



INDIANA UNIVERSITY

The State of Women's Health in Indiana: A Call to Action



October 7, 2011

Lee A. Learman, MD, PhD
Chair and Clarence E. Ehrlich Professor
Department of Obstetrics & Gynecology
IU School of Medicine





Learning Objectives

1. Raise Awareness of Indiana's Performance
2. Identify Evidence-Based Interventions
3. Set Priorities for Raising our Grade



Learning Objectives

1. **Raise Awareness of Indiana's Performance**
2. Identify Evidence-Based Interventions
3. Set Priorities for Raising our Grade



National Women's Law Center 2010

Rank ▲	State	Grade
1	Vermont	S-
2	Massachusetts	S-
3	Hawaii	U
4	Colorado	U
5	Minnesota	U
6	New Hampshire	U
7	Connecticut	U
8	Maine	U
9	Washington	U
10	Oregon	U

Nation's Performance	
Nation's Grade	U
Number of Benchmarks Met	3
Number of Benchmarks Missed	23

- Mammograms
- Dental visits
- Colorectal Cancer Screening

40	Texas	F
41	Missouri	F
42	South Carolina	F
43	District of Columbia	F
44	Tennessee	F
45	Kentucky	F
46	Alabama	F
47	West Virginia	F
48	Oklahoma	F
49	Arkansas	F
50	Louisiana	F
51	Mississippi	F



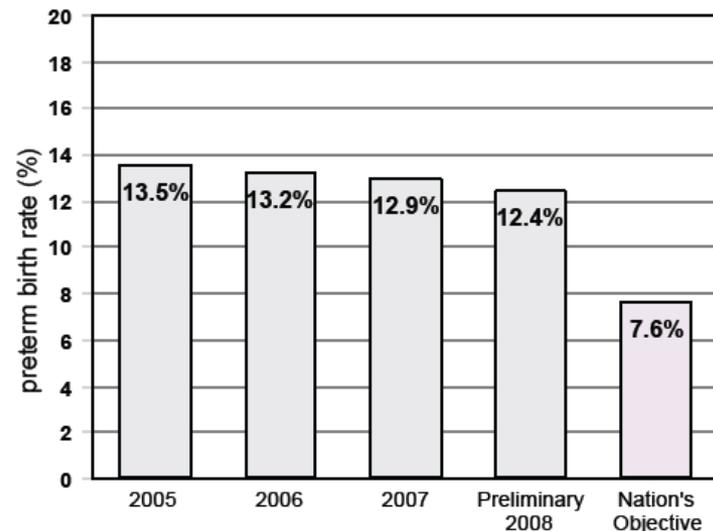
Keeping Pregnant Moms & Babies Safe

March of Dimes 2010 Premature Birth Report Card

The March of Dimes graded states by comparing each state's rate of premature birth to the nation's 2010 objective of 7.6 percent. Preterm birth is the leading cause of newborn death in the United States. We don't yet understand all the factors that contribute to premature birth. The nation must continue to make progress on research to identify causes and prevention strategies, and on interventions and quality improvement initiatives to improve outcomes.

Grade for Indiana
Preterm Birth Rate: **12.4%**

D



Since last year's Report Card, the preterm birth rate in Indiana improved, but not enough to increase the grade.



Keeping Pregnant Moms & Babies Safe

Status of Selected Contributing Factors

Factor	Previous Rate	Latest Rate	Status	Recommendation
Uninsured Women	17.2%	18.5%	✗	Health care before and during pregnancy can help identify and manage conditions that contribute to premature birth. We urge federal and state policy makers to accelerate implementation of health reform by expanding coverage for women of childbearing age, and we urge employers to create workplaces that support maternal and infant health.
Women Smoking	29.0%	26.6%	★	Smoking cessation programs can reduce the risk of premature birth. We urge federal and state policy makers to immediately implement comprehensive Medicaid coverage of smoking cessation coverage of provisions of health reform.
Late Preterm Birth	9.3%	8.9%	★	The rise in late preterm births (34-36 weeks) has been linked to rising rates of early induction of labor and c-sections. We call on hospitals and health care professionals to establish quality improvement programs that ensure consistency with professional guidelines regarding c-sections and inductions prior to 39 weeks gestation.

