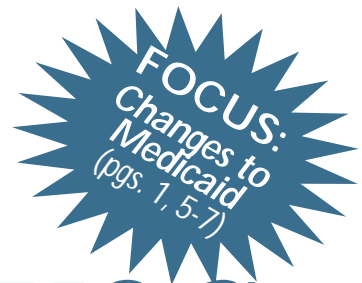


PERINATAL Perspectives



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Should Indiana Raise Tobacco Taxes to Reduce Perinatal Smoking?

By Jan Arnold, MS
State Director of Program Services/Public Affairs
March of Dimes Indiana Chapter

There's no doubt that Indiana has a high incidence of perinatal smoking—in 2004 at least 18.1 percent of expectant mothers smoked during pregnancy, compared to a national average of 10.2 percent (see pg. 2 for more on Indiana perinatal smoking rates). There's also no debate that smoking during pregnancy is harmful to the health of women and their babies.

A growing body of evidence indicates that public policies such as smoke-free ordinances and higher tobacco taxes reduce smoking. The Campaign for Tobacco-Free Kids estimates that within five years of enacting a \$1 per pack increase on the cigarette tobacco tax, 16,000 fewer smoking-affected births would occur with a savings of \$22.8 million on the cost of such births.



Indiana currently ranks thirty-fifth in the highest tobacco taxes (\$.555 cents per pack of cigarettes)—only 15 states are lower. The nationwide average is \$.95, and the highest state tobacco tax is \$2.46.

In his 2006 State of the State address, Governor Mitch Daniels proposed a tobacco tax increase. Administration representatives state that the governor remains in favor of this policy for the 2007 legislative session. The March of Dimes Indiana Chapter has decided to advocate for an increase in the tobacco tax provided that the increased revenue generated is appropriated to programs that are designed to decrease perinatal smoking.

To be kept informed about upcoming tobacco tax legislation and other issues related to maternal and child health, please consider joining the March of Dimes Advocacy Network by visiting marchofdimes.com/Indiana and clicking on "advocacy."

Reach author Jan Arnold, MS, March of Dimes, Indiana Chapter, by calling 317.262.4669 or e-mailing JArnold@marchofdimes.com.



The Indiana Perinatal Network is an alliance of hundreds of individuals and organizations across Indiana committed to the beliefs that:

- Every mother deserves a healthy and safe pregnancy; and
- Every baby deserves to be born healthy and into a safe and nurturing home.



FOCUS

A Summary of Recent Changes to Indiana's Medicaid System

Background

Medicaid is a joint state-federal program available in all 50 states. While there are slight variations between different geographic regions of the country, the federal government pays approximately 65 percent of the Medicaid costs and the state pays the remaining 35 percent. The federal government also sets some standard rules and regulations on eligibility, covered services and reporting requirements that all participating states are required to follow to receive the 65 percent federal share.

Hoosier Healthwise is Indiana's Medicaid program for pregnant women, children and low-income families. Over the next few months, a number of changes at the state and federal level will be implemented. This is a brief summary of the most current information as of the date of this publication.

Managed Care Providers Selected

In August 2006, the Family and Social Services Administration (FSSA) awarded contracts to the following three Managed Care Organizations (MCOs) to serve all pregnant women and children receiving Medicaid through Hoosier Healthwise:

- ▶▶ Anthem Health Insurance Co., Inc.
- ▶▶ Managed Health Services (MHS)
- ▶▶ MDWise

Continues on pg. 5 ▶

Smoking During Pregnancy in Indiana (1990-2004)

By Atossa Rahmanifar, PhD, RD

Smoking during pregnancy in Indiana has declined during the 1990 to 2004 period, in large part, in response to intensive public health education and campaigns that have been waged at the state and national levels. However, efforts to lower prenatal smoking in Indiana have been far less than adequate. In 2004, the prenatal smoking rate in Indiana was 18.1 percent compared to 10.2 percent nationwide. In 2002, Indiana was one of the top six states in high smoking rates during pregnancy. Moreover, the widening gap between the rates in Indiana and the U.S. points to the fact that Indiana is falling further behind the nation in its effort to lower prenatal smoking.

Public health efforts to lower prenatal smoking had disproportionate effects across race, age, and education of mother. While college educated mothers in their late twenties or older had the lowest smoking rates and the sharpest decline in rates over the last decade or so, the younger and less educated mothers had the highest prenatal smoking rates and achieved the least in lowering smoking rates.

Trends

AGE/EDUCATION

- ▶ Smoking rates were consistently higher among non-Hispanic white mothers compared to non-Hispanic blacks and declined

IN MEMORIAM

Jim Sawyers, husband of **Paula Parker-Sawyers**, passed away unexpectedly on August 22. Parker-Sawyers is the executive director of the Office of Faith-Based and Community Initiatives, a past IPN board member and a long-time IPN friend and supporter.

Rebecca S. Wappner, MD, director of Pediatric Metabolism and Genetics at the James Whitcomb Riley Children's Hospital passed away on September 6 after a short battle with cancer.

among both groups during this period; the rate of decline, however, has slowed down after mid 1990s.

- ▶ Smoking rates fell steadily for women 25 years of age and older, whereas trends for younger mothers have been less consistent.
- ▶ Among non-Hispanic white mothers under 25 years of age and among all non-Hispanic mothers with less than 12 years of education, smoking rates have remained alarmingly high since 1990.
- ▶ In contrast, non-Hispanic mothers with more than a high school education had the lowest smoking rates and achieved the sharpest decline in rates.
- ▶ Prenatal smoking rates were considerably lower among Hispanics compared to non-Hispanics and declined sharply and consistently among them regardless of age and educational levels.

METROPOLITAN/NON-METROPOLITAN

- ▶ Non-Hispanic mothers residing in non-metropolitan counties had the highest smoking rates and the least decline and those residing in large fringe metropolitan counties had the lowest smoking rates and the most decline in rates.
- ▶ The gap in smoking rates by urbanization level of the county of residence widened with time.
- ▶ One third of all Indiana counties had prenatal smoking rates of 25 percent or higher, most of these counties (70 to 80 percent) were non-metropolitan, located in the southern half of the state, and had no significant change in prenatal smoking rates since 1990.


INTENSITY OF SMOKING

- ▶ Intensity of smoking (number of cigarettes smoked per day) increased with age and decreased with educational level of mother.
- ▶ Non-Hispanic white mothers smoked more heavily than non-Hispanic blacks and Hispanics.

- ▶ Despite a decline in the intensity of prenatal smoking in all age and educational groups over the last several years, one fifth of pregnant smokers in 2004 smoked 20 or more cigarettes per day.

LOW BIRTH WEIGHT (LBW)

- ▶ LBW rate among infants born to mothers who smoked during pregnancy was almost double the rate of those born to non-smokers.
- ▶ The LBW rate rose steadily with increasing consumption of cigarettes.
- ▶ Compared to non-smokers, LBW rate was considerably higher (by 71 percent) even among births to women who reported smoking fewer than six cigarettes per day, pointing to the fact that there is no safe level of smoking.
- ▶ The higher LBW rate among smokers compared to non-smokers existed along all age and educational categories regardless of race and Hispanic origin.

To reduce prenatal smoking and improve the health of pregnant mothers and their babies, Indiana needs to increase its effort in launching massive public health and educational campaigns across the state to a targeted audience to reach those most at risk. The alarmingly high rates of prenatal smoking among young non-Hispanic white mothers calls for need in waging educational campaigns aiming at children in elementary schools and need for sustained efforts to prevent smoking among teenagers. Higher smoking rate and intensity among the less educated pregnant women calls for special attention to this vulnerable population. Lack of success in lowering prenatal smoking rate in many rural Indiana counties during the past decade manifest the need for special attention to these areas and the importance of developing effective strategies to reach the high risk populations in non-metropolitan counties. 

Smoking During Pregnancy in Indiana: 1990-2004, including detailed statistics on smoking trends, will be available on ISDH's website: [/www.in.gov/isdh](http://www.in.gov/isdh).

