

The Center for Community Health and Well-being, Inc. (CCHWB)

The Center for Community Health and Well-Being, Inc. (CCHWB) is a comprehensive health and human services agency, which has been a CPSP provider since 1992. Over the past 17 years, CCHWB has become a vital asset for low-income women who otherwise would not have access to comprehensive pre and post-natal care. It was originally established to reduce the high mortality rate among African American infants. **CCHWB's Birthing Project Clinic** now serves all of Sacramento's diverse populations. The clinic enrolls an average of 60 new pregnant women each month resulting in approximately 25 to 35 births per month.

When a patient agrees to participate in the CPSP program they are assigned a Comprehensive Perinatal Health Worker (CPHW) who administers the assessment, reassessments and completes the ICP. The CPHW works closely with the clinic's nurse midwives, social worker and delivery doctors to provide appropriate interventions to their patients. The CPHW checks on the patient at every clinic visit up to the time of delivery.

The clinic continues to work creatively to encourage postpartum visits. Of the monthly deliveries, they see two thirds of their patients in their four to six week return postpartum visits. This rate of return is attributed to several factors. Patients are told prior to their delivery that they will be returning to the clinic



for their postpartum visit, which includes family planning. Patients earn "baby bucks" for coming to their appointments or attending certain classes (i.e., parenting, childbirth etc.). Patients can spend these "baby bucks" anytime at the clinic's Baby Bucks store where they can purchase anything from clothes, toys, and books to cribs. Lastly, the clinic has a baby shower of celebration for the patients, which they attend with their immediate family and new babies. The rapport established by the CPHW as well as these other factors contribute to the high return rate for the postpartum visits. Staff encourage and empower the women to be "involved" in their care.

The Center has earned local and national recognition including the National Healthy Mothers, Healthy Babies Community Service award, The Sacramento News & Review's "Best of Sacramento" for Best Family Values award and recognized as a Hero in HealthCare by the California Center on Excellence.



website resources

Department of Health Services,
Maternal Child Health Branch
www.mch.dhs.ca.gov

Medi-Cal Policy Division
www.medi-cal.ca.gov

Sacramento State,
College of
Continuing Education,
Conference & Training Services
www.cce.csus.edu

Visit the website:
www.birthingproject.com

CPSP Questions File

Q:

Can the CPSP practitioners provide CPSP services at the client's home?

A:

It depends. Only physicians and other licensed personnel (such as Certified Nurse Midwives, Registered Nurses, Licensed Vocational Nurses, nurse practitioners, Physician Assistants and licensed social workers) may provide in-home CPSP services. Providers should indicate in the Remarks area or Reserved For Local Use field (Box 19) of the claim the license number and type of professional that provided the in-home preventive service. Please refer to your Medi-Cal Medical Provider Manual, page "preg com 7" for further information.



MARK YOUR CALENDAR

CPSP Overviews/ Steps to Take Trainings

Concord: September 5-7, 2006

Redding: September 19-21, 2006

Concord: October 24-26, 2006

To register, visit:

www.cce.csus.edu/conferences

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The Comprehensive Perinatal Services Program (CPSP)

coordination NEWSLETTER

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Domestic Violence During Pregnancy

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California law defines domestic violence as the infliction or threat of physical harm against past or present adult or adolescent intimate partners, and shall include physical, sexual, and psychological abuse and is part of a pattern of assaultive, coercive, and controlling behaviors directed at achieving compliance or control.

The 2002 California Maternal Infant Health Assessment (MIHA) found that 4% of women experienced physical domestic violence during pregnancy. Of those women experiencing this domestic violence, 24% first entered prenatal care during their second or third trimester or not at all, as compared with 13% of women not experiencing domestic violence. MIHA also found that 84% of women experiencing domestic violence had pregnancy complications, as compared with 65% of women not reporting DV during pregnancy.

Other studies have reported that pregnancy complications for battered women may involve low maternal weight gain (McFarlane et al, 1996), severe nausea or vomiting, kidney or bladder infection, or antepartum hemorrhage (Janssen et al, 2000). Psychosocial maladies associated with domestic violence during pregnancy include increased smoking and substance abuse (McFarlane et al, 1996). Similarly, domestic violence during pregnancy may have health consequences for the infant including intrauterine growth retardation, preterm birth



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“Kindness is the language which the deaf can hear and the blind can see.”

