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**Electronic Newsletter**

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The Perinatal Network News is a publication of the Department of Health and Mental Hygiene's (DHMH) Center for Maternal and Child Health (CMCH). It is funded through a Crenshaw Perinatal Health Initiative grant provided to the Montgomery County Health Department.

The publication is intended as a communication tool for sharing perinatal information for a statewide audience, with information and resources that address statewide issues. It is designed as a vehicle to encourage collaboration and networking throughout the state. The newsletter provides an opportunity to share information on preconception and perinatal health issues and priorities, infant morbidity and mortality, county statistical trends and perinatal and child health indicators. It is an opportunity for local programs to share their strengths and insights as well as opportunities to ask for feedback and assistance in solving a local problem.

To ensure that this newsletter is a success, we need and encourage your participation. Please let us know of any items you would like to contribute, if you have suggestions for topics or areas you would like to see covered, or if you see that incorrect information was provided or that important information was inadvertently left out.

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# Perinatal network

Maryland Department of Health and Mental Hygiene

## Ensuring Babies are Born Healthy: A Center for Maternal and Child Health Approach

*Audrey S. Regan, MCH Policy Analyst*

The Fall 2006 edition of the Perinatal Network newsletter began with an article by Dr. Maureen Edwards, which articulated the poor state of perinatal health in Maryland. This article alerted us to the fact that Maryland ranks 32nd in infant mortality rates (IMR) according to Kids Count 2005, despite having one of the highest median household incomes and rates of higher education. This article highlighted that the infant mortality rate had increased for two consecutive years in 2003 and 2004 for the first time since 1975. The continuation of racial health disparities was illustrated. Furthermore, we were reminded that for every infant death there are many more fetal deaths, premature births, and other poor pregnancy outcomes.

The concerning trends in perinatal health convinced the Center for Maternal and Child Health to launch the Babies Born Healthy Initiative, which is working to improve perinatal health through a comprehensive approach. Because of the complexity of lifetime events that may contribute to a poor pregnancy outcome, there are four overlapping phases that exist as critical times for intervention. The four phases are: (1) preconception or interconception; (2) prenatal; (3) perinatal; and (4) postneonatal.

The preconception period is the phase encompassing a women's life prior to conception, and interconception includes the period from the completion of a pregnancy to before a subsequent conception. Prenatal is the period from conception through completion of the pregnancy either through a birth or a loss. The perinatal period includes the time immediately around the birth from 28 weeks gestation through the first 28 days of life. And, the postneonatal stage includes from 29th day of life through the 365th day of life. Activities to combat infant mortality are required at each of these overlapping phases.

### The Preconception and Interconception Phase

During the preconception and interconception phases, medical and social changes can be made in a family's life to improve the likelihood of a positive pregnancy outcome. This phase is critical for the primary prevention of poor pregnancy outcomes through addressing known risk factors, such as pregnancy planning, pre-pregnancy weight, and health behaviors. This stage is the ideal time to make changes to improve positive outcomes.

### MCH-WIC Collaborative

The Center for Maternal and Child Health—Office of Women, Infants, and Children (MCH-WIC) Collaborative is integrating key public health services into

a user-friendly format that supports preconception and interconception care. WIC families in Baltimore City, Baltimore, and Charles counties are provided MCH services, such as reproductive health and family planning within WIC clinics. By providing WIC families with MCH services within the WIC clinic, Babies Born Healthy is maximizing the services offered to enrolled women. Approximately 6,000 women will be served within this first year.

Women served also will receive a six-month supply of multi-vitamins containing folic acid, a nutrient that can prevent neural tube birth defects, or birth defects of the brain and spine. Furthermore, technology enhancements have allowed a computer prompt at each WIC encounter to remind WIC counselors to inquire and refer for MCH services.

### Helping Everyone After a Loss (HEAL)

The Helping Everyone After a Loss (HEAL) project provides direct and enabling services for women who experience a fetal or infant loss. Services include medical assessment, assistance in accessing services, bereavement support, and referral to home visiting. A woman with a loss is at an increased risk for a subsequent fetal or infant loss.

Through FIMR, it was realized that women who experienced a loss were not being supported. Therefore, women can be identified and assisted for a positive outcome in the future. HEAL is a pilot program with Mercy Medical Center and additional partners including the Baltimore City Health Department and Baltimore City Access. Currently, 30 women are being served. The program is evaluating a means of increasing services to women and assessing potential expansion sites.

## The Prenatal Phase

Once conception has occurred, there are risks that can be addressed during the prenatal phase. Providing high quality prenatal care can assist in preventing a poor pregnancy outcome. Prenatal care also allows for education

that can reduce risks within the perinatal and postneonatal periods.

### Baltimore City's Healthy Start

Baltimore City's Healthy Start, Inc. (BCHSI) has provided enabling services to pregnant and post-partum women in at-risk communities since 1991. This effort addresses risks during the prenatal and postneonatal periods. BCHSI gives family support services designed to improve pregnancy outcomes, reduced infant mortality, and enhanced family health and well-being.

Community health workers provide case management, health education, support services, and referrals for pregnant and post-partum women to enable them to have a healthy pregnancy. Through utilizing community health workers and other community resources, BCHSI develops community capacity for improving health, thus bridging the family and community components of infant mortality.

Baltimore City's Healthy Start, Inc. is seeking to expand their services into additional Baltimore City communities. MCH is supporting them to conduct a needs and capacity assessment, as well as develop the necessary collaboration to efficiently and effectively expand their services. Providing support services to additional women in need can enhance their health and the health of their babies.

### Medicaid Healthy Start

Healthy Start is a Medicaid program, which seeks to identify and ameliorate medical, nutritional, and psychosocial risk factors in order to improve birth outcomes, improve overall health and parenting behaviors, and foster healthy child development. Clients are identified through a pregnancy risk assessment tool then provided enabling services (wrap-around services, such as outreach, education, case management, transportation and home visiting).

Maryland is updating the pregnancy risk assessment tool to better identify women based upon criteria established through evidence-based and promising practices. Furthermore,

a consumer off the shelf (COTS) software package will be piloted in several local jurisdictions to enhance surveillance capabilities through tracking enabling services received and perinatal health outcomes. The data tracking system shall allow for better care coordination, as well as realization of best and promising practices within Maryland.

Through improving pregnancy risk assessment for client identification and implementing a data-gathering system to collect information on enabling services' utilization, Healthy Start enabling services will be strengthened. Again, this activity serves women in the prenatal and postneonatal phase.

## The Perinatal Phase

Risks also occur around the time of birth. Providing child birth in a safe environment, free from adverse events improves perinatal health. Following a tragic event in Boston, Harvard Medical School personnel and Department of Defense personnel collaborated to design a program that changes the culture in perinatal health settings. Kaiser Permanente conducted a similar team building, quality improvement effort that created a safer hospital, reduced medical malpractice premiums, and improved staff retention. These national experts are a part of the MCH-supported effort to improve patient safety.

The Maryland Patient Safety Center, a Delmarva and Maryland Hospital Association partnership, is implementing a Perinatal Collaborative. The Collaborative's goal is to create a perinatal system that delivers care without adverse fetal and maternal outcomes. Maryland Patient Safety Center is bringing hospitals and providers together to conduct team building, which is expected to improve perinatal health and safety, as well as networking among the health care professionals.

This will include arranging for the analysis of pre-intervention baseline and post-intervention data from participating hospitals by the National Perinatal Information Center.

