

# PERINATAL Perspectives



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## IPN Forum Highlights Controversies, Innovations

Over 150 maternal-child health clinicians and advocates gathered at the inaugural Indiana Perinatal Network Forum, *Controversies and Innovations in Perinatal Health*, to discuss the state's recent failing grade on a landmark women's health report, rising obesity rates, newborn brain monitoring, stillbirth assessments, and other developments and challenges to perinatal care.

Held March 19 and 20, the Forum featured keynote speaker **Merry-K Moos, RN, FNP, MPH, FAAN**, research professor in the departments of Public Health and Nursing at the University of North Carolina - Chapel Hill, who spoke about preconception health and the need to translate the science behind it into clinical care strategies. According to Moos, the dominant perinatal paradigm features a categorical focus with little integration of a woman's preexisting care and her future health needs. This

issue will not be solved by creating another categorical service called the "preconception visit", but instead requires an emphasis on routine health promotion.

**Judy Waxman**, Vice President for Health and Reproductive Rights at the National Women's Law Center in Washington DC, addressed the issues underlying Indiana's failing grade in the recent report *Making the Grade on Women's*

**"As attractive and relatively inexpensive as prenatal care is, a medical model directed at a 6 to 8 month interval in a woman's life cannot erase the influence of years of social, economic, physical and emotional distress and hardship."**

—**Merry-K Moos, RN, FNP, MPH, FAAN**

### Controversies & INNOVATIONS in Perinatal Health



Mary Payton receives Spirit of Service award

*Health.* According to Waxman, health indicators such as smoking, obesity, entry into prenatal care, and infant mortality rates ranked Indiana 40th among other states.

Breakout sessions offered participants insight into emerging clinical issues such as the impact of periodontal disease on pregnancy outcomes, bariatric surgery and the pregnancy experience,

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Due to recent unanticipated budget cuts in our current ISDH grant, this edition of *Perinatal Perspectives* will only be available electronically. Depending on the availability of funds, future editions may also only be available electronically. We apologize for any inconvenience this may have created. If you are not an IPN member and would like to support our efforts, the last page of this newsletter includes an individual and organizational membership form. You can also join or donate online at [www.indianaperinatal.org](http://www.indianaperinatal.org) by clicking on the "join IPN" tab. Donations can also be mailed to IPN at 1991 E. 56th Street, Indianapolis, IN 46220.

*Perinatal Perspectives* is now sent to more than 1,000 e-mail addresses. As a result, IPN is saving more than \$1,500 each year in postage and printing costs – enabling us to use more of our resources for programs to improve the health of all Indiana mothers and babies. If you want to contribute to our savings by receiving future editions by e-mail, please e-mail us at [ipn@indianaperinatal.org](mailto:ipn@indianaperinatal.org).

## Perinatal Perspectives

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## IPN Forum (continued from pg. 1)

and interventions to stem the rise in late preterm births. Other sessions addressed breastfeeding ethics, the use of interpreters in maternity services, and varied experiences surrounding the "harm reduction" versus immediate-cessation approaches to treating tobacco-using pregnant women.

Poster presentations included:

- Effect of evidence-based breastfeeding educational program and follow up plan on breastfeeding practices among mothers of preterm infants

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**Mark Your Calendar!** The 2009 Forum will be held March 25-26 at the Sheraton in downtown Indianapolis. Information on applications for presentation and poster submission will be available in early Fall 2008.

- Gestational Weight Gain in Indiana
- Premature triplets: Motor and mental developmental scores in NICU survivors
- Methods of Partnering Between Referral and Regional Hospitals to Improve Communication
- The Spectrum of Perinatal Mood Disorders

Participants enjoyed a reception featuring a performance by the Indianapolis Children's Choir, and honored IPN Spirit of Service

## 2008 EDUCATIONAL PARTNERS (\$5,000)



## WHAT ATTENDEES SAID

"This was the best conference I've been to in quite a while. All the speakers were extremely knowledgeable and informative."

"Good applicable strategies presented."

"The information was new and challenging. We need this to keep us moving forward in our profession."

awardees **Mary Payton** (Baby First Advocates coordinator) and **Ambre Marr-Kennedy** (Legislative Assistant to Senator Vi Simpson) for their exemplary commitment to Indiana's mothers and babies. Marion County Health Department Director **Virginia A. Caine, M.D.** and outgoing IPN Board member **Celisse Morris-Miller** also received special recognition for their work to improve perinatal care and outcomes. 🐾

# Health Care Changes for Uninsured, Low-income Hoosiers Take Effect

## **HEALTHY INDIANA PLAN**

Starting January 1, low-income Indiana residents could apply for health care coverage through the Healthy Indiana Plan (HIP), passed by the 2007 Indiana General Assembly and funded, in part, through increases in the state cigarette tax. To qualify, individuals must be between 18 and 64 years of age, uninsured for at least six months and not eligible for employer-sponsored health insurance. The program will cover about 130,000 residents a year. Pregnant women do not qualify for HIP, and should a woman become pregnant while on HIP, she will be removed from HIP and covered under Package B of Hoosier Healthwise. Following a pregnancy, a woman may re-enroll into HIP. Applications for HIP enrollment are now being accepted.

