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PERINATAL NEWS

The *Perinatal News* is published four times per year by the *South Carolina Perinatal Association*. The newsletter's mission is to keep SCPA members, and other interested persons, informed of state, local, and regional events in the field of perinatal care. The views and opinions presented are not necessarily endorsed by the *South Carolina Perinatal Association.*

To submit comments, letters, and articles, call Laureen Lattin at 843-293-0049, or email at lattinlaureen@yahoo.com.

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FROM THE KEYBOARD OF OUR SCPA PRESIDENT…

Do you sometimes feel the term "health care crisis" is so overused, we barely pay attention to it anymore? Our heads are filled with disturbing images from ER waiting rooms that play over and over again on You-tube. We are bombarded by articles and political ads on sky-rocketing premiums, soaring prescription costs, the uninsured, the underinsured…….no wonder we feel overwhelmed!

Unfortunately, in the midst of this national frenzy, a very REAL health care crisis currently faces mothers and babies in our state. The arrival of Medicaid Managed Care Organizations (MCO) in South Carolina is proving to be a huge threat to the health and well-being of many young families in our state, and to our entire regionalized perinatal care system.

For over 25 years, the South Carolina Perinatal Association, and many other perinatal leaders in the state such as DHEC, March of Dimes, private providers, and hospitals, have worked diligently to assure risk-appropriate care for mothers and babies in our state. Ironically, Medicaid/DHHS (Department of Health & Human Services) played a key role in developing and maintaining our state's strong regionalized perinatal care system. For many years, SC was recognized as a leader in perinatal regionalization.

For example, prior to the introduction of Medicaid MCO in SC: 1) Most high risk patients were routed to appropriate high-risk providers; 2) OB patients had continuity of care, and were not usually reassigned to a different provider mid-way through their pregnancy; and 3) Providers were not overburdened with hours of additional paperwork and phone calls, trying to deal with patients who had been enrolled in a new managed care plan (or worse, denied payment entirely because they were assigned a MCO patient, with whom they had no contractual relationship.)

I know each of you care deeply about your patients. I urge you to express your concern to DHHS about MCO's in SC, and their negative impact on our regionalized system AND on the health of mothers and babies. Ms. Emma Forkner, is the Director of DHHS. Her contact info is as follows: P.O. Box 8206, Columbia, SC 29202; phone: 803-898-2504. Ms. Forkner may also be reached by e-mail via her assistant, Ms. Polatty at polattyj@scdhhs.gov

Thank you for taking the time and effort to help address our SC health care crisis.

Meg Jewell

P.S. Please send me a quick e-mail (mjewell@ghs.org) or voice mail (864-455-8441) when you contact DHHS. I'll provide an update at our membership and business meeting on September 29th, 2008, at the 15th Annual Perinatal Partnership Conference in Myrtle Beach, SC. Our collective voices CAN make a difference!

Changing Demographics in South Carolina: Focus on Women and Children

By Lyn Phillips, LISW-CP
Division of Perinatal Systems/SC DHEC
(Adapted from presentation at the Hispanic Health Issues Conference, May 2008)

South Carolina's foreign-born population grew more rapidly between 2000 and 2005 than did that of any other state in the U.S., with the largest population group being Latino/Hispanic. In order to provide perspective for those of us who work in perinatal systems, the number of births for Latino residents in our state increased by *656%* between 1990 and 2004. This striking change in demographics and emerging trends will significantly impact maternal and child health systems. Public health systems must adapt in order to serve these families, our new neighbors, who contribute to our communities.

The Latino Population in the United States:

Latinos are now the largest minority group. There was an 87% increase in the population from 2000-05, making Latinos the fastest growing racial/ethnic group in the U.S. It is a diverse population: 64% are Mexican; 10% are Puerto Rican; 3% each are Cuban, Salvadoran, or Dominican. The remainder are Central or South American. 1 in 10 Latino children live in a mixed-status household (at least one parent is a non-citizen/one child is a citizen).

