

Perinatal Family Support

CONSENSUS

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POSITION STATEMENT

All Indiana families experiencing a perinatal crisis and its aftermath deserve access to appropriate and timely ongoing support and resources. IPN's Perinatal Family Support Committee aims to alert and inform all health care providers on the incidence and significance of the need for family support during the perinatal period. Significant need arises during a high-risk pregnancy, after the birth of a baby requiring neonatal intensive care, after the diagnosis of an infant with special needs and during and after a perinatal loss. When families encounter any or all of these experiences, their needs must be assessed to allow for appropriate interventions, referrals and support.

INTRODUCTION

"Perinatal family support" is defined as comprehensive, ongoing, coordinated, culturally appropriate emotional support provided by professionals and/or non-professionals to families during pregnancy and up to one year after. The focus on families increased with the passage of Public Law 99-457 and the federal mandate to deliver services to families in a comprehensive, coordinated, community-based and family-centered way. As those serving families and children have learned, family-centered care is participatory—involving families at all levels in their own care. After a family stabilizes, they can also be enlisted to provide peer support for other families.

Regardless of the outcome of pregnancy, all families anticipating a birth need the support of their families and communities during and after a pregnancy. While parents with typical circumstances may talk to their families or friends, those with high-risk pregnancies or poor outcomes may need the additional support of professionals and/or other parents who have experienced similar situations. Hospital staff and public health providers can play a key role by being knowledgeable and aware of a family's need for support and equipped to provide the needed psychosocial support referrals.

The vital need for ongoing crisis support is a public health issue that should be addressed. Objectives should include raising public awareness of the need for a continuum of perinatal family support and developing a plan that meets Indiana's needs. To accomplish these and other objectives, collaboration is imperative between perinatal health and social service groups including the Indiana Perinatal Network (IPN), Neo-Fight, March of Dimes, Indiana State Department of Health (ISDH) Division of Maternal and Child Health, County Health Departments, Healthy Families, Indiana Infant Toddler Mental Health Association, First Steps, About Special Kids (ASK, formerly the Indiana Parent Information Network), IN*SOURCE, all Indiana hospitals local health care agencies and others.

HISTORICAL PERSPECTIVE

Documentation of more formalized family support initiatives in Indiana dates back to the mid 1970s. As medical advances continued to mount and more infants survived initial crises, the acute and chronic needs of these surviving infants led to an increased need for family support. Initially, medical, social work and clergy professionals took the lead. Their expertise and experience with the pressing medical, social and financial issues that families faced were and are critical to support initiatives. In addition, several tertiary hospitals expanded their programs using volunteers—including Riley Hospital for Children, Memorial Hospital in South Bend and others.

In the 70s, the concept of formal support by family peers in the Neonatal Intensive Care Unit (NICU) environment was a relatively new concept nationally. Indiana was one of the few states that documented informal family support available in the NICU. One community-based parent-to-parent support program, Neo-Fight, was initiated in Indianapolis at Methodist Hospital in 1976. Founded by two mothers experiencing high-risk pregnancies, Neo-Fight became one of the first parent-peer,

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community-based support organization in the United States to include the support of non-professionals in the NICU. By the late 1970s, a handful of formal support programs across the country joined Neo-Fight. While many of these groups were hospital based, a few, like Neo-Fight, were community based with no affiliation to a particular hospital. Whether hospital or community-based, these family support groups struggled with funding and the challenges of training and maintaining an active volunteer base.

In 1983, Indiana State University and Indiana University graduate Sara Rich Wheeler, DNS, RNCS, LCPC and Rana Limbo, PhD, RN co-founded National Resolve Through Sharing (RTS)—a perinatal bereavement program for those coping with miscarriage, stillbirth and neonatal bereavement. In 1985, the first RTS conference was held in Indianapolis with participants from St. Francis, Methodist, St. Vincent, Community Hospital, Indiana University Hospital, Home Hospital in Lafayette and Union Hospital in Terre Haute. In 1988, St. Francis Hospital, Methodist Hospital and St. Vincent Hospital began offering RTS conferences for their Indiana service areas. Today, hundreds of certified RTS associates are found throughout Indiana and many of the state's hospitals offer either a bereavement program or a resource to a bereavement program run by certified RTS coordinators. Training in the form of two-day sessions on bereavement is offered annually throughout Indianapolis, along with an annual "Walk to Remember" each October. One-to-one support is available to families as needed and parent-support groups convene monthly in many hospitals statewide.

To meet the needs of families, family support organizations employ activities that include family meetings, listening lines, one-to-one support, NICU reunions and information exchanges. While these groups intend to meet the needs of all families, family support initially tended to draw middle-class families.

Over the years, efforts have been made to broaden the family-support audience. Diversification of support methodologies, recruitment of a diverse volunteer force and increasing awareness of the value of family support have changed the composition and dynamics of family-support initiatives. Technology such as answering machines, voice mail, pagers, cell phones and the Internet have all made information instantly accessible to families and changed the face of support activities. While questions about the accuracy of some information persist, web pages, list serves, chat rooms and on-line services connect people with each other and vast amounts of information instantly. Despite concerns about Internet fraud, this technology provides substantial facilitation for family-support efforts.

Today, several programs utilize professional and lay providers to assist and support families during a perinatal crisis including (but not limited to) clinical nurse specialists, genetic counselors, nurses, social workers, clergy, prenatal care coordinators, Healthy Families workers, community health workers, doulas and others.

