SWEET SUCCESS:
DIABETES AND PREGNANCY NEWSLETTER
FROM CDAPP REGIONAL PROGRAMS

Appropriate Weight Gain in Pregnancy

(Excerpts from proposed Nutrition Chapter of CDAPP Guidelines for Care, 2010 revisions)

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The revisions of the CDAPP Guidelines for Care are in the final stages of review and approval with the California Department of Public Health. We have obtained permission to print excerpts from the proposed nutrition chapter to answer burning questions raised with the 2009 release of the revised Institute of Medicine (IOM) weight gain guidelines. Weight gain charts to accommodate these proposed guidelines are in the review approval stages as well and will be released with the 2010 CDAPP Guidelines for Care.

The nutrition chapter will include sections on the different stages of the reproductive cycle: preconception and interconception, pregnancy, postpartum and lactation. This excerpt will only cover certain aspects of the pregnancy section.

Energy Needs During Pregnancy

Energy needs for a woman with preexisting diabetes increase during pregnancy. However, during the first trimester the woman's energy and nutrient needs remain the same as during the preconception period, unless there are complications of nausea, vomiting or hypoglycemia. Major changes in diet composition may disturb glycemic control and are not recommended in the first trimester. In the second and third trimesters, daily energy requirements gradually increase. See Table 1 to calculate energy needs in pregnancy.

At this time there is no consensus on determining energy requirements for overweight and obese pregnant women. A registered dietitian should evaluate each individual's case and provide the necessary education and monitoring to achieve weight gain goals. Some women, especially those who are sedentary and/or live in developed countries, may not need the recommended additional kilocalories.

Kilocalorie needs for a pregnant woman with diabetes vary depending on her

Table 1: ENERGY NEEDS FOR PREGNANCY BASED ON GESTATIONAL AGE—Estimated Energy Requirements (EER)

The Institute of Medicine formulas for estimating the energy requirements for pregnant women who have ***normal weight*** are as follows:

- 1st trimester = Adult EER + 0
- 2nd trimester = Adult EER + 160 kcal (8 kcal/wk x 20 wk) + 180 kcal
- 3rd trimester = Adult EER + 272 kcal (8 kcal/wk x 34 wk) +180 kcal

This project is supported in part by funds received from the California Department of Public Health, Maternal, Child, and Adolescent Health Program.

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BMI, activity level, age, whether the pregnancy has single or multiple fetuses, pregravid weight and other factors.

The goal is to meet nutrition and energy requirements for normal fetal growth with appropriate maternal weight gain. To meet pregnancy energy demands, the method reviewed in Table 1 can be used to calculate kilocalorie needs. Energy needs may require adjustment during pregnancy based on blood glucose values, ketone levels and weight gain parameters.

Body Mass Index

Body Mass Index (BMI) is used to determine the woman's preconception weight category. BMI is calculated based on pregravid weight using the equation in Table 2.

BMI Cut-Offs

BMI cut-off points are used clinically to identify individuals for:

- absolute risk assessment
- determining the type and intensity of treatment
- monitoring individuals for effects of treatment over time
- determining institutional policies on individuals
- increasing awareness of risk for individuals

Risk assessment for GDM should be done on all pregnant women at the first prenatal visit to determine the need for early testing. The American Diabetes Association recommends testing to detect diabetes for women with a pregravid BMI $\geq$ 25 or any of these additional risk factors: previous GDM, presence of glucosuria, diagnosis of Polycystic Ovary Syndrome, women of ethnic groups with a high prevalence of diabetes: African American, Latina, Native American, Asian American, and Pacific Islander, first-degree relative with diabetes, previous delivery of large-for-gestational age infant, or chronic use of medication that causes hyperglycemia (e.g. prednisone).

Previously, a confirming diagnosis for Type 1 diabetes (DM1) or Type 2 diabetes (DM2) was made outside of pregnancy. This has now changed. The recent ADA position statement based on recommendations from the International Association of Diabetes and Pregnancy Study Groups (IADPSG), recommends that a high-risk woman found to have diabetes at her initial prenatal visit, receive a diagnosis of overt, and not gestational diabetes. (ADA 2010).

The criteria of a BMI $\geq$ 25 for early screening by CDAPP is notably lower than the BMI > 29 which was the cut-off point for obesity according to the 1990 Institute of Medicine.

