Statewide Crib Distribution, Educational Initiative Kicks Off in Indiana

One of three recipients of an $11 million grant to increase safe-sleeping awareness, Indiana is rolling out a program to distribute over 40,000 cribs throughout the state.

Funded by the Bill and Melinda Gates Foundation, the Bedtime Basics for Babies program combines crib distribution, widespread public and professional education, and a rigorous evaluation component designed to reduce infant deaths due to unsafe sleep practices.

The initiative is targeting parents, professionals and the public with educational messages about the importance of creating a “safe sleep zone” around babies. To facilitate breastfeeding and bonding at night, Bedtime Basics for Babies promotes room sharing instead of bed sharing (see Focus for these and other definitions).

“This program will provide essential information to families, and a safe place to sleep for their babies”, says Barb Himes, CLC, Project Director, First Candle’s National Crib Campaign.

“No family should have to take risks with their baby’s safety because they can’t afford a safe place for the baby to sleep.”

Currently, 35 distribution sites exist throughout Indiana, serving approximately 50 counties. “Our goal is for every county to have a place where families can get a crib,” says Himes. “We particularly want to equip every delivering hospital with cribs, so if parents don’t get the safe sleep education and resources prenatally, they will at least get it when the baby is born.”

A program of First Candle, Bedtime Basics will also be implemented in Washington State and the District of Columbia.

For more information about Bedtime Basics for Babies, or to become a crib distribution site, please contact Barb Himes at barb.himes@firstcandle.org, or (866) 599-6419.

ISDH Update

New materials from the Indiana State Department of Health’s Maternal and Child Health Division have been designed to meet the most pressing needs of Hoosier families, and to assist parents in raising happy, healthy babies.

The mission of the Sunny Start: Healthy Bodies, Healthy Minds initiative is to support a coordinated system of resources for young children from birth to age five and their families in Indiana, so that Indiana’s children arrive at school healthy and ready to learn.

With the input of families with young children, Sunny Start committee members have developed tools and fact sheets on topics including child care and early education, health and safety,
Mark Your CALENDARS

IPN will hold its third annual Forum, Controversies and Innovations in Perinatal Health, on March 18th and 19th, 2010. This year’s Forum will have a special focus on the marketing of public health messages, and IPN is pleased to welcome keynote speaker Lynne Doner Lottenberg, MA, co-editor of Social Marketing Quarterly and author of Marketing Public Health: Strategies to Promote Social Change.

This year’s planning committee seeks project, program, and skill-based posters and presentations to share what works best in various practice settings across the spectrum of healthcare. Abstracts are due December 11th.

To download an application, or for exhibitor and sponsorship information, visit http://www.indianaperinatal.org/sections/calendar.

Donor Spotlight: IU National Center of Excellence in Women’s Health

The IU National Center of Excellence in Women’s Health is a 2009 IPN Educational Partner, bringing its expertise in clinical innovation, public health education, and multidisciplinary collaboration to IPN’s efforts to lead Indiana to improve the health of all mothers and babies. “There is a strong synergy between the Center of Excellence’s work and IPN’s programs,” says IPN Executive Director Larry Humbert. “This is a perfect partnership, and we are pleased to have this formal collaboration.” In 2009, IPN also welcomed CoE Director and OB/GYN Chair Lee A. Learman, M.D., Ph.D. to its Board of Directors.
Going the Extra Mile

PCEP participants practice resuscitation skills.

IPN salutes St. Vincent Women’s Hospital in Indianapolis for its leadership role in the 2009 Perinatal Continuing Education Program (PCEP). Under the guidance and expertise of Beth McIntire, RN, WHNP, Val Castrodale, RN, NNP, and John Wareham, MD, the program brought realistic stimulation-based teamwork training to participants from Reid Hospital and Health Care Services in Richmond and Fayette Regional Health System in Connersville. This year’s program included components of the STABLE curriculum and the latest developments in the management of high-risk delivery, neonatal resuscitation, and initial stabilization. Becky Burns, RN and Jo Young, RN from Reid Hospital were certified as NRP instructors, as were Tricia Crawford, RN, Odessa Gray, RN, and Nancy Compton, RN from Fayette Regional Health System.

For more information about PCEP, contact Tina Babbitt, RN, MSN, IBCLC, at (317) 925-0825 ext. 4228, or tbabbitt@indianaperinatal.org.