★ = moving in the right direction n/c = no change ✗ = moving in the wrong direction



Indiana Women's Health Indicators

Perinatal Indicators	2007 Indiana	2010 Indiana	Other State Rankings in 2010
Prenatal care starting in first trimester (linked to prematurity)	81.5%	79.0%	OH 72.9% KY 73.2% IL 86.2%
Infant mortality rate (linked to prematurity)	7.8/1,000 #36	7.9/1,000 #39	OH 7.8 KY 7.0 IL 7.4
Maternal mortality rate	3.3/100,000 #4	2.9/100,000 #3	OH 7.2 KY 8.1 IL 7.8

Green state: best of 4, **Red state:** worst of 4.



Indiana Women's Health Indicators

Women's Health Cancer Prevention Indicators	2007 Indiana	2010 Indiana	Other State Rankings in 2010
Cervical cancer screening (Pap smears)	82.5% #46	73.7% #46	OH 78.0% KY 77.0% IL 78.3%
Breast cancer screening (Mammograms)	69.2% #41	73.9% #36	OH 76.0% KY 75.0% IL 75.8%
Smoking	25.0% #49	21.4% #46	OH 19.5% KY 24.2% IL 16.7%

Green state: best of 4, **Red state:** worst of 4.



Indiana Women's Health Indicators

Women's Health Indicators	2007 Indiana	2010 Indiana	Other State Rankings in 2010
Obesity	26.0% #36	30.9% #42	OH 29.3 KY 30.7 IL 27.4
Diabetes	7.8% #35	8.8% #35	OH 10.0 KY 11.3 IL 8.6
Days of Poor Mental Health per Month	4.3 #42	4.2 #38	OH 4.4 KY 5.3 IL 4.0

Green state: best of 4, **Red state:** worst of 4.



Depression in Pregnancy: 2 Victims

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Indy woman, 34, faces murder, feticide charges

6:11 PM, Mar. 15, 2011 | [31Comments](#)

An Indianapolis woman who admitted to eating rat poison near the end of her pregnancy is facing a murder charge for the death of her baby.

Bei Bei Shuai, 34, was arrested Monday and faces charges of murder and attempted feticide. She's scheduled to appear in Marion Superior Court for an initial hearing Wednesday morning.

Shuai gave birth to a daughter, Angel, on Dec. 31 via Cesarean section. Angel was put on life support but eventually was removed because doctors determined they couldn't help her.

She died Jan. 3 from bleeding in her brain, which was caused by the chemicals in the rat poison her mother ingested.

One of Shuai's friends, who lives in Anderson, discovered her in her car Dec. 23 at a Meijer gas station in Anderson.

He noticed she looked ill and suggested that Shuai go to his house so his wife could help her, according to court documents.

Shuai later confessed that she ate rat poison at her Indianapolis apartment. She was trying to kill herself because her boyfriend left her, according to court documents.





Indiana Women's Health Indicators

Women's Health Indicators	2007 Indiana	2010 Indiana	Other State Rankings in 2010
No health insurance	15.0% #23	17.4% #27	OH 16% KY 20.8% IL 16%
Poverty	12.8% #33	14.4% #37	OH 13.4% KY 17.7% IL 12.3%
Reside in medically underserved area	8.7% #17	7.1% #14	OH 6.0% KY 11.6% IL 17.5%
High School completion	87.7% #30	89.6% #26	OH 89.5% KY 83.4% IL 89.1%



Learning Objectives

1. Raise Awareness of Indiana's Performance
- 2. Identify Evidence-Based Interventions**
3. Set Priorities for Raising our Grade



10 Evidence-Based Opportunities

Infant mortality/prematurity

1. Improve care coordination
2. Prevent preterm birth

Pregnancy planning

3. Extend Medicaid benefits

Cervical cancer

4. Promote HPV vaccination &
5. Cervical cancer screening

Tobacco Exposure

6. Ban smoking in public places
7. Discuss with every patient

Obesity / diabetes

8. Optimize *in utero* environment
9. Promote breastfeeding

Prepare for ACA

10. Implement Institute of Medicine Recommendations



A Field Trip to New York State

“New York State is committed to addressing risk factors that lead to poor birth outcomes, especially in the hard to reach populations of the state. This is evidenced by the improvement in the infant mortality rates over the past few years.

