PERINATAL Perspectives

FOCUS: Late Preterm Birth in Indiana

Volume 14 • Issue 2 • 2010 • News from the Indiana Perinatal Network (IPN) • www.indianaperinatal.org

ISDH UPDATE – New Faces at the Indiana State Department of Health

Greg Larkin, M.D., FAAFP
State Health Commissioner

Dr. Larkin was appointed by Governor Mitch Daniels as the Indiana State Health Commissioner in March 2010. Prior to his appointment, Dr. Larkin served as the chief medical officer for the Indiana Health Information Exchange, which promotes health information technology for the advancement of quality patient and community care, since retiring from Lilly in 2007. He is a recognized leader in the promotion of health information and technology and will extend Indiana's recognized preeminence in that area.

Before joining the Indiana Health Information Exchange as its Chief Medical Officer, Dr. Larkin was the Director of Corporate Health Services for Eli Lilly and Company. He has been a member of the Healthy Indiana Plan task force, served as chairman of the board of the Indianapolis Medical Society and the Indiana Blood Center, and volunteered with many other medical and community organizations.

Prior to his work at Eli Lilly, Dr. Larkin practiced family medicine in Greencastle, Indiana from 1975-1986. He is a graduate of Indiana University School of Medicine and has been board certified in family medicine.

Mary Weber joined the Indiana State Department of Health (ISDH) as the Director of the Division of Maternal and Child Health in October of 2009. Since joining the ISDH, Mary has been re-organizing the MCH division to better reflect the Life Course Perspective approach to improving health outcomes for women and children in Indiana. She looks forward to working with state and community partners to address not only access to quality health care, but also the social, emotional, environmental, and economic determinants that affect health.

Prior to joining the ISDH, Ms. Weber served in leadership roles related to maternal and child health for over twenty years in both for-profit and not-for-profit corporations. Most recently, she was the administrator for Women's Health for the Clarian Health System in Indiana, responsible for strategic planning, program development, labor management, and overall operational administration.

Ms. Weber has been active on many volunteer boards, including the Indiana State Perinatal Advisory Board, the Indiana University National Center of Excellence for Women's Health, the Indiana Mothers' Milk Bank, and Covering Kids and Families. She led the effort to establish the Indiana Mothers' Milk Bank, which pasteurizes human milk from screened donors and distributes it to newborn intensive care units throughout the Midwest. Ms. Weber received her Master's degree in Nursing Administration from Indiana University School of Nursing, and is board certified as a Nurse Executive Advanced.

IPN Update – IPN Honors Spirit of Service Award Winners

An Indiana physician and two non-profit organizations were recently honored with Spirit of Service awards at IPN's annual forum, Controversies & Innovations in Perinatal Health.

Laurie Valera, MD, of Vermillion Parke Community Health Center received the Advocacy Award for her remarkable commitment to ensuring that young women in her rural community have access to comprehensive, quality prenatal care. After completing her residency, Dr. Valera chose to practice in a rural area and has since been a tireless advocate for high standards of care for the underserved.

The Marilyn Graham Community Service Award was presented to **Bloomington Area Birth Services (BABS)**. BABS is an incredible example of a small organization making a difference in its community. BABS not only offers childbirth education and referrals, but also prenatal and postnatal yoga and exercise, breastfeeding support, doula training, parent-baby playtime, support groups, a retail store, and professional seminars and conferences. BABS also partners with many other groups to offer additional services and support to area families.

Finally, **Indianapolis Healthy Start** was awarded the Julie A. Foster Communication Award for their Folic Acid Campaign. In response to a recent study linking folate supplementation to a reduction in premature births, IHS relaunched a multimedia campaign, utilizing posters, bus cards, radio spots, ads and newspaper articles in both English and Spanish to highlight the importance of folic acid. IHS also partnered with St.Vincent Women's Hospital to extend the campaign to all of Marion County, and estimates that 500,000 individuals have been reached by the campaign since the initial launch in 2005.

IPN congratulates the winners, as well as all of our nominees, for their outstanding work to improve the health of mothers and babies in Indiana.

The mission of the Indiana Perinatal Network is to lead Indiana to improve the health of all mothers and babies.

INDIANA PERINATAL NETWORK
Lead/Convene/Collaborate for Mothers & Babies
www.indianaperinatal.org

Perinatal Perspectives

A Publication of the Indiana Perinatal Network (IPN)

IPN thanks these individuals for their contributions to Perinatal Perspectives and its editorial standards.

EDITORIAL REVIEW BOARD

Tina Babbitt, RN, MSN, IBCLC
Perinatal Education Coordinator, IPN

Julia Tipton Hogan, MPA
Community Outreach Coordinator, IPN

Larry Humbert, MSSW, PG Dip
Executive Director, IPN

Sarah Hundagen
Program Services Coordinator, IPN

Beth Johnson, RN, MSN
State Perinatal Liaison, ISDH

Lauri McCoy, RN, MSN

CLINICAL CONSULTANTS

Lauren Dungy-Poythress, MD
Community Health Network

Howard Harris, MD
Retired Neonatologist

Mureena Turnquest Wells, MD
Maternal Fetal Medicine
St. Mary's Hospital, Evansville

Views and opinions expressed herein are those of contributing authors and do not necessarily reflect those of the Indiana Perinatal Network (IPN).

IPN welcomes stories and photo contributions. Send submissions to IPN, 1991 East 56th St., Indianapolis, IN 46220, Attn: Perinatal Perspectives Editor, or e-mail: ipn@indianaperinatal.org. For information on advertising, e-mail: ipn@indianaperinatal.org

1991 East 56th Street
Indianapolis, IN 46220
P: 317.924.0825 • F: 317.924.0831
E: ipn@indianaperinatal.org

Indiana Perinatal Network Staff

Larry Humbert, MSSW, PG Dip
Executive Director
lhumbert@indianaperinatal.org

Leah Sumners York
Director of Operations
lyork@indianaperinatal.org

Tina Babbitt, RN, MSN, IBCLC
Perinatal Education Coordinator
tbabbitt@indianaperinatal.org

Tina Cardarelli, IBCLC, RLC, CLE
State Breastfeeding Coordinator
tcardarelli@indianaperinatal.org

Gayla Hutsell Guignard, MA CCC-A/SLP, CERT AVT
State EHDI Coordinator
ghutsell@isdh.IN.gov

Barbara Himes, CLC
SIDS and Infant Loss Program Coordinator
sidsbhimes@aol.com

Julia Tipton Hogan, MPA
Community Outreach Coordinator
Jthogan@indianaperinatal.org

Sarah Hundagen
Program Services Coordinator
shundagen@indianaperinatal.org

Amy Korbe
Office Coordinator
akorbe@indianaperinatal.org

Sherry Matemachani
Special Projects Coordinator
sherrym@wellnessteaminc.com

Caitlin Finnegan Priest, MPH
Director of Special Projects & Public Policy
cpriest@indianaperinatal.org

2010 Education Partners

Your Ad Here!