"Something's Not Right" Consumer Awareness Campaign Debuts

IPN Introduces Perinatal Mood Disorder Resources for Consumers & Providers

By Julia Tipton Hogan, IPN Community Outreach Coordinator

A consumer education campaign to increase awareness of the incidence and treatment of perinatal mood disorders (PMD) kicks off in Allen, Lake, Marion, St. Joseph and Vanderburgh counties. The cross-promotional "Something's Not Right" campaign encompasses outdoor advertising such as billboards, bus cards, and bus hut displays; professionally produced radio public service announcements (PSAs); and posters.

The campaign represents the latest in a series of consumer and provider resources produced by IPN's Indiana Perinatal Depression Project (IPDP). Funded by a two-year grant from the Health Resources and Services Administration (HRSA), the project focuses on screening, diagnosis and treatment of PMD to promote mental wellness for mothers and families.

Activities commenced with a series of *Regional Perinatal Depression Summits* and *Certificate of Completion Courses* in Indianapolis, Ft. Wayne and Bloomington.

Additional consumer resources and materials include:

- ▶ "Something's Not Right" Booklet*—Identifies symptoms, provides recommended reading and websites, and urges women (and family members) to seek help.
- ▶ Enhancements that make IPN's website a more comprehensive source of consumer information and support.
 - ▶ www.somethingsnotright.org—This new domain links campaign respondents to IPN's website where they can take the [Edinburgh Depression Scale](#) to score their level of depression and receive next-step suggestions.
 - ▶ An interactive state map will soon enable visitors to identify current providers of services, types of payment accepted, and availability. An IPN survey of health care professionals identified more than 250 statewide providers. The Indiana



Family HelpLine is also using this referral list to help connect callers with providers.

- ▶ Plans are under way to enhance the website to enable online support groups.

Health care provider resources and materials include:

- ▶ Updated Postpartum Depression Consensus Statement*—An alert on the incidence and significance of depression and other mood disorders women can experience during and after pregnancy.
- ▶ Indiana Perinatal Depression Guide*—Symptoms, treatments, screening tools and resources.
- ▶ Edinburgh Postnatal Depression Scale*—A diagnostic tool that can assist primary care health professionals in detecting PMD.
- ▶ Decision Tree for Depression



Available in English or Spanish, new resources include (from top left, clockwise) a consumer education booklet; website tools such as the Edinburgh scale; billboards and posters.

During the Childbearing Years*—A tool to assist professionals in better understanding the underlying causes and symptoms of PMD and a woman's readiness for treatment/intervention.

- ▶ Information for Physicians on Prescription Products to Treat Perinatal Depression*—The Illinois State Department of Healthcare and Family Services provides a link to clinical guidelines for the identification and treatment of PMD.
- ▶ Recognizing Perinatal Depression—This interactive self-study course will soon be available on compact disc. Developed by the Indiana University School of Nursing, the course is geared to training frontline care providers and home visitors to recognize and care for women with perinatal mood disorders.

* Available at www.indianaperinatal.org

For more information about the "Something's Not Right" public awareness campaign and the IPDP project, contact IPN's Public Outreach Coordinator Julia Tipton Hogan at 317-924.0825, ext. 4229 or e-mail jthogan@indianaperinatal.org.

What Health Care Providers Should Know About HPV Vaccinations

By Karen Trappe, MSIV

On June 8, 2006, the U.S. Food and Drug Administration approved a quadrivalent human papillomavirus (HPV) vaccine for females aged 9 to 26 years. The American College of Obstetricians and Gynecologists (ACOG) Advisory Committee on Immunization Practices recommends routinely vaccinating girls at 11 or 12 years of age. Ideally, vaccination should occur before potential exposure to HPV through sexual contact. The vaccine can be administered with other age-appropriate vaccines, such as Tdap, Td and MCV4, in the same visit.

Vaccination programs are successful, cost-effective public health measures that save millions of lives through reduction and/or elimination of once devastating infectious diseases. Experience with past vaccines, including measles, polio and small pox, shows that it can take several decades to eliminate disease. The number of years it takes the HPV vaccine to make an impact on the human papillomavirus is dependent on health care providers.

Background

More than 40 types of HPV infect 6.2 million Americans each year through sexual contact. This transmission results in more than 50 percent of sexually active men and women being infected with HPV during their lifetime. Most infections are cleared by the body, but infections with types 6 or 11 cause 90 percent of genital warts, and persistent infection with types 16 or 18, causes 70 percent of cervical cancer. In the U.S., 10,000 women are diagnosed with cervical cancer and 3,700 succumb to it yearly. *This makes cervical cancer the second leading cause of cancer deaths among women worldwide.*

In Indiana, 1,098 women were diagnosed with invasive cervical cancer, yielding an age-adjusted incidence rate of 8.7 per 100,000 for the four-year period of 2000 to 2003. *The incidence rate of cervical cancer in Indiana for those years is higher than the national rate of 7.6 per 100,000.*

The HPV Vaccine

Gardasil, a quadrivalent vaccine against types 6, 11, 16, and 18, was recently approved for use in females age 9 to 26.

The vaccine is administered in a three-dose series: First dose at visit one, second dose two months after the first, and the third dose is given six months after the first dose. No special HPV testing is required prior to vaccination. This revolutionary vaccine has the potential to prevent 70 percent of cervical cancers and 90 percent of genital warts.³ The challenge is to get the vaccine to those who would benefit most, teenagers who are not yet sexually active.

How You Can Help

▶ EDUCATION

Many consumers have just started hearing about HPV and its link to cervical cancer. Studies show that heightened awareness results in increased acceptance and motivates individuals to get vaccinated.

▶ ACCESS

Females 11 to 12 years old, as well as those in the recommended range of 9 to 26 years old, often fall between the cracks because many are only seen if an immediate need occurs. The types of providers they see vary and may include an adolescent specialist, family medicine doctor, internist, pediatrician, and/or obstetrician/ gynecologist. Additionally, they may receive health care from organizations such as Planned Parenthood or their local emergency room. If a facility cares for females between the ages of 9 to 26, the HPV vaccine should be offered.

▶ FINANCIAL BARRIERS

The retail cost of the vaccine is \$120 per shot, totaling \$360 for the series. While some private insurance companies already cover it, others lag behind. Federal health programs such as the Vaccines for Children Program (VFC) also provide the vaccine, allowing local health departments and other VFC agencies to provide free or low-cost vaccines to those in need.⁴ It should be our goal to ensure that perceived barriers do not hinder the progression of this revolutionary vaccination initiative against cancer.

Reach author Karen Trappe, MSIV at kltrappe@iupui.edu. References available upon request. For more information, visit www.cdc.gov/std/hpv.

Milk Depot Opens in Bloomington



Left to right: Moms Kristen Westmore and Rebecca Shaffer with District 60 Indiana State Representative Peggy Welch.

In September, a press conference with State Health Commissioner Judith A. Monroe, MD, ISDH, was held to open Indiana's first "breast milk depot" at a Bloomington Women, Infants and Children (WIC) office. It is the first in a series of breast milk collection sites that will be established at WIC offices throughout Indiana to benefit ill or premature infants.

The donated breast milk is carefully screened and pasteurized through the Indiana Mothers' Milk Bank in Indianapolis. This bank provides breast milk to ill or premature infants who are unable to receive milk from their own mothers.

The Bloomington depot, and others scheduled to open next year, will help Indiana achieve the goals of the *Born to be Breastfed* state plan (see related article on pg. 9). By 2010, the plan calls for 75 percent of the state's infants to be breastfeeding when discharged from the hospital with 50 percent continuing to be breastfed for six months, and 15 percent breastfed for one year.

Mothers' Milk Bank is located in Indianapolis at the Methodist Medical Plaza II, 6820 Parkdale Place, Suite 109. For more information, contact Mary Alexander or Donna Miracle at ph: 317.329.7146.