The Latino Population in South Carolina:

Rapid growth in the population was fueled by the South's economic growth surge in the '90s, and expanded 350% from 2000-05, more rapidly than any other state in the nation. In SC, 62% of Latinos are Mexican, 10% are Puerto Rican, 11% are Central American and 7% are South American. Our state is still in a period of early settlement, with the average length of time living in SC being 4.8 years. Increasingly more of these are families/homes with children. Many families live in temporary and overcrowded situations, sharing with friends, extended family or coworkers. 37% of SC Latinos don't speak English well (or at all) but 78% of their children speak English and are used as informal translators. The counties in SC with the highest percentage of Latinos in the population are: Saluda *(7.3),* Beaufort *(6.8)*, Jasper *(5.8)*, Newberry *(4.2)*, and Greenville *(3.8)*.

The American Community Survey of 2005 (ACS), a project of the U.S. Census Bureau, bases its estimates on an annual, nationwide household sample of 2.5% of the population. According to this survey, 56% of SC's Latino population is male and 44% is female. Many are married but left their spouses in their country of origin. 43,802 (or 32%) are children younger than 18. There has been a significant rise in families and the presence of women over the years. Births to Latina women in the state increased by 656% from 1990-2004. Many families live in marginalized housing due to the lack of affordable housing stock in SC, and share housing with non-immediate family as they work and settle into communities. This can result in 'doubling/tripling up" of children and co-sleeping with infants. In terms of education, 26,201 children were enrolled in SC schools in 2006; 15,000 of these were in Kindergarten through 5th grade. Greenville county schools have the largest enrollment of Latino children in the state. In our state, 22 % of Latino families live below the poverty level.

A Myriad of Challenges and Health Issues:

Latinos are at higher risk for diabetes, obesity, liver disease, heart disease, HIV/AIDS, cervical cancer, and stomach cancer. Because they are disproportionately employed in hard labor and dangerous work settings, they are at much greater risk for injury/musculoskeletal conditions. Latinas are at higher risk for pregnancy-induced hypertension, pregnancy-related mortality, perinatal HIV transmission and inadequate or no prenatal care. One third of Latinas in the U.S. received inadequate or no prenatal care. This is the highest of any subgroup of women.

ACCESS TO CARE BARRIERS:

Medicaid is not available to undocumented immigrants, but Emergency Medicaid is available in some circumstances, including childbirth. Of all racial and ethnic groups, Latina women are the least likely to be insured and to get preventive care and health education. In addition to the obvious language obstacles, the high cost of care is a barrier. Culturally-appropriate Spanish-language prenatal classes (and other health education classes) exist in *very* few areas. Language issues result in lack of information and confusion about the systems (especially around payment/bills). The Emergency Medicaid process is confounding and lacks uniformity. Coverage is an issue for children who are not citizens but need services. There is little political impetus for providing services, despite its proven cost-effectiveness. (Every $1 spent on prenatal care by the state equals $3 - $4 in savings for SC.) Many Latino families live in rural areas, far from community clinics. Transportation, in general, is a problem. Inflexible work schedules add to the difficulty in getting to care. Real discrimination does exist, and there is mistrust and fear of complicated systems. Across the state, Latina women lack information, support and a "network" to enhance their abilities to negotiate health care and other systems. In general, Latina mothers' outcomes tend to worsen the longer they are in the U.S., especially if they are denied access to regular health care, excluded from traditional support systems, and begin to adapt to lifestyles of poverty in the U.S. (Stress levels increase, bad habits of our culture are adopted, health food choices are unaffordable, our lifestyle is more sedentary.) Therefore, if we ignore these issues, health disparities will burgeon.

INFANTS AND CHILDREN AT RISK:

Latino children have lower vaccination rates, higher rates of asthma, and are the population highest in unmet dental needs. Latinos have a higher infant mortality rate. Paradoxically, infant mortality rates for offspring of U.S. - born Latina mothers is consistently higher than rates for infants whose mothers born outside of the U.S. Latino children are 3 ½ times more likely than white children to lack a regular medical home. They are at higher risk for some birth defects, including Down Syndrome, cleft lip/cleft palate and hearing loss associated with external ear anomalies. They are 1.5 to 3 times more likely than other babies in U.S. to be born with a neural tube defect. Maternal diabetes is an established risk factor for NTD and prepregnancy obesity also increases the risk of NTD. This link is not always understood by Latina women with lack of access to women's health education and prenatal care. Latinas may lack language and culturally appropriate information about folic acid for prevention of birth defects (or prevention of recurrence). Culturally appropriate campaigns and outreach efforts are much needed. March of Dimes is working to fill this gap in SC, as are Greenwood Genetic Center, the Latino Perinatal Outreach Program of Palmetto Health, the Division of Perinatal Systems and others. Model programs nationally that are targeting Latinas to promote folic acid use before pregnancy include the North Carolina Folic Acid Council; a San Antonio/ Miami-based program conducted by the CDC, National Council on Folic Acid and the National Alliance on Hispanic Health; the New Hampshire Birth Conditions Program; and the National Children's Study of the Medical College of Wisconsin. March of Dimes national website for folic acid information, in Spanish, can be accessed at: ***http://www.nacersano.org/***

LATINO FAMILY STRENGTHS AND PROTECTIVE FACTORS THAT TRANSCEND HISTORICAL/CULTURAL DIFFERENCES AMONG POPULATIONS LIVING AND WORKING IN THE U.S.:

Healthcare providers with awareness of the following important cultural values can help make care more accessible and understandable.

- ***La familia* (family):** Traditionally, Latinos include in their extended families not only parents and siblings but also grandparents, aunts, uncles, cousins, close friends, and godparents (*padrinos*) of the family's children. When they are ill or injured, Latinos frequently consult with other family

members and may ask them to come along on medical visits. Extended families play an important support role for patients.

- ***Personalismo:*** Latinos tend to stress the importance of personal relationships and traditionally emphasize interdependence over independence and cooperation over competition. The hope is that health care providers will be warm and friendly and take an active interest in their patients' lives. *Personalismo* conveys to the patient that the provider is interested in him or her as a person and helps put the patient at ease before an exam or medical procedure.

- ***Confianza*** (trust): The provider who is able to establish a bond of *confianza* with their Latino patient will find improvement in the quality of care giving and willingness of the patient to take wellness and risk-reduction advice to heart.

- ***Respeto*** (respect): Health providers, by their healing abilities and education, are afforded a high level of *respeto* as authority figures. As a general rule, Latino patients tend to look forward to what the health care provider has to say and value the direction and services. Also due to the worth placed on respecting health care providers, some Latinas will hesitate or choose not to ask certain questions, refute false statements, or provide pertinent information unless asked. This may affect quality of care or outcomes. So, by establishing confianza and working on personalismo, providers can help to reduce a potential barrier to care.

- ***Comunidad*** (community): 'Community' is highly valued. Grassroots local networks have emerged in many Hispanic communities in America. Only a few exist formally in SC at this point, but informally in Latino shops (*tiendas*) or restaurants. They provide a significant point of education and entry and opportunities to expand outreach efforts if public health systems connect with them.

- ***Resistencia***: Ability to handle adversity; resilience.

- ***Etica laboral fuerte:*** Strong work ethic.

Recommendations: Building on the Strengths of Latino Culture

- Culture is a primary source of strength for Latino families and children. Build upon the strengths of Latino culture, emphasizing the importance of family and the interpersonal relationship as a means for creating healthy change.

- Family is at the center - create opportunities for the family's "voice" and their sources of support to be heard in care, service planning and service delivery.

- Consider the "journey" of the child/family to the U.S. - how long they have been here - and provide services in the context of the family's level of acculturation.

- Use an empowerment model for consumers of service. Educate and encourage those who are negotiating the health care system well to empower and advocate for others. Include Latinos in leadership roles in system planning.

- Develop culturally appropriate Spanish-language outreach programs for prenatal classes, well-baby classes and other health needs.

  -Promote classes as a form of support group

  -Include other topics of interest & incentives.

  -Community Health Resource Centers: Work to create bilingual, bicultural advocates/ educators providing education for the Latino community regarding services available, options of care, patient rights, billing, Emergency Medicaid and educational offer

ings. Consider access barriers and cultural dif ferences in order to make them accessible. Nurture interested clients who understand the system as frontline advocates for others.

-Use ‘promotoras’: Lay health care brokers/ community-outreach workers, or *promotoras* can play a key role in establishing trust with a new provider.