Infant mortality in New York State has decreased by more than 34.3% over the past 10 years, taking the state from 32nd in the nation to 9th. Nationally the decline over the same period was 21.7%.

Even though great strides have been made in addressing the needs of women and children in the state, New York continues to make the health of women and children a priority. Several programs have been developed with the purpose of increasing access to prenatal and perinatal care. The mission of these programs is:

To improve the health of under-served women, infants and children through improved access to and enhanced utilization of perinatal and prenatal care and related services."



Maryland Vital Statistics Infant Mortality in Maryland, 2010

August 2011

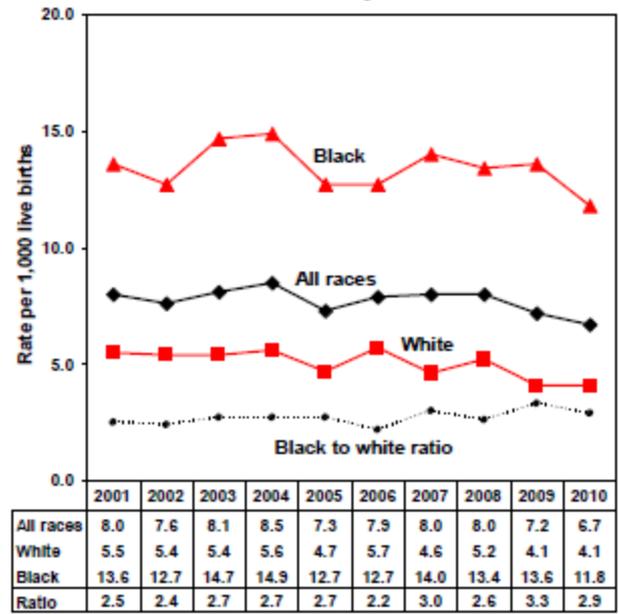
- Maryland's infant mortality rate was 6.7 per 1,000 live births in 2010, 7% lower than the 2009 rate of 7.2 and a historic low for the State.
- The mortality rate for black infants fell by 13% between 2009 and 2010, while the rate remained unchanged for white infants.
- The overall reduction in the infant mortality rate was driven by large declines in the number of infant deaths in Baltimore City and Montgomery County.

Trends

The infant mortality rate in Maryland fell to 6.7 per 1,000 live births in 2010, the lowest rate ever recorded in Maryland. A total of 496 infants died in 2010 compared with 541 in 2009. There were 178 deaths among infants born to white women, 295 deaths among infants born to black women, 17 deaths among infants born to Asian women, and 42 deaths among infants born to women of Hispanic origin, who may be of any race.

The 7% decline in the infant mortality rate between 2009 and 2010 follows a 10% decline in the rate between 2008 and 2009. While a fall in the white infant mortality rate resulted in the overall decline seen in 2009, a fall in the black rate was responsible for the 2010 decline. The black infant mortality rate fell from 13.6 per 1,000 live births in 2009 to 11.8 per 1,000 live births in 2010, a 13% de-

Figure A. Infant Mortality Rates by Race and Black to White Ratio, Maryland, 2001-2010.





Success Stories

Declining Infant Mortality Rates in Maryland: The Babies Born Healthy Initiative

By Bonnie S. Birkel, CRNP, BSN, MPH

Director, Maryland Center for Maternal and Child Health



Babies Born Healthy (BBH) is a collaborative, interagency program focused on three primary strategies for improving birth outcomes – healthier women prior to and between pregnancies (i.e. interconception); early enrollment in prenatal care; and post-delivery follow-up for high-risk infants and mothers. Efforts have been targeted to jurisdictions where infant mortality and racial disparities in pregnancy outcomes are highest – Baltimore City, Prince George’s County and Somerset County (Dorchester County was added in April 2011).