## The Postneonatal Phase

Infant health includes the first year of a baby's life. Thus, positive health behaviors and parental or care giver education is important. Engaging in positive health behaviors during this phase enhances development in early childhood, thus preparing for a successful childhood, adolescence, and adulthood.

The Center for Maternal and Child Health supports the Maryland Breastfeeding Coalition, which seeks to enhance child development, promote knowledgeable and effective parenting, support women in breastfeeding and make optimal use of resources. Human milk plays a unique role in providing immunity and ideal nutrition for babies, and includes health benefits that appear early in life and last through childhood and possibly adulthood.

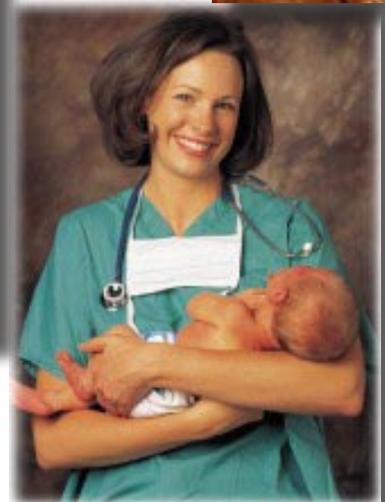
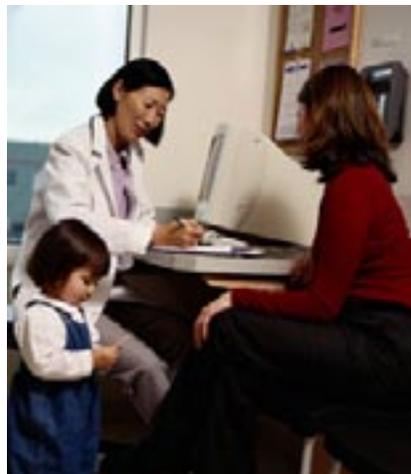
Additionally, MCH works to educate parents and caregivers regarding Sudden Infant Death Syndrome (SIDS) and the importance of safe sleeping. Sudden Infant Death Syndrome (SIDS) is the sudden, unexpected death of an apparently healthy infant remaining unexplained after an autopsy, death scene investigation, and a medical history review. SIDS continues to be the leading cause of infant death. In Baltimore City, the MCH supports the provision of baby sleepers to all new parents, which emphasize the importance of the ABCs of safe sleeping: Alone, on its Back, and in a Crib.

## Conclusion

Improving birth outcomes is a complex task. Risks must be identified and addressed within many phases. But each of these activities is necessary to make advances in babies' health. In order to impact mortality rates, successful pilots will need to be properly evaluated and expanded to additional communities with needs. The Center for Maternal and Child Health will continue to devote resources to ensuring that babies are born healthy in Maryland.



# Healthy Babies!!!



# What Practitioners Need to Know: CDC's New HIV Testing Recommendations and Maryland Law

*Elisabeth Liebow, MPH, Coordinator, Perinatal Infections Outreach Program; Director, Baltimore Regional Perinatal Advisory Group, Baltimore County Department of Health*

Since the Baltimore Regional Perinatal Advisory Group (RPAG) has conducted a Perinatal HIV Prevention Initiative in central Maryland this past year (Perinatal Network newsletter, Fall 2006), it has received questions regarding the new HIV testing recommendations published by the Centers for Disease Control and Prevention (CDC) in September. Practitioners are wondering how to respond to the new HIV testing recommendations since they conflict with current Maryland law.

The new CDC recommendations, Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings<sup>1</sup>, are aimed at both private and public sector health-care providers in medical settings. They do not pertain to HIV counseling, testing, and referral for clients in non-medical settings such as community-based organizations, outreach settings, or mobile vans. These testing guidelines reflect a new direction in the nation's HIV elimination strategy and are considered by the CDC to be a milestone in public health relating to the HIV/AIDS epidemic.<sup>2</sup> The guidelines' objectives are to increase overall HIV testing in the United States (including testing of all pregnant women regardless of risk); further decrease vertical HIV transmission; promote earlier detection of infection; and identify, counsel and link to care, patients with unrecognized infection.

In an effort to encourage universal, routine HIV screening, the new recommendations call for eliminating barriers to testing by adopting an opt-out testing approach—performing HIV screening after notifying the patient that the test will be performed, and notifying the patient about the right to decline or defer testing. The new guidelines encourage, among other things: (1) eliminating requirements for prevention counseling, and (2) eliminating requirements for separate written informed consent. General informed consent for medical care should be considered sufficient to encompass informed consent for HIV testing, according to the recommendations (p.8).

For pregnant women, the guidelines propose that HIV screening be folded into the routine panel of prenatal tests for all pregnant women; testing should be performed after the patient is notified that testing will be conducted unless she declines (opt-out testing); general consent should be sufficient consent for HIV testing; repeat testing should be performed in the third trimester in areas where rates of HIV infection in pregnant women are high.

## In Maryland it's business as usual...at least for now.

Current Maryland laws pertaining to HIV testing and reporting may change soon, but health-care providers in Maryland must comply with current state laws. Maryland's existing HIV laws<sup>3</sup> require that practitioners:

- ▼ Conduct pre-test counseling;
- ▼ Obtain voluntary written informed consent using the Maryland Department of Health and Mental Hygiene's "Informed Consent and Agreement to HIV Testing" (see web site link below), and the brand new "Perinatal HIV Authorization Form," which is a streamlined consent form for pregnant women (available soon on the Web site);
- ▼ Conduct post-test counseling of positive patients; and
- ▼ Generate a Unique identifier to allow for Laboratory reporting of HIV positives. *Note: Because rates of HIV infection in pregnant women in Maryland are high, counseling and testing are also recommended in the third trimester for women who were not screened earlier in the pregnancy, or who were negative at the first trimester screen and are at high risk of infection.*

One or more bills will be introduced in the 2007 Maryland General Assembly addressing opt-out testing and named reporting of HIV infection. Maryland residents interested in any bills being introduced in the General Assembly are encouraged to follow this year's legislative session and to participate in the process by writing to their state representatives and attending public hearings. The next issue of Perinatal Network will contain an update on any HIV-related legislative changes. For now, though, it's business as usual in Maryland.

To access the CDC recommendations, for more information about the new recommendations, and for frequently asked questions for professionals and the general public, go to: [www.cdc.gov/hiv/topics/testing/healthcare/](http://www.cdc.gov/hiv/topics/testing/healthcare/)

For information on program services and provider resources, contact the Maryland AIDS Administration at 410-767-5227, or visit their Web site at: [dhmh.state.md.us/AIDS](http://dhmh.state.md.us/AIDS).

To download the Maryland HIV Consent Form in English or Spanish, go to the AIDS Administration Web site at: [dhmh.state.md.us/AIDS](http://dhmh.state.md.us/AIDS) and select the following links: Provider Resources, then Surveillance-HIV/AIDS Reporting, then Forms.



<sup>1</sup> CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR* 2006;55(No. RR-14):1-17.

<sup>2</sup> "Dear Colleague" letter from CDC Director Julie Louise Gerberding, M.D., M.P.H. September 21, 2006.

<sup>3</sup> Annotated Code of Maryland. Health General Section 13-336 and COMAR 10.18.08

## Best HIV Prevention Programs Build Skills

It takes more than just passing along good information to stop the spread of HIV, a new US-government-backed study on HIV/AIDS prevention programs has found. It takes “enhanced education, where you actually build their skills and don’t just give them information,” says lead author Cynthia Lyles of the Centers for Disease Control and Prevention in Atlanta.