Advertise in ***Perinatal Perspectives***

The Indiana Perinatal Network is now offering ad space in the *Perinatal Perspectives* newsletter distributed to healthcare professionals statewide.

COST $100/issue or $250/year (3 issues)
SIZE Quarter page

For More Information (including file specifications)

VISIT www.indianaperinatal.org
PHONE 866.338.0825
E-MAIL ipn@indianaperinatal.org

Donor Spotlight: Managed Health Services (MHS)

IPN salutes **Managed Health Services**, one of Indiana's three Medicaid Managed Care Organizations, for its support and commitment to improving access to and quality of care for Indiana's mothers and babies. An IPN Corporate Partner since 2007, MHS has signed on as an exhibitor at all three of IPN's statewide Forums, and has purchased and distributed numerous copies of IPN's substance use DVD, *Integrating Screening and Treatment of Substance Use into Prenatal Care*, to its providers. "In addition to providing quality care, MHS has always shown a commitment to the communities it serves, and to grassroots-level involvement," says IPN Executive Director **Larry Humbert**. "We appreciate their partnership with IPN and look forward to continuing to collaborate on our shared goals of healthier moms and babies."

Going the Extra Mile

The **Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)** is the leading professional association for nurses who specialize in the care of women and newborns. The Indiana chapter members include neonatal nurses, APRNs, women's health nurses, OB/GYN and labor and delivery nurses, childbirth educators, nurse practitioners, as well as nurse executives and nurse managers. AWHONN advances the nursing profession by providing nurses with critical information and support to help them deliver the highest quality care for women and newborns.

IPN welcomes Indiana AWHONN as a new Corporate Partner member this year. Through this partnership, AWHONN provides a representative on the State Perinatal Advisory Board, reviews IPN consensus documents as content experts, and helps to promote IPN's Regional Training Series. In addition, the East/Central chapter is collaborating with IPN on a chapter meeting in Muncie in July.

The Indiana Section of AHWONN and the Indiana ACNM (American College of Certified Nurse Midwives) are co-sponsoring a fall conference to be held December 10 in Indianapolis. For conference updates and more about AWHONN, visit the Indiana AWHONN chapter website: http://indianaawhonn.webs.com

AWHONN's Core Values

- **C**ommitment to professional and social responsibility
- **A**ccountability for personal and professional contributions
- **R**espect for diversity of and among colleagues and clients
- **I**ntegrity in exemplifying the highest standards in personal and professional behavior
- **N**ursing Excellence for quality outcomes in practice, education, research, advocacy and management
- **G**eneration of Knowledge to enhance the science and practice of nursing to improve the health of women and newborns

Legislative and Policy Update

Health Care Reform Legislation: How does it impact maternal and child health?

Several provisions in the newly passed health care reform legislation affect maternal and child health programs and professionals. While additional information and details are forthcoming, here are some highlights:

Maternal, Infant and Early Childhood Home Visiting Programs will receive a mandatory appropriation of $100 million for FY 2010 and increasing in subsequent years until 2015. The bill will require States, as a condition of receiving the MCH block grant funds for FY2011, to conduct a needs assessment by September 2010 to identify communities that are at risk for poor maternal and child health and have few quality home visitation programs.

New Sections Added to Title V: The bill provides an initial grant of $3 million to support **Services to Individuals with a Postpartum Condition and their Families, including perinatal mood disorders**; however, no funds have been appropriated yet. The bill also provides mandatory appropriations of $55 million for Fiscal Years 2010 – 2014 for Personal Responsibility Education on both abstinence and contraception for **prevention of teenage pregnancy**.

Restoration of Funding For Abstinence Education. Appropriates $50 million per year through FY 2014 for abstinence education.

Community Health Center Funding: Creates a Community Health Center Fund that provides $11 billion in mandatory funding (over five years) for the Community Health Center program. An appropriation of $1 billion will begin in FY 2011.

New Option for Medicaid Family Planning Expansion. States will now have the option to expand Medicaid eligibility for family planning services without the cumbersome process of obtaining a federal waiver—the process in which Indiana is currently engaged. IPN is collaborating with state agencies and other individuals and organizations to explore this new avenue.

Breastfeeding Breaks for Nursing Mothers in the Workplace: Employers of more than 50 employees must now provide "reasonable" unpaid breaks to nursing mothers to express milk for their infants under an amendment to the Fair Labor Standards Act, unless doing so would "impose an undue hardship by causing the employer significant difficulty or expense."

Additional details are available from the Association of Maternal & Child Health Programs' Health Reform Resources section at http://www.amchp.org/Advocacy/health-reform/Pages/default.aspx.

Other Women's Health Provisions:

Equitable Reimbursement of Midwives under Medicare: Establishes reimbursement for CNMs at 100% of the Part B fee schedule, equivalent to physicians.

Coverage for freestanding birth center services. Provides for coverage of services provided by free-standing birth centers under Medicaid.

Advanced Nursing Education Grants. Strengthens language for accredited nurse-midwifery programs to receive advanced nurse education grants in Title VIII of the Public Health Service Act.

Nurse Education, Practice, and Retention grants. Awards grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention.

Additional details are available from the American College of Nurse Midwives' Health Care Reform section at http://www.midwife.org/health_care_reform.cfm.

For more information, contact Caitlin Priest, MPH, Director of Special Projects and Public Policy at cpriest@indianaperinatal.org or (317) 924-0825.

FOCUS

Late Preterm Birth in Indiana

Late Preterm Birth in Indiana – What's The Problem?

- According to the March of Dimes report *Born too Soon in America*, Indiana **received a grade of D for its 2007 preliminary preterm birth rate of 12.9%**. Indiana's high rate of smoking among women of childbearing age (29%) was deemed a major contributing factor.

- ISDH data indicates that **the greatest increase in early births is occurring among infants born between 34 and 38 weeks**. Babies born just a few weeks too soon (34-36 weeks gestation, or "late preterm") have higher rates of death and disability than full-term babies. Even infants born at 37-38 weeks ("near term") have an increased risk for problems compared to infants born at 39 weeks.

- ISDH birth records from 1990-2006 show that **preterm rates were persistently higher among non-Hispanic blacks** compared to non-Hispanic whites and Hispanics. However, preterm rates have increased noticeably (40%) among non-Hispanic whites. Records also indicate that in 2006, **29.3 percent of Indiana births were delivered by cesarean section**, a 48% increase from 1997. These c-section births also showed the highest increase in preterm delivery. View the complete ISDH presentation at http://www.indianaperinatal.org/sections/spab1109.php.

