
CPQCC MEMBERSHIP MEMORANDUM

TO: CPQCC PARTICIPANTS
FROM: JEFF GOULD, GRACE VILLARIN DUEÑAS
SUBJECT: 2010 CPQCC MANDATED CHANGES
DATE: 6/16/10
CC: BARBARA MURPHY, BEATE DANIELSEN, FULANI IRVING, PEMITA PA'AGA JR., CCS, CPETS

2010 CPQCC MANDATED CHANGES

NOTE: *Highlighted revisions and updates from the 12/17/09¹, 1/14/10² and 6/15/10³ memos.*

The California Perinatal Quality Care Collaborative (CPQCC), the Vermont Oxford Network (VON), the California Perinatal Transport Systems (CPeTS), and the California Children's Services (CCS) have made several important mandated changes to the data collection effective in 2010.

The reporting of total, birth weight and gestational age specific NICU activity, morbidity and mortality through CPQCC has been mandated by the CCS, while the systematic review and reporting of neonatal transports in California has been mandated through the CPeTS. This means that one must be a member of CPQCC and report the required elements using the CPQCC/VON, the CPQCC/CPeTS, and the CPQCC/CCS data formats. The compliance with the dataset changes is required for a CCS-approved NICU to meet this mandate.

I. CPQCC Eligibility Criteria

A. Small Baby Eligibility Criteria

We would like to encourage our members to utilize the on-line 2010 CCS Supplemental Form as an added data validation tool.

We are reiterating the eligibility rules for the Small Babies (birth weight 401-1500 grams or gestational age is between 22 weeks 0 days to 29 weeks 6 days inclusive) for both the CPQCC and VON databases. It is as follows:

Any infant who is born at your hospital and whose birth weight is between 401 and 1500 grams OR whose gestational age is between 22 weeks 0 days and 29 weeks 6 days (inclusive) is eligible, regardless of where in your hospital the infant receives care.

*Any outborn infant who is admitted to any location in your hospital within 28 days of birth, **without a prior home discharge from a hospital,**² and whose birth weight is between 401 and 1500 grams OR whose gestational age is between 22 weeks 0 days and 29 weeks 6 days (inclusive) is eligible, regardless of where in your hospital the infant receives care.*

In summary, any Small Baby infant is automatically eligible into the CPQCC database.

B. Big Baby Selection Criteria

We would like to reiterate that starting in 2009, we added a new High Acuity Criterion for eligibility in the Big Baby database - **Nasal IMV/SIMV for more than 4 continuous hours. For 2010 this modality was updated to “Nasal IMV/SIMV (or any other form of non-intubated assisted ventilation) for greater than four continuous hours.”**¹ **NOTE:** The time that an infant is on this modality should not be recorded as ventilation time in Item 25b.

In summary, any infant who is born at or admitted to your hospital within 28 days of birth, with a birth weight that is greater than 1500 grams **MUST** also meet one of the following 8 criteria: 1) Death, 2) Acute Transfer-In, 3) Nasal IMV/SIMV (or any other form of non-intubated assisted ventilation)¹ for greater than four continuous hours (for 2009 and later), 4) Intubated¹ Assisted Ventilation for greater than four continuous hours, 5) Early Bacterial Sepsis, 6) Major surgery requiring anesthesia, 7) Previously Discharged Home and Readmitted to your hospital for Total Serum Bilirubin => 25 mg/dL (427 micromols/Liter) and/or exchange transfusion 8) Acute Transfer-Out of your NICU.

Note: Non-intubated assisted ventilation is defined as a mechanically-produced breath. CPAP alone doesn't qualify as non-intubated assisted ventilation. However, CPAP with a back-up rate whether administered through the nose, face mask, etc. that is triggered as a back-up rate or intermittently would qualify. Check Yes to Nasal IMV in Item 23e, but do not include these hours in calculating the duration of the initial episode of intubated assisted ventilation (Item 25b).¹

Note: If a Big Baby infant is on CPAP with a back-up rate for greater than four continuous hours, then this infant qualifies under the Big Baby selection criteria of Nasal IMV/SIMV (or any other form of non-intubated assisted ventilation) greater than four continuous hours.¹

II. New and Revised Items to the CPeTS Transport Form

1. The Date/Time of Last Antenatal Steroid Administration (**Item C.11. T_ASTERDATETIME**) will be **discontinued** in the 2010 data collection. This item will appear on the Core CPeTS Acute Inter-facility paper form, the on-line form and the EDS skeleton file, but will be **grayed out and disabled**.
2. Three new items have been added to measure whether or not an infant received hypothermic therapy during referral, initial evaluation, and NICU admission respectively (**Item C.21a. T_COOLING1, T_COOLING2, and T_COOLING3**). The coding rules will be as follows: 0=No, 1=Yes, 7= Not applicable. If an infant is cooled no temperature is entered. The Unknown code is not an option.