To help arm local health agencies with the most effective HIV prevention programs, Lyles and colleagues examined 100 HIV behavioral intervention programs developed and tested between 2000 and 2004. Their findings appear in January’s *American Journal of Public Health*. They identified 18 programs that seem to have a significant effect on reducing HIV risk behavior and that could be adopted by local agencies and funded by the federal government.

Lyles and colleagues say the “best of” programs tend to share one thing in common—they not only teach people about HIV and AIDS but also help them learn how to avoid falling into the trap of risky sex and what to do if they get in a high-risk situation. This is often accomplished through role-playing. Other key components of effective HIV prevention programs include instruction on how to use a male or female condom properly and how to communicate better with others, including negotiation and assertiveness training.

“Most importantly, many of these newly identified efficacious interventions targeted populations disproportionately affected by the HIV/AIDS epidemic and in need of effective prevention tools,” Lyles and colleagues write. “However, important gaps still exist.”

Lyles and colleagues point out that their government-backed review did not consider the value of needle-exchange programs, which provide clean needles to IV drug addicts, because these programs are not eligible for federal funding, despite evidence that they are effective. “We were basically trying to target the prevention-providers that are looking to the CDC for funding,” Lyles says. “They can decide if one of these is best suited for them.”

*Source: American Journal of Public Health, January 2007. Best-Evidence Interventions: Findings From a Systematic Review of HIV Behavioral Interventions for US Populations at High Risk, 2000-2004*



### Updated Women and HIV/AIDS Factsheet

The Kaiser Family Foundation has updated their policy fact sheet on Women and HIV/AIDS which includes a new chart of the number of women estimated to be living with AIDS for the top 10 States, including Maryland, which ranks sixth out of the ten, with 4,703 women living with AIDS.

To access the factsheet: [www.kff.org/content/factsheets.cfm](http://www.kff.org/content/factsheets.cfm)



### New HIV-related Programming to Air on BET

In the lead up to National Black HIV/AIDS Awareness Day (February 7), BET Networks announced a roll out of fresh HIV-themed programming that features two new films and a youth-focused news special, as part of its longstanding public education partnership with Kaiser, the Rap-It-Up Campaign.

All three unique and powerful original shows bring attention to the disproportionate impact of HIV/AIDS in the Black community; and tackle a host of HIV/AIDS-related issues faced by BET’s young African-American audience, including stigma and homophobia, HIV testing, substance abuse, and the impact of HIV/AIDS on personal relationships and family life.

More information is available at: [www.kff.org/hiv aids/php012407nr.cfm](http://www.kff.org/hiv aids/php012407nr.cfm) .

# Reducing Infant Mortality in Maryland: A Center for Maternal and Child Health Approach

Audrey S. Regan, MCH Policy Analyst

Beyond the current reach of quantitative data, many factors are thought to be associated with perinatal health. To identify and understand these factors, the Center for Maternal and Child Health conducted a needs assessment, termed the Key Informant Interviews. Sixteen interviews were conducted individually in-person from July through October 2006, to determine leadership and programmatic needs for infant mortality reduction. All of the interviewed persons have an understanding of infant mortality, especially in Maryland, and are experts in their field. Professional disciplines included obstetricians, neonatologists, nurse mid-wives, and social workers. They were employed in various academic, university hospital, community hospital, community clinic, community-based organization, and governmental agency settings.

## Leadership

The Key Informants opposed the re-constitution of a legislated leadership entity. An Infant Mortality Commission, Coalition, or Advisory Body is not a leading strategy for reducing infant mortality. These formal structures may lack the ability to complete necessary actions and sometimes result in inertia. There are a multitude of people, organizations, and entities engaged in the infant mortality sphere, so an additional organized commission is not required. Key Informants stated that the infant mortality network, however, should be extended beyond the health care sphere and into other social services arenas, such as housing, environmental justice, poverty, and education. The social determinants of health impact perinatal outcomes. These areas should be made aware of

their role in the problem and engaged in the solution.

Improving infant health requires a political champion or entrepreneur to sustain public attention and acquire public resources. Heading the informal network of interdisciplinary health care providers and non-traditional partners must be a leader with political capital, a political champion or entrepreneur. Although the political champion's necessity was acknowledged repeatedly, no specific persons were mentioned. To enhance perinatal health requires the existence of a feasible solution for addressing the problem, which the policy entrepreneur can champion.

## Data Enhancements

The Key Informants repeatedly mentioned that better data analysis is required to more effectively develop and implement appropriate interventions in specific communities. Many Key Informants acknowledged that Maryland's Vital Statistics data has dramatically improved the data's quality and timeliness since the early 1990s, but concluded that Maryland continues to lack the depth in analytic capacity to answer essential questions regarding infant mortality. Specific factors are known nationally to impact pregnancy outcomes, such as income, housing, health behaviors (i.e., tobacco, drug, and alcohol use) and obstetrical problems. These factors, however, have not been studied comprehensively in Maryland. Additional studies among women who have experienced negative birth outcomes are necessary. This could be conducted through a combination of written surveys, comprehensive medical chart or case reviews, or focus groups.

## Preconception Health

The Key Informants repeatedly emphasized the importance of enhancing women's health during the preconception and interconception periods. Although prenatal care is important, waiting for pregnancy is too late. Preconception and interconception health are important to healthy pregnancy outcomes. Women in good health prior to pregnancy are more likely to remain

in good health, which reduces the risk of pregnancy outcomes. Because the unintended pregnancy rate remains almost 50 percent, all women of child bearing age should maintain positive health because many women do not plan to become pregnant but do. Improving women's health would increase the likelihood of a positive pregnancy outcome.

## Racial Health Disparities

The Key Informants recognized the racial disparity in infant mortality and stated that attention should be focused in alleviating this disparity. The cause and exacerbation of racial health disparities is a complex phenomenon with many contributing factors, including the social determinants of health and access to quality health care. The plethora of research in perinatal disparities has shown that the disparity cannot solely be explained through genetics, or education, or income, or health behaviors. Rather there is something unique in the variable race. Race is a socially constructed variable, which has dictated many the societal and cultural norms of America. Within a health care setting, inequities have the opportunity to be expressed and contribute to racial health disparities.

## Conclusion

Through these Key Informant Interviews, the Center for Maternal and Child Health confirmed many thoughts regarding perinatal health. This area needs greater attention and understanding among the public and policy makers. Furthermore, interventions should be driven by enhanced data analysis and focused on preconception health, especially among populations with well documented health disparities.



# Centers for Disease Control and Prevention, Maternal and Infant Health: Preterm Birth

Preterm birth is defined as the birth of an infant before 37 completed weeks of gestation (at least three weeks before the “due date”). These births are often characterized as either “very preterm” (less than 32 weeks gestation) or “moderately preterm” (32–36 weeks gestation). The public health implications of preterm birth are among the most dramatic influences on the status of infant health in the United States.

Being born preterm is the greatest risk factor for infant mortality (death within the first year of life). There are significant racial disparities in preterm birth with African American women having a greater risk of delivering a preterm infant compared to white women. Preterm birth, also called prematurity, is the focus of recent publications prepared by CDC and its partners.

▲ The October 1, 2006, issue of *Pediatrics* presents information from a CDC study on the contribution of preterm births to the rate of infant mortality in the United States. This study found that preterm birth was the leading cause of all infant deaths in 2002. (Source: Callaghan WM, MacDorman MF, Rasmussen SA, Qin C, Lackritz EM. The contribution of preterm birth to infant mortality rates in the United States. *Pediatrics* 2006;118(4):1566–1573.)