- **Among births to women on Medicaid during 2007, 40% occurred before 38 weeks gestation.** Of these early births, 30% were between 37 and 38 weeks, 7% were between 34 and 36 weeks, and 3% were 33 weeks and under.

IPN's Response

Acknowledging the growing prevalence and burden of premature births in Indiana, IPN engages in a variety of provider, consumer, and policy-level initiatives designed to reduce and mitigate the impact of preterm birth.

Among these efforts, the Indiana Perinatal Network…

Helped convene the Indiana Preterm Birth Initiative. Launched in September 2009, the Indiana Preterm Birth Initiative is jointly sponsored by the March of Dimes, the Indiana State Department of Health, and IPN. In its inaugural session, the group convened a meeting of over 20 organizations representing maternal-child health interests statewide to discuss data, outcomes, and recommendations regarding late preterm birth in Indiana. The second meeting of the group, which addressed next steps, occurred in May.

Convenes and connects key providers and decision-makers with the knowledge and influence to affect birth outcomes. In September, IPN—in conjunction with the Indiana State Department of Health and the Indiana Hospital Association—will host a Summit for administrators and OB directors from each of Indiana's birthing hospitals (see article). The focus of the Summit will be the new Joint Commission measures related to perinatal care and the CDC National Survey of Maternity Practices in Infant Care (mPINC).

Equips providers and hospitals with the skills and tools to care for babies born too soon. With the support of St. Vincent Women's Hospital, IPN helps organize and host the Perinatal Continuing Education Program (PCEP), a comprehensive program published by the American Academy of Pediatrics designed to enhance the skills of clinical perinatal healthcare providers. Incorporating simulation training, components of the STABLE neonatal stabilization program, and NICHD fetal monitoring terminology, PCEP strengthens referral relationships between Level I and II hospitals and tertiary facilities.

Advocates for improved and consistent screening and treatment of substance use during pregnancy. In recognition of the correlation between alcohol, tobacco, and other drug (ATOD) use during pregnancy and preterm delivery, IPN has been a longtime proponent of improving education, training, and policies surrounding ATOD use and treatment. IPN convened a widely-hailed substance use summit, developed a consensus statement on the issue, was a participant on the Indiana General Assembly's Prenatal Substance Use Commission, and has produced and distributed nearly 1,000 provider training DVDs.

Ask The Expert

By **Claire Boissevain-Crooke**, BA, RN, Office of Philip A. Crooke, M.D.

What can OB offices and prenatal care providers do to encourage term delivery among their patients?

It is so important to talk to your patients throughout the pregnancy. They need empathy, they need to know they are normal pregnant women, and they need anticipatory guidance. If the office treats the miseries of pregnancy as normal, expected, and great signposts of progress on the path through pregnancy, it is easier for mom to accept the discomforts and see them as positive. Here are some suggestions for responding to common questions and concerns that can help you emphasize the importance of a term pregnancy:

I'm confused about how long pregnancies last—9 months? 40 weeks?

We talk about how a term pregnancy is not 9 months but 10 months or 40 weeks, and just as you don't celebrate your baby's first birthday until he has completed a year, you don't get to be 20 weeks pregnant until the end of the 20th week. I also explain that only 8% of babies come on their due date and that the vast majority of first babies come late –so they can put a star on the calendar for their due date but they can't get their hopes up. They'll know their baby's birth date after the baby comes and not before. And since some of the pregnancy websites seem to use a different dating system, we talk about how we count them pregnant from their last menstrual period (LMP) date, when we know they weren't actually pregnant yet.

"If the office treats the miseries of pregnancy as normal, expected, and great signposts of progress on the path through pregnancy, it is easier for mom to accept the discomforts and see them as positive."

How early in pregnancy will my baby be ok if it were born?

My answer: 40 weeks. I explain that every baby develops a little differently, but that most babies can't reliably breathe until after 38 weeks and that really important brain development happens between 39 and 40 weeks. Babies take 40 weeks to cook and they're just not done until that time.

But what about all those babies that are born early? I know there are babies born at 23 weeks that seem fine!

Many of those babies will never be completely ok and might never achieve their full potential. If labor starts before a certain point in pregnancy (and this varies depending on the patient and medical situation) we will make every effort to stop it. I explain that we really want all moms to get to 35 weeks, we feel a little better at 37 weeks, but we don't feel happy about a delivery until we get to 40 weeks.

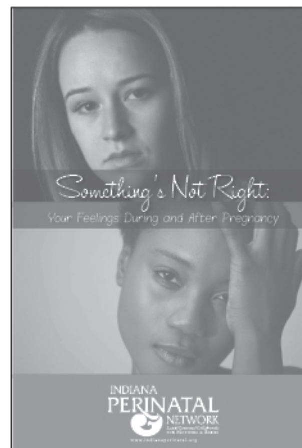
I'm so uncomfortable, I can't sleep, I don't want to be pregnant anymore.

The myth of blissful pregnancy is something we need to caution our patients against. You should be uncomfortable! If pregnancy and labor were easy, your newborn would seem like hard work. If you slept well until your baby came home you would resent him, but by the time he is born you are used to not sleeping and being up with him seems normal. I show patients illustrations that compare how their insides fit before pregnancy with how they fit at the end of pregnancy. Once a mom sees those pictures it is clear why she is uncomfortable, is not able to eat, voids every few minutes, and is plagued by indigestion. It is important for women to know that their experience is normal and they are not unique. We do talk about comfort measures –using lots of pillows for support when they are lying down, back rubs, small meals, etc.—but there is a point where nothing is going to work for very long and I think it is important to be honest about that.

I like to emphasize that pregnancy is not just about you—it's about your baby. Ultimately you have to make choices that are in the interests of your child's long-term safety and well-being, not your short-term personal comfort or desires. We reinforce the message: You're the mom. What will be your parenting decision knowing your baby isn't ready to come out until 40 weeks?

To contact Claire Boissevain-Crooke, BA, RN, email c.b.crooke@gmail.com.

Something's Not Right:
Your Feelings During and After Pregnancy



IPN's Perinatal Mood Disorders brochure has a new look!

The newly redesigned English version of our popular brochure explores the differences between "baby blues" and depression during and after pregnancy, and explains how perinatal mood disorders (PMD) can affect the baby.