IPN also acknowledges the dedication of James J. Nocon, MD, Director of the Prenatal Recovery Clinic at Wishard Memorial Hospital, and Lisa Crane, RN, MSN, Childbirth Education Coordinator at Clarian Health, whose efforts were instrumental in developing IPN’s successful prenatal substance use DVD, Integrating Screening & Treatment of Substance Use into Prenatal Care.

For more information about the DVD, or for an order form, visit www.indianaperinatal.org.

Applications Now Accepted for Maternal-Child Health Leadership Academy

The Maternal-Child Health Leadership Academy (MCH) is an exciting, intense and career-changing experience for nurses committed to leading health care practice changes for maternal-child health. Since 2004, MCH has developed the leadership skills of maternal-child health nurses and nurse midwives in positions of influence in a variety of health care settings, preparing participants to effectively lead interprofessional teams to improve the quality of health care for childbearing women and children up to 5 years old.

Through the partnership between the Honor Society of Nursing, Sigma Theta Tau International (STTI) and Johnson & Johnson Corporate Contributions, MCH has become the premier leadership development experience for nurses dedicated to influencing maternal-child healthcare practice, policy and outcomes.

An 18-month mentored leadership experience serves as the foundation for MCH curriculum. Each mentee selects an expert mentor who will participate in MCH workshops and provide guidance. The blended curriculum of MCH provides a multitude of methodologies for developing leadership knowledge and competence. This investment in personal leadership development elevates the program’s scope of influence.

Previous MCH mentees have become active participants in the national network of maternal-child health nursing leaders. Leslie MacTaggart Myers, DNP, APRN, ANP-BC, found the experience valuable. “I have grown so much in my leadership since going through MCH,” she said. “I have won several state awards for my nursing contributions recently, so I know that I am making the difference that I’ve always wanted. I am looking to the future for ways that I can continue to grow professionally and as a leader.”

Join the community of current and emerging maternal-child health nursing leaders by becoming a mentee in the Maternal-Child Health Leadership Academy. Applications are being accepted beginning 1 November 2009. Visit their website, www.nursingsociety.org/LeadershipInstitute for more information.

ISDH Update

continued from page 1

Newly-released materials available for families and providers include:

• The Wellness Passport for Indiana’s Kids, a personal health care record-keeping tool, and the Special Health Care Needs Addendum, which allows parents to record specialized information

• The Sunny Start Developmental Calendar, available in English and Spanish, which highlights important health and safety information for families and early childhood providers

• A series of Financial Resources Fact Sheets, which highlight the basics of key financial resources and information

• A Sunny Start USB Flash Drive, containing all materials, and which may be used by families to place all records in one convenient location.

For the latest resources and information to help families of young children, as well as for online versions of these materials, visit www.earlychildhoodmeetingplace.indiana.edu.
**Focus**  
Spotlight on . . .

**Infant Health and Safety**

Often described as “the most important index of the health and well-being of a community and our society,” the infant mortality rate in Indiana ranks 39th nationwide. Understanding the causes of fetal and infant death helps illustrate the gaps in resources, policies, and healthcare that compromise the safety and survival of Indiana’s most vulnerable residents—and offers opportunity for improved response and prevention.

**What’s the Problem?**

- 13.4% of Indiana’s babies are born preterm—compared to the Healthy People 2010 goal of 7.6%—putting them at increased for NICU stays, respiratory problems, learning and behavioral issues, vision and hearing loss, and other long-term health issues.
- The percentage of Indiana babies born at low birth weight (less than 2,500 grams) is 8.2%.
- Indiana’s total infant mortality rate is 7.8. Among White babies, the rate is 6.5; among Black babies, it is a staggering 17.1.
- In 2006, 54 Indiana babies died from SIDS or unsafe sleep environments—a number that undoubtedly far under-represents the true total. Lack of uniform infant death scene investigations hampers accurate determination of cause of death.

**IPN’s Response**

As part of its mission to lead Indiana to improve the health of all mothers and babies, IPN engages in a broad variety of consumer, provider, and policy-level activities to improve the state’s infant health outcomes.

The Indiana Perinatal Network . . .

. . . Provides training and education to a broad range of statewide stakeholders. In cooperation with other state and local organizations and advocates, IPN educates health care providers, childcare staff, new parents, grandparents, and others about safe sleep guidelines. IPN also promotes efforts to ensure uniform, consistent infant death scene investigations through trainings for first responder personnel, such as police, firefighters, and EMTs.