▲ The Institute of Medicine, a part of the National Academy of Sciences, released a report from its expert committee in July 2006. *Preterm Birth: Causes, Consequences, and Prevention* is a comprehensive review of scientific, technical and policy issues related to preventing preterm births in the United States.

Source: [www.cdc.gov/reproductivehealth/MaternalInfantHealth/PBP.htm](http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PBP.htm)

## Prematurity is Root Cause of a Third of Infant Deaths

In the CDC study, the authors found that the contribution of prematurity to infant mortality may be twice as high as originally estimated. Standard methods of estimating infant mortality, using International Classification of Diseases, 10th Revision (ICD-10) codes, have yielded an estimate of 17 percent by this method, the National Center for Health Statistics calculated.

But while this type of classification allows monitoring of trends over time, it does not capture adequately the overall contribution of preterm birth (less than 37 weeks of gestation) to the national infant mortality rate, because the relationship between preterm birth and death during the first one year of life is not distinctly identifiable by using available cause-of-death titles. Instead, the CDC researchers developed an approach in which deaths due to conditions that cause premature birth, or result from it, are considered to be the cause of death based on biological factors.

Among preterm infants, short gestation/low birth was the leading cause, followed by maternal complications of pregnancy (incompetent cervix, premature membrane rupture, multiple pregnancy); complications of placenta, cord and membranes (e.g., placenta previa); respiratory distress, and bacterial sepsis.

Extracted from *Medpage Today*: [www.medicalnewstoday.com/medicalnews.php?newsid=53263](http://www.medicalnewstoday.com/medicalnews.php?newsid=53263)

## Podcast Available

### New Information About Premature Births (For Healthcare Providers)

Dr. William Callaghan describes the findings from the CDC study, “*The contribution of preterm birth to infant mortality rates in the United States*,” which sought to understand how preterm birth contributes to infant mortality rates in the United States.

Go to: [www2a.cdc.gov/podcasts/browse.asp?c=3&formsButton2=Go!](http://www2a.cdc.gov/podcasts/browse.asp?c=3&formsButton2=Go!)



## Prematurity Resource Center

### March of Dimes and AWHONN Prematurity Campaign

The Compendium on Preterm Birth is a new online curriculum that helps health professionals learn to better identify patients at risk for having a premature baby. AWHONN partnered with the March of Dimes to develop this online curriculum for health professionals. The compendium is designed to educate health care providers about how to detect patients at risk for early delivery and assess behaviors that trigger premature birth. Download your free copy.

To access the curriculum:

[www.marchofdimes.com/prematurity/21329\\_20738.asp](http://www.marchofdimes.com/prematurity/21329_20738.asp)

## New ACOG Recommendations Call for Screening All Pregnant Women for Down Syndrome

All pregnant women, regardless of their age, should be offered screening for Down syndrome, according to a new Practice Bulletin issued today by The American College of Obstetricians and Gynecologists (ACOG). Previously, women (35 years and older) were automatically offered genetic counseling and diagnostic testing for Down syndrome by amniocentesis or chorionic villus sampling (CVS)

The new ACOG guidelines recommend that all pregnant women consider less invasive screening options for assessing their risk for Down syndrome, a common disorder that is caused by an extra chromosome and can result in congenital heart defects and mental retardation. Screening for Down syndrome should occur before the 20th week of pregnancy.

“This new recommendation says that the maternal age of 35 should no longer be used by itself as a cut-off to determine who is offered screening versus who is offered invasive diagnostic testing,” noted Deborah Driscoll, MD, a lead author of the document and vice-chair of ACOG’s Committee on Practice Bulletins–Obstetrics, which developed the Practice Bulletin with ACOG’s Committee on Genetics and the Society for Maternal-Fetal Medicine.

ACOG also advises that all pregnant women, regardless of their age, should have the option of diagnostic testing. ACOG recognizes that a woman’s decision to have an amniocentesis or CVS is based on many factors, such as a family or personal history of birth defects, the risk that the fetus will have a chromosome abnormality or an inherited condition, and the risk of pregnancy loss from an invasive procedure.

According to the new guidelines, the goal is to offer screening tests with high detection rates and low false positive rates that also provide patients with diagnostic testing options, if the screening test indicates that the patient is at an increased risk for having a child with Down syndrome. Because of the number of multiple screening strategies currently available, the document provides ob-gyns with some suggested screening strategies that they can choose to offer in their practice to best meet the needs of their patients. The guidelines discuss the advantages and disadvantages of each screening test and some of the factors that determine which screening test should be offered, including gestational age at first prenatal visit, number of fetuses, previous obstetrical and family history, and availability of various screening tests.

The following ACOG recommendations are based on good and consistent scientific evidence: First-trimester screening using both nuchal translucency (NT), an ultrasound exam that measures the thickness at the back of the neck of the fetus, and a blood test is an effective screening test in the general population and is more effective than NT alone. Women found to be at increased risk of having a baby with Down syndrome with first-trimester screening should be offered genetic counseling and the option of CVS or mid-trimester amniocentesis. Specific training, standardization, use of appropriate ultrasound equipment, and ongoing quality assessment are important to achieve optimal NT measurement for Down syndrome risk assessment, and this procedure should be limited to centers and individuals meeting this criteria. Neural tube defect screening should be offered in the mid-trimester to women who elect only first-trimester screening for Down syndrome.

*ACOG News Release, Practice Bulletin #77, “Screening for Fetal Chromosomal Abnormalities,” is published in the January 2007 issue of Obstetrics & Gynecology.*



### Report on Innovative Approaches for Improving Pediatric Subspecialty Care Released

“Promising State and Regional Approaches for Extending Access to Pediatric Subspecialty Care and Coordination with Primary Care” presents thirteen examples of exemplary efforts to extend the geographic reach of pediatric subspecialty care and to enhance the capacity of pediatric health professionals to identify and manage chronic conditions. The report is the second in a series of promising practices reports prepared by the Federal Expert Work Group on Pediatric Subspecialty Capacity, convened by the Maternal and Child Health Policy Resource Center with support from the Maternal and Child Health Bureau.

The report is divided into three sections. The first section describes the rationale for strengthening state and regional networks of pediatric subspecialty care within the context of the medical home and the major barriers affecting the expansion of state and regional pediatric specialty systems linked with primary care.

The second section contains descriptions of thirteen promising state and regional pediatric delivery networks. The third section identifies promising features of state and regional pediatric subspecialty arrangements.

The report is available at: [www.mchpolicy.org/practice/documents/StateandRegionalPromisingPractices.pdf](http://www.mchpolicy.org/practice/documents/StateandRegionalPromisingPractices.pdf).

# Neonatal Sepsis: Keeping Those Bugs in Check!

Beth Diehl-Svrjcek, Neonatal Transport Nurse, Maryland Regional Neonatal Transport Program, The Johns Hopkins Hospital, and BDS Consultants, LLC

The incidence of infection is higher in the neonatal period than at any other time in life, even if preterm babies are excluded. In the United States, the incidence is two to four cases per 1000 live births.

Factors that determine increased susceptibility are:

- ◆ Immaturity of the immune system;
- ◆ Exposure to microorganisms from the maternal genital tract;
- ◆ Exposure to viruses from mother without antibodies (Rubella, Herpes, Varicella);
- ◆ Peri-partum factors (Trauma to skin, scalp electrodes);
- ◆ Portals of colonization and subsequent invasion (Eye, skin, umbilicus);
- ◆ Exposure to organisms postnatally; exposure in neonatal unit to organisms from other babies.