Order now at www.indianaperinatal.org

From the Research

Research Sheds Light on Increasing Cerebral Palsy Rates among Preemies

New research sheds light on why cerebral palsy rates are increasing among infants born prematurely in the United States. This new study, which looked at placentas from 222 preterm births, found that cerebral palsy is associated with connective tissue inflammation in the umbilical cord. The inflammation—and infection—occurs more often in cases of preterm labor and premature rupturing of the amniotic sac, and is less common in premature births that occur because of preeclampsia. "These findings are valuable, as we continue to study the link between premature births and cerebral palsy," **Dr. John Gianopolous**, chair of the obstetrics and gynecology department at Loyola University Health System, said in a news release. "While further investigation is needed, managing inflammation may reduce the risk of certain complications in these infants."

Article available at http://www.healthfinder.gov/news/newsstory.aspx?docID=635883

Report Highlights Trends in Late Preterm Births

According to a recent report from the National Center for Health Statistics (NCHS), more than 900 "late preterm" births occur every day in the US, with more than 333,461 occurring each year. The percentage of babies born preterm in the US has increased by more than 20 percent between 1990 and 2006, with most of these babies born during the later preterm period (34 to 36 weeks of gestation). The NCHS report, "Born a Bit Too Early: Recent Trends in Late Preterm Births" also shows an increase in the number of late preterm births resulting from induced labor or cesarean delivery. Overall, increases were seen for mothers of all ages, and for whites and Hispanics. The late preterm birth rate for African American mothers declined during the 1990s, but has continued to rise since 2000.

To access the report online, go to http://www.cdc.gov/nchs/data/databriefs/db24.htm

Study: Impact of Low Birth Weight, Preterm Birth on Motor Development

A study published in the November 25th edition of the Journal of the American Medical Association (JAMA) investigates the relationship between very preterm birth and very low birth weight (VLBW) on a child's motor development. For the purposes of the study, "very preterm" was defined as being born at less than 32 weeks of gestation and VLBW was defined as weighing less than 1500 grams. In comparison with peers who were born full terms, very preterm and VLBW babies had lower scores on tests of motorskills, including some deficits that continued during elementary school and early adolescence.

To access the study online, go to http://jama.ama-assn.org/cgi/content/short/302/20/2235?home

Resources for Parents and Families

American Academy of Pediatrics' Preterm Milestones

The AAP's "Milestone Guidelines for Premature Babies," has been updated and integrated into the Healthy Children section for parents on the AAP website. The brochure encourages families to be active observers of their preterm baby's development, to focus attention on their child's strengths, and to be aware of areas where they need more support. It includes guidelines that help parents convert full-term-baby milestones into preterm-baby milestones, and provides questions for parents to discuss with their child's healthcare provider.

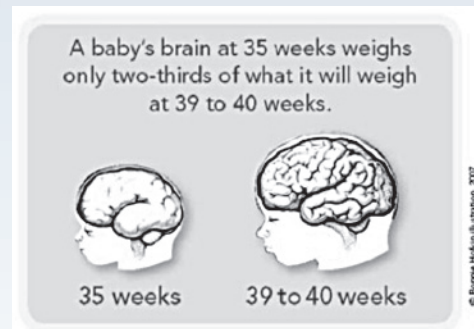
Source: National Healthy Mothers, Healthy Babies Coalition. View the AAP Guidelines online at http://www.healthychildren.org/English/ages-stages/baby/preemie/pages/Preemie-Milestones.aspx

Text4Baby

Text4baby is a free mobile information service designed to promote maternal and child health. An educational program of the National Healthy Mothers, Healthy Babies Coalition (HMHB), text4baby provides pregnant women and new moms with information they need to take care of their health and give their babies the best possible start in life. Women who sign up for the service by texting BABY (or BEBE for Spanish) to 511411 will receive free SMS text messages each week, timed to their due date or baby's date of birth.

For more information, visit http://www.text4baby.org/

Why are the last weeks of pregnancy so important?



Source: March of Dimes, http://www.marchofdimes.com/prematurity/index_women_48590.asp

Quick Facts

Overview—*Preterm Birth in Indiana*:

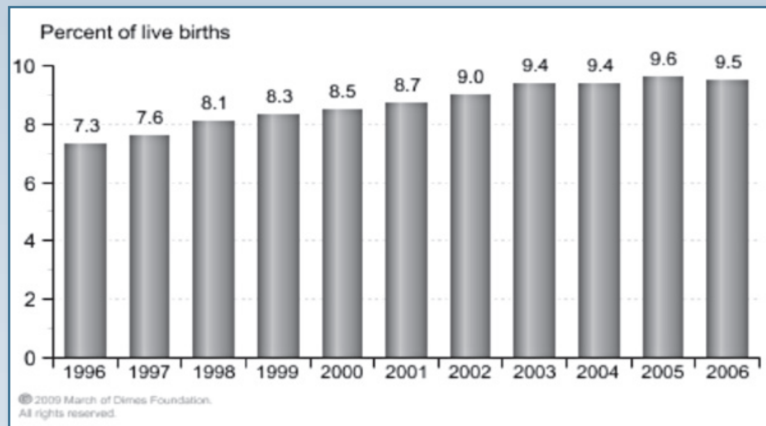
- In 2006, 13.2% of babies were born **preterm** (before 37 weeks)—representing more than a 23% increase since 1996. In the U.S. that same year, 12.8% of live births were preterm.

- In 2006, 9.5% of births were **late preterm** (between 34-36 weeks), compared to 9.1% in the U.S. Between 1996 and 2006, the rate of infants born late preterm in Indiana increased more than 30%.

- In 2006, 2.1% of live births were **very preterm** (less than 32 weeks) in Indiana, slightly higher than the U.S. rate of 2.0%.

Source: March of Dimes Peristats, http://www.marchofdimes.com/PeriStats/

Snapshot—*Late Preterm Birth in Indiana*:



Percent of births that are late preterm (34-36 weeks)

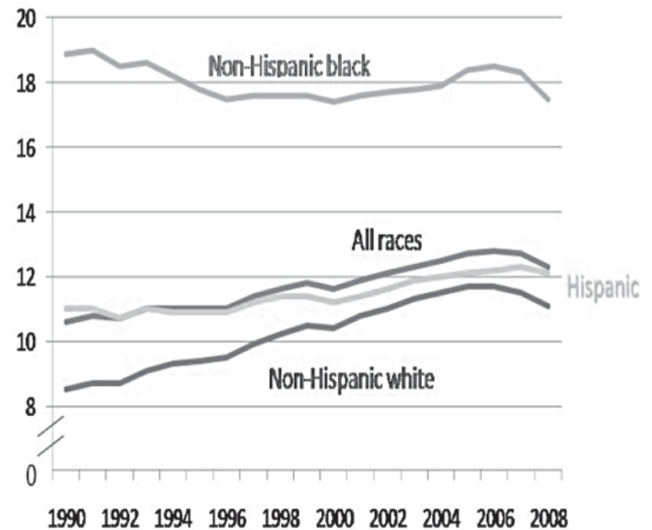


Figure 5. Preterm birth rates[1] by race and Hispanic origin of mother: United States, final 1990-2006 and preliminary 2007-2008

[1] Births <37 weeks of gestation per 100 total births.
Source: CDC/NCHS, National Vital Statistics System

A new report of preliminary birth certificate data for 2008 published by the National Center for Health Statistics shows that preterm births in the U.S. are down 3%, marking a second consecutive year of decline. (12.3% 2008 vs. 12.7% 2007) Nearly 80% of the decline occurred among late preterm babies. Access the full report at http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_16.pdf.

