

Perinatal News

Winter 2006

SCPA Receives NPA State Award

The Perinatal News is published 4 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, regional, and local events in the field of perinatal care. The views and opinions presented are not necessarily endorsed by those of the South Carolina Perinatal Association.

To submit comments, letters or articles, call Pam Talbott at (843) 777-8465 or email ptalbott@mcleodhealth.org.

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The National Perinatal Association (NPA) presented the 2005 NPA State Perinatal Association Initiative Award to the South Carolina Perinatal Association (SCPA). The award honors a state perinatal association with innovative initiatives in legislative activities, membership development, research, education and program development.

SCPA's submission for the award was based on its history of collaboration and partnership with other organizations with similar goals. SCPA partners with the North Carolina Perinatal Association (NCPA), the South Carolina Chapter of the March of Dimes (MOD), the South Carolina Department of Health and Environmental Control (DHEC) and other agencies/

organizations to improve the health of women and infants in the state. This partnership is most visible in major educational activities, both public and professional, and in advocating for legislation to improve the health status of women, infants and children.



Accepting the award are Meg Jewell, Luanne Miles, and Jeannie Thompson

The award was presented at the NPA 25th Annual Clinical Conference in October 2005 at the Lincolnshire Marriott Resort in Lincolnshire, IL. In addition to a plaque, SCPA received a check for \$1000 to be used to advance its mission. SCPA received the same award in 2001 in recognition of legislative advocacy for revised hospital regulations that support the delivery of all very low birth weight infants in Level III hospitals.

Letter from SC Perinatal Association President

The mission of SCPA includes "influencing public policy" and "providing leadership on issues of perinatal health". With the opening of the SC Legislative session, there is a need for active involvement by SCPA members to assure we are meeting our mission in this area. The Public Affairs Committee is coordinating with the March of Dimes to plan and host our annual Legislative Day on February 23. SCPA is focusing on 3 issues: increasing our state's cigarette tax with proceeds dedicated to healthcare services and smoking cessation; stable funding for implementation of a statewide, comprehensive birth defects monitoring program in DHEC; and legislation that allows women to breastfeed in any location where the mother is authorized to be. We anticipate that there will be other issues affecting perinatal health in SC introduced and discussed in this legislative session. The Public Affairs Committee will keep the membership

updated on these issues.

Whether you are able to attend the Legislative Day or not, please know that your voice needs to be heard on these 3 key issues. SCPA has some very dedicated and skilled volunteers working through the Public Affairs Committee to influence public policy. However, their success depends on each of us taking the information the committee provides on legislative issues and using it in contacts with our state representatives and senators. Jane Goodall said, "We have a choice to use the gift of our life to make the world a better place - or not to bother." Please take a few minutes today to write a note or make a phone call; it is worth the bother. Thank you for your continuing support of SCPA and for improving the health of mothers and infants in SC!

Luanne Miles

Hailey Danielle - Our Miracle (A Mother's Story)

By Jennifer Carnagey

On June 2, 2004, I found out that we were expecting our first child. After trying to become pregnant for nearly two years without success, we had just come to the conclusion that it was not meant to be for us to have a child. And then everything changed. My husband Dan and I were so excited and within three hours of finding out, we already began spreading the happy news. As of January 31, 2005 we were going to become parents!

My pregnancy was normal and without complications-I didn't even have morning sickness. Dan and I went to every prenatal appointment as scheduled. We heard her heartbeat at our 12-week visit, and finally got to see her at our 21-week ultrasound. "Do you want to know the sex of your baby?" Without hesitation we both answered, "Yes!" Much to our surprise (and my extreme delight), the technician said, "I see the little girl parts!" Everything was going so great, how was I to know that just four weeks later we were going to meet our little girl, 15 weeks ahead of schedule!

On October 18, Dan and I went for my 25 week check up. I had been experiencing tightening of my belly frequently for the past few weeks. According to all my pregnancy books, I was having Braxton-Hicks contractions. Was this too early? I asked everyone I knew, including my OB. Everyone said that it was normal. Everything was normal. I was scheduled to come back in three weeks to check for gestational diabetes. I didn't make it to that appointment.