The incidence of infection increases with falling birth weight or gestation and low birth weight is the single most important independent variable predisposing to sepsis.

Reasons for greater susceptibility to infection in pre-term neonates includes: invasive procedures, increased postnatal exposure, poor surface defenses, prolonged mechanical ventilation, and resistant organisms. Infections of the neonate can be classified as early or late onset depending on the pathogenesis. Sources vary but early onset infection generally occurs within the first week of life. The sepsis progresses rapidly and babies are often systemically infected at delivery. Ascending infection via the maternal genital tract is the major cause of early onset sepsis, but trans-placental infection can also be the culprit. *Group B streptococcus* is the most common causative organism followed by *Escherichia coli* and then *Listeria monocytogenes*. The mortality rate of early onset sepsis is 10 to 30 percent. In late onset sepsis, the organism first colonizes the baby and only later invades to cause sepsis.

These colonizations occur in the upper respiratory tract, conjunctivae, umbilicus, and skin. The organisms can be acquired perinatally or nosocomially. Organisms causing late onset sepsis are most commonly Coagulase-negative staphylococci, followed by *Staphylococcus aureus* and then *Escherichia coli*. The mortality rate is 5 to 10 percent. The clinical signs of sepsis are often nonspecific. A clinical diagnosis of sepsis overrules any rapid diagnostic laboratory test and empirical antibiotics should be started on suspicion of sepsis. About 30 percent of babies with sepsis are normothermic, 50 percent are febrile and 15 percent are hypothermic. A rational approach to antibiotic therapy is to start early and stop early. Babies with early onset respiratory distress should be started on antibiotics if one or more maternal risk factor exist. The spontaneous onset of pre-term labor is the most common risk factor for sepsis. In addition, antibiotic use should be as narrow spectrum as possible to cover likely organisms. For early onset sepsis, this means the use of Penicillin or Ampicillin and an aminoglycoside such as Gentamicin. For late onset sepsis, Methicillin or Vancomycin and an aminoglycoside are utilized. Antibiotics should be stopped after 48-72 hours if blood cultures are negative. In the case of a positive blood culture, antibiotics are continued for 7 to 10 days, 14 days for *Listeria sepsis* and 14 to 21 days for *Group B Strept meningitis* and at least 21 days for *Gram-negative meningitis*. If prior to a requested transport, the neonate has risk factors for sepsis, the drawing of a CBC, CRP and blood cultures and the initiation of antibiotics is always appreciated!

References: Issacs, D. and Moxon, E. R. Handbook of Neonatal Infections: A Practical Guide. Philadelphia: W. B. Saunders Co. 2003. Karlsen, KA. (2006). The S.T.A.B.L.E. Program learner manual (5th ed.). ParkCity, UT: The S.T.A.B.L.E. Program.

## FDA Approves Head-Cooling Device to Treat Newborn Brain Disorder

The Olympic Cool-Cap has received premarket approval from the Food and Drug Administration as a Class III medical device. The Cool-Cap system for the treatment of hypoxic ischemic encephalopathy (HIE), which affects 5,000 to 9,000 newborns yearly, provides head cooling to prevent or reduce the severity of neurologic injury.

Historically about 20 percent of HIE babies died and another 25 percent suffered permanent disability because of neurological deficits.

The Olympic Cool-Cap system consists of a cooling unit, a control unit, temperature probes and a water-filled cap.

In a four-year international multi-center study, when head cooling therapy was administered to patients within the first six hours of life, lowering the body temperature three to four degrees Centigrade, the severity of brain injury was significantly decreased. At 18 months of age, there were fewer deaths and severe cases of neurodevelopmental disability in the cooled group compared with the control group.

In accordance with the FDA approval conditions, Olympic Medical Corporation of Seattle, maker of the device, will set up a patient registry to collect information on device usage and to track treatment outcomes.

The company will also organize a training and certification process for all operators of the device. The FDA also directed Olympic to restrict the use of the device to patients who meet the eligibility criteria defined by the original study.



## Managed Care and the Complaint Process for Recipients

*Ann Price, Chief, Division of Outreach and Care Coordination, HealthChoice and Acute Care Administration*

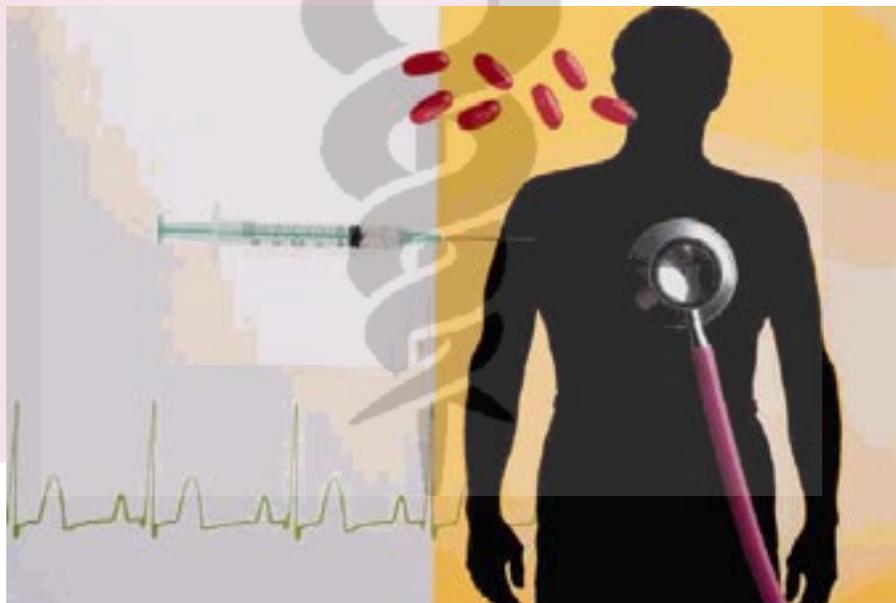
HealthChoice is Maryland's Medicaid Managed Care Program. HealthChoice members who are having trouble getting health care from their Managed Care Organization (MCO) or doctor can get help by contacting their MCO or calling the State's HealthChoice Enrollee Action Line at 1-800-284-4510.

Enrollees are encouraged to call their MCO first if they are having trouble getting an appointment, finding a specialist, getting medications at a pharmacy, need help getting transportation to a medical appointment, or have questions about their care. All MCOs have dedicated Member Service representatives, who will work with the enrollee to assist them in their health care.

If the recipient did not get all their questions answered, were denied care they believe they need, or want to talk to someone about their MCO or doctor, they can call the Enrollee Action Line at 1-800-284-4510. Staff at the Action Line will collect the pertinent information and work with the enrollee in the resolution of the problem. If the problem is medical in nature, or if the issue cannot be handled immediately, the staff will transfer the call to a Nurse Resolver. The Nurse Resolver will work with the enrollee, the MCO and the provider to assist in the resolution of the case. A referral to the local health department Administrative Care Coordination Unit (ACCU) or Ombudsman program may be made to provide localized assistance or education for the enrollee and/or provider.

If the enrollee does not agree with DHMH's decision, s/he has the right to request an appeal immediately or any time up to 30 days from the date of the adverse decision. An enrollee may appeal a decision by calling or sending a request for appeal to DHMH. A hearing will take place through the Office of Administrative Hearings (OAH).

Following the hearing, the Office of Administrative Hearings (OAH) will issue a final decision. Further appeals may be requested according to the Annotated Code of Maryland.