The cooling question refers to the time period just before the TRIPS score timing point:

- Cooling at referral (**T_COOLING1**) is defined as cooling was started prior to referral. If an infant is cooled no temperature is entered.
- Cooling at initial evaluation (**T_COOLING2**) is defined as cooling was started prior to initial evaluation. If an infant is cooled no temperature is entered.

- Cooling at NICU admission (**T_COOLING3**) is defined as cooling was started prior to NICU admission. If an infant is cooled no temperature is entered.
3. Three new items have been added to record the type of hypothermic therapy administered during referral, initial evaluation, and NICU admission respectively (**Item C.21b. T_COOLINGMETHOD1, T_COOLINGMETHOD2, T_COOLINGMETHOD3**). The coding rules will be as follows: 1=Passive, 2=Selective Head, 3=Whole Body, 4=Other, 7=Not Applicable (Only if infant is not cooled). The Unknown code is not an option.

NOTE: If the response to Item C.21a is Yes, then the method (Item C.21b. T_COOLINGMETHOD1 to T_COOLINGMETHOD3) is required. If the response to Item C.21a is No, then the cooling method will be set to 7 (Not Applicable) for non-cooled infants.

4. The temperature at referral, initial evaluation, and NICU admission has been changed from Item C.21 to Item C.21c (**Item C.21c. T_TEMP1, T_TEMP2, T_TEMP3**).

We have clarified that if the attempted reading is lower than the thermometer could measure; record the lowest temperature on the thermometer.

NOTE: If the response to Item C.21a is No, then the temperature (Item C.21c T_TEMP1 to T_TEMP3) is required. If the response to Item C.21a is Yes, then the temperature will be set to 777.7 (Not Applicable) for cooled infants.

III. New and Revised Items to the CPQCC Admission/Discharge Form

5. We have clarified the response choices for the item Previously Discharged Home (for Outborn infants) (**Item 8a. PDH**). The coding rules are as follows: 0=Never Discharged Home from a Hospital after Birth, 1=Was Previously Discharged Home after Birth, 7=Not Applicable.

NOTE: A home birth does NOT qualify for checking “Previously Discharged Home from a Hospital after Birth.”

6. For the item Multiple Births or Gestation, if two or more live fetuses were documented at any time during the pregnancy that resulted in the birth of the infant (If “Yes” to Item 15a. MULT), we have clarified that for Item 15b. Number of Infants Delivered, enter the number of infants actually delivered (count both live born and stillborn infants). For example, if twins were delivered, enter “2”; if triplets were delivered, enter “3”. Do not count fetuses which have been reabsorbed in utero and not delivered. We have clarified the coding rules for the Number of Infants Delivered (**Item 15b. NBIRTHS**) as follows: 77 if [MULT]=0 or [BYEAR]<2010, 1 to 10 if [MULT]=1.

NOTE: For Item 15a, enter “Yes” if at any time during this pregnancy there was more than one fetus documented, no matter how many of these resulted in a birth, stillborn or liveborn. For the case, when two or more live fetuses were documented at any time during the pregnancy that resulted in the birth of only one infant because the other

fetuses were reabsorbed in utero and not delivered, enter “Yes” in Item 15a., and enter 1 in Item 15b. If two infants were delivered, enter 2 in Item 15b.

7. For the item Temperature at Admission to Your NICU (**Item 22b. ATEMP**), we have clarified that if the attempted reading is lower than the thermometer could measure, record the lowest temperature on the thermometer.

NOTE: The temperature has to be entered even if the infant continued cooling in your NICU or started cooling prior to the first temperature.