There are currently no specific IOM BMI cut-offs for women with diabetes. Sweet Success providers are encouraged to give women individualized recommendations on how to slow their weight gain in pregnancy and reduce their body fat composition. (See Table 3 on following page.)

In evaluating the woman's weight gain during pregnancy both total and rate of weight gain must be considered.

Determining Appropriate Weight Gain Based on Prepregnancy BMI Categories

Overweight

There are many publications addressing maternal and fetal complications in women who exceeded the 1990 IOM weight gain recommendations. These include a higher risk of primary cesarean section, preterm delivery, large for gestational age (LGA) infant and more need for medical therapy to control blood glucose levels. Lower amounts of gestational weight gain may be more appropriate for women with insulin resistance, especially if they are provided Medical Nutrition Therapy which focuses on optimal nutrient intake and minimal use of discretionary calories. The IOM does not have specific weight gain recommendations for pregnant women with diabetes. However, until further research is available,

*Table 2: CALCULATING BODY MASS INDEX (BMI) **

To calculate BMI using U.S. imperial units:	To calculate BMI using metric units:
BMI = 703 x (Weight (lb) ÷ Height (in)^2)	BMI = Weight (Kg) ÷ Height (meters)^2
Example: Woman is 5'6" and 155 lbs BMI = 703 x (155 ÷ (66)^2) BMI = 703 x (155 ÷ 4356) BMI = 703 x .036 BMI = 25	Example: Woman is 1.68 m and 70.5 Kg BMI = 70.5 Kg ÷ (1.68 m)^2 BMI = 70.5 Kg ÷ 2.82 m BMI = 25

* If the woman enters into the program during pregnancy, special efforts need to be made to determine her actual or most accurate pregravid weight.

Table 3: PREPREGNANT BMI CATEGORIES AND CUT-OFFS WITH RECOMMENDED WEIGHT GAIN

Weight Category	2009 IOM BMI	Recommended Total Weight Gain Ranges	Rate of Weight Gain (lb/wk) 2nd & 3rd Trimester
Underweight	< 18.5	28-40 lbs	1–1.3 lbs
Normal	18.5–24.9	25–35 lbs	0.8–1 lbs
Overweight	25.0–29.9	15–25 lbs	0.6 lbs
Obese	> 30.0	11–20 lbs	0.5 lbs

weight gain recommendations for women with diabetes in each BMI category should be in accordance with the 2009 IOM guidelines.

Women whose weights are at the higher end of the 2009 overweight BMI category are encouraged to gain toward the lower end of that recommended weight gain range.

Moderate caloric reduction of 30% of energy needs in obese women with GDM may improve glycemic control without ketonemia and reduce weight gain. Sustained weight loss is not recommended during pregnancy. If weight loss is sustained, carefully evaluate food records for adequacy of the diet and monitor urine ketones. Restricting usual caloric intake by 30-33% in obese pregnant women has been demonstrated to prevent macrosomia.

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Sweet Success Post Bariatric Surgery Guidelines

Geetha Desai, MS, RD, CDE, CLE and Leona Dang-Kilduff, RN, MSN, CDE Region 4

Nutrition Post Bariatric Surgery

Nutrition considerations related to pregnancy after bariatric surgery are directly related to the type of bariatric surgery performed. Types of bariatric surgery fall into two main classifications: restrictive surgery and malabsorptive surgery.

Restrictive bariatric surgery slows the emptying time of the stomach portion of the gastrointestinal tract and may reduce the size of the stomach. Two common forms are adjustable gastric banding (AGB), also known as lap band, and vertical banded gastroplasty (VBG). AGB creates a small pouch of stomach that holds approximately 1 ounce of food. A constrictive hollow band is placed at the low end of the small pouch and is inflated with saline solution. Patients can usually eat up to ¾ cup of food before they begin to feel full. The VBG works in a similar manner, however a combination of a hollow band and staples is used to achieve the same result.

Two common malabsorptive surgeries are Roux-en-Y gastric bypass (RGB) and biliopancreatic diversion (BPD). These surgeries bypass all or part of the small intestine resulting in food restriction and malabsorption. Not only is the volume of food and nutrients reduced but so is the absorption of important protein, vitamins and minerals. There is a higher risk of nutritional deficiencies with malabsorptive bariatric procedures.