*Maryland*  
MEDICAL PROGRAMS

## The Maryland Tobacco Quitline

The Maryland Tobacco Quitline—1-800-QUIT NOW (1-800-784-8669)—is a FREE service provided by the Maryland Department of Health and Mental Hygiene, launched in June 2006. The Quitline provides telephone-based counseling to Maryland residents who are 18 years of age and older and who are interested in quitting smoking. The Quitline is available seven days a week, from 8:00 a.m. to midnight. Services are available in English, Spanish, and additional languages. If desired, callers can also be referred to their local health department for cessation classes, in person counseling, and, upon qualification, for free medications.

The Maryland Tobacco Quitline also provides information to non-smokers to assist a family member, a friend, a patient or client. Health providers can also become a certified Fax to Assist provider, in which they can register to have the Quitline make outgoing counseling calls to patients who want to quit. To become a certified Fax to Assist provider visit [www.MDQuit.org](http://www.MDQuit.org).

For more information on The Maryland Tobacco Quitline contact Sara Wolfe, Maryland Tobacco Quitline Coordinator, at [swolfe@dnhm.state.md.us](mailto:swolfe@dnhm.state.md.us) or visit [www.SmokingStopsHere.com](http://www.SmokingStopsHere.com).



## The Maryland Quitting Use and Initiation of Tobacco Resource Center

The Maryland Quitting Use and Initiation of Tobacco Resource Center (MDQuit) is a free state-of-the-art tobacco use cessation and prevention resource for health care providers, educators, and others in Maryland working to reduce the morbidity and mortality from tobacco. MDQuit has been established in collaboration with the Maryland Department of Health and Mental Hygiene to assist programs and providers in reducing tobacco use among citizens across the state.

For more information on MDQuit (including the Fax to Assist program, current information about programs and materials for cessation and prevention, tailored information for providers, as well as information to address special populations), visit [www.MDQuit.org](http://www.MDQuit.org), call 410-455-3628, or email: [info@MDQuit.org](mailto:info@MDQuit.org).



## Tobacco Prevention Resource

The American Legacy Foundation develops national programs that address the health effects of tobacco use through grants, technical training and assistance, youth activism, strategic partnerships, counter-marketing and grass roots marketing campaigns, public relations, research, and community outreach to populations disproportionately affected by the toll of tobacco.

Information is available on the Web site in the Learn to Quit section, including resources, programs and links to other resource sites. One program is Great Start, a national media campaign designed to inform women about the importance of quitting smoking during pregnancy, which threatens the health of mothers and babies across the nation. Quitting is one of the most important actions a woman can take to improve the outcome of her pregnancy.

Visit: [www.americanlegacy.org/index.html](http://www.americanlegacy.org/index.html)

## Revised FDA Tamiflu Warning

Roche and the Federal Drug Administration (FDA) notified healthcare professionals of revisions to the PRECAUTIONS/Neuropsychiatric Events and Patient Information sections of the prescribing information for Tamiflu, indicated for the treatment of uncomplicated acute illness due to influenza infection in patients one-year and older who have been symptomatic for no more than two days and for the prophylaxis of influenza in patients one year and older.

There have been postmarketing reports (mostly from Japan) of self-injury and delirium with the use of Tamiflu in patients with influenza. People with the flu, particularly children, may be at an increased risk of self-injury and confusion shortly after taking Tamiflu and should be closely monitored for signs of unusual behavior. A healthcare professional should be contacted immediately if the patient taking Tamiflu shows any signs of unusual behavior.

For details: [www.fda.gov/medwatch/safety/2006/safety06.htm#tamiflu](http://www.fda.gov/medwatch/safety/2006/safety06.htm#tamiflu)

## Maryland Patient Safety Center Announces the Perinatal Collaborative

The goal of the Perinatal Collaborative is to create a perinatal service that delivers care reliably with a goal of zero preventable adverse outcomes.

Promoting healthy outcomes is among the top priorities identified by the Maryland Department of Health and Mental Hygiene for improving health care in the state. Research indicates that mothers and babies remain at risk of unintended injury during labor and birth in the American healthcare system. The major underlying causes for this risk are both human and system error.

According to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), team communication was the leading root cause in 42 sentinel events involving infant death, and team culture was identified as the underlying cause. Other causes included staff competency, orientation and training process, and inadequate fetal monitoring. One way to curtail the risks of labor and delivery in Maryland is to transform the health care system's culture so that it engenders more proactive behaviors toward safe care.

An effective model for initiating systemic transformation is the Breakthrough Series (BTS) Collaborative approach developed by the Institute for Healthcare Improvement (IHI). By participating in the Maryland Patient Safety Centers Perinatal Collaborative process you will be joining your labor and delivery colleagues to improve perinatal care outcomes in Maryland.

There are documents available at the Maryland Patient Safety Web site including a complete brochure, registration form, memorandum of understanding (MOU) and a document to help you form a collaborative team.

Visit: [www.marylandpatientsafety.org/html/collaboratives/perinatal/index.html](http://www.marylandpatientsafety.org/html/collaboratives/perinatal/index.html)

For additional information please contact: Sheila Agyeman, 410-712-6083 ext. 7661, toll free (800) 876-3362, Email: [agyemans@dfmc.org](mailto:agyemans@dfmc.org)



### Parent Booklet on Non-Maternal Child Care and Children's Development

The NICHD Study of Early Child Care: Findings for Children Up to Age 4-1/2 Years examines how differences among families, children, and child care features are linked to children's intellectual, social, and emotional development and health.

The booklet, published by the National Institute of Child Health and Human Development, presents selected findings from a comprehensive study of children and the many environments in which they develop.

Study findings on child care quality, quantity, and type, as well as on family features, are presented. Information about the families and the sites involved in the study, as well as about the child, family, and home features measured, are provided. The Positive Caregiving Checklist and references are also included.

The booklet, intended to inform parents' decisions about child care and to help parents understand their child's development, is available at

[www.nichd.nih.gov/publications/pubs/upload/seccyd\\_051206.pdf](http://www.nichd.nih.gov/publications/pubs/upload/seccyd_051206.pdf)

MARYLAND  
*Patient Safety*  
CENTER



## Workplace Support for Breastfeeding Moms: Everybody Wins

A newly-formed partnership of state agencies seeks to make breastfeeding easier for Maryland's mothers by engaging support from their employers.

Maryland's Department of Health and Mental Hygiene and Department of Business and Economic Development have joined forces to offer the Breastfeeding-Friendly Workplace Award to employers whose policies encourage new mothers to continue breastfeeding their babies after returning to work.

Employers can earn the Breastfeeding-Friendly Workplace Award by providing mothers with adequate break time and a private, quiet area to pump and store breast milk. The award program will be administered through the Maryland Breastfeeding Coalition, which will review applications from employers seeking the Breastfeeding-Friendly designation. The coalition also offers a toolkit to employers who are interested in learning how to make their workplace more breastfeeding-friendly.

Seventy-five percent of new mothers in Maryland initiate breastfeeding when their babies are born, but only 18 percent are still breastfeeding at 12 months, according to the Centers for Disease Control and Prevention (CDC). Most health experts, including the American Academy of Pediatrics, recommend that infants be exclusively breastfed for the first six months, and that breastfeeding continues along with complementary foods for the remainder of the first year.

Breastfeeding provides a host of health benefits to both mothers and babies, including a lowered risk of breast and ovarian cancer for mothers, and less illness and infections for infants. Healthcare costs are also lower for breastfed infants, since they typically need fewer sick care visits, prescriptions, and hospitalizations. "It is imperative we do everything we can to improve the health of infants and mothers in Maryland," said Secretary of Health and Mental Hygiene S. Anthony McCann.