8. We have added a new item on Infant cooling status during the NICU admission (**Item 22c. ACOOLING**). The coding rules are as follows: 0=No Cooling, 1=Cooling Started, 2=Cooling Continued for Transfer-in. The Unknown code is not an option. The EDS submitters will also have to add the option Not Applicable (7) for DRDs. The option Cooling Continued for Transfer-in is disabled for inborn infants.
9. A new item (**Item 22d. ACOOLINGMETHOD**) has been added to record the Last Type of Hypothermic Therapy Administered During the NICU Admission (Item 22c. ACOOLING). The coding rules are as follows: 1=Passive, 2=Selective Head, 3=Whole Body, 4=Other, 7=Not Applicable (Only if infant is not cooled or DRD for EDS submitters). The Unknown code is not an option.

NOTE: If an infant is administered several methods of hypothermic therapy during the NICU admission, record the last type of hypothermic therapy administered.

10. In California, neonatologists consider any form of ventilation that involves a mechanical breath producing device as assisted mechanical ventilation. This may be delivered via endotracheal intubation as in the case of conventional or HIFI mechanical ventilation **or** via nasal, face mask, or other device as in the case of nasal IMV, SIMV, or CPAP with a back-up rate. CPAP alone does not qualify as it does not involve a mechanical breath producing device. For Big Babies all forms of mechanical ventilation, both intubated or non-intubated (by nose, face mask, etc.) that last more than 4 continuous hours are considered valid entry criteria. However, it is important to note that for both Small and Big Babies we only record the length of initial episode of intubated conventional or intubated HIFI mechanical ventilation. The reason for only recording the length of intubated ventilation is that associations between morbidity/outcomes and length of ventilation have been based on the length of intubated ventilation.²

In 2010, we have clarified Conventional Ventilation (**Item 23b. VENT**) as “**Intubated Conventional Ventilation.**” Intubated conventional ventilation is defined for any infant given intermittent positive pressure ventilation through an endotracheal tube with a conventional ventilator (IMV rate <240/minute).²

NOTE: Intermittent positive pressure ventilation (IPPV) via nasal prongs is not considered **intubated** conventional ventilation. Synchronized intermittent positive pressure ventilation (SIMV) via nasal prongs is not considered **intubated** conventional ventilation.

11. In 2010, we have clarified High Frequency Ventilation (**Item 23c. HIFI**) as “Intubated High Frequency Ventilation.” Intubated high frequency ventilation is defined for any infant given high frequency ventilation (IMV rate ≥ 240 /minute.²

NOTE: High frequency ventilation via nasal prongs is not considered **intubated** high frequency ventilation.

12. In 2010, we have clarified Use of Assisted Ventilation (Title for **Item 25a. DURVENT**, **Item 25b. VENTDAYS** and **VENTHOURS**) as “Use of Intubated Assisted Ventilation.”²

In 2010, we have clarified Length of Assisted Ventilation (**Item 25a. DURVENT**) as “Length of Intubated Assisted Ventilation.”²

13. In 2010, we have clarified If Vent > 4 hours, specify time (**Item 25b. VENTHOURS** and **VENTDAYS**) as “If Intubated Vent > 4 hours, specify time.” For infants who are ventilated for more than 4 hours, we have revised this data element by only requiring the ventilation time in days (**Item 25b. VENTDAYS**). We would like to clarify that an answer of 1=Less than 24 hours, 2=24 hours to less than 48 hours, etc. We do not require the ventilation time in hours (**Item 25b. VENTHOURS**). We have placed a calculator on the on-line Admission/Discharge Form that lets members enter the total number of hours ventilated. The calculator will convert the hours to the correct number of days.

We have clarified the definition for **Item 25b. Use of Intubated¹ Assisted Ventilation. If Greater than 4 hours, specify ventilation time.** Starting in 2009, for an infant treated with **intubated HIFI ventilation or intubated conventional ventilation for more than 4 continuous hours for any reason (surgery or the need for controlled sedation to perform imaging studies are included), record the infant's initial episode of ventilation during the initial stay at your hospital.** In 2009, Nasal IMV/SIMV (or any other form of non-intubated assisted ventilation)¹ is not considered a form of mechanical ventilation. CPAP alone should not be included in the length of time on ventilation.

NOTE: However, for those infants who are ventilated for more than 4 hours, then transferred out, and then readmitted while still ventilated, include only the days at the transferred to hospital as well. However, if this same infant is transferred out and never readmitted, you only include the days at your hospital.

