurance program.



CALIFORNIA ASSEMBLY INITIATIVES

AB 30: Evans - Inborn Errors of Metabolism - Vetoed

This bill would require health plans to cover the cost of treatment, including formula and food, for children with metabolic disorders. Coverage is not required except to the extent that the cost of the necessary formulas and special food products exceeds the cost of a normal diet.

AB 1605: Lieber - State Department of Public Health: Public Health Nurse - Vetoed

This bill requires the Director of the State Department of Public Health to appoint one of the chief deputies as the State Public Health Nurse, to act as a liaison to public health nursing agencies in addition to other duties.

AB 1962: De La Torre - Maternity Services - Vetoed

Existing law provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health insurer that provides maternity coverage may not restrict inpatient hospital benefits, as specified, and is required to provide notice of the maternity services coverage. This bill would require specified health insurance policies to provide coverage for maternity services, as defined.

AB 2129: Beall - Maternal Health: Alcohol and Substance Abuse – Held in Appropriations

This bill would require the State Department of Public Health to develop, coordinate, and oversee the implementation of a model program for the universal screening, assessment, referral, and treatment of pregnant women and women of childbearing age who are suffering from drug and alcohol abuse.

AB 2262: Torrico – Child Protection: Safe-Surrender - Vetoed

This bill appropriates funds from the General Fund to the State Department of Social Services to conduct a statewide awareness campaign publicizing the existence of the Child Protection Safe Surrender Program and to establish a toll-free telephone number for the purpose of providing education and assistance to the public regarding the program.

AB 2599: De Leon – Birth Defects Monitoring Program - Chaptered

This bill makes technical, non-substantive changes to existing law that relates to the activities of the Birth Defects Monitoring Program.

AB 2726: Leno – Healthy Food Purchase Pilot Program - Chaptered

Existing law, until January 1, 2011, requires that the State Department of Public Health develop a “Healthy Food Purchase” pilot program to increase the sale and purchase of fresh fruits and vegetables in low-income communities. This bill would extend the program to January 1, 2012. It would also expand the variety of funding sources to allow more fresh fruits and vegetables to get to inner city grocery stores and to give food stamp participants rebates on purchases of fruits and vegetables.

AB 2898: Mullin – Coroner - Vetoed

This bill relates to situations where the suspected cause of death is sudden infant death syndrome. It authorizes the coroner to retain only those parts of the body as may be necessary or advisable to the inquiry into the case, or for the verification of his or her findings.