A Summary of Recent Changes to Indiana's Medicaid System *(from pg. 1)*

MANAGED CARE ORGANIZATION (MCO) CONTACT INFORMATION

PLAN	PROVIDER CONTACT	MEMBER/PATIENT CONTACT	WEBSITE
Anthem	Bob Sonnessa 800.618.3141	888.232.9613	
Managed Health Services (MHS)	Angela Jackson 800.944.9661	800.414.5946	www.managedhealthservices.com
MDWise	Sherri Miles	800.356.1204 800.356.1204	www.mdwise.org

Subsequently, three MCOs currently providing services, but not awarded a contract, filed an administrative appeal with FSSA/OMPP and a legal challenge by one of the MCOs remains active.



These administrative and legal challenges could impact implementation of the new contracts that are scheduled to take effect on January 1, 2007.

In addition, a variety of individual providers, provider associations and institutions have shared serious concerns with OMPP regarding a number of issues related to the contract provisions. The impact this active protest might have on local services networks and Medicaid recipients is uncertain.

If the three organizations selected by FSSA are in fact the final MCOs, as many as 225,000 Hoosier Healthwise recipients statewide might need to select a new MCO/PMP. OMPP has informed all current PMPs that contracts with MCOs need to be finalized by November 1, 2006.

New features of the MCO contracts include:

- ▶ **Primary Medical Providers (PMPs) may contract with more than one MCO.**
- ▶ **Recipients may pick an MCO and then select a PMP in their network, or choose a PMP and then be enrolled in that MCO.**
- ▶ **Covered services now include most behavior/mental health services.**
- ▶ **Electronic health information records must be used where possible.**
- ▶ **MCOs are encouraged to work with school-based providers and physician extenders (nurse practitioners, certified nurse midwives, physician**

assistants) to increase access to medical care.

- ▶ **MCOs can earn an additional payment based on outcomes and performance measures.**
- ▶ **All three MCOs are responsible for statewide coverage.**



Proof of Citizenship

Citizenship or legal immigration status has always been an eligibility requirement for Medicaid, but it was indicated by checking a box during the application process. One component of the Federal Deficit Reduction Act (DRA) of 2005 requires individuals to provide evidence of citizenship or nationality when initially applying for Medicaid or upon a recipient's first re-determination (renewal).

Beginning August 15, 2006, Indiana Medicaid caseworkers and community-based enrollment centers began verifying citizenship for all new applicants. **All current Medicaid recipients (including children) facing re-determination after August 15 must provide documentation of their citizenship.** Individuals must provide original documents—**ONE from List 1 OR ONE from List 2 AND List 3.**

If one of these accepted forms of documentation is not available for children under the age of 16, parents

Continues on pg. 6▶

Changes to
INDIANA'S MEDICAID

Changes to INDIANA MEDICAID

LIST 1

- ▶ US Passport, issues without limitations, even if it's expired
- ▶ Certification of Naturalization – N-550 or N-570
- ▶ Certificate of Citizenship – N-560 or N-561

OR

LIST 2

- ▶ Birth certificate
- ▶ Report or Certificate of Birth Abroad of a US citizen
- ▶ US Citizen ID Card
- ▶ Adoption papers
- ▶ Military Record

AND

LIST 3

- ▶ State driver's license or state identity card with picture
- ▶ School identification card
- ▶ Federal, state or local government identification card
- ▶ US military identification card with place of birth


or guardians can contact their caseworker for a special affidavit to sign.

The new citizenship requirements also apply to children in foster care. However a federal judge may order a temporary injunction exempting foster children from this regulation.

All babies born to women on Medicaid Package A or Package B (Medicaid for pregnant women) are automatically eligible for Medicaid, but citizenship must be proven at the time of re-determination.

Medicaid recipients have 10 days from the date of their initial application or re-determination interview to provide the necessary documentation or their application could be denied. However, if a community-based enrollment center or Medicaid eligibility caseworker documents that they are making a "good-faith effort" beyond this 10-day period to provide the necessary documentation, their new application or current eligibility can continue.

Undocumented immigrants are still eligible for emergency Medicaid (limited coverage) if they meet all other eligibility requirements. After citizenship is proven, it does not need to be re-established.

As a health care provider, it is not up to you or your staff to verify a patient's citizenship status; this is accomplished at the time of the patient's Medicaid application or Medicaid re-determination process. However, if your hospital or community health center serves as an enrollment center with a Memorandum of Agreement with DFC-FSSA, the new requirements extend to their initial application processing. 

WEBSITES FOR MORE INFORMATION

www.indianamedicaid.com
www.healthcareforhoosiers.com
www.ckfindiana.org

HOW CAN YOU HELP YOUR PATIENTS?

- ▶ **HELP THEM PLAN AHEAD** for their application appointment by encouraging them to start obtaining the necessary citizenship documentation and let them know where in your community this documentation can be obtained.
- ▶ **STRONGLY ENCOURAGE THEM TO NOTIFY THEIR CASEWORKER** anytime they move or get a new phone number. If their caseworker cannot contact them, they may miss a re-determination notice and be dropped from Medicaid. Patients can also update their contact information by calling the Hoosier Healthwise Helpline at 1-800-889-9949.
- ▶ **ASK WHETHER THEY HAVE RECEIVED A RE-DETERMINATION NOTICE.** All children born to Medicaid recipients are automatically deemed eligible for Medicaid. However, since Indiana Medicaid does not have continuous eligibility, children can lose their Medicaid benefits if their parents miss a re-determination appointment or cannot provide the necessary documentation. Although parents can reapply, this can result in lapses of health insurance coverage and create confusion regarding the child's primary medical provider (PMP).


Family Planning Waiver

The 2005 Indiana General Assembly approved legislation requiring the Office of Medicaid Policy and Planning (OMPP) to submit a waiver to the federal government by January 1, 2006 to extend coverage for family planning services for postpartum Medicaid eligible women.



Currently most women lose their Medicaid eligibility approximately two months after delivery. Once enacted, women will maintain their Medicaid coverage for family planning services only for an additional two years.

IPN and other interested organizations provided OMPP with data and background information to help them complete the waiver application. OMPP hopes to conclude work on the waiver in October 2006, and upon approval by the State Office of Management and Budget, it will be submitted for federal review which can take up to two years.

IPN will keep you abreast of any ongoing developments with the waiver. 

Outsourcing of Eligibility Process

In 2005, FSSA began drafting a Request for Services (RFS) for private entities to assume the responsibility of determining Medicaid and other public assistance service eligibility for individuals throughout Indiana.

A great deal of discussion transpired between FSSA and potential companies interested in bidding for the contract—as well as with advocate organizations concerning the complexities of such a system. While FSSA is still interested in streamlining the eligibility determination process with an outside entity, the RFS for the contract is currently on hold.

QUESTIONS, CONCERNS OR WANT TO LEARN MORE?

IPN in conjunction with the Covering Kids and Families Coalition is convening a statewide conference call for interested individuals to share information and concerns regarding these and other Hoosier Healthwise issues.

If you are interested in participating in this informational call, contact Larry Humbert at Lhumbert@indianaperinatal.org or 317.924.0825, ext. 4224.

UPCOMING EVENTS

APRIL 22-23, 2007

THE INDIANA PERINATAL INSTITUTE PRESENTS:
INDIANA NEWBORN DEVELOPMENTAL CARE CONFERENCE
Ritz Charles, Carmel



APRIL 26

INDIANA PERINATAL EDUCATORS CONFERENCE
Ritz Charles, Carmel



SPRING

THE INDIANA PERINATAL INSTITUTE PRESENTS:
2007 PERINATAL SUBSTANCE USE DISORDERS CONFERENCE

PERINATAL CONTINUING EDUCATION PROGRAM (PCEP) TRAIN-THE-TRAINER



FALL 2007

THE INDIANA PERINATAL INSTITUTE PRESENTS:
UNINTENDED PREGNANCY SUMMIT



Perinatal Hepatitis B Program Update

By Cindy Brown,
ISDH Hepatitis B Program Coordinator

The Indiana State Perinatal Hepatitis B program, administered by ISDH, ensures that infants born to Hepatitis-B-positive mothers receive the immunoglobulin (HBIG) and a birth dose of the vaccine within 12 hours of birth.