PROBLEM STATEMENT

A variety of support services—formal and informal—are essential components of quality perinatal care systems. Formal support mechanisms may not appeal to all families. Each year, thousands of Indiana families are affected by a perinatal complication and/or high risk infant. It is estimated that high-risk complications occur in about six to eight percent of all pregnancies. With 86,382 live births in Indiana in 2003, this means nearly 7,000 pregnant women experienced a complication during pregnancy. Of the 86,382 babies born in 2003, 7.4 babies per thousand (641) did not survive their first year of life. In 2002, according to the *March of Dimes Peristats*, Indiana's preterm births comprised 12.5 percent of all live births—an increase of more than 22 percent between 1992 and 2002. The incidence of preterm births among African-American mothers is even higher with a rate of 18.1 percent. In addition, the number of babies born low birth weight increased from 6.7 percent in 1992 to 7.9 percent in 2003 (see *Appendix A Birth Rate Information for Indiana*).

The resources and support provided for Indiana families during and up to one year after pregnancy are often sporadic and uncoordinated. Frequently, a communication gap arises between specialty care providers, primary care providers and patients. Health care providers and others working in maternal and child health may be unaware of existing resources. The need for family support is compounded in some of Indiana's outlying rural areas. Among the specific challenges, rural hospitals and health care agencies do not always receive

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communications from tertiary care centers about infants released back into their home communities. The families might not have accessed the local rural hospital or agency facilities or those facilities may not have the needed specialty care. Follow-up appointments may be required at the tertiary care center rather than the local hospital. A family incurs repeated long-distance travel and expense when accessing specialized care outside of their home community. A plan for the expansion and coordination of family support is necessary to improve maternal and child health. The plan should include the identification of families in rural areas who are willing to support other rural families. Support services delivered by both health care providers and parents with similar experiences must be identified, coordinated and delivered consistently throughout the state.

LITERATURE REVIEW

The literature review includes: prenatal, birth, neonatal, grief/loss, diagnosis and disability, and parent-to-parent support.

PRENATAL-HIGH RISK PREGNANCY

The process of maternal role attainment during pregnancy (maternal identity) was fairly well researched over the past several decades, in particular by Reva Rubin, RN, PhD^{1, 2, 3} and Ramona T. Mercer, RN, PhD.^{4, 5} Rubin outlines four tasks of a mother during pregnancy: "Seeking safe passage, ensuring acceptance of her child, binding-in to her unborn child and learning to give of herself." This developmental and interactional process occurs over time as the mother becomes attached to her unborn child. The ability of the woman to move through these stages depends on factors such as personality, self esteem, cultural beliefs, support systems, health, anxiety, etc. Several factors can enhance maternal-fetal attachment including fetal movement, hearing the fetal heartbeat and viewing the fetus via ultrasound.

A review of the literature reveals that women may not easily or successfully move through these tasks for a variety of reasons. The "normal" process of maternal role attainment may be disrupted if a woman experiences:

- ▶ An unintended or unwanted pregnancy;
- ▶ Complications during pregnancy, e.g. bleeding, preterm labor, diagnosis of a congenital anomaly, depression, substance abuse, domestic violence, etc.
- ▶ Pregnancy after a previous high-risk pregnancy or perinatal loss, e.g. miscarriage, termination, stillbirth or infant death.⁶

Subsequent to any of these experiences, women and their partners may experience anxiety, guilt, fear or denial. They might avoid investing in the fetus and developing an attachment for fear of a poor pregnancy outcome or infant loss.^{7, 8} Women may be less motivated to comply with medical care until the baby reaches the age of viability. In addition, the treatment plan for many high risk conditions can challenge women and their families. For example, treatment for preterm labor (and several high risk conditions) is often extended bed rest for weeks or even months. Findings support the need for health care providers to assess these women for specific concerns throughout the pregnancy and provide ongoing education, support and resources.⁹ Women may also be nervous or anxious about becoming pregnant following a perinatal crisis. Contemplating pregnancy following an infant loss or the birth of a child with a chronic illness or disability can be extremely stressful for families. Preconception counseling and parent support prior to a subsequent pregnancy may be recommended. Anecdotal information from families indicates they find such parent-to-parent support reassuring and helpful.

LABOR AND DELIVERY

Support during labor and delivery empowers families and benefits health care systems. When they find themselves in a hospital setting, parents often feel powerless and "out of control"—particularly during a crisis. The cost benefits are clear when healthy outcomes are increased by decreasing maternal stress. Families supported by other parents experience less postpartum depression, fewer repeat visits to the doctor and report an increase in their ability to cope. Given the research, it is reasonable to assume that family support not only fulfills the mission of health care systems, it also decreases the cost of patient care as evidenced by a decrease in repeat admissions to the hospital, fewer repeat visits to the doctor and decreased lengths of stay.

Strober (2005) evaluated a program designed by “veteran” parents to help acclimate newer parents the workings of a hospital (hierarchies, how information is communicated, etc.) and what to expect.¹⁰ Parents who experienced this type of training gave the hospital higher ratings in terms of satisfaction with the care they received in the hospital.

Although families who experience a perinatal crisis may receive some support from family, friends and health care providers, studies show that parents report they are not getting enough support from these resources.^{11, 12, 13, 14, 15} Parents state that they want more support,¹⁶ in particular from other parents with similar experiences.^{17, 18, 19, 20, 21}

NEONATAL

Many studies have been performed to examine family support in the NICU.

Previous research supports the importance of social support for families in challenging situations.^{22, 23} Zahr (1991) reported that mothers of NICU babies who lack social support are at a greater risk for poor mother-infant interaction than those who have adequate support. Research also shows that social support positively influences the provision of an optimal home environment by mothers of preterm infants (Pascoe, Loda, Jefferies and Earp, 1981). Minde et al. (1980, 1983) found specifically that parent-to-parent group intervention increased the frequency of maternal visits to the NICU, improved maternal confidence in caretaking and led to increased parent-child interaction after discharge.^{24, 25} Respondents to an informal 2005 IPN survey on family support indicated that support would be most helpful at different times, ranging from very soon after the start of the crisis to annually as their needs changed over time. Many would have liked support throughout all stages of their crisis. The survey concluded that Indiana parents and professionals are interested in expanding family support through training and access to the many statewide support groups for various perinatal issues.