. . . Develops cutting-edge guidelines to promote risk-appropriate inpatient perinatal care. IPN’s 2008 Levels of Hospital Care document—endorsed by the Indiana section of ACOG and the AAP Indiana Chapter—includes recommendations for appropriate consultation, referral, transport, and criteria for services offered at Level I, II, III A, III B, III C, and III D obstetric and neonatal units. The goal of the document is to ensure that pregnant women deliver in a facility deemed most appropriate based upon risk factors, to help achieve optimal outcomes for mothers and babies. Download the Levels of Care document at http://www.indianaperinatal.org/downloadsLevelsofCareFinal2009.pdf.

. . . Creates and distributes consumer education pieces designed to help pregnant women and new mothers have safe pregnancies and healthy babies. IPN’s popular consumer materials include “How to Have a Healthy Baby”, the “Something’s Not Right” guide to perinatal mood disorders, “Safe Sleeping for Your Baby”, and “I Want to Breastfeed . . . But I’m Going Back to Work”.

Visit http://www.indianaperinatal.org/sections/mothers_and_families.php to view these documents.

**Key Definitions**

**S.I.D.S.**—Sudden Infant Death Syndrome. The sudden death of an infant under one year of age, which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical histories.

**Bed Sharing**—The practice of a parent, sibling, or other individual sleeping together with the baby on a shared sleep surface, i.e., a bed, sleeper, recliner, etc. Not Recommended.

**Room Sharing**—Baby sleeping in a crib or other safe surface in the same room as the parent/caregivers. Recommended.

**Co-sleeper**—A three-sided crib that attaches to the parent’s bed. Safety standards have not been established for these devices.

**Tummy Time**—Baby is placed on tummy when he is awake and someone is supervising. Tummy time helps strengthen the baby’s head, neck, and shoulder muscles, and helps prevent flat spots on the head.
PROFILE: Sue Hoopengarner, RN, RTS Bereavement Services Coordinator, Union Hospital

“It really impacted me,” recalls Sue Hoopengarner of the first time she encountered an infant death while working as a labor and delivery nurse in 1980. “I never thought about it before. No one ever talked about it. I realized we needed to have something in place to help these families.”

Now, as the RTS Bereavement Services Coordinator at Union Hospital in Terre Haute, Hoopengarner fills that gap. Working with families who lose babies anytime during the pregnancy or after birth, she offers support, information, and resources to help them through what she describes as a “difficult, intense experience.” If she knows ahead of time about a situation that will likely end in loss, she will contact the parents before the delivery to answer questions or provide assistance. “It makes it easier to follow up with them afterward if they can put a name with a face,” she notes.

“A crucial resource for families is Hoopengarner’s monthly support group, as well as the hospital’s annual memorial service and Walk to Remember, held each fall. She is now gearing up for the annual Holiday Open House, where parents can meet other bereaved families, and display an ornament to commemorate the baby. “It helps them during that busy time of year to take time to remember.”

Hoopengarner also trains providers at Union Hospital, as well as nursing and medical students, on pregnancy and infant loss and working with grieving families. “Not everyone is comfortable dealing with these issues,” she says “and we have to respect that. But they also need to be aware in case it happens to their patient.”

Dealing with families’ emotions can be a difficult part of her role. “I’ve been yelled at by parents,” she says. “They’re angry. But that’s ok—it’s part of their grieving.” Another challenge comes from well-meaning family members who want to protect the bereaved parents by not talking about the loss. “Grandparents will tell me ‘You’ll make them cry’”, Hoopengarner says. “But this impacts them for the rest of their lives, and it’s OK to talk about it.” Emphasizing the importance of providing parents and families with information and resources, she recognizes “They’ll have so much to deal with at home. I don’t want them to have regrets we could have prevented.”

Hoopengarner lauds the hospital’s progress in addressing and responding to pregnancy and infant loss. She cites the “huge change” in acceptance and awareness among physicians and staff, and says “We are definitely doing things right.”

She notes more work needs to be done to prevent these losses and to assist parents, expressing particular concern for “families coming to the ER because their infant has died from unsafe sleep situations. We need more education about how to avoid these deaths.” She also emphasizes the need for additional research on causes and prevention of pregnancy and infant loss, “so that we can work on stopping it from happening.”

Hoopengarner is a long-time member of the Indiana State Department of Health Community Council on Infant Health and Survival, a group which has spearheaded efforts to develop sample newborn hospital nursery protocols related to safe sleep practices, developed parent education tips for home visitors, hosted statewide conferences, and supported expansion of crib programs throughout the state.