Planning Pregnancy after Bariatric Surgery

Approximately 83% of bariatric surgery patients are women and many are of childbearing age. Pregnancy after bariatric surgery should not be attempted until weight loss and nutritional intake have been stabilized. Therefore, it is highly recommended that women who have had bariatric surgery wait at least 18 months before attempting pregnancy. Foods that can be difficult to tolerate during the year post surgery include fruits, vegetables and protein source foods, all of which are essential for a healthy pregnancy.

Although future studies are warranted, one study by Sheiner, et. al., has found bariatric surgery in patients with gestational diabetes was not associated with adverse perinatal outcomes. However, standard testing for gestational diabetes can become problematic for some pregnant women after bariatric surgery. A glucose tolerance test can bring on symptoms of dumping syndrome with nausea, abdominal cramps, diarrhea, and heart palpitations. If this is the case, it is recommended to do a fasting blood sugar and continuous glucose monitoring to assess for blood glucose variances requiring intervention. An A1C level is also suggested.

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Women who have had bariatric surgery and are considering pregnancy should ideally have preconception nutritional assessment and counseling. Laboratory data will assist in this assessment and if there are deficiencies they are best corrected early in the pregnancy. Ideally, the time to correct nutritional problems is preconception, making pregnancy planning the most sensible approach. Those who have had bariatric surgery should already be taking a multivitamin, preferably in a liquid or chewable form, to enhance absorption and avoid obstruction. Prenatal vitamins should be given in addition to the women's usually prescribed vitamin and mineral supplementation and not instead of that supplementation. Post stabilization, patients can usually ingest as little as 1200 kcal/day. Therefore, wise selection of protein, carbohydrates and healthy fats is imperative. Vitamins and minerals of particular importance during pregnancy after bariatric surgery are:

> "Screening with hypertonic glucose solutions can result in dumping syndrome"

Calcium

Post bariatric women many require 1,200-1,500mg of calcium to meet personal skeletal needs and needs for mineralization of the fetal skeleton. Calcium citrate with Vitamin D is the optimal form of calcium for bariatric patients since it does not require an acidic environment for metabolism to take place.

Folic Acid

Adequate folate absorption becomes a matter of concern for post bariatric surgery. Foods high in folic acid such as lentils, asparagus, spinach, broccoli, peanuts, orange juice, enriched breads and cereals may not be well tolerated and also many bypass the duodenum. Serum blood levels should be measured to verify this nutritional need is being met. Homocysteine may be the most sensitive markerof folic acid status in conjunction with erythrocyte folate. Supplementation of 800 - 1000 mcg/day folic acid will treat and/or prevent a deficiency. Greater than 1000 mcg/day is not recommended due to potential masking of a Vitamin B 12 deficiency.

Iron

Malabsorption and decreased nutritional intake may also cause iron deficiency post surgery. Iron in the form of ferrous fumerate, at a dose of 40 to 64 mg, is best tolerated because the iron has already been broken down from the ferric state making absorption more effective. Restrictive bariatric surgery patients may not require as much iron supplementation, but periodic hemoglobin levels should be taken to verify sufficiency.

Vitamin B12

Vitamin B12 absorption is greatly affected by the malabsorptive form of bariatric surgery due to lack of intrinsic factor. Deficiencies may result in elevated serum homocysteine levels that are related to early pregnancy loss. Women should be encouraged to take 500 mcg of Vitamin B12 daily in the crystalline form. Serum cobalamin levels should be periodically drawn to ensure Vitamin B12 intake is sufficient.

General Guidelines for Post Bariatric Surgery

There are no standardized nutritional guidelines for bariatric surgery. However, here are some recommended general guidelines that pertain to pregnant women who have had bariatric surgery.

- Protein should be preferentially eaten before fats and carbohydrates, ideally in the amount of 60-80 grams of protein per day.
- Each meal should take 20-30 minutes to eat, to avoid bolus eating and to allow the feeling of satiety to occur.
- Food should be well chewed and should be eaten in small volumes.
- Liquids should be avoided during meals. Ingest liquids 30-60 minutes before or after meals.
- Drink only sugar free, caffeine-free or decaffeinated, non- carbonated beverages.
- Eat three to six small meals per day.
- Avoid chewing gum, obstruction can occur if swallowed.