A new comprehensive women’s health model has expanded family planning services to include risk assessment and screening for chronic diseases. Through close partnership with Medicaid, a new Accelerated Certification of Eligibility (ACE) process assures Medicaid-eligible women that they will have access to prenatal care as early as possible and a Quickstart prenatal care visit is offered at health departments in the target jurisdictions. To ensure that high-risk babies and mothers receive post-partum follow-up, a statewide standardized post-partum discharge referral process is being developed and a post-partum Infant and Maternal Referral Form has already been implemented statewide (more information available [here](#)).

Promoting safe sleep has also been an integral component of the program. A safe sleep video developed by the B’More for Healthy Babies program in Baltimore City has been distributed widely around the state (video available [here](#)). Key partners in all of these efforts have been the Department of Health and Mental Hygiene Office of Minority Health and Health Disparities, the Governor’s Office on Children, the Maryland Department of Human Resources, the Community Health Resources Commission, the Maryland Patient Safety Center and Carefirst.

For more information on Babies Born Healthy, please contact Maura Dwyer, DrPH, Health Policy Analyst, Maryland Center for Maternal and Child Health, at (410) 767-3702 or mdwyer@dhmh.state.md.us.

SPECIAL ARTICLE

NICU care for VLBW in California

Level and Volume of Neonatal Intensive Care and Mortality in Very-Low-Birth-Weight Infants

Ciaran S. Phibbs, Ph.D., Laurence C. Baker, Ph.D., Aaron B. Caughey, M.D., Ph.D., Beate Danielsen, Ph.D., Susan K. Schmitt, Ph.D., and Roderic H. Phibbs, M.D.

N Engl J Med 2007; 356:2165-2175 | May 24, 2007

There has been a large increase in both the number of neonatal intensive care units (NICUs) in community hospitals and the complexity of the cases treated in these units. We examined differences in neonatal mortality among infants with very low birth weight (below 1500 g) among NICUs with various levels of care and different volumes of very-low-birth-weight infants.

We linked birth certificates, hospital discharge abstracts (including interhospital transfers), and fetal and infant death certificates to assess neonatal mortality rates among 48,237 very-low-birth-weight infants who were born in California hospitals between 1991 and 2000.

the delivery hospital. The effect of volume also varied according to the level of care. As compared with a high level of care and a high volume of very-low-birth-weight infants (more than 100 per year), lower levels of care and lower volumes (except for those of two small groups of hospitals) were associated with significantly higher odds ratios for death, ranging from 1.19 (95% confidence interval [CI], 1.04 to 1.37) to 2.72 (95% CI, 2.37 to 3.12). Less than one quarter of very-low-birth-weight

Mortality among very-low-birth-weight infants was lowest for deliveries that occurred in hospitals with NICUs that had both a high level of care and a high volume of such patients. Our results suggest that increased use of such facilities might reduce mortality among very-low-birth-weight infants.

Lessons from California

- Lowest mortality occurred in hospitals with high level and high volume NICU
- Less than 25% of VLBW infants are born in hospitals with such services.
- Increased regionalization of care has potential to prevent 21% of deaths in VLBW

State Levels of Care Oversight

- 33 states designate multiple levels of neonatal care
- 2-6 levels used
- Regulatory sources: state licensure, certificate of need, state health department, or affiliated NGO
- 24 States single reviewer, 9 two reviewers
- 13 states link funding to levels of care

The Indiana Perinatal System Standards

STANDARD	TITLE	SUMMARY
I	Organization	Refers to the administration of a hospital's neonatal-perinatal programs.
II	Obstetrical Unit Capabilities	Refers to the resources of equipment, supplies, and personnel needed for the delivery unit within the hospital.
III	Obstetric Personnel	Describes the roles, responsibilities, and availability of obstetric personnel in the perinatal program.
IV	Obstetric Support Personnel	Describes the roles, responsibilities, and availability of the other personnel in the obstetric program.
V	Obstetric Equipment	Refers to the availability of specific equipment needed for the obstetric program.
VI	Obstetric Medications	Refers to the availability of specific medications needed for the obstetric program.
VII	Neonatal Unit Capabilities	Refers to the resources of equipment, supplies, and personnel needed for the neonatal units within the hospital.
VIII	Neonatal Personnel	Describes the roles, responsibilities, and availability of neonatal personnel in the neonatal program.
IX	Neonatal Support Personnel	Describes the roles, responsibilities, and availability of the other personnel in the neonatal and perinatal programs.
X	Neonatal Equipment	Refers to the availability of specific equipment needed for the neonatal program.
XI	Neonatal Medications	Refers to the availability of specific medications needed for the neonatal program.
XII	Universal Laboratory	Refers to the resources of the equipment, supplies, and personnel needed for the laboratory unit within the hospital.
XIII	Universal Education	Refers to educational requirements for all health care providers involved in providing neonatal-perinatal care in relation to their roles and responsibilities.
XIV	Performance Improvement	Describes the performance improvement process that is required for hospital neonatal-perinatal programs.
XV	Policies and Protocols	Identifies the administrative and medical policies and protocols that shall be in place for neonatal-perinatal programs.