Outside the hospital, Hoopengarner relishes gardening, working on craft projects, sewing, and reading. She has two daughters, and enjoys spending time with her 15-month-old grandson.

“Sue is exactly what bereaved families need during the difficult journey through grief. She has been a tremendous asset to SIDS and Infant Loss issues in Indiana for over 20 years.”

— Barb Himes, SIDS and Infant Loss Program Coordinator
What are top strategies to reduce infant mortality in Indiana?

By Barb Himes, CLC, Project Director, First Candle’s National Crib Campaign

As she travels the state providing education on Bedtime Basics for Babies, Barb Himes is frequently asked for her top tips and evidence-based practices to reduce infant mortality and save babies’ lives in Indiana.

Top 3 strategies for healthcare providers and breastfeeding educators to share with new and expectant parents, grandparents, and those caring for infants:

1. Babies need to sleep on their backs for EVERY sleep—at nighttime and naptime. Sleeping on their backs keeps babies’ airways open...and contrary to some parents’ fears, they won’t choke if they throw up.

2. Create a safe sleep space. Babies should have their own separate sleep surface, such as an approved crib, bassinet, or play yard placed near parent’s bed. Remember, adult beds are not made with infant safety in mind. Today, many adult mattresses have pillow tops or are made with memory foam. Baby’s sleep area should have a firm mattress with only a fitted sheet, free of pillows, blankets, toys, positioners, and bumper pads. Use a sleep sack (wearable blanket) in place of loose blankets or covers. Another option is to layer baby’s clothing with a t-shirt and socks under the sleeper.

3. Don’t forget “tummy time”! Healthy babies need some tummy time while awake and supervised. This helps to develop strong muscles and prevent a flat spot from forming on the back of baby’s head.

What are the “best practices” that must be implemented to reduce infant death in Indiana?

1. Hospitals should place a Baby Keepsafe Bracelet on the baby after its first bath. The bracelets read “Place on back to sleep. Don’t shake me or smoke around me” and serve as a helpful reminder for staff to discuss safety issues with parents. Sleep Sacks should be provided to new parents upon discharge; Halo has reduced pricing for hospitals for these products. Every new parent should view the Bedtime Basics for Babies DVD in the hospital, and should be asked where the baby will sleep at home.

2. Primary care providers should play the Bedtime Basics for Babies video in their waiting rooms, and should routinely ask parents where and in what position the baby sleeps, as well as share information on bedtime rituals and tips for soothing a fussy, crying baby.

3. Policy makers must understand the importance of educating all new parents and healthcare providers on this lifesaving message. Organizations providing education and support to families need sufficient resources to provide this critical information and serve vulnerable families in our state.

Why don’t parents, grandparents, and caregivers follow the American Academy Pediatrics (AAP) recommendations on safe sleep?

1. Not everyone understands the importance of the safe sleep message. We tend to parent the way our parents did—and if we are accustomed to babies in our families sleeping on their tummies with fluffy blankets, we are more likely to do the same. A false sense of security may arise if you bed-share once and everything is okay. It is best to start and maintain a pattern of safe sleep practices.

2. They don’t receive the message at the appropriate time. Some new parents say they were only given a brochure at the time of discharge...and, if you are not a first time parent, it is assumed you already know the current recommendations. The optimal time for safe sleep education is during pregnancy when parents are thinking about setting up a nursery and acquiring necessary baby items. Time immediately after birth should be spent supporting breastfeeding efforts.

Far too many babies are dying in our state. We need to do a better job of giving a uniform safe sleep message at the appropriate time. Everyone knows the phrase “Stop, Drop, and Roll”. We need to make sure parents and care givers are just as familiar with “Room Sharing is Safer than Bed Sharing” and “Back to Sleep, Tummy to Play!”

For more information or to order the materials listed in this article, contact Barb Himes at barb.himes@firstcandle.org.
During the month of August, over 120 countries around the world celebrated World Breastfeeding Week. This year’s topic, Breastfeeding: a Vital Emergency Response, educated the public about the protective effects of breastfeeding and the role breastfeeding plays in increasing survival in emergencies.