Glucose Screening Post Bariatric Bypass Surgery (Post Roux-en-Y or Gastric Sleeve Surgery)

Screening with hypertonic glucose solutions in women who have had prior gastric bypass surgery can result in dumping syndrome. Dumping or rapid gastric emptying happen when the lower end of the small intestine, the jejunum, fills too quickly with undigested food from the stomach. After ingestion, foods high in sugar can cause an osmotic shift in the small intestine, drawing fluid in. This causes a myriad of uncomfortable symptoms including lightheadedness, sweating, fatigue, nausea, vomiting, diarrhea, bloating, heart palpitations, and shakiness. Glucola testing should not be done in this population. However, these recommendations do not apply to women who have had laparoscopic adjustable banding.

Recommendations for screening women post gastric bypass surgery include the following two options:

- Fasting and 1 hour postprandial blood glucose level checked at 22- 24, 28-32, and 34 weeks gestation

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- Obtain fasting and 1 hour post-meal blood glucose for 1 week with a blood glucose meter while she continues her usual diet.

Treat as if she has GDM if abnormal glucose levels are detected at any testing point.

For parties interested in more detail please feel free to contact Geetha Desai at: rdgeeth@stanford.edu

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Every Woman California

Cathy Fagen, RD, MA and Katina Krajniak, RN Region 6.1

As a rule, finding a rare jewel usually takes time… and in our efforts as healthcare professionals, it also takes time to help our patients understand important, yet complex aspects of their personal health. This is true not only for the here and now but especially for the span of life. Currently many live their lives for the moment, but as gatekeepers, how can we spark an interest in our patients to look beyond the moment? This in itself is a rare jewel. Looking at improving health, creating a better quality of life and enhancing societal well-being requires a focus on preconception health.

For many years, the stride for improving preconception health has been developing on many fronts. Healthy People 2020 will contain recommended criteria that will focus on improving preconception care and healthy behaviors, under the Maternal, Infant and Child Health section (MICH HP2020-25). Recently a dynamic new website has come to help healthcare professional and consumer alike. "Every Woman California," www.everywomancalifornia.org is a jewel for all. The site has been able to capture the HP 2020 objectives in practical and usable ways. What you will find at the site is:

- Comprehensive preconception health information for consumers and providers

- Low-literacy, printer friendly handouts on 20 preconception topics:

  - Folic Acid, Guide to Healthier Eating, Healthy Weight, Physical Activity Guidelines, Medical Conditions, Genetic Conditions, Medications, Vaccines, Sexually Transmitted Diseases, Dental Health, Smoking, Drugs, Alcohol, Mental Wellness, Healthy Relationships, Hazardous Materials, Financial Stability, Food Safety Tips, Healthy Community and Make a Reproductive Life Plan

- Provider discussion forum and resource sharing

- Links to the latest preconception health resources including toolkits and best practice guidelines. All 20 easy-to-read educational handouts include the **take home message** of preconception care, "**Here are some ways to stay healthy EVERYDAY**," and they list the following information:

Exercise- 30 minutes daily

Vitamin- 400 micrograms of folic acid daily

Educate yourself about medicines and toxins that can cause birth defects

Reproductive life planning

Yearly doctor visits to discuss physical and mental wellness

Diet-vegetables, fruits and whole grains daily

Avoid tobacco, drugs and alcohol

Your Partner, friends, and family should be sources of support

This website includes information for women and men

who want to learn what they can do to be healthier for themselves and for their families. They can learn how to make a Reproductive Life Plan.

The key components of preconception health are a healthy body, a healthy mind and a healthy environment. Help yourselves help your patients and the public at large by logging on and telling others to log on to the website: www.everywomancalifornia.org. Materials are currently being translated into Spanish.

Kudos to the Preconception Health Council of California who has provided direction for the preconception activities delineated in the MCAH Division's Title V Implementation Plan. The Every Woman California website is one of its greatest accomplishments during this past year. Other accomplishments of the Council over the past three years include: contributing to the development of the CDC's clinical components of preconception care; hosting the Second National Summit on Preconception Care in Oakland; an education day for all the local MCAH directors; and an education day for legislators.