When administered at birth, the Hepatitis B vaccine can prevent transmission from mother to newborn. The Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control (CDC) recommend that *all newborns* receive the vaccine before hospital discharge. Hepatitis B is a reportable communicable disease per the *Communicable Disease Reporting Rule for Physicians, Hospitals & Laboratories*, 470 IAC 1-2.3, effective October 11, 2000. By law, all positive cases must be reported to ISDH, as well as to the local health department.

When ISDH receives a report of a positive pregnant woman, an investigation begins. A public health investigator contacts the mother, obstetrician, delivering hospital and the infant's physician. To help ensure that the mother and her newborn receive both the HBIG and birth dose, the program provides information about infection and the importance of the vaccine. The investigator also interviews the mother to learn about all household and sexual contacts to complete Hepatitis B testing.

Follow up helps to ensure the three-dose immunization series and subsequent serological testing are completed. The investigator assists in arranging the tests and immunizations—provided at no cost to the family.

For more information about the ISDH Perinatal Hepatitis B program, contact Program Coordinator Cindy Brown at 317-234-3072 or e-mail cybrown@isdh.in.gov.

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TOTAL PERCENT OF PREGNANT WOMEN ENTERING PRENATAL CARE IN FIRST TRIMESTER BY COUNTY, COMPARISON 2003-2004

Infant Mortality Rate by Race (per 1,000 Live Births)

COUNTY	2004	2003	% CHANGE	COUNTY	2004	2003	% CHANGE
Adams	73.5	76.1	-3.4%	Lawrence	83.2	84.6	-1.6%
Allen	84.2	83.9	=	Madison	80.3	82.8	-3.0%
Bartholomew	80.0	85.6	-6.5%	Marion	74.6	76.4	-2.3%
Benton	85.9	84.7	+1.4%	Marshall	78.9	82.2	-4.0%
Blackford	88.1	86.5	+1.8%	Martin	83.3	88.2	-5.5%
Boone	88.7	87.6	+1.2%	Miami	81.7	86.3	-5.3%
Brown	85.2	87.9	-3.1%	Monroe	84.0	82.8	+1.4%
Carroll	83.2	85.7	-2.9%	Montgomery	76.7	81.8	-6.2%
Cass	77.5	76.1	+1.8%	Morgan	85.3	83.7	+1.9%
Clark	70.1	82.7	-15.2%	Newton	81.6	84.5	-3.4%
Clay	83.4	83.0	=	Noble	71.9	76.0	-5.4%
Clinton	72.1	72.2	=	Ohio	79.7	93.5	-14.8%
Crawford	77.1	85.2	-9.5%	Orange	81.0	82.0	-4.8%
Daviess	68.9	65.9	+4.5%	Owen	80.5	77.6	+4.0%
Dearborn	86.4	92.2	-6.3%	Parke	81.5	71.7	+13.7%
Decatur	76.5	81.7	-6.4%	Perry	74.7	85.8	-12.9%
DeKalb	81.0	80.7	=	Pike	86.8	83.0	+4.6%
Delaware	89.6	89.3	=	Porter	83.0	82.0	+1.2%
Dubois	90.2	91.2	-1.1%	Posey	87.0	86.4	+0.7%
Elkhart	60.5	64.6	-6.3%	Pulaski	83.7	82.9	+1.0%
Fayette	81.3	85.2	-4.6%	Putnam	76.2	81.7	-6.7%
Floyd	70.7	85.7	-17.5%	Randolph	88.7	84.4	+5.1%
Fountain	77.9	82.9	-6.0%	Ripley	87.3	82.3	+6.1%
Franklin	88.1	89.0	=	Rush	80.1	84.8	-5.5%
Fulton	74.3	82.1	-9.5%	St. Joseph	72.5	71.3	+1.7%
Gibson	86.8	86.3	+0.6%	Scott	72.2	81.9	-11.8%
Grant	74.8	70.8	+5.8%	Shelby	85.1	84.5	+0.7%
Greene	86.3	80.7	+6.9%	Spencer	80.4	87.5	-8.1%
Hamilton	89.4	87.8	+1.8%	Starke	82.3	80.4	+2.4%
Hancock	93.2	90.9	+2.5%	Steuben	80.1	82.1	-2.4%
Harrison	73.6	88.8	-17.1%	Sullivan	83.2	82.0	+1.4%
Hendricks	88.1	90.6	-2.8%	Switzerland	68.2	82.5	-17.3%
Henry	87.0	89.1	-2.3%	Tippecanoe	79.4	84.1	-5.6%
Howard	80.2	85.1	-5.8%	Tipton	88.4	84.5	+4.6%
Huntington	88.4	89.2	-0.9%	Union	86.1	91.9	-6.3%
Jackson	77.6	79.7	-2.6%	Vanderburgh	85.8	86.2	-0.5%
Jasper	82.6	81.0	+2.0%	Vermillion	77.3	84.5	-8.5%
Jay	81.2	79.8	+1.2%	Vigo	84.6	82.5	-8.5%
Jefferson	74.9	86.6	-13.5%	Wabash	81.2	83.4	-2.6%
Jennings	76.9	85.2	-9.7%	Warren	79.8	87.2	-8.5%
Johnson	87.3	88.9	-1.8%	Warrick	90.0	87.7	+2.6%
Knox	84.0	85.7	-2.0%	Washington	74.7	77.1	-3.1%
Kosciusko	77.9	78.3	-0.5%	Wayne	77.8	78.1	-0.4%
LaGrange	46.1	46.5	=	Wells	88.4	91.3	-3.2%
Lake	79.0	78.5	+0.6%	White	82.7	85.2	-2.9%
LaPorte	78.3	74.2	+5.5%	Whitley	85.1	84.5	-0.7%

In 2004, 79.3 percent of all expectant mothers with a live birth entered prenatal care in the first trimester compared to 80.1 percent in 2003—a 1.2 percent decrease from 2003.

Two counties, *Dubois and Warrick (in blue above)*, met the *Healthy People 2010* goal (90 percent) for early entrance into prenatal care.

In 59 counties, a higher percentage of women entered prenatal care in the first trimester than the state percent; 23 counties (*in blue above*) ranked significantly higher than the state.

In 33 counties, fewer women entered prenatal care in the first trimester than the state average; 9 counties (*in blue above*) ranked significantly lower than the state.

In eight counties, entrance into prenatal care decreased more than 10 percent: Perry, Harrison, Floyd, Clark, Scott, Jefferson, Ohio and Switzerland.

Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team
Indiana Natality Report – 2004 Table 32. Outcome Indicators by Race of Mother: Indiana Counties.

NATALITY REPORT

Comparison of Indiana Outcomes 2003-2004 & 2000-2004

OUTCOME	2004	2003	CHANGE 2003-04	2000	CHANGE 2000-04
Low birthweight	8.1%	7.9%	+2.5%	7.3%	+10.9%
Very low birthweight	1.5%	1.4%	+7.1%	1.4%	+7.1%
Preterm	10.2%	9.9%	+3.0%	9.0%	+13.3%
Prenatal care 1st Trimester	79.3%	80.6%	-1.6%	79.4%	—
Alcohol use during pregnancy	0.6%	0.6%	—	0.7%	—
Smoked during pregnancy	18.0%	18.5%	-2.7%	20.2%	-10.9%
Unmarried parents	38.8%	37.1%	+4.5%	34.6%	+12.1%

White

OUTCOME	2004	2003	CHANGE 2003-04	2000	CHANGE 2000-04
Low birthweight	7.4%	7.2%	+2.8%	6.7%	+10.4%
Very low birthweight	1.3%	1.2%	—	1.2%	—
Preterm	9.9%	9.5%	+4.2%	8.5%	+16.4%
Prenatal care 1st Trimester	80.8%	82.1%	-1.5%	81.0%	—
Alcohol use during pregnancy	0.6%	0.6%	—	0.6%	—
Smoked during pregnancy	18.8%	19.1%	-1.6%	21.1%	-10.9%
Unmarried parents	34.4%	32.6%	+5.5%	29.8%	+15.4%