Just six days later, on Sunday, October 24, 2004, I woke up feeling sick to my stomach. I had cramps that came and went all day. My husband kept asking me if I felt like we needed to call the doctor. I said, "No, it's just a stomachache. I don't want to call for something stupid." So I went on with the rest of my day, doing laundry, watching a movie on TV-all the while having cramps that came and went. As I realized later, I had been having contractions all day-the real thing. How was I to know? I had no idea what contractions were supposed to feel like-we hadn't even started our child-birth classes yet! I wasn't supposed to have this baby for another 3½ months! So of course I wasn't having contractions. I was so wrong!!

At 3:00 that afternoon, the cramps I was having finally got to the point where I had

to lay down and could do nothing else. Dan finally decided to call the doctor-even though I was still telling him I was fine. The doctor didn't seem too concerned with what Dan had told him, but said that he should probably bring me in to be checked out just in case. Dan got off the phone and asked me to put my shoes on. "I can't," I said. So he put them on for me. He had to help me get off the bed, and after taking two steps towards the bedroom door, my water broke. Exploded would be the better word. I immediately felt my baby drop. It happened so fast, I thought she was going to fall out onto our bedroom floor. At this point, we both became terrified. Dan kept saying we had to go, and I kept saying I couldn't move or else she was going to be born. Somehow he got me to the car and got us to the hospital at lightening speed. After arriving at the emergency room, it seemed to take forever for them to realize that we were really having an emergency. I looked like I had just wet my pants times a thousand, and I kept making these horrible noises as I was pushing (of course I didn't know that's what I was doing!). Finally someone realized the urgency of the situation and began to run with me in the wheelchair down the hallway. We got to the delivery room and within minutes of lying down on the bed, Hailey Danielle Carnagey was born at 3:40 pm.

I was in a state of total shock. What just happened? Did we have a baby? Was she dead? She can't possibly survive-it's too early. I didn't even ask if she really was a girl. I just kept thinking that she was gone. All I saw of her was a tiny little bluish-purple hand. Dan wasn't even in the room when she was born-he was still parking the car. By the time he arrived, she was already dried off and being intubated and bagged. I kept asking if she was dead. Dan looked like a zombie. The doctor kept telling me that she was really small.

The nurse was my saving grace. She was so positive and uplifting and a source of great strength. She kept telling me how beautiful she was and that she was already a fighter. She asked me to name the baby, but I wouldn't do it. I kept thinking that if I gave her the name we had picked out for her, it would be a waste because there was no possible way that this baby was going to survive. Thankfully Dan gave her the name. After this point, the guilt began to set in. As if reading my mind, Gina (our nurse) began saying, "None of this is your fault.

Don't even start thinking that. There is nothing you could have done to prevent this. Dan saved her life by getting you here to the hospital." She kept repeating these words throughout the rest of her shift. I really needed to hear this.

After two hours, we finally got to meet our little girl. She was being kept in the special care nursery, but a transport team was already on the way from Richland Memorial Hospital to take her to the NICU. When we finally saw Hailey, I could not get over how small she was. Those other babies looked like giant monsters compared to her. At 1 pound, 10 ounces, she could literally fit into the palm of your hand. She was hooked up to so many wires, you could barely see her. I remember being able to put my finger in her open palm and she immediately closed around it. That was the closest I got to holding my new baby girl for nearly three weeks. I was then surrounded by all sorts of medical personnel. The transport team was there and was preparing Hailey to move. People kept shoving papers in my lap to sign. I was so upset I had no idea what I was signing, but kept saying, "Please do everything you can to help her." Gina took Hailey's first pictures and handed them to us. Then it was time for Hailey to go to the other hospital and for me to go to my room.

Dan went to Richland to see Hailey once they got her stabilized in her new "home". I meanwhile, lay in my hospital room across town trying to figure out what had just happened. I kept feeling my stomach where only that morning I had felt her kicking and moving around. "This is not really happening. I am still supposed to be pregnant!" We had already called our family and my mom was already making plans to arrive in a few days. Everyone kept telling me "Congratulations!" But that was not at all what I wanted to hear. When Dan finally returned, I finally broke down and cried saying, "This was supposed to be a happy day. My mom was supposed to be here, and I was supposed to have a big pink ribbon on my door saying 'It's A Girl!'"