-Consider forming a local committee of Providers, consumers, public health officials and community leaders around perinatal health issues of Latino families, such as the Partnership for Latino Perinatal Health in the Midlands *(Contact: Julie Smithwick-Leone)*.

References:

The American Community Survey (U.S. Census Bureau) – Hispanics: 2005

*The Economic & Social Implications of the Growing Latino Population in SC (Consortium of Latino Immigration Studies, USC, Aug.2007 *on website*

Looking at the Present and Towards the Future: The Perinatal Outlook for Latina Women and Children In the Midlands Region of South Carolina (Julie Smithwick-Leone, USC/PRMH)

Critical Disparities in Latino Health (National Council of La Raza, 2005)

SC Mother & Child Health Data Book 2007 (DHEC)

CDC Fact Sheet: Hispanic Health Disparities

2002 National Health Interview Survey (& CDF)

The Golden Hour

No...tiny babies are *not* miniature adults. Sometimes, however, we can learn from our colleagues in adult care.

The “Golden Hour” concept is one such model that is making it’s way into neonatal care. You can view a great powerpoint outline/lecture notes on the Golden Hour through the AAP.org website. Simply type *Golden Hour* into the search window, and begin the learning adventure provided by Nick Mickas, MD, and William Rhine, MD. Stay tuned: The ***SC Neonatal Consortium*** is currently hard at work adopting our own version of a *Golden Hour* protocol.

Membership Update

I hope everyone is having a great summer!

Just a reminder:
If you're attending the NC/SC Perinatal Conference in Myrtle Beach , you can re-new your SCPA membership for 2009 when you register for the conference.

If you are not attending the conference or choose not to re-new your membership at that time, you will receive a renewal notice by email.

Please make certain we have a current email address for you.

If we do not have an email address, your renewal notice will be mailed to the address we have on record. You can expect to receive this renewal notice in October.

I hope to see many of you in September at the conference! Don't forget to attend the membership luncheon too!

Respectfully,

Cheryl Suttles, Membership Chair

FOLIC ACID...IT WORKS !!

By Kathleen Swanson

The 28th annual Society for Maternal-Fetal Medicine meeting was held in January 2007 in Dallas, Texas. At this meeting, an abstract of an NIH study was presented that links preconception folic acid intake to a 50-70% reduction in very preterm births. This reduction occurred irrespective of age, race, or history of previous preterm birth in babies born very preterm (<32 weeks).

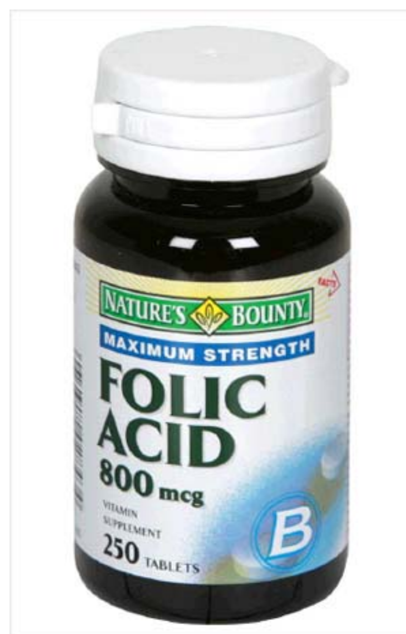
How much folic acid is recommended? All women of reproductive age should consume 400 mcg of folic acid daily to prevent serious neural tube defects. If a woman has already had a child with a neural tube defect, she should take 4000mcg when trying to conceive to prevent a recurrence. Periconceptional multivitamin use can also reduce the risk for other defects (e.g., orofacial clefts, conotruncal heart defects, and urinary tract defects). In addition, Doctors at Brigham and Women's Hospital in Boston examined medical records from over 150,000 women ranging in age from 23 to 70, followed for over eight years, and found that those who took folic acid supplements had a reduced risk for the development of hypertension. The researchers caution that this study does not prove that folic acid supplements can be used to treat high blood pressure, since a clinical trial has not been carried out that answers this question. Still, the results are encouraging and point to a possible additional benefit of dietary folic acid supplementation. Folic acid supplements are inexpensive, readily available without a prescription, and are considered safe.