14. In 2010, we clarify that for Respiratory Support at Discharge – Mechanical Ventilation (**Item 35c. SUCFINAL**), we refer to **Intubated² Mechanical Ventilation.** To reiterate, intubated² mechanical ventilation includes intubated conventional ventilation or intubated High Frequency / Jet ventilation. **Nasal IMV/SIMV (or any other form of non-intubated assisted ventilation)¹ does NOT count as mechanical ventilation for the purposes of this dataset.** This item refers to mechanical ventilation through an endotracheal tube only.

15. The CPQCC Data System builds upon Vermont Oxford Network’s (VON) neonatal system for Very Low Birth Weight babies (VLBW). As a result of recent changes made

by VON to their dataset, the following codes have been added or revised for infants born in 2010:

For the First Other Surgery Code to the Tenth Other Surgery Code (**Item 43. SRGCD1-SRGCD10**), the following are New Surgery Codes for 2010:

AREA	CODE	DESCRIPTION
Head and Neck	S109	Craniotomy
Thorax	S214	Sternal closure
Abdomen	S337	Umbilical hernia repair
Open Heart or Vascular	S506	Implanted pacemaker (permanent – do not use code for temporary pacemakers)
Central Nervous System	S905	Encephalocele repair

The following are Modifications to Surgery Code Descriptions:

CODE	CURRENT DESCRIPTION	REVISED DESCRIPTION
S204	Thoracoscopy	Thoracoscopy (with or without pleuridesis/pleurectomy)
S206	Lobectomy or partial lobectomy	Pneumonectomy, lobectomy or partial lobectomy
S307	Ostomy creation	Ostomy creation (with or without fistula creation)
S310	Duodenal atresia/stenosis repair	Duodenal atresia/stenosis/web repair
S322	Partial or complete splenectomy	Partial/complete splenectomy or splenorrhaphy
S327	Gastrostomy tube	Gastrostomy/jeunostomy tube
S329	Colonoscopy	Colonoscopy/sigmoidoscopy
S336	Open liver biopsy	Liver biopsy done during laparotomy or laparoscopy (includes wedge or needle techniques)
S413	Drainage of ovarian cyst	Drainage or removal of ovarian cyst

S903	Ventricular drain with reservoir	Ventricular drain with reservoir placement or removal
S904	Myelomeningocele	Meningocele or myelomeningocele repair

Other Surgery Code Modification: A note will be added at the end of the Abdomen section in the Manual of Operations appendix for surgery codes:

Note: The code for Inguinal Hernia is S410 (see Genito-Urinary section).

Please also refer to Appendix C. Surgery Codes for Item 43, Infants Born in 2010 in the 2010 EDS Instructions and Specifications.

IV. New and Revised Items in the 2010 CCS Supplemental Form

16. Starting in 2010, CCS approved the revision of the birth weight category less than 501 grams into two categories: **less than 401 grams, 401-500 grams**. This change will allow us to completely validate all of the VLBW infants in our Centers in the 2010 CCS Supplemental On-line Form specifically in **Tables A. Hospital Births and Deaths of Infants Born in 2010 by Birth Weight, B. Total Admissions to Your NICU of Infants Born in 2010 by Birth Weight, C. Total Transfers from Your NICU of Infants Born in 2010 by Birth Weight**.
17. CCS approved the collection of two new items in the CCS Supplemental Form (**Table D. Hospital Births and NICU Inborn Admissions of Infants Born in 2010 by Gestational Age**): 1) Total Live Births in your Hospital by Gestational Age, and 2) Total Inborn NICU Admissions by Gestational Age. We will collect gestational age in Table A2. using the following seven categories: **<= 21 6/7, 22 0/7-29 6/7, 30 0/7 - 33 6/7, 34 0/7 - 36 6/7, 37 0/7 – 38 6/7, 39 0/7 – 41 6/7, >= 42 0/7**.

It is important to know the numbers of babies by gestational age in order to determine if perinatal measures, implemented now and in the future, will result in decreasing numbers of premature infants. Numbers of babies, outcomes and conditions particularly for late preterm (34 to 37 weeks) infants are extremely important to measure and track, as perinatal measures are implemented to reduce the numbers of these babies who can have serious morbidity. It is also important to determine the numbers of early term infants (37 to 38 weeks) and the numbers of 39 to 41 week term infants, as efforts are initiated to eliminate elective singleton deliveries before 39 weeks gestation.