*For more information or to apply, visit [www.hip.in.gov/](http://www.hip.in.gov/) or call 1.877.GET.HIP.9.*

## **MEDICAID ELIGIBILITY FOR PREGNANT WOMEN**


Medicaid coverage for pregnant women increased to 200 percent of the Federal Poverty Level as of July 1, 2007. *For income guidelines, visit [www.in.gov/fssa/dfr/2948.htm](http://www.in.gov/fssa/dfr/2948.htm) or call the Hoosier Healthwise Helpline at 1.800.889.9949.*

Following the April 2008 decision by the Office of Medicaid Policy and Planning (OMPP) to halt work on an implementation plan for presumptive eligibility, IPN and other maternal-child health advocates are collaborating with OMPP to clarify key issues and rules related to presumptive eligibility and explore solutions to facilitate early entry into prenatal care. *IPN will provide updates on presumptive eligibility developments when they become available at [www.indianaperinatal.org](http://www.indianaperinatal.org) and via e-mail.*

## **MEDICAID & PUBLIC ASSISTANCE APPLICATION PROCESS**

Indiana's Family and Social Service Administration recently announced that it is suspending the continued rollout of its "eligibility modernization" initiative, designed to automate the Medicaid/public assistance application process.

While initial reports attributed the suspension to a June 23rd letter from the United States Department of Agriculture ordering the state to improve its timeliness in processing food stamp applications, FSSA Secretary Mitch Roob has stated that he ordered the halting of the rollout on June 13 due to issues related to early-summer flooding. A hallmark of the modernized process, the Voluntary Community Access Networks (VCAN) — formalized networks of community organizations and service providers that offer information, referrals and access for clients who want to apply for services and benefits—will still continue to exist.

Clients may continue to apply for benefits at local Division of Family Resources offices and can obtain up-to-date application information by visiting [www.in.gov/fssa](http://www.in.gov/fssa) and selecting "apply for benefits." The Hoosier Healthwise Helpline at 1.800.889.9949 can also answer questions. 

## **Disparities in Folic Acid Intake Highlight Need for Education and Intervention** *Continuing Education Opportunity Offered by Indiana Folic Acid Council*


Despite over 15 years of grain fortification with folic acid, non-Hispanic black women continue to have the lowest intake of folic acid and Mexican American women show decreases in intake, according to the Indiana Folic Acid Council.

When awareness of folic acid benefits for pregnancy was assessed, studies found that 40.7% of black women and 30.3% of American Indian women were not aware of the benefits, compared to 18% of white women.

The Indiana Folic Acid Council advocates for the elimination of these disparities through use of folic acid supplementation, and an increase in fortified foods as well as foods high in folate. The council recommends a three-pronged educational approach which urges women to

- Consume a diet rich in food folate
- Consume fortified foods (grains)
- Consume folic acid supplements

Folic acid is an essential vitamin for healthy growth and development and is critical in neural tube formation, which occurs very early in gestation—many times before a woman may even know she is pregnant. Folic acid can be obtained through food and through supplementation. The most recent DRI (Dietary Reference Intakes) recommends that women of childbearing age should consume 400 mcg of synthetic folic acid in addition to food folate.

Established in 2002, the Indiana Folic Acid Council is a joint venture of the Purdue Foods and Nutrition Department, Purdue University Cooperative Extension Service and the March of Dimes. It seeks to inform women of childbearing age of the benefits of folic acid consumption to the health of their babies and to inform men and women of all ages of the research based benefits of folic acid consumption. See page 11 for continuing education opportunity information. 

For more information, visit [www.ces.purdue.edu/infolicacid](http://www.ces.purdue.edu/infolicacid) or contact Donna Vandergraff, MS, RD, CD, Department of Foods and Nutrition, Purdue University, at [vandergraff@purdue.edu](mailto:vandergraff@purdue.edu) or (765) 494-8228.

## It Takes Two to Raise Kids

The Fathers and Families Center, Indianapolis, has implemented a new program called *It Takes Two*, designed to help couples strengthen their relationship to improve the life chances for their children. Funded through a five year grant from the Department of Health and Human Service Administration for Children and Families, the program's mission is to "inspire couples to build a noble legacy of partnership and parenthood through education, mentoring, and advocacy".

As **Terrence Harper, LMHC**, Family Support Services Manager explains, "Today, one child in three is born out of wedlock. The erosion of marriage has created enormous difficulties for children, parents, and society. There are a lot of couples who have not taken the plunge of getting married but are raising children without really parenting together and communicating well. *It Takes Two* is our response to helping young couples in Indianapolis achieve better outcomes for their children. By parenting together, working at a more committed relationship, communicating better and resolving conflicts, these couples will hopefully create a brighter future for their children."

Currently in its second year of the five year grant, the program targets unwed couples who are expecting a baby or who have a child three months of age or younger. The couples also have to meet federal poverty guidelines to participate. In 2007, the program enrolled 66 couples, and anticipates serving 84 couples this year. According to Harper, people are often surprised to learn the program is voluntary. Pointing to the success of this

approach, Harper says, "The couples that attend really want to be here," which has pushed the completion rate for the program to 50%.

*It Takes Two* program components include sessions on Pre-marriage Education, Healthy Relationships, Communication Skills, Sexual Responsibility, Life Skills, Commitment, and Conflict Resolution. Additional services include assistance with job



Program participants pose with Fathers and Families staff

placement and retention, money management, parenting and child development, social service referrals, and use of a computer lab.