- CDAPP is listed as one of the professional resources on the Every Woman California website.
- CDAPP hosted a booth at the Second National Summit on Preconception Care in Oakland.
- Now CDAPP is represented on the Preconception Health Council to assist with a project to maximize the postpartum visit by addressing risk factors that could affect a subsequent pregnancy (ie diabetes).

Sweet Success 2009 Special Achievement Award Winners

Joann Henry, RNC, MSHS ***(Photo and information reprinted with permission)***

The Sweet Success Express Conference, November 5-7, 2009, recognized and rewarded Sweet Success affiliate programs for developing and sharing innovative programs, teaching tools, and educational materials that improve care to women with diabetes related to pregnancy. The 2009 winners include: *First Place*: Southwest Healthcare System, My Sweet Success Food Bank - Joyce Evans, RN and Debbie Edwards, RN, CDE (right); *Runner Up: St. Mary Medical Center, Culturally Appropriate Postpartum Screening of GDM Women – Rosa A. Rangel RN MSN/Ed CDE (left)*

Individual and Group Psychotherapy for Pregnant Women with Diabetes

Funded by a community grant from the March of Dimes

(Intended to Increase risk reduction education and /or services for all women of childbearing age, not a scientific study)

Noelle D. Coppola, MA, MFTI Region 5.0

Recently I ran into a friend who is pregnant and was just diagnosed with Gestational Diabetes (GDM). Within a couple of minutes we were discussing her concerns about the health of her baby. She talked about the frightening statistics she had discovered about GDM on the internet, and was baffled about how she contracted this illness. Instantly I was whisked back to the year I spent counseling underserved women in this same predicament. As I reflected more on my friend who is considered upper middle class and has good health insurance, I was reminded of how much more difficult it is for women without access to the same support and resources she has.

My time counseling these women all began with a reoccurring theme that seemed to come up at many site visits while working at CDAPP. This theme or question asked by many affiliates is, "What do I do with a patient who is non-compliant?" With the help of my director, and the California Health Collaborative we wrote and submitted a grant to the March of Dimes. It was accepted, and with their sponsorship, a great supervisor and one local affiliate I was able to address this issue. The Diabetes Care Center (DCC) in Fresno, CA was gracious enough to offer office space so I could in turn offer free individual and group counseling for their pregnant clients. With one year to impact 600 women, I surmised that an improvement in psychological well-being would directly correlate with an improvement in maternal self-care and compliance with medical care.

As I started my work at DCC it quickly became obvious that I would need to figure out how to normalize therapy in order to motivate these women to attend. This was done by offering services multiple times throughout pregnancy, as well as postpartum in the form of a "mommy and me" class. I attended DCC's nutrition class bi-weekly, and spoke on depression and other perinatal mood disorders during this time. In some cases getting these women to attend therapy required incentives, for others a referral from a caring staff member was the motivator. In the end the primary factor in getting them to begin counseling was simply being available for the women when they were already scheduled to be there. Making an

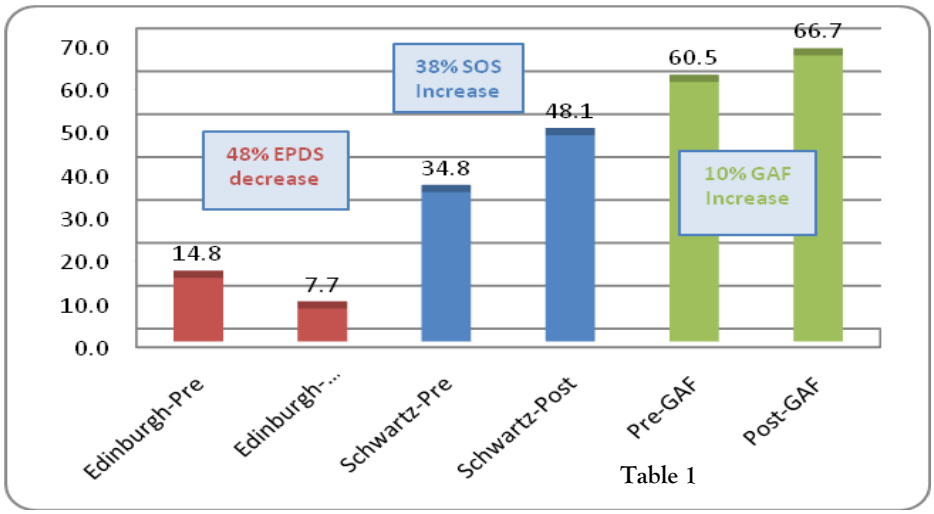


Table 1

appointment for therapy with these women before or after their regularly scheduled diabetes appointment was the most effective way to offer therapy.