The next day I was discharged and after going home, getting cleaned up, and trying to force myself to eat, we went to see Hailey. That began our daily pilgrimage to Richland hospital for the next 195 days. If it were not for the nursing staff of the Richland hospital NICU, I don't think we (Continued on page 6)

Early Postpartum Depression

Black and Hispanic mothers are substantially more likely to suffer from early postpartum depression than white mothers. However, similar factors play a role in depression for all of them, according to a study supported in part by the Agency for Healthcare Research and Quality. Screening for postpartum depressive symptoms is important, particularly in women of color, conclude the researchers who conducted the study. Two weeks after delivery, nearly one half (47 percent) of Hispanic mothers and 45 percent of black mothers reported depressive symptoms compared to about 31 percent of white mothers. These differences persisted, even after controlling for demographic, personal, and situational factors, such as a colicky infant.

Despite these racial differences in depression prevalence, the burden of



Fetal Alcohol Syndrome

The CDC has recently released "Guidelines for Identifying and Referring Persons with Fetal Alcohol Syndrome". The summary states that "Fetal alcohol syndrome (FAS) results from maternal alcohol use during pregnancy and carries lifelong consequences. Early recognition of FAS can result in better outcomes for persons who receive a diagnosis. Although FAS was first identified in 1973, persons with this condition often do not receive a diagnosis. In 2002, Congress directed CDC to update and refine diagnostic and referral criteria for FAS, incorporating recent scientific and clinical evidence. In 2002, CDC convened a scientific working group (SWG) of persons with expertise in FAS research, diagnosis, and treatment to draft criteria for diagnosing FAS. This report summarizes the diagnostic guidelines drafted by the SWG, provides recommendations for

physical symptoms, lack of social support, and lack of self-confidence in infant care were factors independently associated with postpartum depression among all the women.

Worse physical symptoms (for example, severe fatigue) were associated with 15 percent greater likelihood for postpartum depression and infant colic with nearly twice the likelihood. In contrast, social support and confidence in managing the infant and household were both associated with 10 percent less likelihood of postpartum depression.

Unlike previous reports, the study found no link between past depression history and early postpartum depression. The study findings were based on responses to a telephone survey by 655 white, black, and Hispanic mothers between 2 and 6 weeks postpartum. They were

asked about demographic characteristics, physical symptoms, social support, confidence in infant care, provider access, and other issues.

More details are in "Racial and Ethnic Differences in Factors Associated with Early Postpartum Depressive Symptoms," by Elizabeth A. Howell, MD, MPP, Pablo A. Mora, PhD, Carol R. Horowitz, MD, MPH and Howard Leventhal, PhD, *Obstetrics & Gynecology* 2005; 105: 1442-1450.



when and how to refer a person suspected of having problems related to prenatal alcohol exposure, and assesses existing practices for creating supportive environments that might prevent long-term adverse consequences associated with FAS. The guidelines were created on the basis of a review of scientific evidence, clinical expertise, and the experiences of families affected by FAS regarding the physical and neuropsychologic features of FAS and the medical, educational, and social services needed by persons with FAS and their families. The guidelines are intended to facilitate early identification of persons affected by prenatal exposure to alcohol so they and their families can receive services that enable them to achieve healthy lives and reach their full potential. This report also includes recommendations to enhance identification

of and intervention for women at risk for alcohol-exposed pregnancies." These guidelines are available on the internet at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5411a1.htm>

SAVE THE DATE!!

FRIDAY, APRIL 7, 2006

MIDLANDS PERINATAL REGION
**ANNUAL PERINATAL
CONFERENCE**

TO BE HELD at SEAWELL'S
COLUMBIA, SC

REGISTRATION MATERIALS WILL BE
SENT SOON!

Full Moon: Uh-Oh?

In labor wards and delivery rooms, where personnel typically are guided by evidence-based approaches to their work, a superstitious belief that a full moon brings a spike in the number of deliveries or delivery complications causes some staff a certain amount of monthly distress. If this belief were grounded in fact, it could have implications for staffing patterns. However, a study of more than 500,000 North Carolina births spanning 62 lunar cycles should bring comfort to health care personnel who approach their work with baited breath every 28 days. Using analysis of variance and tests to compare outcomes across the eight phases of the moon, the researchers found no statistically significant differences in the number of births overall or of births to women who had had more than one pregnancy, in types of delivery or in complications.



Nevertheless, with a nod to human nature, they expect that the superstition will endure and that some labor and delivery personnel "will continue to look up and sigh in dread when they see the full moon looking back." Maybe not. Keep your fingers crossed.