Every day, we hear news of fires, floods, power outages, winter storms, flu pandemics, hurricanes, tornadoes, accidents, or job loss. In emergencies such as these, infants and children under two are the most vulnerable and are three times more likely to become ill or die. This is because appropriate foods and formula—and the money to buy these items—can be in short supply, safe water may not be available, stores may be closed, donation centers may be without infant supplies, access to transportation can be difficult or impossible, sanitation may be poor, and formula may be diluted to make it last.

Breastfeeding provides a safety net for babies in any emergency by providing a safe, secure and readily available food supply, immunity protection, and proper hydration. In stressful or dangerous situations, the mother’s body will release cortisol, a hormone that keeps both the mother and the baby calm.

Because only mom needs to be fed, breastfeeding conserves money and resources. The breastfed baby is at a much lower risk for inadequate nutrition and hypothermia, and is protected and kept warm and secure in its mother’s arms.

What can advocates for mothers and babies do to improve care during emergencies? We can raise the awareness about the extreme vulnerability of babies, and make managing and protecting babies a priority. We can encourage pediatricians, nurses, lactation consultants, and La Leche League members to be involved in disaster planning and response. A good plan needs to include breastfeeding support, and guidelines for safe formula distribution and feeding. Practices for formula use need to be carefully planned and communicated, and must include clean water, bottles and nipples, infant feeding education for response workers, and awareness that when formula is necessary, ready-to-feed is the safest choice.

Ultimately, the safest and best way to protect babies in an emergency is to encourage and support women to breastfeed.

---

For more information, contact Tina Cardarelli at tcardarelli@indianaperinatal.org or (317) 924-0825 ext. 4223.

---

**Indiana Safe Haven Law**

Authored by Sen. Jim Merritt, Indiana’s Safe Haven Law (SEA 330), enacted in 2000, enables a person to give up an unwanted infant anonymously without fear of arrest or prosecution.

A parent, family member, friend, minister or priest, social worker or any responsible adult may give up custody of a baby less than 45 days old to a hospital emergency room, fire station or police station in Indiana. As long as there are no signs of intentional abuse on the baby, no information is required of the person leaving the baby. Once the baby is examined and given medical treatment (if needed), the Family and Social Services Administration will take the baby into custody through Child Protective Services where it will be placed with a caregiver.

Distressed parents can receive counseling and get addresses and directions for any hospital, fire station or police station in Indiana by calling the Safe Haven Hotline, 1-877-796-HOPE (4673), or 2-1-1. Parents can learn more by visiting the National Safe Haven Alliance in Indiana website www.safehaven.tv to get more information.

---

For more information, visit the Department of Child Services website at http://www.in.gov/dcs/2915.htm, or http://www.safehaven.tv/states/indiana/.
What is the Fetal and Infant Mortality Review (FIMR) program?

The goal of fetal and infant mortality review is to enhance the health and well-being of women, infants, and families by improving community resources and service delivery systems. The FIMR process brings together key members of the community to review information from individual cases of fetal and infant death to identify factors associated with those deaths, establish if they represent system problems that require change, develop recommendations for change, assist in the implementation of change, and determine community effects (American College of Obstetricians and Gynecologists, 2008).

Three FIMR programs exist in Indiana, operating in Marion and Lake Counties and in Southwestern Indiana.

Indiana FIMR Program Updates

Marion County

Major Findings
• Leading causes of fetal and neonatal death: prematurity and congenital anomalies. The major cause of postneonatal deaths has consistently been safe sleep related deaths such as Accidental Suffocation.
• Major contributing factor to fetal and infant death continues to be maternal pre-existing medical conditions such as diabetes, hypertension and mental health conditions. Substance abuse, maternal obesity and previous fetal and infant loss consistently rank high.
• Recent increase in anemia after the first trimester, as well as poverty.

Current Activities: Vital record quality improvement, developing and piloting new OB Triage Department form, and technical assistance to other states’ FIMR programs.

For more information about Marion County FIMR, contact Teri Conard at tconard@hhcorp.org

Southwestern Indiana (Vanderburgh, Warrick, Posey and Gibson Counties)

Major Findings:
• Infant deaths: prematurity, positional/mechanical asphyxia, congenital anomalies
• Fetal deaths: IUFD/unknown, placental abruption, umbilical nuchal cord
• Continue to see high numbers of cases of late/no prenatal care (42% of Vanderburgh County cases), tobacco use, and other drug use.
• Asphyxia deaths accounted for 25% of infant deaths
• Continue to see a number of cases with no fetal movement

Current Activities: Inaugurating new community education message, “Back to Sleep—By Myself”. Partnership with Healthy Start to address obesity by developing a healthy weight management initiative.