Studying the effectiveness of parent-to-parent support²⁶, the Beach Center on Disabilities at the University of Kansas (1989-92) brought parents and researchers together to collaborate on a three-year national study to evaluate the effectiveness of parent-to-parent support. The study found that parent-to-parent support increases parents' acceptance of their situations and their sense of being able to cope.

Singer et al (1999) designed a national evaluative study of parent-to-parent programs. Parents with challenging family experiences were randomly allocated to a two-month parent-to-parent group or a no-intervention control group. Parents participating in the parent-to-parent support group showed improvements in coping, attitude and addressing problems, whereas the control group did not change.²⁷ Researchers at the Beach Center continued their studies of parent-to-parent support throughout the 1990s and found that parents prefer three types of support: One-on-one emotional support, informational support and group support sessions.²⁸ In addition, Ireys, Sills, Kolodner, and Walsh (1996)²⁹ used randomized trials comparing a parent mentor group to a no-intervention control group. Ireys et al. (1996) findings illustrated positive outcomes from support and a decrease in mental health symptoms for those in the mentor group.

Iscoe and Bordelon (1985) have also used a questionnaire to survey a small sample of parents involved in parent-to-parent support groups.³⁰ In this survey, 88 percent of those responding defined their parent-to-parent support experience as effective. Similarly, Rahi, J.S., Manaras, I., Tuomaninen, H. and Hundt, G.L. (2004)³¹ found that the implementation of a program designed to provide information and emotional support to parents at the time of their diagnosis and afterward led to improved parent satisfaction with services.

During pediatric surgery, Hug, Tonz and Kaiser (2005)³² report that parents identified insufficient preparation as one of the biggest factors contributing to their stress. When measures were taken to increase the information provided prior to surgery (including the creation of an interactive CD-ROM), parents reported more feelings of “well-being” and were more satisfied with their hospital experiences. Thus, increased information and support seem to empower families and contribute to their positive evaluations of hospital experiences.

GRIEF/LOSS

Families experience a profound and sometimes long-lasting grief after a perinatal loss. The standard medical definition of perinatal loss is restricted to a stillbirth beyond 20 weeks gestation or death in the first 28 days of life. A broader definition of loss is considered here, specifically: Loss of the pregnancy at any point from conception to age one.^{33, 34, 35}

Many types of losses can occur prior to delivery including miscarriage, ectopic or molar pregnancies, stillbirth and terminations. Every minute of every day, four women in the United States experience a pregnancy loss.³⁶ Miscarriage occurs in 15 to 20 percent of all pregnancies with 1.4 percent of the losses occurring as ectopic pregnancies. At least one in 100 pregnancies ends in stillbirth.^{37, 38, 39}

Losses after birth include the death of a child in the NICU or shortly after the family returns home. Neonatal deaths were reported at 4.7 per 1,000 births in 2002.⁴⁰ Also included are the unexpected deaths of babies born healthy, through Sudden Infant Death Syndrome (SIDS) or injury. Some injuries may be the result of accidents while others stem from abuse or neglect. The psychological impact of loss on mothers and families has been well researched during the past 25 years.

After a perinatal loss, mothers or family members will experience a range of emotions—a few will suffer some form of prolonged psychological abnormality.⁴¹ It has also been reported that early pregnancy losses are frequently viewed as less traumatic than stillbirth by caregivers, while stillbirth is less traumatic than neonatal death. However, when Peppers and Knapp compared the intensity of grief responses among parents who had experienced miscarriage, stillbirth or neonatal death, no differences were found.⁴² Consequently, a structured, empathetic environment with strategies that enable the mother and family to manage the reality of perinatal loss has become the standard nursing practice in most patient care settings.⁴³ Additionally, parent support groups have been successfully established to meet the ongoing needs of the patient and family.⁴⁴

A subsequent pregnancy after a perinatal loss can also be mentally, emotionally and physically stressful and the anxiety experienced by patients has been reported by investigators.^{45, 46} Less is known about the effect of perinatal loss on the parenting of subsequent children,⁴⁷ although replacement child syndrome and vulnerable child syndrome are concepts that have been used to describe potential areas of conflict for parents.⁴⁸ Finally, infertility also can be viewed as a loss by patients and partners, and it affects approximately 10 to 15 percent of childbearing-age couples. Infertility has multiple aspects—including physical, emotional, financial, social and psychological. Although most health care professionals are more aware of the problems related to the physical aspects of infertility, the difficulties and needs that arise from the emotional aspects are often seen as more significant for couples.⁴⁹

DIAGNOSIS AND DISABILITY

When an infant is born prematurely or is diagnosed with an illness or disability, families experience the usual stressors associated with parenthood as well as unique stressors and wide range of emotions associated with their child's condition.^{50, 51} Grief occurs, and can reoccur, during transitional challenges throughout the child's life. Compounding this grief are the stressors of daily life and challenges related to accessing needed community resources for the child and family.⁵²

Families of infants/children with special health care needs face numerous difficulties not encountered by families with typically developing children. The family must process and master volumes of medical information; make repeated visits to specialists; meet demanding caregiver responsibilities; and pay the resulting medical bills. These families try to maintain a normal family routine, balance the needs of other family members and find the emotional and practical support to maintain family balance, often with little or no respite.^{53, 54} Providing support for these families is a critical component of the provision of health care.⁵⁵