(Article reprinted from Perspectives on Sexual and Reproductive Health, Sept. 2005)

SAVE THE DATES

**NC/SC Perinatal
Association 2006
Annual Conference**

**Surfing the Waves
of Perinatal Change**

**13th Annual Perinatal
Partnership
Conference**

**September 17 -19,
2006**

**Embassy Suites at
Kingston Plantation
Myrtle Beach, SC**

SCPA Membership

We have welcomed 45 new members to SCPA for 2006, but we have several members who have not renewed their membership. If you have not renewed your membership for 2006, this will be your last newsletter. Renewal forms are available on the web site: www.scpaperinatal.org.

Don't forget to update your address if you move.

Mail changes to:

South Carolina Perinatal
Association
P.O.Box 5247
Columbia, SC 29250

HPV Vaccine



There were over 10,000 new cervical cancers reported in the United States in 2004. Half of all cervical cancers reported worldwide are related to the human papillomavirus (HPV). There are 40 types of HPV with HPV 16 being the more common. (1)

There have been randomized controlled trials underway to test the effectiveness of HPV 16 vaccine. The results are very promising with 100% vaccine efficacy among participants in one study. These results demonstrate that HPV vaccine has the potential to significantly reduce the incidence of cervical cancer. (2) At this time the protection lasts for at least 3.5 years. Further follow up of participants will be needed to establish long term effectiveness.

The next step will be to bring the vaccine out of the laboratory and establish distribution, age for immunization and whether universal immunization will be required. Keep a look out for further information on this promising vaccine. (3)

1. American Cancer Society. Cancer Facts and figures 2004. Available at www.cancer.org.

2. Mao C, Koutsky LA, Ault KA, Wheeler CM, Brown DR, Wiley DJ, et al Efficacy of human papillomavirus-16 vaccine to prevent cervical intraepithelial neoplasia: a randomized controlled trial. *Obstet Gynecol* 2006; 107: 18-27.

3. Noller KL, HPV Vaccination More Questions Than Answers. *Obstet Gynecol* 2006; 107:4-5.

BIRTH DEFECTS: 8 MILLION ANNUALLY WORLDWIDE

Hidden Toll of Dying and Disabled Children: A Comprehensive Global Analysis Identifies Trends and Interventions

WHITE PLAINS, N.Y., JANUARY 30, 2006 -- Every year an estimated 8 million children -- about 6 percent of total births worldwide -- are born with a serious birth defect of genetic or partially genetic origin, according to a new report from the March of Dimes.

Additionally, hundreds of thousands more are born with serious birth defects of post-conception origin due to maternal exposure to environmental agents, such as alcohol, rubella, and syphilis, says the **March of Dimes Global Report on Birth Defects: The Hidden Toll of Dying and Disabled Children**.

The report reveals that at least 3.3 million children less than 5 years of age die annually because of serious birth defects, defined as any serious abnormality of structure or function. An estimated 3.2 million of those who survive may be mentally and physically disabled for life.

Birth defects are a global problem, but their impact is particularly severe in middle- and low-income countries where more than 94 percent of births with serious defects and 95 percent of the deaths of these children occur, the report finds. Both high prevalence rates and larger numbers of births contribute to the differences between low- and middle-income countries and those with higher incomes.

"Our report identifies for the first time the severe, and previously hidden global toll of birth defects," explains Dr. Jennifer L. Howse, president of the March of Dimes. "This is a serious, vastly unappreciated and underfunded public health problem."

"The human toll of birth defects is even greater when one considers the impact of lifelong disability on children, their families, and society," says Michael Katz, M.D., senior vice president for Research and Global Programs at the March of Dimes.

The database prepared for the March of Dimes report details the prevalence rates and the numbers of affected births in 193 countries. The data collected include information on single-gene disorders, chromosomal disorders, and physical malformations.

What Can Be Done to Save Babies

The authors of the report say that it is a common misconception that attention to birth defects will draw funding from other priority public health efforts -- when, in fact, increased efforts to reduce birth defects in children contributes to the health of the entire population.

Their recommendations in this report are aimed both at addressing health disparities between richer and poorer nations and at reducing the toll of infant deaths, especially in low- and middle-income countries.

Among the interventions that would have immediate impact are folic acid supplementation to prevent neural tube defects; iodination of salt to

prevent severe congenital hypothyroidism; and rubella immunization to prevent congenital rubella syndrome.