For more information about Southwestern Indiana FIMR, contact Susan Bonhotal at sbonhotal@hotmail.com

Lake County

Major Findings
Fetal Deaths
• 37% of fetal deaths were to babies born between 20-23 weeks (very premature). Over half of women had a medical risk factor such as obesity, hypertension, diabetes, abruption, depression, stress, or incompetent cervix.
• Leading causes of death: Unknown, cord accident, fetal demise/stillborn, prematurity, and perinatal condition.

Infant Deaths
• Vascular collapse has been the major cause of death noted on death certificates in recent years.
• Other frequent findings: Pneumonitis /bronchiolitis/congestion of lungs, positional asphyxia/co-sleeping.

Current Activities: Continuing work on safe sleep initiative and crib distribution, as well as access to care issues. Continuing to emphasize kick count education.

For more information about Lake County FIMR, contact Shirley Borom at sabfaith@aol.com
In the News

Study Examines SIDS and Co-sleeping

A study in the October edition of the British Medical Journal investigates risk factors for Sudden Infant Death Syndrome (SIDS) including an examination of specific circumstances in which SIDS occurs while co-sleeping (infant sharing the same bed or sofa with an adult or child). Researchers found that many of the SIDS infants had co-slept in a hazardous environment. They concluded that the major influences on risk included use of alcohol or drugs before co-sleeping, regardless of parents’ socioeconomic status. In addition, more mothers of SIDS infants smoked during pregnancy, and a greater proportion of SIDS infants were preterm. To access the study online, go to http://www.bmj.com/cgi/content/abstract/339/oct13_1/b3666.

Source: National Healthy Mothers Healthy Babies Coalition

Depiction of Infant Sleep Environment in Women’s Magazines

This study evaluated pictures in magazines widely read by women of childbearing age, for adherence to American Academy of Pediatrics (AAP) guidelines for safe infant sleep practices. The study found that more than one third of pictures of sleeping infants in these magazines demonstrated infants in an inappropriate sleep position, and two thirds of pictures of infant sleep environments were not consistent with AAP recommendations. Authors conclude that messages in the media that are inconsistent with health care messages create confusion and misinformation about infant sleep safety and may lead inadvertently to unsafe practices.


Study Reviews Characteristics of Infant Homicides

A recent review of the National Violent Injury Statistics System examined 71 incidents involving 72 infant homicides. Type 1 incidents involved beating/shaking injuries inflicted by a caretaker; type 2 involved all other homicides (including neonaticide, intimate partner problem-related homicide, crime-related death, and other types). The circumstances involved in the type 1 homicides (75%) suggested that those attacks occurred impulsively, death was unintended, and emergency care was summoned, often with a false story. Previous abuse was suspected in more than half of these incidents.


Hospitals Tighten Rules for Elective Inductions, C-Sections Ahead of New Joint Commission Reporting Requirements

In anticipation of new quality reporting requirements that will take effect in the spring, some hospitals are tightening rules for elective inductions and caesarean sections, the AP/Google News reports. National guidelines from the American College of Obstetricians and Gynecologists discourage elective deliveries prior to 39 weeks gestation, but many physicians and hospitals allow inductions and scheduled c-sections at 37 weeks, according to the AP/Google News. According to the Centers for Disease Control and Prevention, one in five pregnancies is induced, double the rate in 1990. There is little data on the percentage of inductions that are elective, though a Hospital Corporation of America study of nearly 18,000 births at its 27 hospitals placed the figure at 10% of all births before 39 weeks. Recent research shows that infants born prior to 39 weeks face a higher risk of breathing disorders and other problems than those who remain in the womb longer.

The Joint Commission, which accredits hospitals, this spring will begin requiring hospitals to report all elective deliveries to a public database. Hospitals will also have to report gestational age at induction and c-sections for first-time births, which can be linked with failed inductions. “We believe this will be a very important driver of improvement in prenatal care,” Mark Chassin, the organization’s president, said (Neergaard, AP/Google News, 10/27).

Source: National Partnership for Women and Families
Pilot Centering Parenting Program Addresses Birth Spacing, Promotes Assessment, Education, and Support

In an effort to improve rates of rapid, repeat pregnancies among patients, a new partnership between Clarian Women’s Services and Indianapolis HealthNet clinics is implementing a Centering Parenting program.