Program participant Clarissa told Fathers and Families staff that she didn't know what to expect when she and her boyfriend John first began the marriage education class. After completing the class, Clarissa stated that she and John agreed that they argued less. John's other family members comment that the couple's relationship has changed positively since completing the program. Now engaged to be married, Clarissa and John have volunteered to speak with other new couples in the program.

For more information about this program, contact Fathers and Families at (317) 921-5935 or [ittakestwo@fatherresource.org](mailto:ittakestwo@fatherresource.org).

## Statewide Breastfeeding Summit Prepares Advocates for New Workplace Law, Outreach



Breastfeeding summit participants discuss goals and activities

On May 8th, the Indiana Perinatal Network held a Breastfeeding Summit that brought together breastfeeding educators, advocates, and members of Indiana's large network of breastfeeding coalitions to celebrate their successes and plan activities for the year ahead. The coalition members had an opportunity to network with each other, share resources, and learn about current state projects. Agenda items included the Lactation Support in the Workplace legislation (SEA 219) recently passed by the Indiana General Assembly, which goes into effect July 1st. Speakers included attorney **Lisa Hiday**, a mother of four, who provided a "real life" account of what it is like to work full time while continuing to provide breast milk, and IPN Executive Director **Larry Humbert**, who spoke about advocacy and the process of getting SEA 219 passed.

It was also shared that Indiana was one of ten states selected to participate in A Business Case for Breastfeeding, a federal pilot program sponsored by the Health Resources and Service Administration (HRSA) to promote lactation in the workplace. This unique pilot program utilizes a "train-the-trainer" format to familiarize participants with a new comprehensive toolkit that enables

Continued on page 5

# New Data Released on Interpregnancy Intervals, Adverse Birth Outcomes in Indiana

Although Indiana natality data show a modest decline in the percentage of births following a short interpregnancy interval of less than six months, the decrease has remained unchanged since the late 1990s, according to a new report from the Indiana State Department of Health.

The report, *Short Interpregnancy Intervals and the Risks of Adverse Birth Outcomes in Indiana: Statistics from the Live Birth Data 1990-2005*, presents trends in prevalence of short interpregnancy intervals among births to multiparous mothers

from 1990 to 2005 according to a variety of maternal characteristics. The report also includes information on low birth weight, preterm birth, and small-for-gestational age rates at various interpregnancy intervals and on the association of short interpregnancy interval and adverse birth outcomes. The data for this study were obtained from the birth certificates of singleton infants born alive between 1990 and 2005 in Indiana.

Short interpregnancy interval is defined as less than 12 completed months between the last live birth and the following conception.

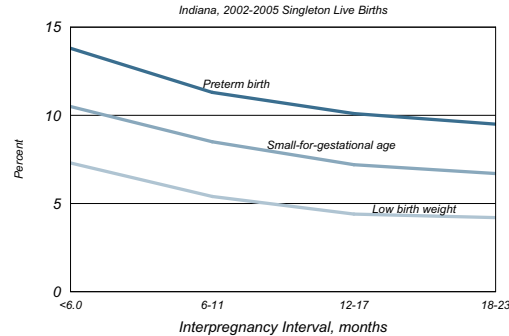
## Key Findings

Interpregnancy interval of less than 6 months was associated with significantly higher risks of low birth weight, preterm, and small-for-gestational age births. The negative impact of short interpregnancy interval was stronger on very low birth weight and very preterm births and continued to be statistically significant even at interpregnancy interval of 6-12 months.

According to the report, between the periods of 1990 - 1993 and 2002 - 2005, the percentage of births

following an interpregnancy interval of less than 12 months declined from 21.1 to 18.3 percent, whereas interpregnancy interval of 24 months or longer increased from 52.1 to 55.8 percent. Between 2002 - 2005, 61.1 percent of all singleton live births

Prevalence of Low Birth Weight, Preterm, and Small-for-Gestational Age Births According to Interpregnancy Interval



Source: Indiana State Department of Health, Maternal and Children's Special Health Care Services

in Indiana were to multiparous mothers. Among those, 6.1 had pregnancy intervals of less than 6 months, and 12.2 percent had pregnancy intervals between 6-11 months.

The report found that the prevalence of short interpregnancy intervals was highest among multiparous teen mothers, followed by those in their early twenties, and declined only modestly over the years. Compared to mothers with longer interpregnancy intervals, mothers with short interpregnancy intervals were more likely to be black, Hispanic, less educated, unmarried, of higher parity, smokers, and receive inadequate or no prenatal care.

## Recommendations

Continued efforts to prevent repeat pregnancies among teenagers and interventions to lower short birth spacing among young adult mothers deserve high priority, according to report author **Atossa Rahmanifar, PhD, RD**. Higher prevalence of short interpregnancy interval among non-Hispanic blacks and Hispanics, and among the young, less educated, and unmarried mothers warrants

special attention and allocation of resources to improve birth spacing among minorities and vulnerable populations. Considering the adverse effect of short interpregnancy intervals of up to 12 months on birth outcomes, efforts of public health agencies to improve birth spacing should continue at a minimum beyond 12 months postpartum. 🐦

A copy of this report is available at [http://www.in.gov/isdh/files/Interpregnancy\\_Interval.pdf](http://www.in.gov/isdh/files/Interpregnancy_Interval.pdf). For more information, contact Beth Johnson, RN, MSN, Indiana State Department of Health, at (317) 233-1344 or [bmjohnso@isdh.in.gov](mailto:bmjohnso@isdh.in.gov).