Step-By-Step Approach

The report recommends first steps for low-income countries with high rates of infant mortality that are consistent with the established maternal and child health programs. These include:

- Educate the community, health professionals and workers, policy makers, the media and other stakeholders about the toll taken by birth defects and opportunities for effective prevention, treatment and care.
- Ensure a healthy, balanced diet during a woman's reproductive years.

- Control infections in pregnant women.
- Train physicians, nurses, allied health professionals and workers in the recognition and care of children with birth defects.
- Establish national capacity for birth defects surveillance and monitoring.

Some middle-income countries have infant mortality rates that approximate those of the United States in the early 1960s, when it began its systematic effort to strengthen medical genetics services for the care of affected children and prevention of birth defects. For these countries, the next steps recommended include:

- Train health care professionals in medical genetics;
- Identify couples at higher risk of having children with genetic disorders;
- Establish newborn screening programs to identify babies born with devastating but treatable metabolic disorders such as phenylketonuria (PKU);

- Educate women and men of childbearing age about how they can work with health professionals to maximize the chances of having a healthy pregnancy and a healthy baby.

Improvement Is Possible, March of Dimes Says

Although poorer nations may lack resources for these recommended programs and their health services are already severely stretched, the March of Dimes report says major improvements can be made within existing health care systems, for example by training health care providers to use simple diagnostic and preventive tools that are available.

To order printed copies of the March of Dimes Global Report on Birth Defects:

Call toll-free in the U.S.: 1-800-367-6630 -- Outside the U.S., phone: 1-770-280-4115, Fax: 1-770-280-4116, E-mail: mod@pbd.com
Mail: March of Dimes, P.O. Box 932852, Atlanta, GA 31193-2852
Executive Summary and Color Wall Chart: 31-2009-05, 31-2008-05

A print copy of the full report is available for \$4.00 and the executive summary for \$1.00, plus shipping and handling of \$5.95

SCPA Board 2005

Officers

	Term expires 12/31	
• President	Luanne Miles	2006
• President Elect	Meg Jewell	2006
• Treasurer	Sabrina Capell	2006
• Secretary	Mary Mathes	2006
• Past President	Jeannie Thompson	2006

Committees

• Education	Kathy Swanson, Chair	2006
• Public Affairs	Janice Simmons, Chair	2007
	Pattie Durham, Vice	2006
• Membership	Jean Shearer, Chair	2006
	Carole Bundy, Vice	

• State Forum Rep	Meg Jewell	2006
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Regional Representatives

• Low Country	Kathy Ray
• Midlands	Debra Brown
• Pee Dee	Jeannie Thompson
• Piedmont	Meg Jewell

Discipline Representatives

	Term expires 12/31
• Nursing	Nira Daleda 2006
• Medicine	Victor Iskersky 2006
• Social Work	Angel Payton-Harmon 2007

Community

• March of Dimes	Carrie Windham 2006
	Dorothy Priester

Hailey Continued...

would have made it through. From the beginning they became our "family". They were so supportive, understanding, compassionate, and loving-not just to Hailey, but to us as well. They answered our myriad of daily questions without irritation, and if they didn't know an answer, immediately went to find out the answer. They were with us on our darkest days, when things looked really bad, to hold and comfort us, and were with us on our good days to celebrate with us. They talked to me when I called to check on her at 1:00 in the morning, and they would give us time alone with Hailey so that we could get to know each other. They took pictures of all our milestones: me holding Hailey for the first time when she was 16 days old, Dan holding Hailey for the first time at 1 month, me "kangarooing" with Hailey for the first time after coming off the ventilator two days before Christmas, our first family picture on Christmas day, and various other pictures they would take of her throughout the rest of her hospital stay. We were quickly finding out that she was no longer our baby. She was the "unit baby". We would come to see her only to find a new stuffed animal in her isolette, or a new blanket covering it. She was given a "Sleep Sheep" by the nurses of the NICU following one of her five major surgeries, and was dressed in several preemie outfits bought by several nurses. They absolutely loved her. They would all come to see her at the beginning of their shifts even if they were working in a room across the unit. Some would even call on their days off to check on her progress.