Breastfeeding also contributes to a more productive workforce, since mothers who breastfeed miss less work because their infants are sick less often. Employer medical costs also are lower and employee productivity is higher. "A workplace that makes mothers happier and babies healthier makes economic sense for employers," said Aris Melissaratos, Secretary of Business and Economic Development. "A more mother-friendly workplace reduces health care costs, lowers employee absenteeism, and improves workplace satisfaction."

Despite these benefits, many mothers give up breastfeeding after they return to work, often due to the lack of time or facilities to use a breast pump while at work. The Breastfeeding-Friendly Workplace Award program kicks off in September to follow Breastfeeding Awareness Month in August.

For more information about this program, call Mary Johnson at 410-767-5581 or visit the Web site at [www.marylandbreastfeeding.org](http://www.marylandbreastfeeding.org).

### Maryland Breastfeeding Coalition Resources for Employers

The Maryland Breastfeeding Coalition of the Department of Health and Mental Hygiene, Center for Maternal and Child Health, has developed an Employer's Toolkit consisting of four new information pieces geared towards helping employers consider and provide for the needs of their breastfeeding employees.

The titles are:

- ▲ Breastfeeding Supports Employees
- ▲ Workplace Guidelines for Mothers' Room
- ▲ Breastfeeding Friendly Award Application
- ▲ Breastfeeding Benefits Flyer

The materials can be downloaded from: [http://www.fha.state.md.us/mch/breastfeeding/html/employer\\_toolkit.cfm](http://www.fha.state.md.us/mch/breastfeeding/html/employer_toolkit.cfm)

For further information contact: Mary D. Johnson, Maryland Breastfeeding Coalition, 410-767-5581 or [MDJohnson@dhmh.state.md.us](mailto:MDJohnson@dhmh.state.md.us).



## Evaluating Intervention Aimed at Preventing Alcohol-Exposed Pregnancies

“This randomized trial found that a brief motivational intervention considerably decreased the risk of alcohol-exposed pregnancy (AEP) in high risk women by altering the targeted behaviors of risky drinking and ineffective contraception use,” state the authors of an article published in the American Journal of Preventive Medicine. The Project CHOICES Feasibility Study, a single-arm trial, evaluated a motivational intervention for women determined to be at risk for an AEP. At six months post-enrollment, 68.5 percent of the women had reduced their risk for AEP by reducing drinking, using effective contraception methods, or both. The article presents major findings from a randomized controlled trial following the feasibility study.

Project CHOICES was conducted in six community-based settings in Florida, Texas, and Virginia. The risk of AEP in these combined settings was estimated to be 12.5 percent, compared with two percent of fertile women of childbearing age in the United States overall. Recruitment strategies included flyers, newspaper and radio announcements, and group presentations. Recruitment was conducted from July 1, 2002, to January 30, 2004. Inclusion criteria were as follows: (1) 18-44 years old; (2) no condition causing infertility; (3) not pregnant or planning to become pregnant in the next 9 months; (4) had vaginal intercourse during the previous three months with a fertile man without using effective contraception; (5) engaged in risky drinking; and (6) available for the follow-up period.

Participants (N=830) were randomized into two groups: information only (IO; the control group) and information plus counseling (IPC; the intervention group). Women assigned to the IO group received brochures on alcohol use and women’s health in general and a referral guide to local resources. Intervention visits comprising four motivational interviewing counseling sessions and one contraception counseling session were delivered to the IPC group for 45 to 60 minutes each over a 14-week period, with approximately two to three weeks between sessions. Participants were contacted at three, six, and nine months for follow-up assessments. At baseline, all women reported risky drinking (defined as consuming five or more drinks on any day, or on average eight or more drinks per week) and ineffective contraception (any occurrence of vaginal intercourse without effective contraception use). At follow-up, women were categorized as “at reduced risk of AEP” if they reported no risky drinking, effective contraception use, or both.

The authors found that:

- ★ Across all three phases of follow-up (three, six, and nine months), the unadjusted odds of being at reduced risk for an AEP were approximately twofold greater in the IPC group than in the IO group.
- ★ After controlling for confounders, odds ratios increased slightly, with women in the IPC group again being significantly more likely to be at reduced risk for an AEP, compared with women in the IO group.

The authors conclude that “this study demonstrated that a brief behavioral motivational intervention produced significant reductions in risk for AEP among women who met high-risk criteria prior to the study.”

Floyd RL, Sobell M, Velasquez MM, Ingersoll K, et al. 2007. Preventing alcohol-exposed pregnancies: A randomized controlled trial. *American Journal of Preventive Medicine* 32(1):1-10.

Abstract available at <http://dx.doi.org/>

Copy and paste the following into the textbox: doi:10.1016/j.amepre.2006.08.028

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## Maryland Fetal Alcohol Spectrum Disorder Coalition (FASD)

The Maryland FASD now has a speaker’s bureau, consumer brochure, and professional’s brochure available. Promotional materials can be ordered from Mary Johnson, Maryland State FASD Coordinator, Department of Health and Mental Hygiene, Center for Maternal and Child Health.

Phone: 410-767-5581

Fax: 410-333-5233

MDJohnson@dhmh.state.md.us

There’s a form on the Web site to download material orders.

[www.fha.state.md.us/mch/fasd/](http://www.fha.state.md.us/mch/fasd/)



## Intervention Kit to Prevent Fetal Alcohol Spectrum Disorders

*Drinking and Reproductive Health: A Fetal Alcohol Spectrum Disorders Prevention Tool Kit* presents strategies to help health professionals identify women who drink at risky levels and engage them in changing behavior to reduce their risk for an alcohol-exposed pregnancy. The continuing education activity, sponsored by the American College of Obstetricians and Gynecologists with support from the Centers for Disease Control and Prevention, is designed to help health professionals who care for women prevent fetal alcohol spectrum disorders (FASD) when they encounter risky drinking, regardless of the woman’s pregnancy status. More information is available at: [www.acog.org/from\\_home/misc/dept\\_pubs.cfm](http://www.acog.org/from_home/misc/dept_pubs.cfm).

## Maryland's Folic Acid Program

In March 2002, the Center for Maternal and Child Health (CMCH) accepted the March of Dimes Folic Acid Leadership Grant Award for \$15,000. Under this grant and through collaboration with WIC, the Department of Health and Mental Hygiene agreed to provide leadership and administrative support for continued folic acid activity in our State. These funds provided support for the council meetings and folic acid education activities. Another \$15,000, from the March of Dimes, supported the Council activities in 2003. Although these funds ended in December of 2003, CMCH is committed to continuing the folic acid message across Maryland.

The Council includes representation from the Center for Maternal and Child Health; the Maryland WIC Program; Health Choice and Acute Care Administration, Department of Health and Mental Hygiene; Office of Genetics and Children with Special Health Care Needs (DHMH); Local Health Departments; Chesapeake-Potomac Spina Bifida Association, Inc.; Maryland State Department of Education; Johns Hopkins University; Mid Shore Perinatal Advisory Council; March of Dimes; and a local pharmacist. The Council is co-chaired by the Center for Maternal and Child Health and the Maryland WIC Program.

As part of their efforts to increase the awareness of the need for folic acid for all men and women, display boards have been developed. These display boards spread the message of folic acid helping to prevent birth defects of the brain and spinal cord, as well as, other health benefits. Five display boards are located regionally throughout the State with WIC Directors. They are being marketed for use by local health departments for various events within their jurisdictions. Fact sheets have been created to spread the broader health message of folic acid to accompany the display boards.