Black

OUTCOME	2004	2003	CHANGE 2003-04	2000	CHANGE 2000-04
Low birthweight	13.7%	13.3%	+3.0%	12.7%	+7.8%
Very low birthweight	3.0%	3.3%	-9.0%	2.9%	-3.4%
Preterm	13.9%	13.3%	+4.5%	12.4%	+9.4%
Prenatal care 1st Trimester	67.1%	68.2%	-1.6%	67.1%	—
Alcohol use during pregnancy	0.9%	1.1%	—	1.2%	—
Smoked during pregnancy	14.4%	15.2%	-5.3%	15.2%	-5.3%
Unmarried parents	77.9%	76.2%	+2.1%	75.9%	+2.6%

INFANT MORTALITY BY RATE & ETHNICITY, INDIANA 2002-04

Infant Mortality Rate by Race (per 1,000 Live Births)

RACE	2002 TOT. DEATHS	IMR	2003 TOT. DEATHS	IMR	2004 TOT. DEATHS	IMR
Total	649	7.6	641	7.4	702	8.1
White	479	6.5	479	6.4	522	6.9
Black	144	15.6	148	15.9	164	17.1
Hispanic	49	8.0	38	5.6	65	9.0
B/W Disparity 2.4		B/W Disparity 2.5		B/W Disparity 2.5		

Born to be Breastfed: The Next Step Regional Coalitions Form Across Indiana

On September 7, community leaders gathered at the Government Center South in Indianapolis to explore the formation of regional coalitions to implement recommendations contained in *Born to Be Breastfed: A Call to Action to Promote Breastfeeding in Indiana*. This state plan, developed by the Indiana State Breastfeeding Task Force, challenges Indiana to make breastfeeding the norm.

The workshop, sponsored IPN, ISDH's Community Nutrition Obesity Prevention (CNOP) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), provided an array of tools to help attendees build successful coalitions. "The event drew representatives statewide and was a great first step toward implementing the *Call to Action* in an organized grassroots manner," says IPN Breastfeeding Committee Chair **Kathy McCoy, RN, IBCLC**.

Participants received a toolkit with suggestions for projects that coalitions can undertake to promote breastfeeding in their regions. "Not all of the ideas required monetary resources," notes McCoy. "The materials served as a wonderful idea starter and blueprint for action." In the afternoon, panelists expanded on successful projects that included a "fathers supporting breastfeeding" group, employer support for lactation and grants writing.

"Our next step is to identify currently operating coalitions and assist in the development of others," says McCoy. "By working together, we can protect, promote and support breastfeeding to make a difference in the health of the state, its people and the economy."

For more information, contact IPN Perinatal Education Coordinator Tina Babbitt, RN, BSN, IBCLC at 317.924.0825, ext. 4228, or e-mail Tbabbitt@indianaperinatal.org.

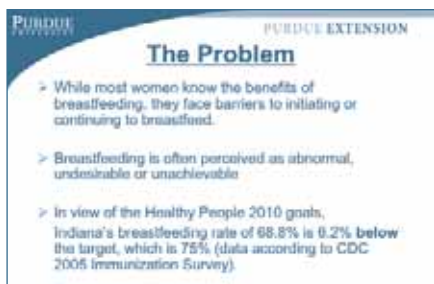
How Religious & Cultural Traditions Can Influence Breastfeeding

An understanding of religious and cultural practices can improve a provider's ability to successfully promote breastfeeding. A case in point is described in a paper published in a recent issue of *Breastfeeding Medicine*.

According to *Islam and Infant Feeding*, religious beliefs and cultural practices are important factors in early infant care and feeding. The paper notes that the Islamic holy book, the Qur'an, recommends that mothers breastfeed their children for two years and states that every infant has the right to be breastfed.

Examining cultural influences, the authors, **Ulfat Shaikh, MD, MPH**, and **Omar Ahmed, MD**, describe the values of privacy and modesty and suggest that the lack of privacy in hospitals, and especially in neonatal intensive care units (NICUs), might discourage women from breastfeeding. Cultural practices that include substituting honey or water supplements for colostrum could deprive the infant of important nutrients. Similarly, Muslim women who wear veils and have little sun exposure might have low vitamin D levels, putting their breastfed infants at risk for a deficiency.

Islam and Breastfeeding, published in *Breastfeeding Medicine* (Vol. 3, No. 1), can be viewed in its entirety at <http://cl.exct.net/?ffcb10-fe5a1c77746103787510-fdf01779716d02797415727d-ff281776736c>.



Attendees explored aspects of the decision to breastfeed, as well as techniques to build solid, effective coalitions.



Safe Sleep Training for Child Care Providers

By Melissa Chalman, Indiana Association for Child Care Resource & Referral

TTo promote information about safe sleeping, Indiana law requires that all licensed in-home child care providers, as well as all homes receiving Child Care Development Fund (CCDF) vouchers, receive training.

"Safe Sleeping Practices and Reducing the Risk of SIDS in Child Care"—a 2.5 hour training presentation—was produced by the Indiana Association for Child Care Resource & Referral (IACCRR). Based on American Academy of Pediatrics (AAP) information and approved by the Bureau of Child Care, the course was reviewed by a committee that included representatives from the Indiana Association for the Education of Young Children, Indiana Child Care Association, Indiana Child Care Health Consultant Program, Indiana Child Protection Program, Indiana Family and Social Services Administration (FSSA), Indiana Safe Sleep Network, IPN and ISDH.

Indiana's legislation required that 4,000 current in-home child care providers receive training by September 30, 2006. Faced with the need to prepare numerous trainers to deliver consistent, accurate information in a short time, the committee used a pre-recorded voice-over to convey the most critical information. IPN's SIDS & Infant Health & Survival Coordinator **Barb Himes, CLC** served as the voice for the "Safe Sleeping Practices" training.

Last spring, IACCRR teamed with IPN and the Indiana Health Consultant Program for a "train the trainer" event with 60 Safe Sleeping Practices trainers. By October, more than 5,000 child care providers completed the training with a total of about 250 training sessions conducted.

Participants have found the training to be a positive experience and have expressed gratitude for the specific information, sample policy templates, and other resource materials offered.

Reach IACCRR's Orientation Training/Safe Sleep Project Director Melissa Chalman by phone: 317.924.5202 or e-mail: mchalman@iaccrr.org.

The Value of Adopting a “Learner’s Stance”

Lessons Learned from Pregnant & Parenting Women

By Larry Humbert, MSW, PG Dip &
Theresa L. Roberts, PhD, ACSW, LCSW

The voices, perspectives and experiences of pregnant and parenting women are vital sources of information that professionals may overlook or misunderstand. As part of the *Indiana Access* program’s goals of better understanding access to maternal and child health services and enhancing patient-provider communication, a qualitative focus group study of diverse consumers yielded some valuable insights on the qualities of a mutually beneficial patient-provider relationship.

Learner’s Stance

To address calls for more competent and higher quality care, providers urgently need practical approaches that enable entire health care teams to transform their professions and institutions. When it comes to adopting a “learner’s stance,” providers must be genuinely willing to view themselves as “learners” instead of “experts.” They must cultivate a reciprocal relationship with patients by validating the patient’s ability to “teach” them about their own particular cultural and health care beliefs. The more providers know about these dimensions of their patients, the better they can respond to and meet them “where they are.”

Provider Recommendations & Practice Implications

The study yielded recommendations that are rooted in a definition of “access” as not only what brings people in the door, but also what keeps them returning for subsequent services. Beyond access, these recommendations can serve to enhance the overall patient-provider relationship.

▶ Assume a learner’s stance with patients to better grasp the dynamics of their lives, cultural practices, social networks and the meaning and impact of pregnancy.