## Breastfeeding Summit

(continued from pg. 4)

managers, human resource personnel, employees, breastfeeding advocates, and others to help businesses support breastfeeding employees. Attendees were given information and education to assist businesses in their local areas to provide lactation services to their staff. For anyone who would like to

**While about 75 percent of mothers initiate breastfeeding at the time of birth, only 30.5 percent are exclusively breastfeeding at three months postpartum and 11.3 percent at six months—by which time, most mothers are back at work.**

—United States Breastfeeding Committee

participate in a more in-depth review of workplace lactation, an advanced level "Gold Medal Train the Trainer" class will be held at the Garrison Conference Center in Indianapolis on September 8th. To register, or for more information on workplace lactation support, contact **Tina Cardarelli, IBCLC**, State Breastfeeding Coordinator, at (317) 924-0825, ext. 4223 or [tcardarelli@indianaperinatal.org](mailto:tcardarelli@indianaperinatal.org). 🐦

# Spotlight on Cesarean Delivery

## ACOG Committee Opinion: Cesarean Delivery on



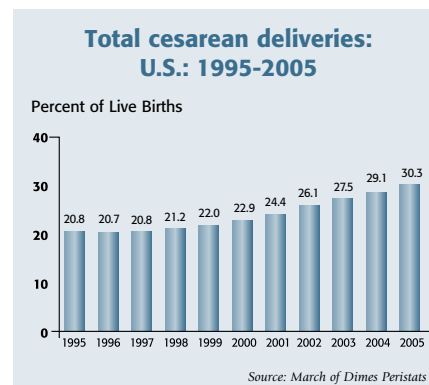
## Maternal Request

**Abstract:** Cesarean delivery on maternal request is defined as a primary cesarean delivery at maternal request in the absence of any medical or obstetric indication. A potential benefit of cesarean delivery on maternal request is a decreased risk of hemorrhage for the mother. Potential risks of cesarean delivery on maternal request include a longer maternal hospital stay, an increased risk of respiratory problems for the baby, and greater complications in subsequent pregnancies, including uterine rupture and placental implantation problems. Cesarean delivery on maternal request should not be performed before gestational age of 39 weeks has been accurately determined unless there is documentation of lung maturity. Cesarean delivery on maternal request should not be motivated by the unavailability of effective pain management. Cesarean delivery on maternal request is not recommended for women desiring several children, given that the risks of placenta previa, placenta accreta, and the need for gravid hysterectomy increase with each cesarean delivery.

For the full text of this Committee Opinion, see: Cesarean delivery on maternal request. ACOG Committee Opinion No. 394. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2007;110:1501-4.

## National Cesarean Rates at Record High

According to the National Center for Health Statistics report *Births: Preliminary Data for 2006*, the U.S. cesarean delivery rate rose to 31.1 percent of all births in 2006, a new record high. The percentage of all births delivered by cesarean has climbed 50 percent over the last decade. The NCHS had previously showed a cesarean delivery rate of 29.1% in 2004, finding that a trial of labor was attempted for 36% of women who had an eventual cesarean birth. Only 9.1% of women having a repeat cesarean delivery were reported to have had a trial of labor.



From 2003–2004 the primary cesarean rate rose 8 percent, according to the NCHS, and the rate of vaginal birth after cesarean delivery (VBAC) dropped 13 percent.

Since 1996, the primary rate has climbed 41 percent and the VBAC rate has fallen 67 percent.

### Trends in Cesarean and Vaginal Birth

A February 2008 *News and Numbers* bulletin from the Agency for Healthcare Research and Quality (AHRQ) reported that:

- About 1.3 million women gave birth via cesarean section in 2005, a 62 percent increase over the 800,000 c-sections performed in 1995.
- Vaginal deliveries among women who gave birth in hospitals declined from about 3 million in 1995 to 2.9 million in 2005, a decrease of 3 percent.
- The sharpest decline in vaginal deliveries in hospitals was among women who had previously given birth via c-section. Vaginal deliveries among those women dropped 60 percent, from 157,200 in 1995 to 62,300 in 2005.

AHRQ had previously reported that pregnancy-related maternal deaths are more common for cesarean than for vaginal birth, citing a University of Washington study which explored the association between method of delivery and maternal death and found that

### “Maternal Outcomes Associated With Planned Primary Cesarean Births Compared With Planned Vaginal Births”

Declercq, E., Barger, M., Cabral H.J., Evans, S.R., Kotelchuck, M., Simon, C., Weiss, J., & Heffner, L.J. (2007). Maternal outcomes associated with planned primary cesarean births compared with planned vaginal births. *Obstetrics & Gynecology*, 109, 669-677.

- 1.4% of births studied were via optional c-sections, and women over age 40 had the highest rate of optional c-sections at 3.1%.
- Black women and women who were delivering their first infants were more likely to have an optional c-section and had rates of 2.3% and 2.1%, respectively.
- Optional c-sections resulted in hospital stays that were 77% longer and cost 76% more than vaginal births.
- Women who choose optional c-sections also were 2.3 times more likely to be rehospitalized within 30 days.
- According to the authors, there could have been unrecorded medical reasons for some of the optional c-sections, which might have contributed to the rehospitalization rate.