How can the Prenatal Care Coordinator help avert preterm birth?

An Interview with Diana Collins, RN, Prenatal Care Coordinator for Wishard Health Services

If you have a client that you think might be at risk for a preterm birth, what types of interventions would you try?

As a care coordinator, I would treat any client as someone at risk of preterm birth and begin teaching signs and symptoms of preterm labor. My assessment also includes questions about previous pregnancies, nutrition, and social support which I would incorporate in the teaching. Then if the client has been seen in the ER for preterm labor I would examine, with her, factors that could help improve her chances of reaching term.

Do you have an example of an intervention that you were able to make that either worked or didn't?

The best intervention I have used is education. When I sit and talk about what contractions might feel like I can tell my client what the textbooks say, but that is not what is going to help them understand. I begin with basics and help them to see and feel what they may experience. I want them to understand that "balling up" and contractions are the same so we can discuss what to watch for. I take the time to allow the client to ask a lot of questions and explain back to me whether she understands, which is something that can't happen in the clinic.

What is the attitude of your clients when it comes to having their baby early? Do they understand the risks to a late preterm baby?

I think most women understand the need to go full term for a healthy baby. Understanding what full term means is sometimes hard to get across. I use a hand out that is a weekly account of how the baby develops and I break it down by month and trimester so it all makes sense. I don't think I have ever worked with a woman who did not take care of herself so she would deliver early.

IPN has new services for Indiana's Prenatal Care Coordinators (PNCC)

- IPN has developed a new monthly PNCC e-newsletter. To receive the e-newsletter, visit the IPN website and click on 'Add me to the email list' on the home page, then check 'Prenatal Care Coordination'.
- Visit the Prenatal Care section on the Provider Tab of IPN's website to get the latest information on Medicaid PNCC services for pregnant women
- Watch for information on PNCC networking sessions in your area soon!

New Perinatal Care Core Measures Set by Joint Commission

In late 2007, The Joint Commission's Board of Commissioners recommended retiring and replacing the Pregnancy and Related Conditions measure set with an expanded set of evidence-based measures. A technical advisory panel comprising experts in the perinatal care field was convened in February 2009 to select the replacement set of measures from among those endorsed for national use by the National Quality Forum.

This expanded measure set, now referred to as Perinatal Care (PC), includes the following measures:

- Elective delivery
- Cesarean section
- Exclusive breast milk feeding
- Antenatal steroids
- Health care–associated bloodstream infections in newborns

The PC measure set began with April 1, 2010 discharges.

For more information, visit http://www.jointcommission.org/PerformanceMeasurement/PerformanceMeasurement/Perinatal+Care+Core+Measure+Set.htm

IPN Hospital Summit to Define and Assess New Joint Commission, CDC Measures and Practices

The Indiana Perinatal Network, in cooperation with the Indiana State Department of Health and Indiana Hospital Association, will convene an invitation-only summit for hospital and birth center Administrators and Directors of OB Departments.

The focus of the summit, to be held September 24, 2010, will be the CDC National Survey of Maternity Practices in Infant Nutrition and Care (mPINC) and the new Joint Commission measures related to perinatal care.

This summit will educate key clinical and administrative hospital staff about breastfeeding, other perinatal practices, and the importance of developing sound internal policies and procedures to meet new quality improvement and regulatory standards.

The summit provides a unique opportunity for all hospitals to receive consistent information, discuss key issues, raise common questions and share emerging practices to address mPINC practices and the new Joint Committee measures. All hospitals will receive a "tool kit" of sample policies, procedures and best practice guidelines used to implement the perinatal measures and mPINC survey.

Key stakeholder agencies such as the Office of Medicaid Policy and Planning, managed care organizations, and professional associations will also be invited.

For more information, contact IPN at ipn@indianaperinatal.org or (317) 924-0825.

Breastfeeding Update

Breastfeeding and the Late Preterm Baby

By **Tina Cardarelli**, IBCLC State Breastfeeding Coordinator

By appearances, it is easy to assume that a late preterm baby is simply just a bit smaller than a 40 week, full term baby. This is not the case and very often becomes evident the first time the mother puts the baby to her breast.

The impact of late preterm birth on breastfeeding

The late preterm baby is at higher risk for a number of feeding difficulties, including weak suck, weight loss, jaundice, hypoglycemia, and respiratory distress. These babies are at high risk for breastfeeding failure and are much more likely to receive a significant amount of formula supplementation. Babies born even a week too soon are at a feeding disadvantage: they have smaller mouths which can make latching onto the breast very problematic, they have higher energy needs, take smaller amounts per feed, and tire more easily.

Often when a baby is born just a little too soon it is not acknowledged that this baby is at high risk for breastfeeding failure and a skilled breastfeeding clinician may not be consulted from the outset. Mom may be counseled to "just try breastfeeding and see how it goes", and supplementation has often begun before an International Board Certified Lactation Consultant (IBCLC) with experience working with this population of babies is called. Assisting the preterm mother-baby dyad until the infant is well established at the breast is a much longer and more labor intensive process for a breastfeeding educator.

Why is breastfeeding so vitally important for the late preterm infant?

During the last couple of weeks of pregnancy, the formed organs have their final stage of maturation in preparation for the baby's life outside of the womb. The last weeks of development are especially critical for brain development. The milk of the mother of a preterm baby is quite different from that of a full term baby—it is much higher in the components that promote brain myelinization than full term milk. Across the board, preterm milk is designed to meet the needs of the baby at its current stage of development, and possesses the anti-infective and immune building properties that protect this more vulnerable infant.

Since breastmilk is so important to the growth, protection, and maturation of the baby's brain and organs, a growing list of hospitals across Indiana and the rest of the country have adopted donor human preemie milk as their Standard of Care in their NICUs if a mom is unable to supply her own milk or is not able to provide an adequate supply.