- ▶ Regard cultural practices that run counter to traditional medical advice as deriving from the desire to have a healthy baby, be perceived as a “good parent” or maintain harmony within the family. Choosing the term “family traditions” might generate a more in depth discussion of cultural influences and practices with some patients. It is vital to begin where patients are rather than on a mission to prove them wrong.
- ▶ Do not assume that instructions and recommendations will translate into action, especially when they contradict family practices or strongly held personal beliefs.
- ▶ Engage patients in identifying social networks, sources of support and the power issues that confront them.
- ▶ Acknowledge that many patients may not have fully explored, much less resolved, the complex issues that impact their feelings about pregnancy, its potential impact on their lives and their decision to seek or to delay seeking care. Coming to terms with an unintended pregnancy may not be a linear, rational or logical process.
- ▶ Recognize that all the members of an organization—from the telephone receptionists to the direct care providers—shape a patient’s perception of the quality of care, cultural competence, overall satisfaction and current and future utilization of needed services.
- ▶ Be aware of how behaviors that might be perceived as discriminatory or racist impact access to services for current and future patients. Regardless of the provider’s intent, the patient’s perceptions are their reality.

Questions to Engage the Learner’s Stance

These suggested questions can help providers move from a conceptual understanding of the learner’s stance to

employing it by engaging diverse consumers. The questions focus on listening, acknowledging unique perspectives, demonstrating respect and exploring options.

- ▶ *“Help me understand how mothers in your family decide when to introduce solid foods”* may solicit a more honest discussion than *“Don’t feed the baby solid foods for 4-6 months.”*
- ▶ *“I’m aware that different families have different things they do to have a healthy pregnancy. I’m interested in learning about some of the things that are important to you.”*
- ▶ *“I’m wondering how the ideas we just discussed regarding [baby’s name] medication are similar to what you usually do? How are they different?”*
- ▶ *“If we were to draw a picture of all the people in your life who have a say in your decisions, either positive or negative, who would be in that picture?”*
- ▶ *“Before we explore your options for services, what are you most concerned about right now with your pregnancy?”*

Conclusion

The process of transforming public health care institutions and reframing professionals as learners or explorers presents challenges along with opportunities to eliminate health disparities. Qualitative research is needed to examine providers’ perceptions of the approach; curriculum and training need to be developed to support providers in systematically implementing and evaluating the efficacy of the learner’s stance approach on patient relationships and medical outcomes. Integrating the approach into health care practice involves the interplay of technical, practical, cultural, emotional and distinctly human elements. 🦋

For more information, contact Indiana Access Director Larry Humbert at 317.924.0825, ext 4224 or e-mail Lhumbert@indianaperinatal.org.

Judith Roepke Exemplifies Life-Long Commitment to Indiana's Mothers & Children

Although she says she is retired and no longer in “direct service,” Judith Roepke’s many activities and involvements seem to belie the conventional meaning of “retirement.”

A registered dietician and former professor and administrator for Ball State University, Muncie, Judith Roepke, PhD now serves as a board member for the: Indiana Mothers Milk Bank; March of Dimes Program Committee; Delaware County Board of Health; Indiana Public Radio; American Dietetic Association’s (ADA) Practice Group on Women’s Health and Reproductive Nutrition; and until recently, was an ADA delegate to the United States Breastfeeding Committee (USBC). She also chairs the: Delaware County Healthy Mothers, Healthy Babies, an IPN subcommittee; Sexual Abuse Awareness committee of Prevent Child Abuse of Delaware County; Medical Education Advisory Committee at Ball Memorial, and is an ADA liaison to the La Leche League.

The retiree’s unflinching interest in maternal and child health issues springs from the experience of having two children and encounters with a nutrition professor at the University of Manitoba. “This educator worked with the World Health Organization overseas and understood the long-term impact of maternal nutrition on societies,” she recalls.

From Roepke’s unique vantage point, she sees how challenges to the health and well-being of Indiana’s mothers and babies have changed over the years. “In the past, availability of care was an issue. Now that care is more readily available, we find young mothers who don’t access care and aren’t interested in breastfeeding. Consequently, our job is to sell the value of prenatal care and breastfeeding.” Roepke also cites obstacles when employers do not



A registered dietician and former Ball State University professor, Judith Roepke, PhD has a lifetime of experience working with and for Indiana’s mothers and babies.

support breastfeeding by allowing time and space to pump milk. “This makes breastfeeding very difficult for the working mother.”

In her mission to help improve access to prenatal care and promote breastfeeding, Roepke confronts several challenges. “There’s still a surprising lack of awareness among some of the public about the value of prenatal care and breastfeeding, as well as a lack of awareness among some health care professionals about the many benefits of breastfeeding.” Further, she is sometimes daunted by the amount of “pressure the formula industry applies on providers.”

Despite the challenges, Roepke is enthused and appreciative of great strides in statewide access to prenatal care and a better level of understanding among medical professionals of the value of breastfeeding. “I’m gratified by the amazing progress made in just the last 10 years and the passion, energy, vision and know-how of young people in this field

“Now that care is more readily available, we find young mothers who don’t access care and aren’t interested in breastfeeding. Consequently, our job is to sell the value of prenatal care and breastfeeding.”

today.” Success in the future hinges on positive approaches to partnerships with professional, voluntary and lay groups. “These are important to moving IPN’s goals forward, and I see that in the working relationships of IPN’s leadership and staff. Bravo!”

In her tireless fashion, Roepke points to the need for continued consumer education on the importance of prenatal care, including avoidance of drugs; risks of not breastfeeding and the importance of keeping mothers and babies together from birth onward.

Apart from her involvements in maternal and child health issues, Roepke and her husband enjoy traveling—particularly to Spain. While they also engage in some joint volunteer work, “our greatest joy has to be our two children and four beautiful grandchildren—one of whom we care for each week. 🐾

Reach Judith Roepke at jroepke@comcast.net.

Bloomington Summit Provides Thorough Overview of Perinatal Mood Disorders



Planning committee members before a quilt that memorializes deceased PPD sufferers. *Left to right, back row:* Elizabeth McDaniel, Andrea Headdy, Claire Boissevain-Crooke, Dana Watters, Birdie Gunyon Meyers. *Front row:* Georg'ann Cattelona; Donna Cutshall, Cathy Greene.

The Perinatal Depression Task Force of Monroe County, Bloomington Hospital and IPN teamed up on August 25 to 26 to host the *Indiana Regional Depression Summit & Certificate of Completion Course* at Bloomington Hospital.

Evaluations from conference attendees were overwhelmingly positive with many citing the event as the “best conference ever attended,” according to Task Force member Claire Boissevain-Crooke.

After conducting post-conference follow-up, the conference planning group reports that several providers modified educational materials to include more information about perinatal mood disorders (PMD), while others increased screening to better detect the disorder. Other providers reported changing their practices by “encouraging new mothers to seek care for changes in sleeping patterns and other behaviors that could be early indicators of PMD.” Additionally, Southern Indiana Pediatrics now distributes educational materials provided by the Task Force and IPN to all new mothers and is evaluating the

AGENDA HIGHLIGHTS

- ▶ *Overview of Perinatal Mood Disorders*—Birdie Gunyon Meyer, RN, MA, CLC
- ▶ *Perinatal Mood Disorders Etiology, Symptomatology & Risk Factors*—Ronald Rosenberg, MD
- ▶ *An Alternative Approach: Acupuncture in the Treatment of PMD*—Jennifer Meador, DOM, LAc
- ▶ *Let's Not Forget the Children! A Pediatric View of PMD*—Richard Malone, MD
- ▶ *Psychotherapeutic Models & Techniques*—Cami R. Lokken, PhD, Clinical Health Psychologist
- ▶ *Pastoral Care of the PMD Family*—Rev. Annette Briggs, BS, MDiv & Rev. Lynnette Carlson, BA, MDiv, STM, LMHC
- ▶ *Cooking Demonstration: Handmade Chocolate Truffles & Discussion of the Value of Chocolate in Depression*—Francie Hurst, RN & Jan Bulla-Baker
- ▶ *For Home Visitors: More Than Just the Blues*—Sara Rich Wheeler, DNS, RNCS, LMHC

feasibility of adding a brief PMD screening to all well-child visits.