During the 2006 legislative session, HB 507 passed providing for distribution of folic acid to women of childbearing years who are at or 185 percent of poverty level. This legislation was contingent upon funding which did not come about. However, with funds under the Babies Born Healthy Initiative funds became available to pilot this program in the Maternal and Child Health/Women, Infants and Children Collaborative (further information on these pilots can be found in this newsletter).

## Maryland Folic Acid Display Board Contacts

### Baltimore City

Pam Putman, RN, MPH, MCH Nurse Consultant  
Center for Maternal and Child Health  
Maryland Dept. of Health and Mental Hygiene,  
201 West Preston Street, Room 317, Baltimore, MD 21201  
Phone: (410) 767-6713, Fax: (410) 333-5233  
E-mail: [putmanp@dhhm.state.md.us](mailto:putmanp@dhhm.state.md.us)

### Central Maryland

Tracey Leef, RD, LD, WIC Coordinator  
Frederick County WIC Program  
350 Montevue Lane, Frederick, MD 21702  
Phone: (301) 694-2507, Fax: (301) 631-3193  
E-mail: [tleef@fredco-md.net](mailto:tleef@fredco-md.net)

### Western Maryland

Carol Bass, Director, Garrett County WIC Program  
1025 Memorial Drive, Mountain Lake Park, MD 21550  
Phone: (301) 334-7711, Fax: (301) 334-7771  
E-mail: [cbass@dhhm.state.md.us](mailto:cbass@dhhm.state.md.us)

### Eastern Shore

Shannon Morris, WIC Director, Wicomico County Health Department  
801 North Salisbury Road, Salisbury, MD 21801  
Phone: (410) 749-2488, Fax: (410) 548-5166  
E-mail: [shmorris@dhhm.state.md.us](mailto:shmorris@dhhm.state.md.us)

### Southern Maryland

Sandy Webb, RN, CNP, Director, Southern Maryland WIC Program  
Charles County Health Department, P.O. Box 1050/4545 Crain Highway  
White Plains, MD 20695  
Phone: (301) 609-6812, Fax: (301) 934-0922  
E-mail: [webbs@dhhm.state.md.us](mailto:webbs@dhhm.state.md.us)

## Folic Acid Materials Available

Sponsored by the March of Dimes and the National Alliance for Hispanic Health and managed by the National Folic Acid Council (NCFAC), a project of the National Healthy Mothers, Healthy Babies Coalition, the tool kit contains a media outreach worksheet and outreach activity ideas, including activities for the Hispanic community, a fact sheet and local press release (in English and Spanish.) Materials may be downloaded from the NCFAC Web site, or ordered free-of-charge.

More information is available at: [www.folicacidinfo.org/campaign](http://www.folicacidinfo.org/campaign).

## Continuing Education Course on Folic Acid Counseling

ABCs of Folic Acid Counseling is a new continuing education (CE) tutorial designed to help health professionals learn how to counsel women about folic acid and help them reduce their risk of having a child with spina bifida. Developed by the Spina Bifida Association and the Centers for Disease Control and Prevention, topics addressed include the importance of folic acid, folic acid recommendations, and the steps in folic acid counseling.

Guidance on how to conduct a one-minute folic acid counseling session during an interaction with a woman, how to identify women at risk for recurrence of spina bifida or another neural tube defect, and how to prepare evaluation plans for folic acid counseling is also provided. CE credits are offered for nurses and health educators, based on one hour of instruction. The tutorial is available at <http://sba-resource.org/sbaacd>.

# Calendar Events

## March

24

### G.I.R.L.S. Only Conference

Over 200 young women will attend the G.I.R.L.S Only conference at Coppin State University in Baltimore. Sponsored by a consortium of government and non-profit agencies, the G.I.R.L.S Only conference, whose acronym stands for Girls who are Independent, Resourceful, Leaders and are Strong, will target middle school girls, ages 11-14 years old with a diverse array of events to highlight girl power.

The free conference will offer dynamic workshops, speakers, leaders, activities and performers who are all involved with empowering and celebrating girls. Some of the workshops include: Abstinence in the City: Everybody is Not Doing It, College Girl and Express Yourself: Slam Poetry which focuses on the young women making positive life choices. Although the conference targets middle school aged young women, parents in attendance will gain insight on building stronger relationships with their daughters. Three workshops will cover topics such as Parent-Child Connectedness, Setting Boundaries, and Improving Parent-Child Communication.

For more information regarding the G.I.R.L.S Only conference, please contact Bronwyn Mayden at 410-706-2077 or [bmayden@umaryland.edu](mailto:bmayden@umaryland.edu).

## April

15

### ICAP Conference for Teen Parents

Held at the University of Maryland, Shady Grove Campus. Sponsored by the ICAP and funded by Montgomery County's Collaboration Council for Children, Youth and Families. Further information is available by contacting M Jane Larsen, RN, Consultant, Teen Pregnancy Prevention Coordinator, 240-777-1570 or [Jane.Larsen@montgomerycountymd.gov](mailto:Jane.Larsen@montgomerycountymd.gov)

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Twenty-fifth Annual Reproductive Health Update

Will be held in Clarksville (Howard County), at the Ten Oaks Ballroom and sponsored by the Maryland Department

of Health and Mental Hygiene, TRAINING 3, and Howard Community College. The program provides a comprehensive review of family planning knowledge, skills, and issues for reproductive health care providers in Maryland and the region who offer low-cost, high quality reproductive health services to women and men in need. This year's conference topics will include: current trends in contraceptive options and management; today's issues in cervical cancer screening, HPV testing, and vaccines; helping women make positive changes in health practices; smoking cessation techniques for use in the family planning clinic setting; and adolescent obesity and complications. The cost of the day-long conference will be \$35, which includes continental breakfast, lunch, breaks, and all conference materials. Brochures will be available by mid-March. Application is being made for nursing, social work, and nurse-midwifery continuing education credits.

For more information, contact Helene O'Keefe at the Center for Maternal and Child Health, DHMH at 410-767-6723, or [okefeh@dhhm.state.md.us](mailto:okefeh@dhhm.state.md.us).

## May

17

### Maryland Fetal Alcohol Spectrum Disorder Meeting

12:30 p.m. Location to be announced.

23

The Maryland Annual STD meeting a free one-day conference, is scheduled for Wednesday, May 23, 2007 and will be directed towards clinicians and staff working in the field of STD treatment and prevention. CEUs will be offered. More details will be available after April 15th.

For questions contact Heather Rutz, Maryland Department of Health and Mental Hygiene, at 410-767-6982, or [HRutz@dhhm.state.md.us](mailto:HRutz@dhhm.state.md.us).

## June

15

### Maryland Maternal and Child Health Update

Time: 8:30 a.m.—4:00 p.m. At the

Ten Oaks Ballroom, Howard County. Conducted for Health Department staff in MCH programs.

For further information: Lois Beverage 301-609-6803; [loisb@dhhm.state.md.us](mailto:loisb@dhhm.state.md.us)

## August

16

### Maryland Fetal Alcohol Spectrum Disorder Meeting

12:30 p.m. Location to be announced.

## September

20

### Maryland Fetal Alcohol Spectrum Disorder Conference

Location to be announced at a later date.

## November

15

### Maryland Fetal Alcohol Spectrum Disorder Meeting

12:30 p.m. Location to be announced.