Folic acid is essential for the formation and maturation of both red and white blood cells and deficiency is often expressed as anemia, especially among the elderly, the poor, alcoholics, and pregnant women. Folic acid-deficiency anemia is associated with fatigue, weakness, apathy, headaches, irregular heartbeat, sore tongue, diarrhea, lack of appetite, weight loss, irritability and forgetfulness.

Yet with all these benefits of folic acid, South Carolina's PRAMS data (Pregnancy Risk Assessment Monitoring System) states that in 2005, 59% of women did not take a vitamin prior to becoming pregnant. Preliminary data suggests that in 2006, this number has risen to 61.3%. We need to get the message out that all women and men 14 years and older should take folic acid daily. Make sure that you and all age-eligible members of your family, as well as all the patients and families you serve, know how important it is to take folic acid daily.

BEFORE YOU MAKE THIS...

TAKE THIS !



Teen Pregnancy: We *Are* Failing Our Children

By Kenneth F. Trofatter, Jr., MD, PhD

What is wrong with these scenarios?!?....

Last Thursday night while I was in the hospital on call for our Residency Program, we had 8 patients on our Labor and Delivery unit. The mean maternal age was 17...

The next day, I was covering our ultrasound unit and three of the last patients I saw were age 14 (2) and age 15. I had seen a couple of 16 year olds earlier in the day. None knew when they had gotten pregnant, how many weeks gestation they might be, or even what that meant. All were "late entries to prenatal care" with estimates of gestational age between 25 and 33 weeks, thus missing any benefit of early counseling, screening, and medical care...

Within the past year, I saw an 11 and a half year old who also presented at 28 weeks gestation. Her mother was excited that her daughter was having a girl – all I could think about (while tactfully suppressing my blind rage) was finding the criminal who had gotten her pregnant...

Recently, I saw a 16 year old who presented for her initial visit and ultrasound at 33 weeks gestation. The baby had an abdominal wall defect called gastroschisis in which the intestines are outside the abdomen exiting through a small defect next to the umbilicus. When I tried to explain what the condition was all about to the patient and her family, she became angry at me, demanded to know what she could "do about it" (in the context of terminating the pregnancy) and then told me that she was going to go outside and smoke before she would "talk about it anymore." Her mother handed her a cigarette as she was heading toward the door...

In almost every instance above, the father of the baby was significantly older than the mother...

While I was discussing these observations with one of our nurses on L&D, I was told that "60 girls in her daughter's high school are currently pregnant..."

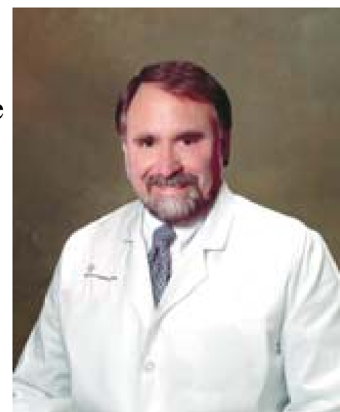
The children are not to blame. *We* have failed them. We have *all* failed them – parents, social services, schools, counselors, religious leaders, government leaders, the criminal justice system, and health care providers. The annual summary from the National Center for Health Statistics and the Centers for Disease Prevention and Control for 2006 (most recent data) support my simple observations in the trenches that began a few years back. Teen pregnancy rose 3% in 2006, to 41.9 per 1000 females aged 15 to 19 years, the first increase after 14 years of steady decline *(Martin, et al., Pediatrics 2008;121:788-801)*. From what we have seen recently in our own practice, I anticipate now that the rates for 2007 and 2008 will be even worse. It goes without saying that the rates among Blacks and Hispanics will probably be nearly *twice* those seen in the White populations.

We live in times when there has *never* in the history of humans been a greater *disparity* between the age of puberty and the social and economic demands that allow us to survive productively in this world. That also means that children are now reaching the age of 'reproductive maturity' when they are least likely to be in a position to control impulses, to understand the consequences of, and to make sensible decisions (or to resist sexual overtures of older and more experienced males) related to, sexual activity. The consequences are not only pregnancies and sexually transmitted disease but, in most cases, as has been shown repeatedly in the past, a loss of lifetime opportunities for success, a life spent in poverty, poor health, a long history of dependency on social welfare, limited access to an adequate health care system, and the high likelihood that their inheritance to their children will be a life similar to theirs.