According to the Centering Healthcare Institute, CenteringParenting® is a multifaceted model of group care that integrates the three major components of care—health assessment, education, and support—into a unified program within a group setting. Mother-baby dyads meet together to learn care skills, participate in a facilitated discussion, and develop a support network with other group members. The practitioner, within the group space, completes standard physical health assessments for women and babies. When CenteringParenting® care is used in conjunction with CenteringPregnancy®, groups provide a continuing community for families for a total of 12-24 months and provide an opportunity for competence and confidence building.

Jane Meyer, MA, CHES, Health Promotions Manager at HealthNet, sees the potential for the model to improve birth spacing, bolster parenting skills, and reduce risk factors for subsequent preterm birth. “This is a wonderful program with excellent health outcomes” she says, “and we think it is a perfect fit.” Meyer’s goal is to improve birth spacing among participants to 18 months between delivery and subsequent conception.

People’s Health Center was selected in November 2008 as the site of the inaugural program because of its high repeat pregnancy rate and the strong Centering Pregnancy programs there. “At People’s, we’ve seen that 100% of the Centering patients attended their postpartum visit,” says Meyer. “The women have been together and are very comfortable talking to each other.”

The current group has six women with infants aged 8-11 months, and meets postpartum and then at 3, 6, 9, and 12 months. Sessions address topics such as healthy eating, postpartum depression, domestic violence, and birth control. Partnerships with outside agencies such as Purdue Extension and the University of Indianapolis Occupational Therapy program provide guest speakers and supplementary resources. “One of the most popular sessions covers what parents can expect developmentally over the next months, and how activities like playing with pudding on paper can support infant development,” notes Meyer. “The parents love that.”

Meyer’s main challenge has been linking the meetings to well-baby visits, and convincing providers and medical staff of the benefits and efficiency of group care. “We know now that’s the route we have to go to sustain the program,” she says. “Getting administrative support to bring in the well-baby component will improve participation and outcomes.”

“The great thing is the relationship these women have,” she believes. “Centering Parenting allows them to continue that, and build on what we do prenatally.”

For more information, contact Jane Meyer, MA, CHES, at Jane.Meyer@Clarian.org.

Policy & Legislative Update

Indiana General Assembly to Reconvene

The Indiana General Assembly will reconvene in January for a “short session”, expected to end by mid-March. IPN will send updates on legislation of interest to the perinatal community throughout the session. IPN anticipates seeing legislation filed to reauthorize the Prenatal Substance Use Commission, and to update perinatal HIV testing codes. It is also predicted that comprehensive smokefree workplace legislation will also be reintroduced.

To sign up for IPNs legislative and policy alerts, visit www.indianaperinatal.org, click on “Add me to the email list”, and select “Legislative Alerts”.

Presumptive Eligibility (PE) and Notification of Pregnancy (NOP) Update

Medicaid Presumptive Eligibility for pregnant women has been met with success since its July 1 implementation. Within the first four months, over 4,000 pregnant women have been enrolled into Hoosier Healthwise via PE.

To locate a PE Qualified Provider in your area, go to http://www.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx—and be sure to select “Show only Presumptive Eligibility Qualified Providers?” Information for providers is available at http://www.indianamedicaid.com/ihcp/MCE/content/pelInfo.asp.

Over 3,500 Notification of Pregnancy forms have been submitted by providers since July 1st, with nearly one-third of patients being identified as high risk. The form is a comprehensive risk assessment used by all three Medicaid managed care organizations; its use has been associated with improving birth outcomes for women enrolled in Medicaid. Providers who complete and electronically submit the NOP using Web interChange may be eligible for a $60 incentive.

Other salient findings from the NOP forms include high rates of tobacco use history, unemployment, high BMI, and history of STIs. Additional information about the NOP is available at http://www.indianamedicaid.com/ihcp/MCE/content/nopInfo.asp.
Improving Care for Indiana’s Refugees from Burma: Strategies for Providers

By Carleen Miller, MA, LMHC, LMFT, Executive Director, Exodus Refugee Immigration Inc., with Naw Eh Paw, MA, Indianapolis Interpreters

Indiana has become one of the largest refugee resettlement sites in the United States for several ethnic groups from the tropical country of Burma, renamed Myanmar by the military junta. Many are victims of ethnic cleansing, religious persecution, massive human rights violations and terrorism at the hands of their own military government. Ft. Wayne's approximately 5,000 newcomers are mainly from three ethnic groups—the Karen, the Mon, and the Burmese. Indianapolis has welcomed more than 5,000 Karen, Chin and Karenni from Burma. All prefer to be referred to by the name of their specific ethnic group rather than being called “Burmese,” which is the name of the predominant ethnic group in Burma. The refugees’ religions affiliations are Christian, Buddhist, Muslim and Animists.