When an infant is discharged from the NICU with a guarded prognosis, research shows parents have difficulty coping with and preparing for discharge.⁵⁶ The educational and informational support are essential to the transition home, however, it might be difficult for parents to assimilate during a crisis.⁵⁷ Further, family support services often do not extend beyond discharge.^{58, 59} To complicate the issue, some parents report that family and friends withdraw their support following discharge with the belief that the crisis ends when the child goes home.^{60, 61, 62}

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Social support services can be an effective buffer against the stress and isolation faced by families.^{63, 64, 65} Some researchers suggest the greatest stress-reduction benefits occur when parents can share and compare their experiences. Professional literature supports the theory that a parent-to-parent support network is a powerful tool for helping parents of children with chronic illness or disabilities develop a realistic outlook and adequate coping mechanisms. Social support helps families cope with the demands of caregiving and moderates the effect of stressful situations on health and functioning outcomes.^{66, 67, 68, 69, 70} Professionals should be aware of the potential benefits of parent-to-parent support and provide parents with information about appropriate local organizations and contacts, as early as possible after a child's diagnosis or the loss of a child.

PARENT-TO-PARENT SUPPORT

Parent-to-parent support refers to a one-to-one peer support or a group led by a trained parent. Parents often seek emotional and informational support from another family, with similar family and disability experiences.⁷¹ Parent-to-parent support programs have been providing support to families for over 35 years. This self-help, grass roots movement has grown rapidly over the past decade.⁷² Parent-to-parent is a key element of family-centered care.⁷³

Scientific studies using a quasi-experimental design of parent-to-parent support are limited. However, anecdotal and survey information suggests that when support is provided by a fellow survivor, the recipient perceives it as more comforting and effective. This holds true for any number of support organizations from alcoholics to victims of violence to mothers of multiples.

CURRENT & FUTURE RECOMMENDATIONS

Goal: To assure access to comprehensive, culturally appropriate family support services for all families experiencing a perinatal crisis and its aftermath.

■ Public Awareness

- ▶ Increase awareness among the general public, including key stakeholders, of the need for family support and the importance of ensuring that services are available for all families.
- ▶ Increase awareness of existing community resources among parents and providers.
- ▶ Identify, advertise and maintain a centralized referral number that families can call 24 hours a day to be connected with the support they need when they need it.
- ▶ Include resources and information about parent support on IPN's website.
- ▶ Distribute resource compendium to all perinatal providers and hospitals.

■ Provider Education

Encourage hospitals to:

- ▶ Identify and develop protocols for family support during hospitalization. This may include education and training of hospital personnel at all levels. Collaboration between caregivers is needed to ensure the family's social and emotion needs are addressed.
- ▶ Establish a centralized location for all family support resources (i.e., electronic access, video library, a file cabinet containing hand outs). A designated area on each unit for easy access to information is helpful. Hospitals with resource centers should be adequately stocked with current family support materials related to an array of diagnoses and pregnancy outcomes.
- ▶ Establish a policy among hospital discharge planners, care coordinators, Healthy Families workers and others to provide periodic calls to families for one year after the initial crisis. Support resources can be reiterated during these calls. If families are not interested in receiving calls, they should be given a phone number to call if they change their minds.
- ▶ Integrate parent support training into the curriculum of health-related professional schools throughout the state to ensure that health professionals are technically and culturally competent in delivering services. Incorporate research-based curricula and standardized competencies.
- ▶ Collaborate with maternal and child health training programs and other state agencies to provide training to those professionals and parents who want to support families in crisis.
- ▶ Utilize evidence-based information to educate health care professionals.
- ▶ Urge continuing education requirements for health care providers.
- ▶ Identify or develop curriculum to inform health care professionals about the advantages of parent-to-parent support and the resources available in Indiana.
- ▶ Identify or develop curriculum to train parents providing parent-to-parent support.

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- ▶ Engage in research activities to continue to identify family support groups, model programs and best practice, especially as pertains to rural issues.
- Infrastructure
 - ▶ Work collaboratively with state agencies, all Indiana hospitals and other perinatal-related organizations to ensure support is available to all families in Indiana during pregnancy and up to one year following (i.e. Indiana State Department of Health and County Health Departments; Indiana Perinatal Network; Healthy Families; March of Dimes; ASK, formerly the Indiana Parent Information Network; IN*SOURCE; NeoFight; First Steps and others).
 - ▶ Facilitate integration of family support services into the public health system available to all families.
 - ▶ Assemble a committee to plan a Family Support Summit for the state within the next year to continue the dialogue regarding family support and to plan how best to provide appropriate support to families statewide.
 - ▶ Collaborate with existing support programs including the March of Dimes NICU Family Support® program to disseminate best practices and resources for family support during a NICU hospitalization to all interested NICUs.
 - ▶ Appoint a statewide family support coordinator to oversee the family support consensus recommendations and to raise awareness of the need for improved family support in Indiana.
 - ▶ Develop, maintain and distribute a list of family support programs throughout the state to all health care providers including hospital staff, community health centers, clinics and private practice providers.
 - ▶ Apply for funding from government, private foundations, corporations, and other community sources to leverage funding and resources for family support in Indiana.
 - > Write grants for resources, outreach, summit, development and training.
 - > Collaborate with existing training initiatives to promote family support.
 - ▶ Develop a comprehensive compendium of resources that addresses specific needs of families and that includes:
 - > Trained parent to parent listeners: Parents who have had a similar experience and have been trained would make themselves available by phone or in person to other parents as “listeners” or supportive parents.
 - > Parent-to-Parent support via the internet: Parents giving permission to share their contact information could e-mail each other for support.
 - > Support groups: A group of people, sometimes led by a therapist, who provide each other with moral support, information and feedback on issues related to a shared characteristic or experience.
 - > Printed literature: Books, pamphlets and articles on relevant perinatal topics would be indexed and made available to parents in crisis.
 - > Websites: A list of websites where families can access information and or resources related to perinatal issues (with disclaimer possibly like the SAMHSA website disclaimer). Note: only select sites would be reported because many are linked to one another and others may be active for a limited length of time.
 - > Professional services: Information about how and where to refer those families in need of more than parent-to-parent support.