—Mark Twain

Fetal Fibronectin Testing in Preterm Labor

Emmett Gonzalez, MD, FACOG, Maternal, Child and Adolescent Health/Office of Family Planning Branch

Background

Fetal fibronectin (fFN) is a complex glycoprotein found in the extracellular matrix of the fetal membranes. It may be thought of as the, "adhesive", of the placenta and the membranes to the wall of the uterus. It is important to note that fFN is normally present in cervical secretions until the 20th week of gestation.

When does fFN have major significance in testing for preterm labor?

Fetal fibronectin testing has its greatest benefits if the testing is performed between 24 to 34 weeks gestation in women *with* symptoms of preterm labor, particularly in women who have risk factors for preterm labor.

fFN Testing

It is important to understand the results of the fFN testing because if the test is negative, that is, no fetal fibronectin is found in the cervicovaginal secretions in a woman who has symptoms of labor; the woman has a 95% chance that she **will not** deliver in the next 14 days. This is generally known as a test that has good negative predictive value. Unfortunately, if the test is positive it does not necessarily mean that the woman



with symptoms of labor has an imminent delivery. A positive test in this case is not as helpful.

A problem in clinical obstetrics is that medical interventions with medications may be responsible for in hospital complications in women that are treated for preterm labor. Fetal fibronectin testing gives the clinician another tool to determine which patient may need medical intervention.

Candidates for fFN testing (from Brigham and Women's Hospital in Boston) are:

- Patients between 24-0/7 and 34-6/7 weeks of gestation with intact amniotic membranes, cervical dilatation less than 3cm and no intercourse in the preceding 24 hours.

AND

- One or more of the following symptoms/signs of preterm labor
- Intermittent lower abdominal pain, dull backache, pelvic pressure
- Vaginal bleeding during the second or third trimester
- Menstrual-like intestinal cramping (with or without diarrhea)
- Change in vaginal discharge (amount, color, consistency)

Specific protocols may be developed for your hospital using the guidelines set up by ACOG. The fFN testing is a Medi-Cal benefit.

References:

Compendium of Selected Publications-2005, ACOG Practice Bulletin. Clinical Management Guidelines for Obstetricians-Gynecologist Number 31, October 2001 pages 303-307.

Agency for Health Research and Quality. Management of preterm labor. Evidence Report/Technology Assessment no. 18. Rockville, Maryland. AHRQ, 2000. AHRQ publication number 00-E-021.

Malak TM, Sizmur F, Bell SC, et al. Fetal fibronectin in cervicovaginal secretions as a predictor of preterm birth. British Journal of Obstetrics and Gynaecology 1996;103:648-653.

Domestic Violence During Pregnancy

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(Janssen et al, 2003), low and very low birth weight*, and increased admission to neonatal intensive care (Jagoe et al, 2000).

In order to ameliorate the effects of domestic violence during pregnancy, it is important that women be routinely screened in health settings. The American College of Obstetrics and Gynecology (ACOG) recommends that health care providers use RADAR. That is:

Routinely screen every patient.

Ask directly, kindly, non-judgmentally.

Document your findings.

Assess the patient's safety.

Review options & provide referrals.

Screening can begin by simply *Asking About Domestic Violence*. Questions may include:

- How do you and your husband get along?
- We all have disagreements at home; what happens if you and your husband disagree?
- Have you ever been harmed by him or felt afraid of him?
- I ask all families in my practice a few questions about violence.



- Do you have any guns in your household?
- Have you (or your children) ever been hurt or threatened by your partner?

Guidelines for screening and assessment of domestic violence during pregnancy are provided by ACOG in Screen Show on Intimate Partner Violence During Pregnancy: A Guide for Clinicians. These guidelines may be accessed at: www.cdc.gov/reproductivehealth.

Other domestic violence training for health care professionals may be obtained through:

California Medical
Training Center
UC, Davis Medical Center
3300 Stockton Boulevard
Sacramento, CA 95820
916.734.4141
email: mtc@ucdmc.ucdavis.edu
web: [www.ucdmc.
ucdavis.edu/medtrng/](http://www.ucdmc.ucdavis.edu/medtrng/)

Patients experiencing domestic violence services may be referred to the **National Domestic Violence Hotline** at 1-800-799-SAFE.