Hailey suffered every major complication a 25-week preemie could have. She had IVH grade 2, upgraded to 3 once she started having hydrocephalus. She had NEC followed with emergency surgery to repair a ruptured intestine (with a second surgery coming two and a half months later to close this). She had a left pneumothorax and had to have a chest tube for several days. She had to have surgery to close a PDA, and also laser eye surgery to treat rapidly progressing ROP. She had a life-threatening yeast/fungal infection throughout her entire blood stream for nearly two months (which thankfully saved her from having to get a shunt in her brain, as the swelling began to resolve before they considered her stable enough for that surgery). She had three Broviac catheters, and a horrible case of reflux, which resulted in yet another surgery-Nissen fundoplication to create a tighter valve around the esophagus. This left us with a G-tube. Finally she was discovered to have alarming low blood sug-

ars following the Nissen. After running a multitude of metabolic screening tests, the results indicated that she was normal-therefore puzzling all doctors as to the cause and ultimately the treatment for this. She was put on a strange diet of breast milk mixed with cornstarch first, then with formula and cornstarch. The cornstarch did not seem to help the blood sugars, so they began to add sunflower oil. The theory was she was having dumping syndrome and they needed something to slow down the emptying of the stomach contents. Finally they switched her formula to a thickened one that already had rice starch added, and put her on a medication to impair her ability to produce insulin. This was the magic combination that worked.

Of all the setbacks that were the most frustrating and upsetting to us, the blood sugar issue was the worst. We went for nearly two months not knowing what to do for her to fix the problem. She went back and forth from being on constant drip feed to pumped feed every two hours, back to drip feed and so on for almost a month. She was getting her blood sugar checked at least every 6 hours, and at some points every three hours when they were attempting to move her to the normal feeding schedule of every three hours. Her poor heels looked like hamburger-it was awful. This whole process kept us in the hospital two months longer than we were anticipating. And of course during this time, when the blood sugar issue seemed to be resolving itself, then she would begin to have apnea/bradycardia spells, mixed with various bacterial infections here and there.

I was beginning to think that Hailey was going to go to her first day of Kindergarten from the hospital, and finally the doctors began to discuss D-day-discharge day. She had to make it for three days in a row with no "life-threatening desats or bradys" and have no major blood sugar issues and we could get ready to bring her home. It was the middle of April and she had finally made it through three A & B free days. We were all set to room in that weekend and take her home the following Tuesday. However, that Saturday morning we received a phone call from the doctor saying that during the night she had suffered a major life-threatening event. She had a major desat (12!) and brady (40's!) and was not coming back with the usual blow-by O2 and bagging. They had to start chest compressions and were just getting ready to intubate when she came out of it. It was discovered three days later that she had yet another infection and would need to stay for 10 more days to be treated with antibiotics. Again, what can I say about the nursing

staff? They all acted as if our huge disappointment and heartbreak was their own. Finally, at the end of the ten days, Hailey's health improved dramatically. She went two full weeks with no A/B's and came down significantly on her oxygen. The doctors starting talking about discharge again, but I was so worried the same thing would happen, I wouldn't let them say it around her. Finally the day came for us to room in. One of our favorite nurses requested to have Hailey that night, and she would come in periodically to check on us. The next morning before they left Jocelyn and Ashley came to say good-bye. They took pictures with Hailey and started sharing stories about "the beginning" and how they really didn't think she was going to make it. They both said that she was a true miracle baby and that they wanted to come see her at our house. Jocelyn has come twice to visit (bringing her presents of course) and twice to baby sit for us. Two other NICU nurses have come to baby sit also. We had several phone calls from nurses and nurse practitioners after coming home-just to see how things were going. And of course we have been back to visit frequently.

As I look back on this journey, I am frequently stunned and awed by what an amazing miracle God has given us. I remember her birthday and what a horrible day that was, and then I remember her homecoming day-May 5, 2005, and revel in the celebration that took place. She came through everything with no major lasting effects other than some mild hearing loss in her left ear. She is no longer on oxygen, no longer has a G-tube, and is not on any special medication. She is being seen by a physical therapist weekly, and a speech therapist once a month. We are all doing everything we can to help her catch up in her development to other 14 month olds. As for now, the future looks promising. Hailey is growing and developing as she should be. She is a beautiful, rambunctious, and happy child.

I remember listening tearfully to all the doctors as they proclaimed her to be "the sickest baby in the unit", "she has an 80% chance of death, and if she actually survives, she will be dealing with several physical and neurological issues". I appreciate everything the doctors did for us, but I'm so happy that she proved everyone wrong. Taking her back to visit at the hospital, the doctors are astounded. Many of them have said, "It's just not possible!" Do you believe in miracles? I do now. Hailey is our daily reminder that through prayer and faith in God, anything is possible.