LESSONS LEARNED

To provide comprehensive care for families, health care providers must acknowledge and understand the need to support families through the stages of perinatal crisis. Indiana must increase the number of families who receive needed resources and supports. This may require the reallocation of resources in order to ensure families receive appropriate and timely support. Hospital and community-based health partnerships are essential to ensuring that all families have access to support when they need it.

Indiana Resources

- www.inf2f.org—Family to Family offers information, resources, and connections for families nurturing children with special needs.
- www.in.gov/fssa/first_step—First Steps provides information about a variety of disabilities.
- www.in.gov/isdh/programs/mch/ifh.htm/—Indiana State Department of Health (ISDH) helpline providing information, referrals, consumer education, advocacy and follow-up to individual callers on a variety of topics.
- www.ipin.org/resourcedirectory.asp—ASK (About Special Kids, previously Indiana Parents Information Network) provides information, peer support, education, and an array of resources and information on specific topics for families of children with special needs.
- www.indianaperinatal.org—The Indiana Perinatal Network (IPN), a leader in perinatal education and advocacy, strives to improve health care for Indiana's mothers and babies.
- www.connect2help.org—IRNI makes its extensive listing of health and human service organizations and programs available to people in central Indiana.
- www.marchofdimes.com/share—March of Dime's site for parents to share their stories, participate in online discussions about premature babies, and meet other NICU families.
- www.mentalhealthassociation.com/entrance.htm—Links from the Mental Health Association to other mental-health-related sites.
- www.nacersano.org—Culturally competent, Spanish language perinatal health information from the March of Dimes.
- www.neofight.org—Neo-Fight's 24-hour parent-to-parent support for families experiencing a perinatal crisis, provides parent speakers and hospital visitations.
- www.familycenteredcare.org—The Institute for Family-Centered Care provides leadership to advance the understanding and practice of patient- and family-centered care in hospitals and other health care settings. Patient- and family-centered care is grounded in mutually beneficial partnerships among health care patients, families and providers.

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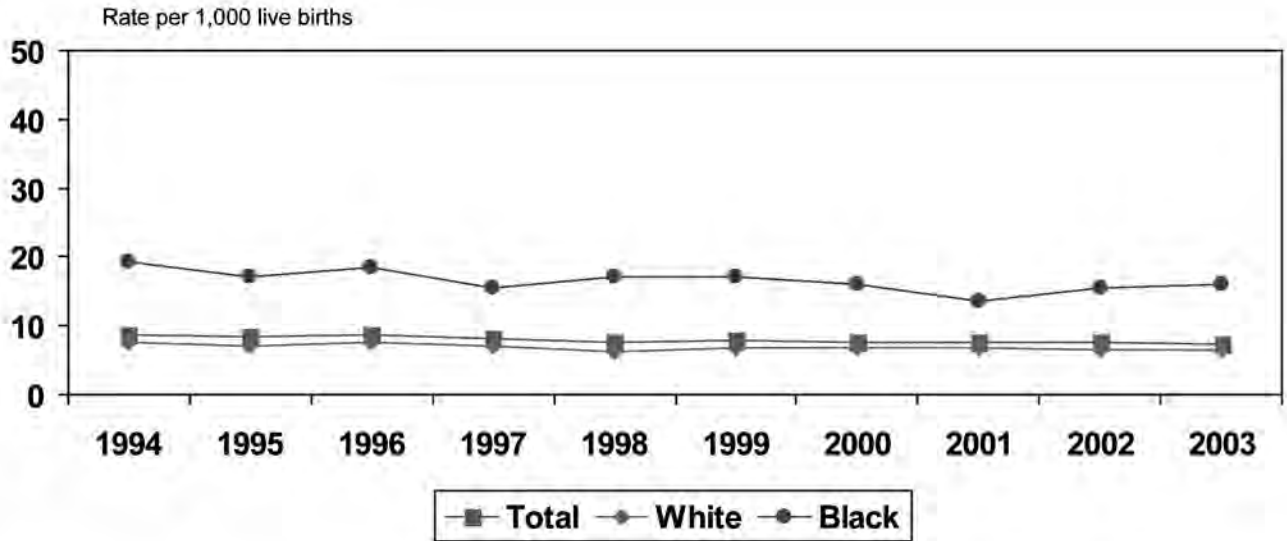
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Appendix A Birth Rate Information for Indiana