Pregnancy and Prenatal Care

Pregnancy in Burmese culture is a revered time in family life. While women from Burma of all ethnic groups are not typically treated as equals to men, pregnant women are very respected and treated as special. Pregnancy is viewed as a natural time that does not require a great deal of medical support. Prenatal regimens generally do not include prenatal vitamins, but rather consist of traditional foods and herbs. Midwives typically deliver their babies and provide any prenatal care they receive. Both men and women serve as midwives.

Pregnant women in refugee camps may receive limited prenatal care. When they arrive in the US they are encouraged to follow up with a physician on a regular basis, a practice that is unexpected and confusing to most. Seeing a physician may be intimidating for many of the women and they sometimes assume that frequent visits mean something is wrong with the pregnancy.

Breastfeeding and Sleeping Practices

Women from all the ethnic groups view breastfeeding as the natural and best option for their child and breastfeed their infants in public. They typically do not cover themselves, as it is not a shameful act or an issue of immodesty, and are generally surprised and hurt when asked to cover up or to go to another room. Women will often breastfeed until their next child is born. Many do not practice birth control as they believe they cannot get pregnant while nursing. It is also a common practice for parents to sleep with their infants and they will be unfamiliar with the recommendations for safe infant sleep protocols.

Caring for Refugees from Burma

Healthcare providers not familiar with the cultural norms of refugees from Burma may unwittingly make assumptions that are not accurate. It is important that providers strive to know the patient and suspend the automatic perceptions they may have in response to the patient. Culturally, persons from Burma show little facial expression or emotion, and providers may perceive them as apathetic or uncaring about their pregnancies when in reality they may be happy, scared or confused. Out of respect, refugee patients will often tell providers that they understand or agree to what is being said, when they may not have a clear understanding.

It is helpful not only to tell patients what they want them to do, but to explain in detail why and how. Telling a patient to eat healthy foods may not be enough. Most persons from Burma will not be well educated on which foods are healthy or the dangers of chewing tobacco, smoking or using alcohol.

Due to their reserved manners, patients may need providers to encourage them to ask questions and become more engaged in the health care process. It is crucial that providers have access to qualified interpreters. All of the ethnic groups from Burma speak separate and distinct languages from one another. Without an appropriate interpreter, who speaks the specific language of the patient, the provider and patient will both be unclear as to whether they truly understand one another.

Refugees from Burma have endured unimaginable hardships. Those who make it to the US are strong and courageous. They have lost their homes, families, livelihoods, culture, and identities. Yet they are full of hope for what is possible for their children and families here in the United States. Giving birth to an American citizen baby is often a source of pride and a symbol of hope for the future.

Exodus Refugee Immigration works with refugees—worldwide victims of persecution, injustice and war—to establish self-sufficient lives in freedom and sanctuary for themselves and their families in Indiana. For more information, visit www.exodusrefugee.org, or call (317) 921-0836.
Coming to Your Community: 2010 Regional Training Series

IPN will soon publish its 2010 Regional Training offerings, designed to bring updated clinical and programmatic information and networking opportunities to communities throughout Indiana.

Between May and August 2010, IPN will be visiting Porter, Terre Haute, Muncie, Jasper, Columbus, and South Bend.

Topics of the Regional Trainings will include:

- Integrating Screening and Treatment of Substance Use into Prenatal Care
- mPINC (Maternity Care Practices in Infant Nutrition Care): Strategies for Using this National Perinatal Quality of Care Standard as a Guide to Action
- The “Golden Hour”: An Opportunity to Improve Neonatal Patient Safety
- Sudden Infant Death Syndrome (SIDS) Reduction: A Curriculum for Nurses
- Updates and Issues in Perinatal Health

Watch your email! IPN will send an electronic alert when the calendar has been posted to our website.

Education and Training Opportunities Available from IPN

IPN continues to travel the state providing training and education on a host of topics including safe sleep and bereavement, excellence in childcare for the breastfed baby, domestic violence and pregnancy, Advocacy 101, and much more. For more information, contact IPN at ipn@indianaperinatal.org or (317) 924-0825.