# Spotlight on Cesarean Delivery

women who had c-sections were four times as likely to die a pregnancy-related death as women who had vaginal deliveries. However, the researchers note that cesarean delivery may be a marker for serious preexisting maternal problems and not necessarily a risk factor for death.

## Reasons behind the Rising C-Section Rate

Issues precipitating the rise in cesarean rates have been the topic of debate among healthcare providers, advocacy groups, and the media. Contributing factors may include:

- Rising maternal age
- Increases in maternal weight
- More multiple gestations
- Fewer attempts at vaginal breech deliveries
- Fewer attempts at vaginal delivery after cesarean sections (VBAC)
- Increase in induction of labor

In addition, some analyses have found associations between rising professional liability insurance premiums and primary cesarean delivery rates, greater maternal willingness to accept obstetric interventions, maternal perception of cesarean delivery as safer than or as safe as vaginal birth, patient and/or physician convenience, and physician fear of litigation.

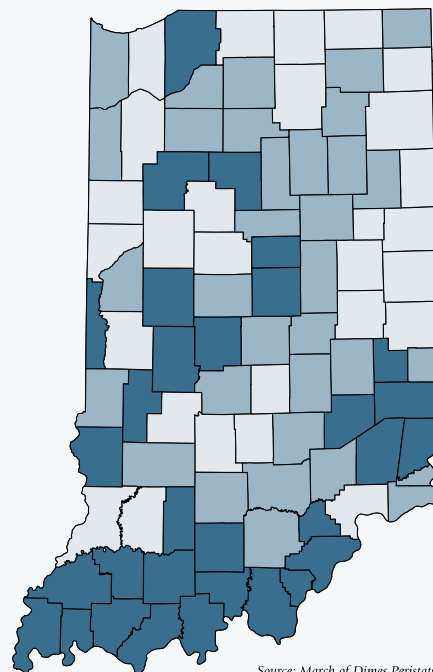
## Healthy People 2010 and Cesarean Sections

According to Healthy People 2010, the cesarean rate objective for low-risk women giving birth for the first time should be no more than 15 per 100 first births. For low-risk women who have previously delivered via cesarean section, the objective is no more than 63 per 100 births. According to the NCHS, however, in 2003 the cesarean birth rates for these populations were 23.6% and 88.7%, indicating a significant shift away from these goals.

## Indiana: Mirroring National Trends

State-specific data show Indiana reporting increasing percentages of cesarean deliveries overall, and a wide geographic variance ranging from 13.9% in LaGrange County to 35.1% in Spencer County.

### Total cesarean deliveries: Indiana, 2002-2005 Average

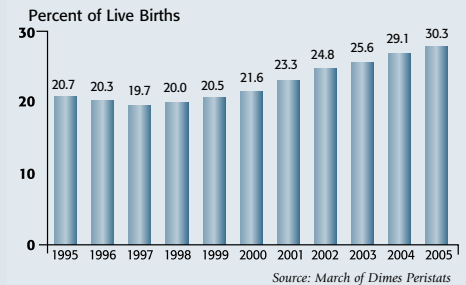


#### Percent of live births

- Over 28.8 (31)
- 25.4-28.8 (33)
- Under 25.4 (28)

According to the March of Dimes, in Indiana 28.2% of live births in 2005 were cesarean deliveries. The rate of primary cesarean deliveries was 18.5 per 100 live births to women who have not had a previous cesarean delivery. The rate of vaginal births after a previous cesarean (VBAC) during this time was 6.9 per 100 live births to women who have had a previous cesarean delivery.

### Total cesarean deliveries: Indiana, 1995-2005



### Statewide Trends

According to the Indiana State Department of Health, total cesarean delivery rate decreased from 21.9 percent in 1990 to 19.7 percent in 1997, followed by a steady increase until 2005. The upward trend in cesarean delivery rates after the late 1990's is evident among both non-Hispanics and Hispanics and is comparable to the national trend.

ISDH data also show that increases in cesarean deliveries have been accompanied by declining VBAC rates.

### Percent of Live Births by Method of Delivery, Indiana Residents

	2000	2003	2005
<b>Primary c-section</b>	13.1%	15.2%	16.0%
<b>Repeat c-section</b>	8.8%	10.7%	12.3%
<b>VBAC</b>	2.2%	1.2%	0.9%
<b>Vaginal</b>	75.7%	72.8%	70.7%
<b>Unknown</b>	0.2%	0.1%	0.1%

### Indiana Cesarean Rates among Multiple vs. Single Gestations

In 2005, cesarean delivery rate was 70.1 percent among multiple births compared to 26.8 percent among singletons. Among singleton births, cesarean delivery rates were higher among older mothers and more educated mothers compared to those who were younger and less educated. Cesarean delivery rates, however, have risen among women in all age and educational groups since late 1990's.

# Spotlight on Cesarean Delivery



## Ask the Expert

By James E. Sumners, MD

St. Vincent Women's Hospital, Center for Prenatal Diagnosis

As medical technology has developed and advanced, both the frequency of cesarean delivery and the reasons behind it have changed. In the 1960s, the practice of obstetrics was more "black and white"—the baby either lived or died, was healthy or unhealthy. The main reason for performing a c-section then was failure to progress. In the 1970s continuous electronic fetal monitoring (EFM) became available, which provoked concerns that precipitate c-sections because our tolerance of abnormalities of the fetal heart rate is low. Now, we have better anesthesia options, which have made cesarean section risks fairly low and which have lowered fetal and maternal morbidity and mortality.