A copy of the revised 2010 CCS Supplemental Form is attached to this memo. And an Excel spreadsheet will be posted on the www.cpqcc.org website including a CCS NICU Activity Log for your internal use only.¹

V. 2010 Data Trainings

18. In consultation with the Data Center Advisory Group, we have decided to develop on-line training modules to be part of the 2010 Data Trainings. In addition, we will only be offering two face-to-face CPQCC-CPeTS Data Training sessions in **March 2010: Monday, March 8th at Long Beach Memorial Hospital in Long Beach from 9 am**

to 3 pm, and Thursday, March 11th at Lucile Packard Children's Hospital in Palo Alto from 10 am to 4 pm.² We plan to focus on interactive learning sessions and case studies to further apply lessons from the on-line training modules. The Program Announcement and Course Description is attached.²

We are revising the forms and manuals to reflect these changes. Although these changes may involve work adjustments to fulfill the new requirements, ultimately the addition of these new data items support the best interests of the membership since CPQCC Members have previously requested the addition of several of these data items for quality improvement purposes.

We anticipate that Members who submit data electronically and use their existing internal databases for tracking clinical events and outcomes at the NICU may be impacted by this change. If this is the case for your center, please do not hesitate to contact the CPQCC Data Center at 650.721.1844 or email us at support@cpqcc.org. We welcome the opportunity to assist centers as they meet this requirement.

Thank you for your cooperation.

2010 CPQCC-CPeTS Data Training
Monday, March 8, 2010, 9 am – 3 pm, Long Beach Memorial
Thursday, March 11, 2010, 10 am – 4 pm, LPCH

Program Announcement:

The California Perinatal Quality Care Collaborative (CPQCC) 2010 dataset has changed dramatically from the 2009 dataset.

This year due to budget issues we are reorganizing the **2010 Data Trainings** to cut down on expenses.

- First, we are developing an on-line continuing education module for our membership. The module will provide an overview of CPQCC and the California Perinatal Transport System (CPeTS), the CPQCC Network Database and data finalization.
- Second, we will only have two in-person trainings throughout the state, one in Southern California on Monday, March 8th at Long Beach Memorial and one in Northern California on Thursday, March 11th at Lucille Packard Children's Hospital. All trainings will be once again jointly conducted by both the CPQCC Data Center and the CPeTS Executive Committee.
- The format of the in-person trainings has also been modified. This year the morning session will be focused on program updates from CPQCC, CPeTS, and the CCS/CPQCC High Risk Infant Follow-up Quality Care Initiative (HRIF QCI). The afternoon session will be focused on applying lessons from the on-line modules through interactive learning sessions using case studies and guided discussions.

More details on the on-line continuing education module, on-line registration and logistics to follow.

The CPQCC Data Center strongly encourages all current CPQCC Data Contacts, Report Contacts, Transport Contacts, Quality Improvement Contacts and those considering CPQCC membership to attend one of these scheduled data trainings since **these will be the only dates that will be scheduled for this year.**

Course Description:

This course is intended to assist the CPQCC Data Teams to utilize the CPQCC Network Database as a perinatal tool for quality improvement.

Intended Audience:

- CPQCC designated Report Contacts and Data Contacts, Transport Coordinators, Neonatologists, Perinatal/Neonatal Nurses, CCS/CPQCC HRIF QCI designated HRIF Coordinators and NICU Contacts, Discharge Planners (who refer patients to HRIF Programs), Hospital and Perinatal Administrators, and Healthcare Quality Professionals.

Learning/ Course Objectives:

Following self-study of the slide presentation and attendance to the in-person data training, the participant will have/be able to:

- Develop a collaborative network/team to support a system of benchmarking and performance improvement activities for perinatal care;
- Identify and develop systems for case review and abstraction of perinatal data for quality improvement from the time of transport through the high risk infant follow-up phase of care;
- Demonstrate understanding of data definitions, requirements and tools to ensure high-quality data abstraction; and
- Identify three ways your facility will be able to use the CPQCC, CPeTS, CCS/CPQCC HRIF QCI data to improve the understanding of internal perinatal issues.

Continuing Education Credits:

The Community Perinatal Network (CPN) is an approved Continuing Education Provider (CEP) by the California Board of Registered Nursing, CEP# 14797. This course is approved for 4 hours of continuing education credits. All attendees must complete all portions of the course in order to receive credits. Certificates must be maintained for a period of 4 years following the course.

Agenda:

This course typically requires approximately: 150 minutes to study the presentation materials, et al, 30 minutes to complete the post-test and reporting requirements, (6 hours for in-person training and 4 hours for self-study).