What can we do to increase the odds that a preterm baby will be breastfed?

There are four simple steps that can increase a preterm baby's likelihood of getting breastmilk:

- Advise the mother of the connection between a preterm birth and a more complicated breastfeeding experience, and educate her on how important her breastmilk is to her baby.
- Bring the baby skin-to-skin as soon as possible after the birth and often thereafter. Many studies show that skin-to-skin contact is the most protective and optimal environment for baby.
- Encourage frequent feedings or use a breast pump to support and enhance Mom's milk supply.
- Consult with a skilled lactation clinician as soon as possible after the birth.

For additional information and resources, consult *Clinics in Human Lactation: Breastfeeding the Late Preterm Infant*, © 2009 by Marsha Walker, RN, IBCLC. Ordering information is available at http://www.ibreastfeeding.com/catalog/p215/Clinics-in-Human-Lactation:-Breastfeeding-the-Late-Preterm-Infan/product_info.html.

To contact Tina Cardarelli, IBCLC, email tcardarelli@indianaperinatal.org or call (317) 924-0825 ext. 4223.

Model Program: Indiana Hospital Policies Tackle C-Section, Induction, and Preterm Birth Rates

Across the state, hospitals are addressing the issue of reducing preterm births, inductions, and c-sections through a variety of methods, including policy initiatives. Both of the hospitals profiled below have developed a comprehensive labor induction policy, and have been willing to share their challenges and successes with other hospitals.

Reducing late preterm births will be one of the discussion topics at IPN's *Hospital Perinatal Summit: Linking Science with Practice* in September. Attendees will leave with a toolkit filled with practical information similar to the following case studies.

Case Study: Implementation of Elective Induction Policy in a Large/Urban Hospital

St. Francis Hospital & Health Services, Indianapolis IN

St. Francis Hospital & Health Centers is one of the largest health care systems in Indiana, with three main facilities in Beech Grove, Indianapolis and Mooresville. St. Francis Hospital is part of a network of 12 hospital campuses in Indiana and Illinois owned and operated by the Sisters of St. Francis Health Services, Inc.

The Need: The need was first identified by Quality Management and Nursing leadership after a review of NICU admissions of infants electively induced prior to 39 weeks. We also experienced a lack of room availability if our induction schedule had been full for more than one day. With the advent of the IHI Induction bundle and Anthem's request regarding an institutional policy the Vice President of Medical Affairs charged us with amending our induction policy using evidence-based practices to present to the Obstetrics department.

Barriers/Fears/Protests: Our primary barrier was the lack of a physician champion. We initially heard the common complaints of "cookbook medicine" and "my patients expect me to deliver them so I have to schedule inductions on my call day." We reinforced the importance of doing what is clinically best for the infant and that we were often times functioning outside of established ACOG guidelines. We also wanted to proactively change our policy before being required by outside agencies. Those arguments, in addition to the voice of the Vice President, brought at least a beginning acceptance of the policy.

Process: Our current practice strives to keep the nurse out of the middle. All inductions prior to 39 weeks without sufficient medical documentation are reviewed by the Patient Care Committee. Physicians' practices are trended and they receive letters or phone calls from the departments' quality chairmen or the Medical Director as needed. Over the past few months, we have reviewed fewer cases due to improved documentation.

Benefits: Since implementing the policy in the spring of 2009, the NICU manager has noticed a significant reduction in the number of infants admitted for 3-7 days, which was often associated with pre-39 week inductions. Bed availability in the NICU has also improved and the most common admissions are now for long-term or few hours transitional stay.

For more information, contact Cheryl Boys Fore at Cheryl.BoysFore@ssfhs.org

Case Study: Implementation of Elective Induction Policy in a Small/Rural Hospital

St. Vincent-Frankfort, Frankfort, IN

St.Vincent-Frankfort, part of Ascension Health, is a 25-bed acute care facility serving the residents of Clinton County. St.Vincent Frankfort provides a full range of healthcare services including inpatient, outpatient and ambulatory surgery, a full service OB program and a 24-hour physician-staffed emergency department.

About St. Vincent-Frankfort's Implementation Process

We began implementing the 39-week standard in May 2006. The new policy was communicated to nursing staff through OB unit meetings.

Our CNO is the main point of contact for enforcing the policy and is contacted any time an induction is scheduled for a patient under 39 weeks. If the induction is not within the parameters of the policy, the admitting physician is contacted directly by the CNO.

The CNO has a very good rapport with all our physicians and they respect her authority. The physicians are aware of the parameters and know what to expect if they schedule an induction outside of the parameters.

While physician resistance has been minimal, we have experienced pressure from patients to be induced early. We have a large Hispanic population who often request to plan around family availability. However, we hold to our policy unless the patient demonstrates a clinical need met by the policy.

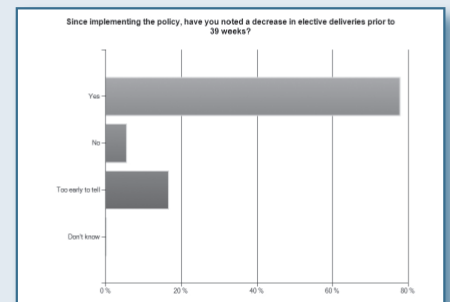
For more information, contact Kristi Bledsoe at klbledso@stvincent.org

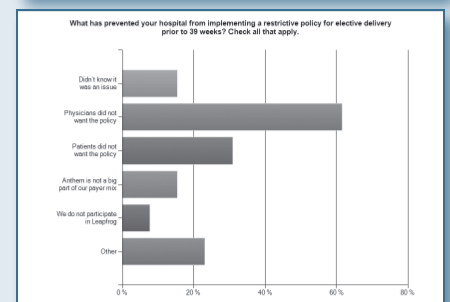
Hospital Survey: Elective Delivery Before 39 Weeks

In April 2010, IPN and the IU National Center for Excellence in Women's Health, Best Practices Committee distributed a survey to assess how perinatal hospitals are addressing the issue of elective deliveries. We received responses from approximately half of the delivering hospitals.

Key Findings:

- 61% of hospitals responding have a policy limiting elective delivery before 39 weeks
- 78% of hospitals implementing a policy have noted a decrease in elective deliveries before 39 weeks
- 62% of hospitals without a policy stated that one reason was because physicians did not want the policy; 31% stated that one reason was because patients did not want the policy





PROFILE: *Mureena A. Turnquest Wells, MD*

Maternal-Fetal Medicine and Genetics Center, St. Mary's Hospital for Women & Children

"Our patients just want healthy babies," says Mureena Turnquest Wells, MD, a maternal fetal medicine specialist at St. Mary's Hospital in Evansville. "It's up to us as physicians to provide our patients with sound advice and make the right recommendations."