It is much too simplistic after decades of neglect and inadequate education – denial and repression are not education – and actively withholding information to state simplistically that "it is the parents' responsibility." Parents have failed, but most 'parents' do not themselves have the necessary skill sets to deal with this problem. Two wage earner households, high divorce rates, and times of a poor economy have left many parents struggling to cope themselves and too easily tempted to turn their children over to the internet as a poor substitute for distraction, nurturing, attention, and sustenance.

Abstinence-alone efforts have also failed as a widespread approach and are practically meaningless anyway to children at the age at which they are now reaching puberty. There is growing data to support that teaching about contraception is "not associated with increased risk of adolescent sexual activity or STD. Adolescents who received comprehensive sex education had a lower risk of pregnancy than adolescents who received abstinence-only or no sex education *(Kohler, et al., J Adolesc Health 2008;42:344-51)."* But, all this needs to be presented in a program of ongoing education and practical incentivization. "The most expedient way to strengthen the impact of pregnancy prevention programs on adolescent childbearing is to shift the focus of intervention …to helping young women develop goals that make adolescent childbearing a threat to what they want in life. This means intervening actively enough to ensure that goal setting translates into an internal desire to postpone childbearing beyond adolescence *(Sheeder, et al., Matern Child Health J 2008: epub May 16)*."

Responsible living, grade-appropriate sex education, nutritional counseling, and physical education need to be a part of every school curriculum starting in early grades. These need to be integrated into programs that address responsibility by teaching not only the consequences of shirking responsibility but also the meaning of the word itself in terms of what is necessary to survive. Group support systems conducted by trained and objective educators may be the way of reducing first-time pregnancies as well as recidivism among adolescents *(Key, et al., J Adolesc Health 2008;42:394-400)*. Perhaps it may even be time to reconsider going back to a system of separate education for girls and boys! These programs are going to require a mandate and funding from the governments at the federal, state, and local levels, but what could be more important than the legacy that could provide. It is a small investment to make. The future not only of our children, but the country as a whole is at stake here...



Dr. Trofatter trained at Duke University (B.S. Zoology, '73) and Duke University Medical Center (MD, PhD, '79) between 1969 and 1985, completing a residency in OB/GYN and a fellowship in Maternal-Fetal Medicine. He remained on faculty there for a couple of years and then assumed the positions of director of Maternal-Fetal Medicine and medical director of the East Tennessee Regional Perinatal Program at the University of Tennessee in Knoxville (1987-96). Within 5 years there, he advanced to full professor (with tenure), but still foolishly left for brief interludes in chillier climes (chairman of OB/GYN at Mt. Sinai Hospital and professor of OB/GYN at Case Western Reserve University in Cleveland and then director of Maternal-Fetal Medicine and consultant to 3M Pharmaceuticals at the University of Minnesota in Minneapolis/St. Paul), before he returned to his senses and the Southeast in 2002.

His PhD degree is in pathology with a research focus in herpes simplex virus immunology. Primary clinical interests include high risk obstetrics (e.g., diabetes, hypertensive disorders, autoimmune diseases, and thrombophilias in pregnancy), preconceptual counseling, obstetrical ultrasound, Doppler flow velocimetry, recurrent pregnancy loss, virus infections in pregnancy, and screening for aneuploidy in pregnancy. Currently, he is director of Maternal-Fetal Medicine and professor of Clinical Obstetrics in the Department of Obstetrics and Gynecology of the University of South Carolina, a part of the University Medical Group at the Greenville Hospital System in Greenville, South Carolina. Outside interests include stamp collecting, soccer, exercise, and outings on his Harley. He is married and has 6 children ranging between 8 and 24 years of age.

IT'S CONFERENCE TIME !!

Join us for the 15th Annual

Perinatal Partnership Conference:
Navigating Change in Perinatal Practice

September 28-30, 2008
Embassy Suites @ Kingston Plantation
Myrtle Beach, South Carolina
Registration Deadline September 14, 2008