Various materials were shared during the event, including a poster presentation from the Task Force on how to form collaborative groups to provide community education and support for PMD families. Additionally, the Task Force shared a networking list to foster collaboration within geographic areas. 🐾

For more information, contact the PPD Task Force of Monroe County at 812/337-8121.

Infant Mental Health Conference Examines Effects of Parental Addiction

The Indiana Association for Infant and Toddler Mental Health (IAITMH) focused on *The Effects of Parental Addiction on Very Young Children* during an August 25 conference conducted at Riley Hospital for Children.

The conference enabled health care professionals, early intervention providers, psychologists, social workers and mental health professionals to identify the major challenges associated with prenatal substance use and pregnancy; discover intervention methods and strategies for helping families of infants and children exposed prenatally to alcohol; and understand ongoing issues and concerns related to Fetal Alcohol Spectrum Disorders (FASD). 🐾

For more information, contact IAITMH, ph: 317.638.3501 or visit www.mentalhealthassociation.com/index_netscape.htm.

AGENDA HIGHLIGHTS

- ▶ *Addiction in Pregnancy*—James J. Nocon, MD
- ▶ *Prenatal Substance Use Prevention Program (PSUPP)*—Carolyn S. Waller, PhD
- ▶ *Parents with Addictions: How Early Intervention Professionals Help*—Stephan Viehweg, ACSW, LCSW
- ▶ *Parenting with Co-Occurring Substance Use & Mental Health Disorders*—GEORGE BRENNER, LCSW, LMFT, CADAC 1
- ▶ *Fetal Alcohol Spectrum Disorders (FASD)*—Karen Barnett, MS
- ▶ *Effects of Alcohol/Substance Abuse on Parent/Child Relationships*—Janice Gabe, LCSW, MSW
- ▶ *Special Issues Associated with Children of International Adoption*—Julie Keck, MD
- ▶ *Genetics of Alcoholism*—Howard Edenberg, PhD
- ▶ *Meth Addiction: From the Eyes of a Child*—Ann Hecht

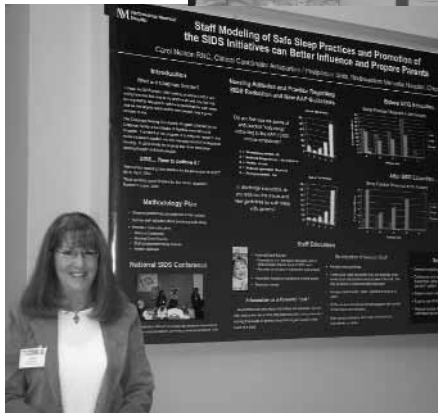
Hundreds Gather for *Safe Sleep: Getting Out the Right Message*

On October 4, more than 150 health care professionals gathered to explore the topic of safe sleep for infants and how to impart the “right message” to providers and consumers alike. Held at the Indiana Government Center South, the conference drew care coordinators, nurses, physicians, childbirth educators, coroners, childcare providers, law enforcement workers, social workers and faith-based workers such as ministers, clergy and lay leaders.

After a welcome from Indiana State Health Commissioner **Judith A. Monroe, MD**, Medical Director **Judith Ganser, MD, MPH**, Maternal Child Special Health Care Services, ISDH, delivered a “state of the state” message.

A panel of experts subsequently convened to explore the latest data about infant survival and safe sleeping practices. **Teri Conard, RN, MSN**, FIMR coordinator for the Marion County Health Department, Indianapolis, facilitated the discussion.

Themes that emerged from this session included the need for: common definitions when discussing safe sleep practices and death scene investigations and a consistent way to identify and label deaths, according to **Roberta Hibbard, MD**, professor of pediatrics for the Indiana University School of Medicine. Meanwhile, the panel expressed the need for better education of families on fetal and infant mortality and the importance of consistent, non-



Poster presenters included (above) **Laura Bravos, RNC**, Good Samaritan Hospital, Downers Grove, IL; and (at left) **Carol Nelson, RNC**, Prentice Women's Hospital, Northwestern Memorial Hospital, Chicago.

confusing messages. **Joseph D. O'Neil, MD, FAAP**, Riley Hospital for Children, pointed to the need for primary death prevention, as well as improving outcomes for babies with life long developmental problems that result from near-death experiences. Panelists also discussed the importance of collecting accurate data and monitoring program outcomes.

After a break, **Fern Hauck, MS, MD**, associate professor of Family Medicine & Public Health Sciences for the University of Virginia Health System, and a member of the American Academy of Physician's (AAP) Task Force on Sudden Infant Death Syndrome (SIDS), took a close look at new AAP Guidelines that contain recommendations for SIDS risk reduction. The

Calls to action that emerged from *Safe Sleep: Getting Out the Right Message* included the need for:

- ▶ **Common definitions** when discussing safe sleep practices and death scene investigations along with a **consistent way to identify and label deaths**.
- ▶ **Better education of families** on fetal and infant mortality via consistent and clear messages.
- ▶ Increased focus on **primary death prevention**, as well as **improving outcomes for babies** with life long developmental problems that result from near-death experiences.
- ▶ **Placing infants in a supine position** for sleep in a **separate, but proximate**, sleeping environment, per AAP Guidelines.
- ▶ Utilization of **SUIDI reporting form**, conducting a **complete autopsy, examination of the death scene** and **review of clinical history**.

SAFE SLEEP: CALLS TO ACTION FOR INDIANA

recommendations include placing infants in a supine position for sleep in a separate, but proximate, sleeping environment.

Exploring the subject of uniform death-scene investigations, **Terry W. Davis, EDD**, maternal and infant health branch, division of reproductive health, Centers for Disease Control and Prevention (CDC), emphasized how thorough, consistent and comprehensive case investigations will ultimately help to prevent infant death. She highlighted the new Sudden Unexplained Infant Death Investigation (SUIDI) reporting form (see sidebar) and described the importance of conducting a complete autopsy, examining the death scene and reviewing clinical history.

Later in the afternoon, **Natalie Wolfe**, a bereaved parent, shared a parent's perspective on loss, as well as insights on how to best help families experiencing the loss of a child. Minority Health Coalition of Marion County Outreach Coordinator **Mary O. Payton** presented the activities of *Baby First Advocates*, including a safe sleep survey. Bringing the conference to a close was **Carol Palmer, RN, MSN**, professor, Henderson Community College, Evansville who facilitated a “call to action” response to the day's information. 🐾

CDC RELEASES SUDDEN, UNEXPLAINED INFANT DEATH INVESTIGATION (SUIDI) REPORTING FORM & TRAINING CURRICULUM

As part of an ongoing effort to improve the investigation and reporting of sudden, unexplained infant deaths, the Centers for Disease Control (CDC) released the *Sudden, Unexplained Infant Death Investigation (SUIDI) Reporting Form* for state and local use in infant death scene investigations. This form replaces the *Investigation Report Form* that accompanied the *1996 Guidelines for the Death Scene Investigation of Sudden, Unexplained Infant Death*.

Additionally, to standardize investigations and reports of the causes of sudden infant deaths, CDC developed a training curriculum and materials for infant death investigators.

CDC is disseminating the reporting form and conducting “train-the-trainer” classes throughout the United States.

For more information, visit www.cdc.gov/SIDS/SUID.htm#training.

Johnson County's "Ready or Not, Here I Come!" Informs & Equips

The birth of a newborn is often a matter of "ready or not, here I come!" A program of the same name in Johnson County helps expectant mothers and their families get ready for parenting by equipping them early in pregnancy with valuable information and links to local resources.

"Ready or Not, Here I Come!" utilizes a two-and-a-half hour series of presentations from local experts to impart a variety of information to expectant mothers and their families," says Assistant Program Coordinator **Beth Ross** of Partnership for a Healthier Johnson County. "The program expands on the education provided during physician visits. For example, while a physician advises patients on the benefits of breastfeeding, the program features a LaLeche League representative who expands on the maternal and infant benefits in a 20-minute presentation."