When discussing the issue of late preterm birth and elective inductions, Turnquest Wells freely admits that physicians need to be willing to adapt to new guidelines. "The issue of late preterm birth has definitely become more of a hot topic in recent years," she says, adding that when she finished her residency, 37 completed weeks was considered full term. "Now, the criteria are much stricter."

Mureena A. Turnquest Wells

Since many of her patients have medical complications, Turnquest Wells realizes that sometimes a full term delivery is simply not possible. However, she does emphasize that whenever possible, certain guidelines such as documentation of lung maturity still need to be met.

"It costs significantly more money to care for a preterm baby," Turnquest Wells says. "But more importantly, we need to understand, and help our patients understand, the potential short-term and long-term complications for the baby." She points out that sometimes obstetricians don't see the effects of a preterm delivery on the baby, because the pediatrician is the one who will have to deal with any issues.

The solution is to have an evidence-based hospital policy in place addressing elective inductions, Turnquest Wells says, and make it one of the hospital's Best Practices. "There is already a model in place because of the way we handle other conditions", she says, adding that many hospitals have a physician driven quality committee that can help create and implement such policies. Another key is to implement tracking and follow-up components as part of the policy to ensure accountability, she says.

Turnquest Wells spent eight years as a faculty member at Indiana University Medical Center before realizing she was ready for a change. St. Mary's Hospital was recruiting for their first full-time maternal fetal medicine specialist; Turnquest Wells decided to take a chance and has now been at St. Mary's for nine years.

"There is truly a need for our services in this area," she says, adding that she has delivered over 30 sets of triplets, four sets of quadruplets and even a set of quintuplets during her time in Evansville, where she sees patients from three different states. She is quick to praise the staff at St. Mary's and the services they offer. "There is so much we can do here—we can take care of the extreme preemie, we can take care of minor surgical corrections. I really believe we are making a difference."

Controversies & Innovations in Perinatal Health Highlights Emerging Issues, Interventions

Georg'ann Cattelona accepts an award on behalf of Bloomington Area Birth Services

Perinatal providers from across Indiana gathered on March 18-19 at the third annual IPN Forum, *Controversies & Innovations in Perinatal Health*, to network, share information, and discuss emerging topics in maternal and child health.

Keynote speaker **Lynne Doner Lotenberg**, MA, author of *Marketing Public Health: Strategies to Promote Social Change*, discussed how to apply social marketing principles to issues such as breastfeeding, safe sleep, and prematurity. According to Lotenberg, providers need to focus on making a desired health behavior seem 'fun, easy and popular' to improve the chances that a client will begin to engage in such a behavior. She emphasized that hard-sell, negative or intimidating messages rarely result in success, asking attendees, "Would you want to spend time with people who scare you?" Lotenberg also reminded providers to take into account the short-term costs and benefits of a desired behavior versus the long-term costs and benefits; long-term behaviors will be more complex and harder to achieve.

> *"Thank you for providing high-quality, up to date education, encouragement and camaraderie!"*
>
> *"I really enjoyed this conference and the focus on evidence-based care. Thank you for doing this, it is very important."*
>
> *—2010 Forum participants*

Two panel discussions focused on applying social marketing principles to common perinatal topics. **Diane Rogers**, RN, BSN, of Wishard Health Services, **Laura Chavez** of Healthy Families and **Kimberly Antoine Kaiser**, a mother of four, discussed the gap that sometimes exists between what healthcare providers tell their clients regarding breastfeeding and safe sleep practices, and what clients actually do at home.

Sandy Ernst, RN NP, of Better Indy Babies, **Lora Sparkman**, RN, MHA, from Ascension Health and **Rana Snipe Berry**, MD, of Indiana University School of Medicine, discussed the complex issue of preventing premature births. They encouraged providers to help women challenge the assumption that if they had a premature baby in the past, they will have a premature baby again. Sparkman also pointed out the downfall of comparing data among hospitals, and the benefit for each hospital to set a baseline and measure their progress over time.

IPN Director of Special Projects and Public Policy, **Caitlin Priest**, MPH, presented an update on the distribution of delivering providers in Indiana and discussed changes that have occurred since her presentation at the 2009 forum.

Breakout sessions featured a wide variety of topics, including using simulation to improve perinatal patient safety, creating a community-based breastfeeding clinic, preventing rapid repeat pregnancies, and innovations in presumptive eligibility for pregnant women.

The conference closed with an inspiring presentation by **Richard Gunderman**, MD PhD, of Indiana University. His message, 'We make a life by what we give' encouraged attendees to look at their work as not merely a job, but as a calling.

IPN is already making plans for the 2011 Forum, which will feature a new one-day format and tracks for clinical and community participants. The 2011 Forum will be held March 11 at the Sheraton Indianapolis Hotel on the city's north side.

View materials from the 2010 IPN Forum online at www.indianaperinatal.org.

The "*Latina Paradox*": Acculturation and Birth Outcomes among Latinas in the US and Indiana

What is the Latina Paradox?

What accounts for the Latina paradox—the observation that despite socioeconomic disadvantage, Latinas in the United States have birth outcomes comparable to those of White women? Researchers cite an informal system of prenatal care delivery within Latino communities—comprised of family, friends, community members, and lay health workers—whose social support contributes to healthy birth outcomes (McGlade et al, 2004). Other protective factors include traditions of passing down healthy behaviors from one generation of women to the next, as well as strong extended support networks of other women. Collectively, these factors "enable immigrant mothers to resist adopting the negative risk behaviors of the new host society, particularly those related to smoking, alcohol abuse, and diet." (McGlade et al, 2004)

What Happens Over Time?

Despite these positive outcomes, these protective factors appear to fade over subsequent generations as Latina women acculturate to US norms. Data from the Hispanic Health and Nutrition Examination Survey reveal that higher levels of acculturation among Mexican American women (as measured by language preference, ethnic identification, and nativity status) were associated with higher rates of low birthweight deliveries, increased smoking, and poorer nutrition (McGlade et al., 2004).

Additional research has shown that that a higher acculturation level is also associated with prematurity, teen pregnancy, neonatal mortality, smoking and drug use during pregnancy, and lower rates of breastfeeding (Lara et al., 2005). Other literature, however, suggests mixed or no effects on birth outcomes, reflecting the differing effects of language, place of birth, and length of stay in the United States (Lara et al., 2005).

What's Happening in Indiana?