Changes in Program Guidelines for Postpartum/Infant Home Visits

Medicaid currently reimburses for a Postpartum/Infant Home Visit by a nurse within 14 days of delivery. This often does not allow for a visit to the mother/infant if their hospital discharge was delayed due to medical complications. Because the most fragile infants are frequently not discharged until after 14 days, the following changes in the Postpartum/Infant Home Visit program will be implemented effective with dates of services starting on or after February 1, 2006:

- The initial visit must be made within six (6) weeks after delivery.
- The initial visit may be billed only one time per pregnancy. For example, if the mother and twins, triplets, etcetera are present – only one procedure code may be billed for that visit.

A repeat visit may be made in the event of the following two instances:

- When the nurse makes the Postpartum/Infant Home Visit, occasionally the mother or the infant is not present. The repeat visit to see the absent individual can be done and must be billed as a repeat visit.
- The mother or infant has an acute medical problem (e.g., the mother/infant has a fever), which requires follow-up.

No changes have been made to the Pre-Discharge Home Visit.

To receive Medicaid bulletins by email, please go to the following web site for instructions: <http://www.dhhs.state.sc.us/dhhsnew/QLEbulletins.asp>

*March of Dimes
and
SC Perinatal Association
Legislative Day
Thursday, February 23
8 to 19 AM
Solomon Blatt Building
Room 221
Columbia, SC*

Drop-In Breakfast

SCPA Café Traveling Lecture Series

Meeting the Challenges: Birth Defects

Speaker: Richard Curtis Rogers, M.D.

Clinical Geneticist, Greenwood Genetic Center & Greenville Hospital Systems

Friday March 3, 2006	Columbia, SC Palmetto Health Richland, 9 Medical Park Room 130	1:00 PM to 4:15 PM
Tuesday March 7, 2006	Greenville, SC The Community Center, Village at Pelham 2755 S. Highway 14, Greer, SC 29650	1:00 PM to 4:15 PM
Tuesday March 14, 2006	Charleston, SC East Cooper Regional Medical Center Complex 1200 Johnny Dodds Blvd., Mt Pleasant, SC 29464. First Floor Conference Room	1:00 PM to 4:15 PM
Tuesday March 21, 2006	Florence, SC McLeod Family Medicine, AHEC Classroom 555 East Cheves St.	1:00 PM to 4:15 PM

Objectives

1. Identify causal relationships and prevention for the most common birth defects in SC.
2. Explore the role of genetic counseling and testing.
3. Discuss diagnostic testing, prenatal screening, neonatal screening and fetal pathology.
4. Explain autopsy protocols and available resources.

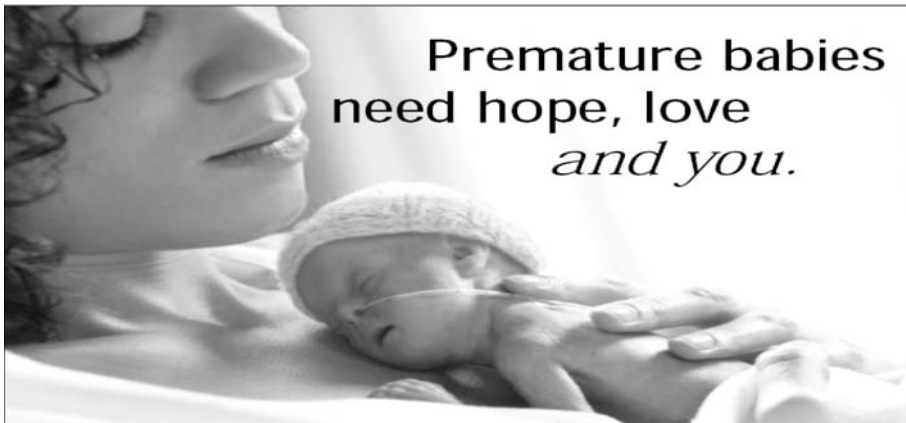
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Premature babies
need hope, love
and you.

 **March of Dimes WalkAmerica**
walk for someone you love

One in every 8 babies in the U.S. is born too soon. Some die; others face lifelong disabilities. Prematurity is a common, serious and costly problem that affects us all. That's why we need you to join March of Dimes WalkAmerica. Walk and raise money to help fund research into why premature birth happens and what can be done to prevent it.

Thank You
to Our
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