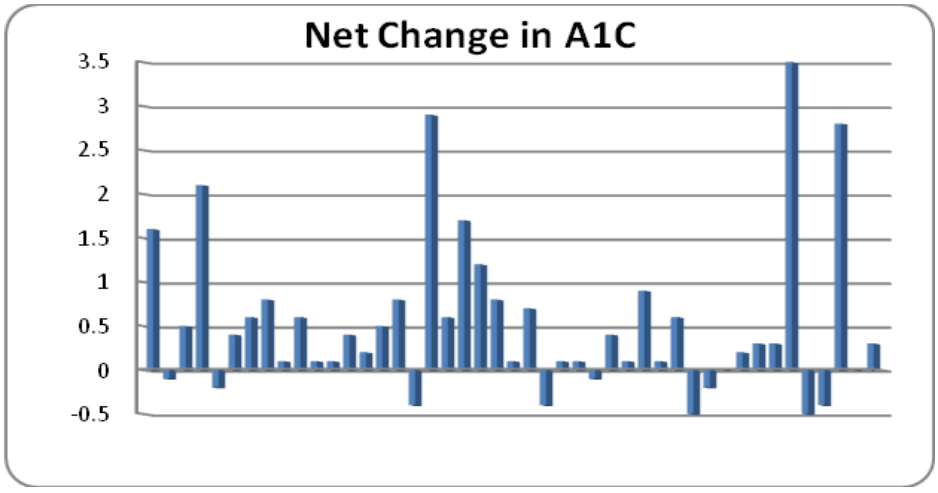
Another way that we attempted to reach these women was to screen those visiting DCC by administering the Edinburgh Prenatal Depression Scale (EPDS). This tool was placed in every new patient packet, giving those who did not attend the class an opportunity to be screened as well. A flyer inviting the women to seek free counseling was also given out at the class and in every new patient packet. If the staff had a concern about a patient, they would simply fill out a referral sheet and I followed up with the patient.

During the year I was at DCC there were approximately 600 women seen. Of these, 342 women were screened using the EPDS and 124 scored high enough to receive a follow up call from me. Out of these women 52 participated in therapy. My work with these women convinced me that by treating their mental health issues first, or at least simultaneously, they were much more likely to comply with medical treatment and advice. Table 1 shows three different tools used to measure depression, quality of life, and assessment of functioning (EPDS, SOS-10, and DSM-Global Assessment of Functioning). These scales were utilized to measure pre and post-therapy scores in order to monitor the success of treatment. In all three cases the average score of the participants indicates lessening depression and improved functioning after therapy. This same group was also monitored to see how their blood glucose levels (A1C) changed throughout treatment. As you can see in Table 2, which shows the net change of individual participants, they saw a significant improvement in their A1C levels. The average initial A1C was 6.32 whereas their average after treatment was 5.78 for an average decrease of 8.5%.

While this was not intended to be a scientific study, the results do seem to warrant further investigation on the relationship between mental health and patient compliance. There is no way to differentiate in this case whether the improvement in the women's A1C levels stemmed from medical care or the patient's improved mental health. The strong correlation between lessening depression and lower blood glucose levels suggests that mental health care may impact improved medical care for people with diabetes. In the longer term I hope to see studies done in which a control group would allow a definitive correlation to be established between these two variables.

Ultimately, thanks to the March of Dimes grant, I had the chance to participate in seeing 52 women become healthier mentally and physically. These women have become more positive mothers as a result of their work towards decreased depression and improved mental health. Their decreased A1C levels indicate better self-care and this will result in healthier babies. So the question of "What do I do with a patient who is non-compliant?" was answered for one affiliate this year.