New breakthroughs in assisted reproductive technology have allowed more women to get pregnant who otherwise would not have been able to, but carry with

them increased c-section rates. Cesarean delivery rates are higher with multiple gestations and the overall rate of twins and triplets are rising. The number of triplets has increased two and a half times between 1990 and 2004.

Many more medically complicated women are pursuing pregnancy, and there are certain maternal conditions that are ill-advised for labor—such

*Tolerance for  
uncertainty and risk  
amongst some groups  
of patients is small.*

as some heart conditions—that raise a patient's c-section risk. In addition, rates of obesity are rising, and obesity can complicate labor. Obese patients are more difficult to monitor with EFM, and have

higher rates of failure to progress. Some fetal conditions, like certain congenital anomalies, are also not conducive to labor—and we are able to identify more of these conditions prenatally with ultrasound.

Cesarean rates are proportionate to the risk of the population served. We see lower rates among Certified Nurse-Midwives and Family Practice physicians because they take care of lower-risk patients. On the other hand, maternal-fetal specialists have the highest cesarean rates (perhaps around 70%) mainly related to the population they serve.

We must remember that cesareans are safer now than 50 years ago, and allowing more liberal use of this operation to reduce risks for both mother and baby is a good thing. Taking pride in the obstetrical skill to "get that baby out vaginally" in difficult circumstances is, I think, a fading phenomenon. 🙄

## IPN Welcomes New Board Members

**Dr. Sandra Long**, President of The OMNI Centre for Public Media, Inc., has been active in the communication and human relations fields since the early 1980's. Her academic background includes degrees from the universities of Auburn and Alabama in English, Sociology, Human Development and Family Life, and Early Childhood and a Ph.D. from Indiana University in Curriculum and Instruction. Prior to her position with The OMNI Centre, she taught in the public schools and Indiana University. She has also authored numerous articles related to contemporary social issues and the role of technology in educational change.

**Ethel Hong Badawi** is an associate attorney in the Finance, Bankruptcy and Restructuring division of Barnes and Thornburg LLP, where she specializes in creditor representation, bankruptcy, and commercial lending. A graduate of the George Washington University Law School, she is a former law clerk for the Superior Court of the District of Columbia and has been involved in a wide range of service activities.



# Remembering Julie Anne Foster

April 4, 1962 - March 28, 2008

The Indiana Perinatal Network mourns the loss of longtime Communications Coordinator **Julie Foster**, who died suddenly and unexpectedly on March 28th, 2008.

For more than a decade, Julie conceptualized and developed many of our organization's documents and publications, creating the "IPN look" that we are known so well for throughout the state. Her intuitive understanding of and sensitivity to the needs and experiences of mothers and families guided her to craft materials that resonated with our diverse groups of consumers and providers. Her creativity, insight, command of technology, and humor made her an invaluable colleague and friend to IPN staff, Board, and constituents.

One of IPN's first staff members, Julie felt a deep connection to our mission and work. "Early on when one of our doctors took her on a tour of the NICU, Julie's big heart turned

that visit into passion and advocacy for those little babies she visited" recalls IPN founder and former Executive Director Julia Brillhart. Lauri McCoy MSN, RN, of St. Vincent Women's Hospital, remembers Julie's "gentle, loving, kind spirit," and how her work "brought much recognition to our state both from the local providers as well as regionally and nationally. She made us all look really good."

Julie was a graduate of Carmel High School and went on to earn a bachelors degree from Indiana University with a triple major. She was a prolific writer and reader, and used her graphic design and writing skills to assist numerous groups and organizations. Julie is survived by her husband, Chester Foster; her daughter, Leah A. Foster; her son, Scott T. Foster, II; and her mother, Elaine McLaughlin. A celebration of Julie's life was held on April 3rd at the East 91st Street Christian Church in Indianapolis. 🐾

IPN is considering how best to honor Julie's talents and spirit, and we welcome your thoughts and input as we commemorate the legacy of her work and impact she has had on our organization.

## LEGISLATIVE UPDATE

Despite the hectic and sometimes contentious atmosphere during the recent session of the Indiana General Assembly, dominated by property taxes and illegal immigration, the following bills of interest to the perinatal community were passed, signed into law by the Governor and took effect July 1, 2008. Information concerning these and other bills can be found at: <http://www.in.gov/legislative>

### **SB 219 LACTATION SUPPORT IN THE WORKPLACE**

Requires state and political subdivisions and other employers with 25 or more individuals to make reasonable efforts to provide a private location for an employee to express breast milk during any period away from the employee's assigned duties and a refrigerator or other cold storage space, or allow the employee to provide their own portable cold storage.

### **HB 1118 ALCOHOLIC BEVERAGES**

This very complex and extensive bill addresses a variety of issues related to the sale of alcoholic beverages. It also requires tobacco vending machines and establishments that sell tobacco to post a notice that that smoking by pregnant women may result in fetal injury, premature birth, and low birth weight, and to provide a phone number for assistance to quit smoking.