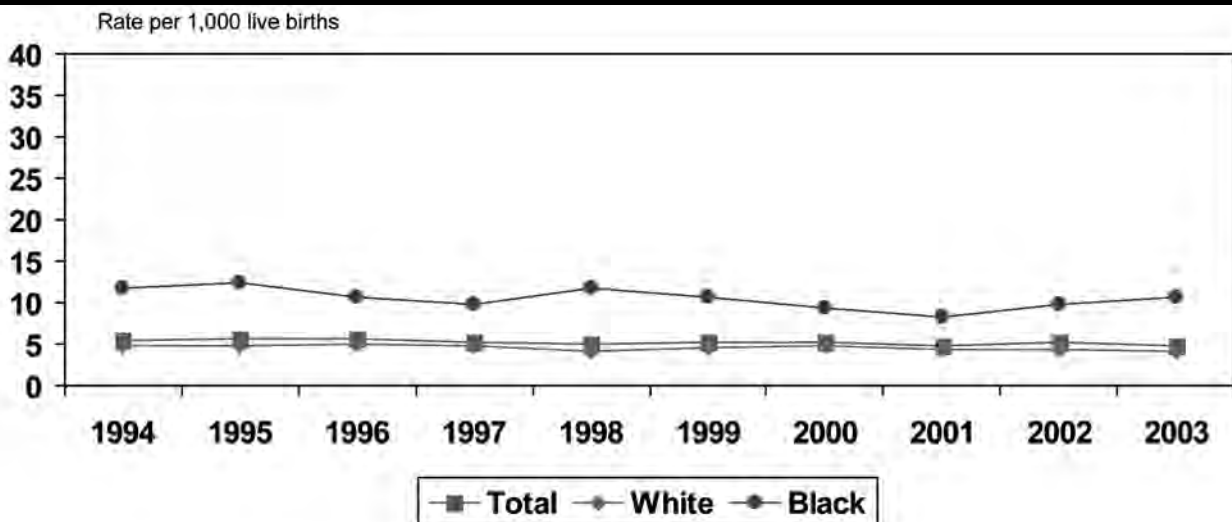
Indiana's Infant Mortality Rates by Race (1994-2003)



| | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 |
|-------|------|------|------|------|------|------|------|------|------|------|
| Total | 8.8 | 8.3 | 8.7 | 8.1 | 7.5 | 7.8 | 7.7 | 7.6 | 7.6 | 7.4 |
| White | 7.6 | 7.2 | 7.5 | 7.2 | 6.3 | 6.8 | 6.7 | 6.8 | 6.5 | 6.4 |
| Black | 19.2 | 17.0 | 18.4 | 15.6 | 17.1 | 17.0 | 15.9 | 13.6 | 15.6 | 15.9 |

Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team, 2006

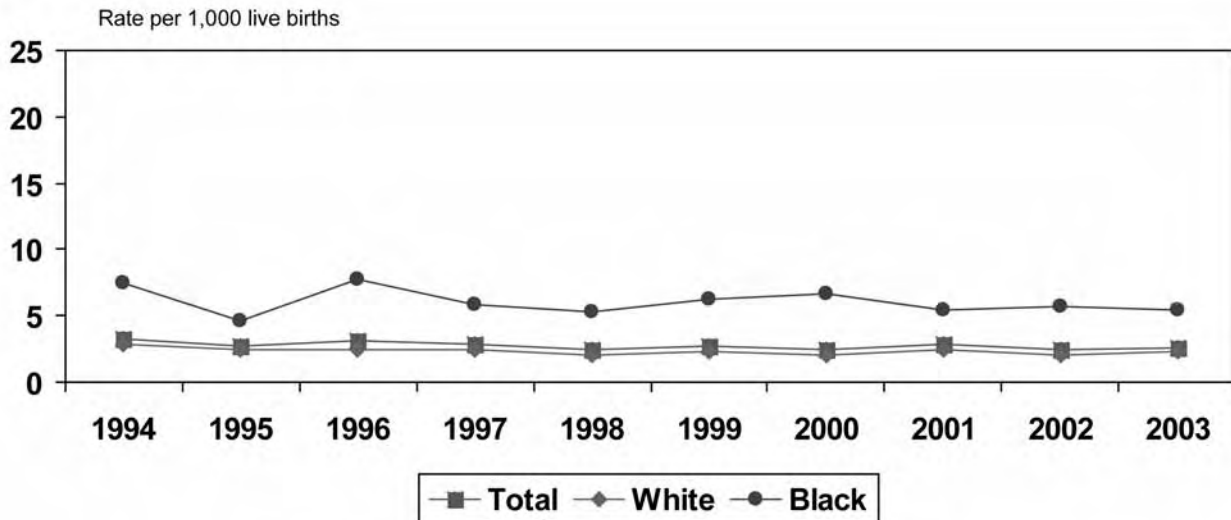
Indiana's Neonatal Mortality Rates by Race (1994-2003)



| | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 |
|-------|------|------|------|------|------|------|------|------|------|------|
| Total | 5.5 | 5.6 | 5.6 | 5.2 | 5.1 | 5.2 | 5.2 | 4.8 | 5.2 | 4.8 |
| White | 4.8 | 4.8 | 5.0 | 4.7 | 4.2 | 4.5 | 4.7 | 4.4 | 4.4 | 4.1 |
| Black | 11.7 | 12.5 | 10.7 | 9.7 | 11.8 | 10.7 | 9.3 | 8.3 | 9.8 | 10.6 |

Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team, 2006

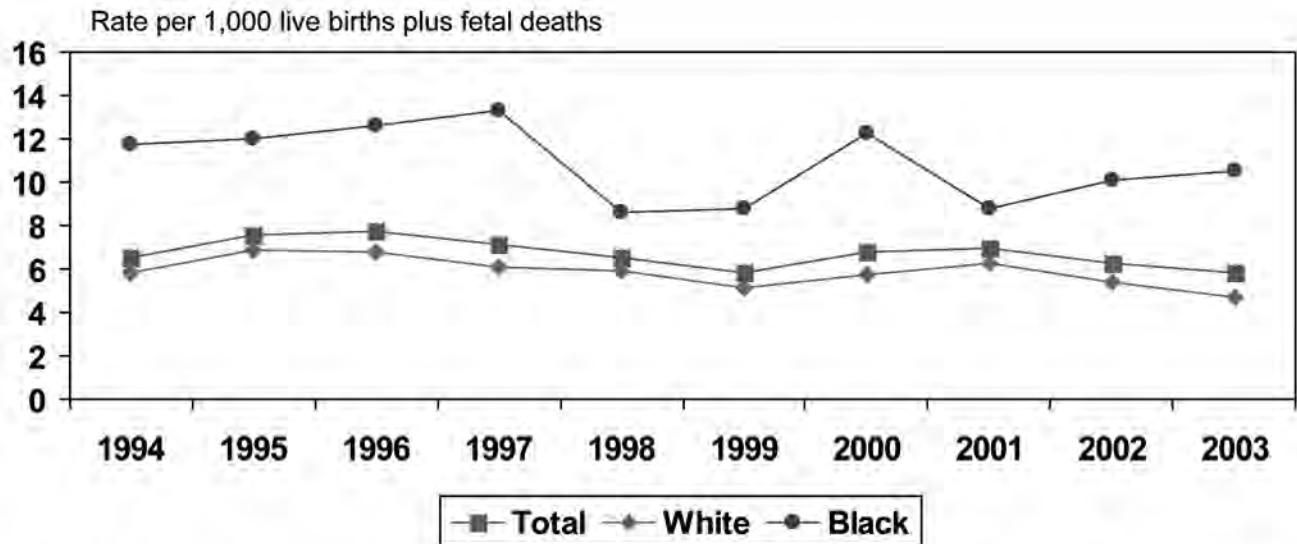
Postneonatal Mortality (1994-2003)



| | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 |
|-------|------|------|------|------|------|------|------|------|------|------|
| Total | 3.3 | 2.7 | 3.1 | 2.9 | 2.4 | 2.7 | 2.5 | 2.8 | 2.5 | 2.6 |
| White | 2.8 | 2.4 | 2.5 | 2.5 | 2.0 | 2.3 | 2.0 | 2.5 | 2.0 | 2.3 |
| Black | 7.5 | 4.6 | 7.7 | 5.8 | 5.3 | 6.3 | 6.6 | 5.4 | 5.7 | 5.4 |

Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team, 2006

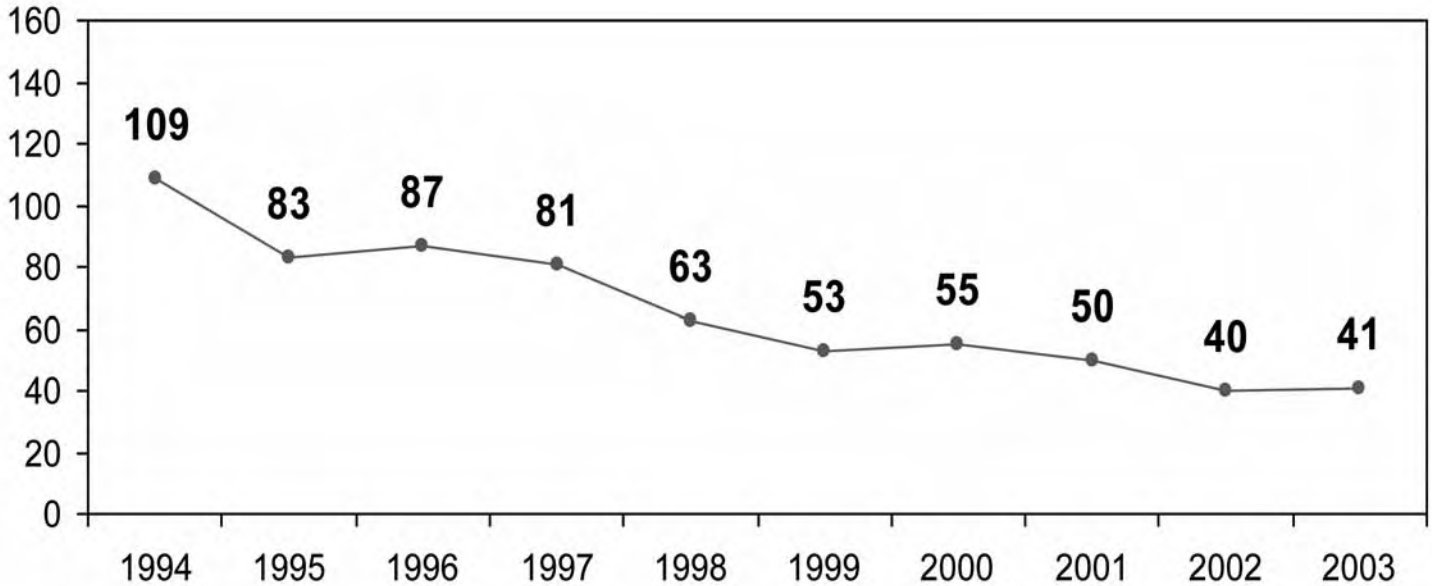
Indiana's Fetal Mortality Rates by Race (1994-2003)



| | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 |
|-------|------|------|------|------|------|------|------|------|------|------|
| Total | 6.5 | 7.6 | 7.7 | 7.1 | 6.5 | 5.8 | 6.8 | 7.0 | 6.3 | 5.8 |
| White | 5.8 | 6.9 | 6.8 | 6.1 | 5.9 | 5.1 | 5.7 | 6.3 | 5.4 | 4.7 |
| Black | 11.7 | 12.0 | 12.6 | 13.3 | 8.6 | 8.8 | 12.3 | 8.8 | 10.1 | 10.5 |