The educational program addresses a variety of topics including proper nutrition, food safety, breastfeeding, budgeting techniques, risks of tobacco and exposure to second-hand smoke, early childhood literacy, relationship issues and more. "In particular, the importance of smoking cessation and the risks of exposure are strongly emphasized," says Ross. In addition to comments from cessation providers, a physician also speaks to the expectant mothers and their families about the dangers of perinatal smoking and secondhand exposure.

In addition to providing valuable information, "Ready or Not..." also helps to reduce barriers for expectant mothers by raising their awareness of available maternal and child health services and linking them to resources. "Thousands of area children who are eligible for free or reduced-fee health care are not enrolled in Hoosier Healthwise," says Ross. "It's estimated



At left: Deb Baker leads a "Ready or Not, Here I Come!" class of parents-to-be.

Below, left to right: "Ready or Not..." presenters Kevin Short, Michelle Bisesi, Cindy Boughton, Deb Baker, Kathy Robertson and Judy Jacobs. Not pictured: Sarah Hall and Joanne Spencer.

"The program expands on the education provided during physician visits...."

*—Beth Ross,
assistant program coordinator*



that only 60 percent of the county's Medicaid, uninsured or under-insured expectant mothers receive first trimester medical care."

Funded by an Indiana State Department of Health grant, "Ready or Not..." programs are planned quarterly throughout 2007. Plans are under way to

coordinate an Hispanic prenatal program working with Esperanza en Jesucristo. 🐾

For more information on "Ready or Not, Here I Come!" contact the Partnership for a Healthier Johnson County by visiting partnershipjc.org, phoning 317.346.3768 or e-mailing Assistant Program Coordinator Beth Ross at bross@johnsonmemorial.org.

PARTICIPANTS EVALUATE "READY OR NOT, HERE I COME...!"

The information below was gleaned from participant evaluations (37) of two "Ready or Not..." sessions.

- ▶▶ The majority of participants (75 percent) were 19 years of age or older.
- ▶▶ Among participants, 95 percent had health insurance with 5 percent on Medicaid and 95 percent privately insured.
- ▶▶ Participants were largely ineligible (73 percent) for WIC or food stamps.
- ▶▶ Of the expectant mothers, 86 percent were not smoking; 59 percent reported no one in their home smoked.
- ▶▶ All of the participants considered the presenters "well prepared" and that the program increased their knowledge about local services.
- ▶▶ The majority (89 percent) rated the program as "good to excellent."
- ▶▶ Breastfeeding was reported as the favorite topic.
- ▶▶ Of those on or eligible for Medicaid (14), the majority said they learned something new about every service/agency presented.
- ▶▶ Those with private health insurance learned the most about Johnson County's libraries, the La Leche League of Franklin and Marriage Investors.

INDIANA PERINATAL NETWORK NEWS

Kendra Benecke Joins Indiana Family HelpLine

IPN welcomes back Kendra Benecke, a former IPN employee, who joined the Indiana Family HelpLine in August as an administrative assistant. At ISDH, Benecke responds to an average of 40 to 60 daily incoming HelpLine calls from across the state while also assisting the resource database staff in preparing mailings and performing a variety of administrative tasks for HelpLine Supervisor Mary Bisbecos.



"The HelpLine work is diverse and quite interesting," she says. "It's also a pleasure to work with a group of very compassionate and caring people."

A busy mother of Maddie, 12, and Ryan, 6, Benecke assisted IPN in 2000 to 2001 as office manager. In her free time, she enjoys gardening, cooking and traveling with her family.

Reach Kendra Benecke at 800.433.0746 or e-mail kbenecke@isdh.IN.gov.

IPN Membership Meeting & Spirit of Service Awards

Following the September 20 State Perinatal Advisory Board meeting at ISDH, IPN conducted its First Annual Membership Meeting & Awards. The business portion of the agenda kicked off with introductions by Board Chair Britt McDermott, CPA, followed by an update from IPN's Executive Director Julia Brillhart, RN, MSN, as well as a review of IPN's finances and bylaws.

A "Spirit of Service" award for "advocacy" was presented by Kathy McCoy, RN, IBCLC to Kinga Szucs, MD, FAAP, IBCLC, assistant professor of pediatrics, Methodist Hospital, Indiana University School of Medicine; while Lisa Harris, MD, PhD, Wishard Health Services, for "community service." The award was accepted by Michael Graham, MD, IU Medical Group-Primary Care.

The meeting closed on an energizing note with a presentation on how to "transform from tired to terrific" by Life Coach Lynn Shaw, ACSW, LCSW, CLL.

NEW IPN MEMBERS*

INDIVIDUAL MEMBERS (\$55)

Carla Ault, RN
Lisa Crane, RN, ICCE
Morella Dominguez
Michelle Farris, RNC
Robert Gray, RN
Beverly Keller, RN, CCE, CLC
Kathy McCoy, RN, IBCLC
Cheryl Roberts, RN
Lisa Secrist, RNC
Kathryn Shanahan, RD, IBCLC
Denise Shoemaker, RNC
Kinga Szucs, MD, FAAP, IBCLC
Shelley Vaughn, MS
Darla Vote, RN

CONSUMERS, STUDENTS & COMMUNITY OUTREACH WORKERS (\$20)

Trish Adams

CONSUMERS, STUDENTS, OUTREACH WORKERS (cont')

Sharlene Banks, RN, CPN
Robin Bueckers
Melissa Chalman
Jill Erickson
Toni Galyan, RN
Lisa Henley
Katie Johnson
Penny Lane, RN, IBCLC
Lanissa Maggert
Stephanie Moore
Claudia Ogborn
Kimberly Sampson
Martha Sattinger
Tonya Scott
Angela Snyder, RN
Joslyn Sullivan
Kristi Swope

RENEWING IPN MEMBERS*

INDIVIDUAL CONTRIBUTING MEMBER (\$250)

Maureen Greer

INDIVIDUAL MEMBERS (\$55)

Janet Estes
Maureen McLean, RN, MSN
Suellen Williams, RN, IBCLC

* As of November 14, 2006

2006 IPN CONTRIBUTING PARTNERS (\$5,000)



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Hospitals Value Perinatal Continuing Education Program (PCEP)

Since 2000, more than 24 Indiana hospitals have participated in the Perinatal Continuing Education Program (PCEP), sponsored by IPN and ISDH. Based on comments elicited in an informal survey (see sidebar), the participating hospitals found the educational experience positively impacted policies, procedures and day-to-day operations.

PCEP provides a practical, useful and cost-effective perinatal education for physicians, nurses, nurse midwives and practitioners, respiratory therapists, and all others who care for pregnant women or newborn babies.

The self-instructional and self-paced program presents concepts and skills important to the care of patients within the hospital and the care of those stabilized before transfer to a sub-specialty center. Nearly all of the educational activities take place within the participating hospital.

HOSPITALS PRAISE PCEP

An informal survey of Indiana hospitals participating in the Perinatal Continuing Education Program (PCEP) during the past six years yielded these comments.

"PCEP tested our knowledge and put some things in a better perspective."

"The program made us more aware of possible situations."

"I think it would be beneficial if all community hospitals went through this training...especially the smaller hospitals."

"It made us more aware of the actions to take in critical situations and the consequences of inappropriate actions or inaction."

"Keep up the program!"

"The program seemed a bit daunting at first, but I'm glad we went through it. We changed policies, protocols and guidelines as a result—and created new ones that we realized we needed after experiencing PCEP."

"PCEP identified our strengths and weaknesses."

Each participant receives a set of PCEP manuals to use during the program and to keep for future reference. Cognitive concepts are accompanied by hands-on, step-by-step instruction.

After initial participation, hospitals rotate through a "refresher course" every three to four years.

Contact Perinatal Education Coordinator Tina Babbitt, RN, BSN, IBCLC, ph: 317.924.0825, ext.4228 or e-mail: tbabbitt@indianaperinatal.org