### **SB 27 COOLING OFF PERIOD**

Requires a facility having custody of a person arrested for a crime of domestic violence to keep the person in custody for at least eight hours from the time of the arrest, and prohibits release on bail during the eight-hour period.


### **HB 1172 VARIOUS PROFESSIONS AND OCCUPATIONS**

This very extensive bill addresses a variety of issues regarding the licensing and regulation of various professional groups. It also includes a provision requiring FSSA to form a nonprofit corporation to establish and operate an umbilical cord blood bank to promote public awareness concerning the medical benefits of umbilical cord blood.

### **SB 164 HUMAN SERVICE MATTERS**

Requires the Office of Medicaid Policy and Planning (OMPP), managed care organizations, and individuals contracting with OMPP to meet certain requirements concerning payment and denial of claims. Established eligibility for the children's health insurance program at 300% of the federal income poverty level *or the maximum percentage approved by the federal government if the approved percentage is less than 300%*. Requires the health finance commission to study the feasibility and costs of allowing individuals who meet certain requirements to participate in the Indiana HIP Program without state funding for coverage.

### **SB 143 LEAD POISONING PREVENTION**

Specifies certain provisions related to childhood lead poisoning prevention and actions by ISDH for noncompliance with these provisions. The law also establishes the childhood lead poisoning prevention fund for outreach and prevention activities, a lead-safe housing advisory council and an interim committee to study issues related to childhood lead poisoning prevention. 

## INDIANA PERINATAL NETWORK NEWS

### **RECOGNIZING PERINATAL DEPRESSION E-LEARNING CD**

Developed in cooperation with the Institute for Action Research at the IU School of Nursing, this unique, interactive CD is designed to help home visitors, health care professionals and other care providers recognize and respond to perinatal mood disorders. For information on how to order the CD, or other IPN materials, go to <http://www.indianaperinatal.org/files/resource%20order%20form%202008.pdf>



### **FREQUENTLY ASKED QUESTIONS – LACTATION SUPPORT IN THE WORKPLACE**

This comprehensive document provides answers to common questions about the recent Indiana legislation and practical suggestions to employers on how to implement the provisions of this legislation. To download a copy, go to: <http://www.indianaperinatal.org/files/Breastfeeding%20FAQ%20for%20email.pdf>



### **FREQUENTLY ASKED QUESTIONS – HEALTH CARE FOR UNINSURED AND LOW INCOME HOOSIERS**

Developed in cooperation with Covering Kids and Families of Indiana, this guide provides answers to common questions about recent Medicaid changes, the new Healthy Indiana Plan and eligibility modernization, as well as important web sites and contact information. To download a copy, go to: <http://www.indianaperinatal.org/files/Health%20Insurance%20FAQ%206%2008.pdf>

### **AN AUTHOR IN THE HOUSE**

Congratulations to Larry Humbert, IPN Executive Director, and Dr. Theresa Roberts, IU School of Social Work. Their article, *The Value of the Learners Stance: Lessons Learned from Pregnant and Parenting Women*, was selected for publication in the upcoming edition of the Maternal and Child Health Journal. To view a copy of the abstract, go to: <http://www.springerlink.com/content/m18u113707w739q3/>

# Important Upcoming Events




## NATIONAL CENTERING HEALTHCARE CONFERENCE COMES TO INDIANAPOLIS

Indiana Perinatal Network is pleased to announce that Indianapolis has been selected as the site of the Centering Healthcare Institute's 2008 National Conference, *The Power of Connection: Building Community Through Group Care*. Taking place on September 21-23, 2008, the conference will celebrate the power of groups and the developing national trend toward group health care in all areas of specialty.

Conference attendees will be a diverse group of health care professionals, including physician specialists and generalists, nurse practitioners and midwives, nurses, social workers, nutritionists, administrators and others interested in health care reform. By hosting the national conference, IPN has a unique opportunity to showcase Centering programs already in existence throughout Indiana, as well as to learn about the successes and challenges of other programs. These insights will be invaluable as the Centering model spreads across the state, and our goal is to have a large Indiana presence at the conference.


The conference, to be held at the Sheraton City Centre hotel in downtown Indianapolis, will focus on outcomes in and academic training for group care, facilitative leadership skill-building, system redesign, cultural humility in health care delivery, and the power of circles. A variety of pre- and post-conference workshops on topics such as Centering Parenting, Group Facilitation and Teen Centering

Pregnancy will also be offered.


Registration is now open, and workshops are expected to fill quickly. Sponsorship and exhibitor opportunities are also available. Please visit the Centering Healthcare Institute website at [www.centeringpregnancy.org](http://www.centeringpregnancy.org) for more information and to download a registration brochure, or contact IPN with any questions. 




## REGISTER NOW FOR THE INDIANA NEWBORN DEVELOPMENTAL CARE CONFERENCE

The Indiana Newborn Developmental Care Committee's fourth annual conference, *Moving Forward in Newborn Developmental Care*, will be held September 28-29, 2008, at the Marriott Hotel in Fort Wayne, Indiana. Featuring national speakers **Robert Cicco, MD**, **Terry Johnson, ARNP, RNC, MN**, **Susan Ludington, PHD, CNM, FAAN**, and **Lynn Wolf, MOT, OTR, IBCLC**, the conference is designed for medical professionals, nurses, community outreach workers, counselors and anyone interested in newborn developmental care. Topics will include kangaroo care, oral feeding progression, practice change and intrauterine substance exposure. For more information, visit [www.indianaperinatal.org](http://www.indianaperinatal.org). 