MAR 8, 2010	DURATION	TOPIC	SPEAKER
8:15 – 9:00	45 min	Registration	Group
9:00 – 9:10	10 min	Welcome – CPQCC Overview/ Quality Improvement	BM, GVD
9:11 – 9:40	30 min	CPeTS Update	LB, AH, MP
9:40 – 10:00	20 min	CPQCC Data Update	GVD
10:00 – 10:30	30 min	HRIF Update	EG
10:30 – 10:45	15 min	BREAK	
10:45 - 11:45	60 min	Case Study 1: Head Cooling (Format: Introduce case study, group work, report out and guided discussion)	Group
11:45 - 12:15	45 min	LUNCH	
12:15 – 1:15	60 min	Case Study 2: Infant transported from a non-standard place or Transport Special Situation (Format: Introduce case study, group work, report out and guided discussion)	Group
1:15 – 1:30	15 min	BREAK	
1:30 – 2:20	60 min	Case Study 3: Standard micropremie (Format: Introduce case study, group work, report out and guided discussion)	Group
2:30 – 2:45		Summary	Group
2:45 – 3:00		Evaluations, Continuing Education	Group
3:00		ADJOURN	

MAR 11, 2010	DURATION	TOPIC	SPEAKER
9:15 – 10:00	45 min	Registration	Group

10:00 – 10:10	10 min	Welcome – CPQCC Overview/ Quality Improvement	BM, GVD
10:10 – 10:40	30 min	CPeTS Update	LB, AH, MP
10:40 – 11:00	20 min	CPQCC Data Update	GVD
11:00 – 11:30	30 min	HRIF Update	EG
11:30 – 12:15	45 min	LUNCH	
12:15 – 1:15	60 min	Case Study 1: Head Cooling (Format: Introduce case study, group work, report out and guided discussion)	Group
1:15 – 2:15	60 min	Case Study 2: Infant transported from a non-standard place or Transport Special Situation (Format: Introduce case study, group work, report out and guided discussion)	Group
2:15 – 2:30	15 min	BREAK	
2:30 – 3:30	60 min	Case Study 3: Standard micropremie (Format: Introduce case study, group work, report out and guided discussion)	Group
3:30 – 3:45		Summary	Group
3:45 – 4:00		Evaluations, Continuing Education	Group
4:00		ADJOURN	

Principal Faculty

- Cyndi Atkinson, RNC, BSN, CPQCC Data Contact & CPQCC Data Center Advisory Group member, Children’s Hospital Los Angeles
- D. Lisa Bollman, RNC, MSN, CPHQ, SCPeTS Director, Community Perinatal Network Executive Director
- Grace Villarin Dueñas, MPH, CPQCC Data Center Program Manager
- Sandy Forbis, Senior Data Control Coordinator, CPQCC Data Contact, CPQCC Data Center Advisory Group member, Cedars-Sinai Medical Center
- Erika Gray, BA, CCS-HRIF QCI Program Manager
- Al Hackel, MD, NCPeTS Director
- Amy Johnson, RN, Clinical Data Coordinator, CPQCC Data Contact & CPQCC Data Center Advisory Group member, Sutter Medical Center Roseville & Sutter Medical Center Sacramento
- Barbara Murphy, RN, MSN, CPQCC Executive Director
- Sharon Olson, RN, Data Manager, CPQCC Data Contact & CPQCC Data Center Advisory Group member, Good Samaritan Hospital, San Jose
- Michelle Padreddi, RN, Patient Safety Quality Manager, CPQCC Clinical Data Coordinator, NCPeTS Data Manager, Lucile Packard Children’s Hospital at Stanford
- Kevin Van Otterloo, MPH, SCPeTS Manager, Community Perinatal Network

Cost & Cancellation/Refund Policy

This self-study continuing education course is free. No cancellation or refunds required.

Sponsorship

This program is jointly sponsored by CPQCC, CPeTS, CCS/CPQCC HRIF QCI and the Community Perinatal Network (CPN), a Regional Perinatal Programs of California. This program is made possible, in part, by Title V Block Grant Funds from the California Department of Public

Health, Maternal, Child and Adolescent Health Division.

Community Perinatal Network
13601 E. Whittier Blvd., Ste 208,
Whittier, CA 90605
Tele/Fax: (562) 945-6484 / 945-6489
lisa@perinatalnetwork.org
D. Lisa Bollman, RNC, MSN, CPHQ