The Maternal, Child and Adolescent Health/Office of Family Planning Branch funds 97 domestic violence shelters throughout California to provide direct services to victims of domestic violence. Contact information for domestic violence shelters in your area may be found at: www.safenetwerk.net.

Additional resources and on-line information regarding domestic violence is provided by:

- Family Violence Prevention Fund
www.endabuse.org
- California Alliance Against Domestic Violence
www.cpedv.org

* *Conditions found in MIHA to be significantly associated with intimate partner violence*

References

Jagoe, J., Magann, E.F., Chauhan, S.P., Morrison, J.C., The effects of physical abuse on pregnancy outcomes in a low-risk obstetric population. American Journal of Obstetrics and Gynecology May 2000, 182(5).

Janssen, P.A., Holt, V.L., Sugg, N.K., Emanuel, I., Critchlow, C.M., Henderson, A.D., Intimate partner violence and adverse pregnancy outcomes: a population-based study. American Journal of Obstetrics and Gynecology May 2003 188.

McFarlane, J., Parker, B., Soeken, K., Abuse during pregnancy: associations with maternal health and infant birth weight. Nursing Research 1996 45(1).

McFarlane, J; Parker, B; Soeken, K; Bullock, L. (1992). Assessing for abuse during pregnancy: Severity and frequency of injuries and associated entry into prenatal care. JAMA 267:3176-8.

Stark, E; Flitcraft, A. "Spouse Abuse," Violence in America: A Public Health Approach. Ed. Mark L. Rosenberg and Mary Ann Fenley. New York: Oxford U.P., 1991. p. 141.

West Nile Virus, Pregnancy and Breastfeeding



What risk does West Nile Virus (WNV) illness during pregnancy present to a fetus?

Based on the limited number of cases studied so far, it is not yet possible to determine what percentage of WNV infections during pregnancy result in infection of the fetus or medical problems in newborns.

In 2002, one case of transplacental (mother-to-child) transmission of WNV was reported to CDC. In this case, the infant was born with WNV infection and severe medical problems. It is unclear, however, whether WNV infection caused these problems or whether they were due to other causes (see *MMWR Dec 20, 2002*).

In 2004, CDC is continuing to gather clinical and laboratory information on outcomes of pregnancies of women with WNV illness during pregnancy. Pregnant women who think they may have become infected with WNV should contact their private health care providers. Clinicians who are aware of WNV infections of pregnant women are encouraged to report such cases by calling their state or local health departments, or by contacting CDC (970-221-6400).

Because of ongoing concerns that mother-to-child WNV transmission can occur with possible adverse health effects, pregnant women should take precautions to reduce their risk for WNV and other mosquito-borne infections by avoiding mosquitoes, using protective clothing, and using repellents containing DEET. Repellents with DEET are safe for pregnant women, and there are other options as well such as a soybean oil based repellent that provides good, though quite limited, protection, as judged by a study published in the *New England Journal of Medicine*.

Pregnant women who become ill should see their health care provider, and those who have an illness consistent with acute WNV infection should undergo appropriate diagnostic testing.



For more information, visit the Centers for Disease Control and Prevention, West Nile Virus website at: www.cdc.gov/ncidod/dvbid/westnile/index.htm or call the hotline:

Public:

English: 800-CDC-INFO

Español: 888-246-2857

TTY: 888-232-6348

Clinicians:

English: 877-554-4625

Breastfeeding

If I am pregnant or breastfeeding, should I use insect repellent containing DEET?

Yes. Insect repellents help people reduce their exposure to mosquito bites that may carry potentially serious viruses such as West Nile virus, and allow them to continue to play and work outdoors. There are no reported adverse events following use of repellents containing DEET in pregnant or breastfeeding women.



Should I continue breastfeeding if I live in an area of WNV transmission?

Yes. Because the health benefits of breastfeeding are well established, and the risk for West Nile Virus transmission through breastfeeding is unknown, the new findings do not suggest a change in breastfeeding recommendations.

If I am breastfeeding, should I be tested for West Nile Virus?

No. There is no need to be tested just because you are breastfeeding.

West Nile Virus, Pregnancy and Breast-Feeding, May 14, 2004, (www.cdc.gov/ncidod/dvbid/westnile/qa/breastfeeding.htm).