## BELLIES AND BABIES MATERNITY EXPO COMING TO INDIANA CONVENTION CENTER

Billed as "the world's biggest baby shower," the 2008 *Bellies and Babies Maternity Expo* sponsored by St. Vincent Women's Hospital will take place from 10 AM to 8 PM on Saturday September 6th at the Indiana Convention Center. Featuring giveaways, celebrity guests, a fashion show, health and wellness information, and programs for expectant fathers, the Expo promises to inform, inspire, and motivate anyone who is expecting or caring for a new baby. Entry for adults is \$5, and children 12 and under will be admitted at no cost. Childcare will be provided. For more information, visit <http://www.belliesandbabiesexpo.com>. 

## SAFE SLEEP CONFERENCE

*Redefining Safe Sleep*, a statewide conference for healthcare professionals, will be held October 15, 2008, in Indianapolis. Featuring national speakers **Rachel Moon, MD**, from the Children's National Medical Center in Washington, DC, and **Jennie Boden** from the First Candle National Crib Campaign in Baltimore, the conference will address issues such as disparities in Indiana, the statewide crib program, and the breastfeeding and safe sleep relationship. Watch for more information coming soon! 

## Folic Acid Continuing Education Opportunity

*Folic Acid: It's more than a fad* was presented originally in September 2007 as part of the *Harvesting a Safe Environment During Pregnancy* seminar. The presentation has been updated and is available on the Indiana Folic Acid Council webpage, [www.ces.purdue.edu/infolicacid](http://www.ces.purdue.edu/infolicacid).

Details related to accompanying print materials and mechanism for obtaining 1.0 CPE are listed on the website.



1991 East 56th Street  
Indianapolis, IN 46220



# IPN MEMBERSHIP

Join today by completing and returning the coupon below. For more information, contact IPN at 317.924.0825 or 866.338.0825, or e-mail: [ipn@indianaperinatal.org](mailto:ipn@indianaperinatal.org)

## Individual Membership OPTIONS

Contributing Member—\$250 Individual Member—\$60  
Physician Member—\$100  
Consumer, Student, Community Outreach Member—\$25

### BENEFITS INCLUDE:

- ▶ Monthly member-only e-bulletin
- ▶ Perinatal Perspectives newsletter
- ▶ Discounted registration at select events
- ▶ Recognition on IPN's website and in annual report
- ▶ Sample copies of all new resources as they are released
- ▶ Voting privileges to elect the Board and approve bylaw changes

## Corporate Membership OPTIONS

If your organization's annual budget is:  
More than \$1,500,000 Dues \$500  
\$500,000-\$1,500,000 \$250  
Annual less than \$500,000 \$100  
Each additional, individual member \$50

### BENEFITS INCLUDE:

- ▶ One individual membership upon joining
- ▶ Post up to two job openings at a time or link from IPN's website to your organization's employment web page

### CONTRIBUTING PARTNER (\$2,500):

Includes corporate partner benefits above plus:

- ▶ Your logo on IPN's home page with a link to your website
- ▶ Your logo in Perinatal Perspectives newsletter

### EDUCATIONAL PARTNER (\$5,000):

Includes corporate and contributing partner benefits above plus:

- ▶ Your logo in all IPN conference materials
- ▶ Sponsor recognition with exhibit table and one free registration at each event

## CONTACT INFORMATION

Name \_\_\_\_\_ Credentials (i.e. "R.N.") \_\_\_\_\_

Job Title \_\_\_\_\_

Organization \_\_\_\_\_

Address ( Business or  Home) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( Business or  Home) \_\_\_\_\_ Fax \_\_\_\_\_

E-mail Address (important: please provide to receive membership benefits) \_\_\_\_\_

## CREDIT CARD BILLING ADDRESS

Name on card \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Credit Card No. \_\_\_\_\_ Exp. \_\_\_\_\_

Signature \_\_\_\_\_

## TOTALS

Individual Membership \$ \_\_\_\_\_

Corporate Membership \$ \_\_\_\_\_

Add'l Individual Membership(s) w/ Corporate Membership \$ \_\_\_\_\_

TOTAL \$ \_\_\_\_\_

## PAYMENT METHOD

Check payable to IPN enclosed

Mastercard

Visa

- PROFESSION (check as many as apply)
- Clergy
  - Coroner
  - Health
  - Educator
  - Home Visitor
  - Legislator
  - Mental Health Professional
  - Nurse
  - Midwife
  - Nutritionist

- Physician
- Retired
- Social Worker
- Student
- Other

- EMPLOYED BY (check as many as apply)
- Academic Institution
  - Coalition or Professional Organization
  - Community Health Center
  - County Health Department
  - Hospital
  - Insurance Company
  - Media
  - Perinatal Center
  - Private Clinic/Agency
  - Public Agency

- Self
- WIC
- Other

- AREA OF SPECIALTY (check as many as apply)
- Breastfeeding
  - Family Planning
  - Family Practice
  - Genetics
  - Infant Development
  - Early Childhood
  - Neonatology
  - Obstetrics
  - Pediatrics
  - Public Health
  - Other