In the case of my friend I mentioned above, I recently found that she had been prescribed insulin to control her diabetes. Despite having a good doctor and great health care, fear has stopped her from complying with her physician's directive. If this well-educated woman struggles with these fears, then there is no doubt that many less fortunate than her will have the same fears and need extra support such as counseling during their pregnancy.



(continued from page 3)
Underweight

> "In evaluating the woman's weight gain during pregnancy both total and rate of weight gain must be considered"

At the other end of the spectrum, women in the 1990 BMI underweight category of <19.8 who gained less than the IOM recommendations were at higher risk for a small for gestational age (SGA) infant. There is a possibility that thin women with BMI 18.5 to 19.7 will not be encouraged to gain the full 28-40 lbs now that underweight is defined as BMI <18.5. It is very important for pregravid underweight women to gain 28-40 lbs to prevent growth restriction of the infant.

As more data about population-specific BMI cut-offs and risk factors become available, population-specific BMI cut-off points may need to be reconsidered for determining a weight category. The WHO suggests lower BMI cut-off points be added as points of public health action for Asians. Several Asian subgroups have been identified as particularly at risk for GDM. Asian American ethnicity is recognized by the American Diabetes Association (ADA 2009) and CDAPP as a risk factor for GDM. The WHO BMI cut-off points for Asian populations suggest an overweight category at BMI 23-27.4 and obese category at > 27.5. It may be prudent in developing individualized weight gain recommendations with a woman of Asian background to suggest that this woman gain at the lower end of the weight gain recommendation for their weight category. For more information go to www.ndep.nih.gov.

In a prospective study of over 1000 mother-child pairs utilizing the 1990 IOM Guidelines, researchers found that mothers with excessive gestational weight gain, independent of maternal BMI and maternal glucose tolerance, had children with more adiposity at 3 years of age. They concluded that efforts to moderate weight gain during pregnancy may help to stem the rising tide of childhood obesity.

With the epidemic of obesity in this country, the risk of retaining extra pounds gained during pregnancy, and with increasing insulin resistance associated with gaining extra pounds, it seems prudent to avoid any extra weight gain in women with diabetes. Sweet Success programs encourage regular physical activity which is associated with reduced risk for excessive gestational weight gain.

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One of our happy couples with a Sweet Success outcome who received the services of a southern California Sweet Success Program.

CDAPP Regional Programs

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Region 2
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Region 5
San Joaquin/Sierra Region
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Region 6.1
Miller Children's Hospital Perinatal Outreach Education Program
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Region 6.2
Harbor/UCLA Medical Center South Bay
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Region 7
Inland Counties Region
909-558-3996

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Orange County Region
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San Diego & Imperial Counties
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Region 10
Kaiser Permanente System-North
408-366-4102

Region 11
Kaiser Permanente System-South
951-353-3569

CDAPP Regional Data Center
562-945-6484

Upcoming Educational Opportunities

February 23-24, 2010: Region 7 and 8 Affiliate Training and Clinical Update in Loma Linda. For more information contact, Suzanne Sparks, at 909-558-3646 or via email at susparks@llu.edu.

February 26, 2010: Region 7 and 8 Promoting Behavior Change in Diabetes: A skill building workshop for Sweet Success Health Care Professionals. For more information contact, Suzanne Sparks, at 909-558-3646 or via email at susparks@llu.edu.

March 12, 2010: Region 2 Annual Affiliate Share Day. For more information contact, Wendy Ly, Grant Programs Secretary, 916-733-1705 or LyW@sutterhealth.org

March 22, 2010: Region 4 Annual Affiliate Share Day in Scotts Valley. For more information contact, Sanray Lou at 650-736-2210 or sanraylou@stanford.edu

April 8-10, 2010: GDM Pasadena II: An International Conference on Gestational Diabetes will be held at The Westin in Pasadena, CA. For more information visit www.sweetsuccessexpress.com/conferences.htm

April 30, 2010: Regions 6.1 and 9 Annual Affiliate Share Day on Asian Indian Foods and the Diabetic Meal Plan. For more information contact Elena Leal, Program Secretary at 562/595-6459 or eleal@memorialcare.org

June 21-22, 2010: Region 4 Affiliate Training in Scotts Valley. For more information contact, Sanray Lou at 650-736-2210 or sanraylou@stanford.edu

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