Selected Perinatal Indicators Hispanic Population

	1997	2001	2007*
Number of Births	3393	5865	8785
Infant Mortality Rate	7.4	8.5	6.8
% Low Birthweight	6.9	6.5	7.2
% 1st Trimester PNC	64.7	61.9	49.5
% Preterm Births	7.3	8.1	9.4
% Smoking During Pregnancy	6.3	4.5	4.1
% Breastfeeding at Hospital Discharge	58.6	74.2	77.9
% Births to Unmarried Mothers	40.5	47.9	56.2

*Because of certificate revisions, 2007 data on prenatal care and tobacco use are not strictly comparable with data from prior years.

Source: http://www.in.gov/isdh/reports/natality/2007/toc.htm
http://www.in.gov/isdh/reports/mortality/2007/index.htm

From 1997 to 2007, the most recent year for available data, Indiana has experienced a significant increase in the number of Hispanic births. For the Hispanic population, there has been a slight decline in the infant mortality rate; the percentage of low birthweight babies and the percentage of premature births has increased. These trends mirror those for the non-Hispanic population. However, with the exception of 1st trimester prenatal care and the percentage of births to unmarried mothers, prenatal behaviors and perinatal outcomes for Hispanic women are significantly better, or at least comparable to non-Hispanic women in Indiana. A similar trend exists in Marion County where more than one-fourth of all Hispanic births in the state occur.

Strategies and Recommendations

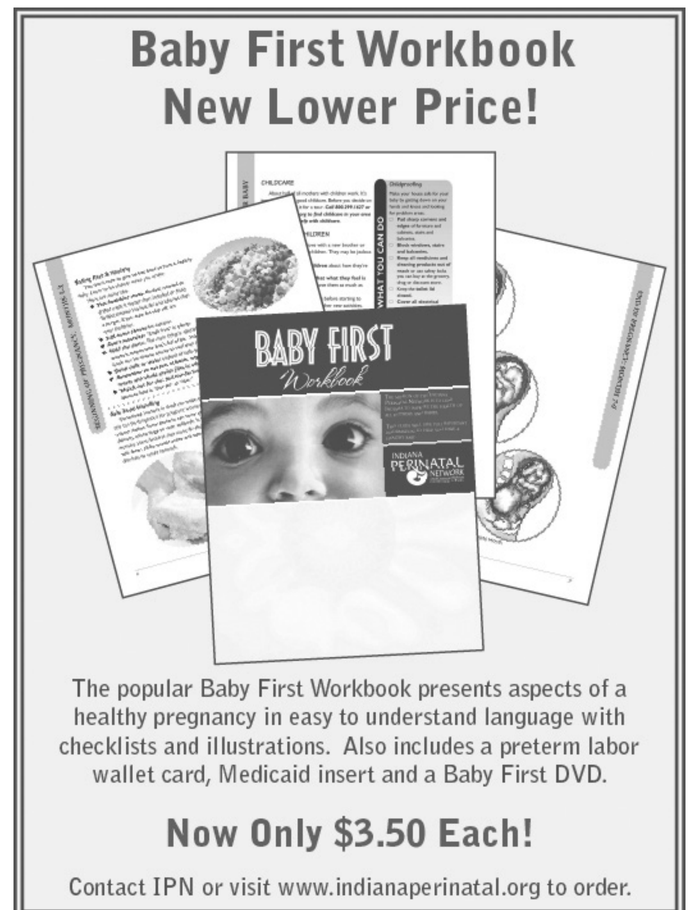
Researchers point to the importance of the informal systems of prenatal care and the benefits of the "health-promoting cultural and social milieu" that underpin the positive birth outcomes of first-generation Latinas, but warn that without support, this "collective, community-based" context will deteriorate (McGlade et al., 2004).

Other public health practice recommendations include increasing the knowledge and awareness of the role of acculturation in Latino behaviors, outcomes, and healthcare use at the practitioner, administrative, and academic levels, as well as promoting the maintenance of healthy behaviors among the less acculturated and the reacquisition of these behaviors among the more acculturated (Lara et al., 2005).

References and Resources

Lara, M., Gamboa, C., Kahrahmanian, M.I., Morales, L.S., & Hayes Bautista, D.E. (2005). Acculturation and Latino health in the United States: A review of the literature and its sociopolitical context. Annual Review of Public Health, (26), 367–97.

McGlade, M.S.., Saha, S., & Dahlstrom, M.E. (2004). The Latina Paradox: An opportunity for restructuring prenatal care delivery. American Journal of Public Health, 94(12), 2062-2065.



INDIANA PERINATAL NETWORK
Lead/Convene/Collaborate for Mothers & Babies

2010 Fall Conferences

Infant-Caregiver Interaction: Supporting Optimal Development of the High Risk Newborn

Indiana Newborn Developmental Care Conference

October 18, 2010
Carmel, Indiana

Safe Sleep Education: Sharing the Same Message

October 27, 2010
Indianapolis, Indiana

Find out more about IPN's fall conferences and register online at **www.indianaperinatal.org**.

Mark Your Calendars!

Don't miss the remaining dates for IPN's Regional Training Series! These half-day trainings are a great opportunity to receive low-cost, high quality clinical education, close to home. Visit www.indianaperinatal.org to register or view complete descriptions of each topic. Continuing education for nurses and social workers is available.

Date	Title	Location
June 30	Integrating Screening and Treatment of Substance Use into Prenatal Care	Muncie
June 30	Updates and Issues in Perinatal Health	Muncie
July 20	Integrating Screening and Treatment of Substance Use into Prenatal Care	Jasper
July 20	Sudden Infant Death Syndrome (SIDS) Risk Reduction	Jasper
Aug 5	Updates and Issues in Perinatal Health	Columbus
Aug 5	The "Golden Hour": An Opportunity to Improve Patient Safety	Columbus

Save the Date!

The 4th Annual IPN Forum, *Controversies & Innovations in Perinatal Health*, will be held March 11, 2011 at a new location—the Sheraton Indianapolis Hotel at Keystone at the Crossing.

We Need Your Input!

IPN is in the process of reevaluating our Perinatal Perspectives newsletter, and we would greatly appreciate your feedback.

Please take a few minutes to visit **http://www.surveymonkey.com/s/IPN** and complete a brief survey.

Results of Maternal-Child Health Needs Assessment
ISDH staff are currently working to finalize the 2010 Needs Assessment. This assessment, done every five years, identifies the Maternal-Child Health Title V priorities for the next five years. Results are scheduled to be available by July 15th at http://www.in.gov/isdh/19575.htm.

Congratulations!

Special Delivery!

IPN's Director of Special Projects & Public Policy **Caitlin Priest** and her husband **Chad** welcomed a baby boy on May 13. **Eli Frederic Priest** joins older sisters **Emerson** and **Nora**. Welcome, **Eli**, to the IPN family!