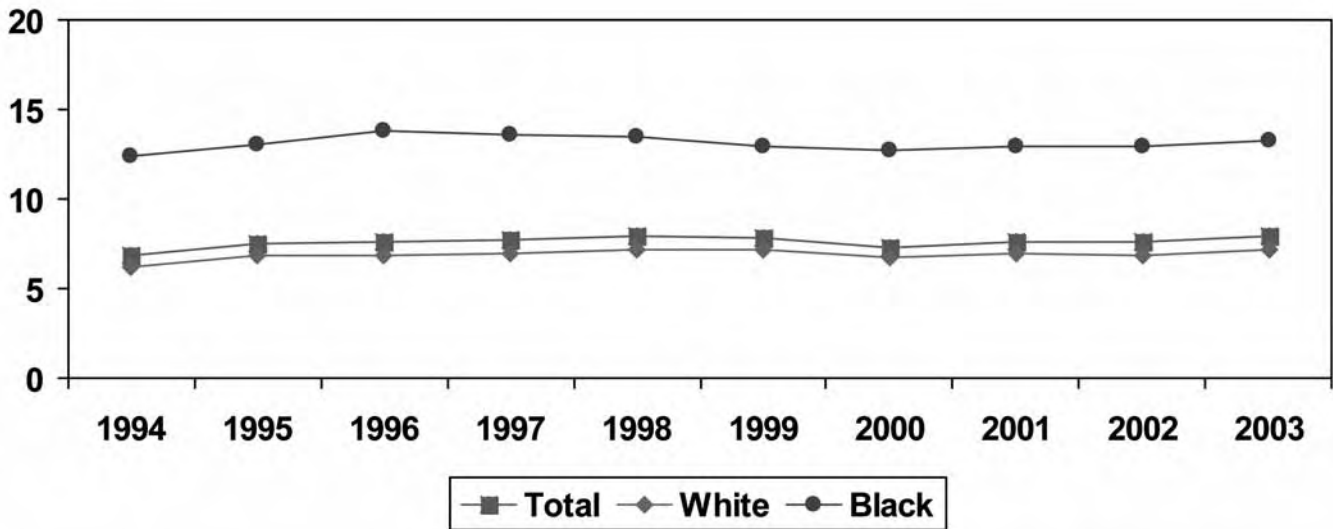
Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team, 2006

Number of SIDS Deaths (1994-2003)



Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team, 2006

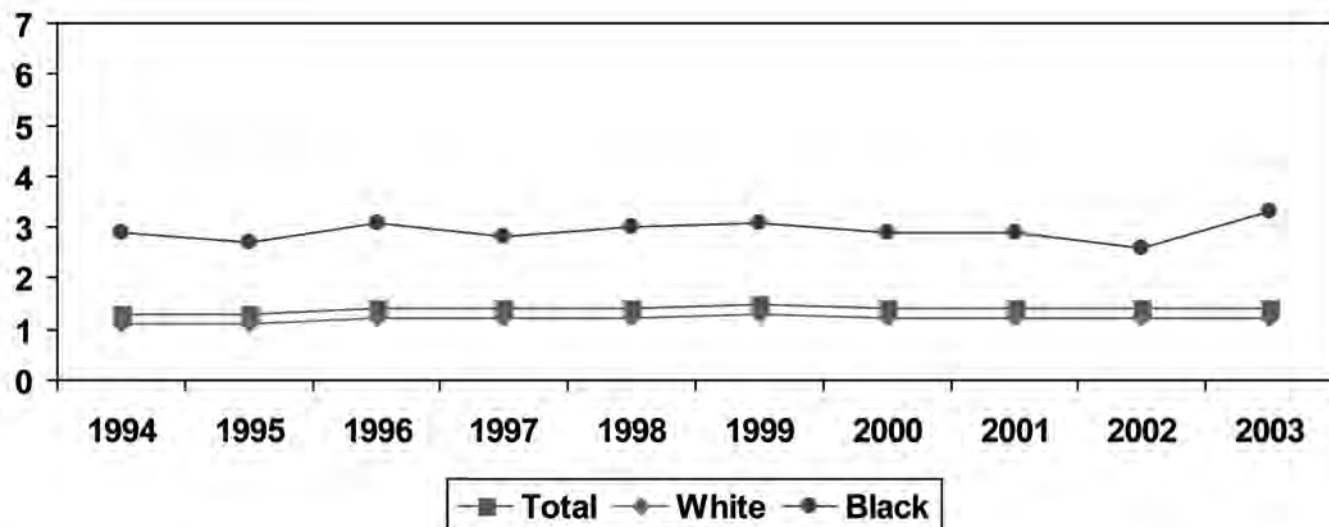
Percent Low Birthweight by Race (1994-2003)



| | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 |
|-------|------|------|------|------|------|------|------|------|------|------|
| Total | 6.8 | 7.5 | 7.6 | 7.7 | 7.9 | 7.8 | 7.3 | 7.6 | 7.6 | 7.9 |
| White | 6.2 | 6.8 | 6.8 | 7.0 | 7.2 | 7.2 | 6.7 | 7.0 | 6.9 | 7.2 |
| Black | 12.4 | 13.0 | 13.8 | 13.6 | 13.5 | 12.9 | 12.7 | 12.9 | 12.9 | 13.3 |

Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team, 2006

Percent Very Low Birthweight by Race (1994-2003)



| | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 |
|-------|------|------|------|------|------|------|------|------|------|------|
| Total | 1.3 | 1.3 | 1.4 | 1.4 | 1.4 | 1.5 | 1.4 | 1.4 | 1.4 | 1.4 |
| White | 1.1 | 1.1 | 1.2 | 1.2 | 1.2 | 1.3 | 1.2 | 1.2 | 1.2 | 1.2 |
| Black | 2.9 | 2.7 | 3.1 | 2.8 | 3.0 | 3.1 | 2.9 | 2.9 | 2.6 | 3.3 |

Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team, 2006