ISDH Perinatal Initiative, Fiscal Year 2012

Thanks to all the hard work of the Levels of Hospital Care Task Force we are on track to meeting our timeline. Your dedication and hard work are helping to create a better system of care for our mothers and babies to improve our perinatal outcomes.

There is still much to do. From the Task Force meetings, four perinatal initiatives have been identified as priorities for the coming 2012 Fiscal Year starting October 1, 2011. These priority initiatives include:

1. Implement Hospital Standards of Care.

This continuing initiative will include

- Sharing the Standards document with providers, hospitals, and professional organizations to obtain input and negotiate changes.
- Sharing the Standards with all birthing hospitals at the September 23, 2011 Hospital Summit.
- Developing a new hospital survey to identify hospital capabilities for self-report designation of hospital maternal and neonatal levels of care.
- Developing policy around issues of Levels of Care and licensure and a waiver program.

2. Create a State Perinatal Database System

3. Develop a Perinatal System Consisting of Perinatal Centers and Affiliates

4. Implement a statewide Quality Improvement Collaborative that will decrease early prematurity rates, continue to decrease our late prematurity issues, and prevent neonatal injury and provide follow-up of very low birthweight babies.



Prevention of Preterm Birth

Specifications Manual for Joint Commission National Quality Measures (v2012A)

BAN Elective Delivery < 39 0/7 weeks.

13-21% of earlier elective deliveries go to the NICU.

****NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE****

Measure Information Form

Measure Set: [Perinatal Care\(PC\)](#)

Set Measure ID: PC-01

Performance Measure Name: Elective Delivery

Description: Patients with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed

Rationale: For almost 3 decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to ELECTIVE delivery, either vaginal or operative (ACOG, 1996). A survey conducted in 2007 of almost 20,000 births in HCA hospitals throughout the U.S. carried out in conjunction with the March of Dimes at the request of ACOG revealed that almost 1/3 of all babies delivered in the United States are electively delivered with 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13- 21%) (Clark et al., 2009).

Prevention of Preterm Birth

Progesterone Reduces the Likelihood of Recurrent Preterm Birth by 1/3

ESTABLISHED IN 1812

JUNE 12, 2003

VOL. 348 NO. 24

Prevention of Recurrent Preterm Delivery by 17 Alpha-Hydroxyprogesterone Caproate

Paul J. Meis, M.D., Mark Klebanoff, M.D., Elizabeth Thom, Ph.D., Mitchell P. Dombrowski, M.D., Baha Sibai, M.D., Atef H. Moawad, M.D., Catherine Y. Spong, M.D., John C. Hauth, M.D., Menachem Miodovnik, M.D., Michael W. Varner, M.D., Kenneth J. Leveno, M.D., Steve N. Caritis, M.D., Jay D. Iams, M.D., Ronald J. Wapner, M.D., Deborah Conway, M.D., Mary J. O'Sullivan, M.D., Marshall Carpenter, M.D., Brian Mercer, M.D., Susan M. Ramin, M.D., John M. Thorp, M.D., and Alan M. Peaceman, M.D.,

for the National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network*

CONCLUSIONS

Weekly injections of 17P resulted in a substantial reduction in the rate of recurrent preterm delivery among women who were at particularly high risk for preterm delivery and reduced the likelihood of several complications in their infants.

are listed in the Appendix.

N Engl J Med 2003;348:2379-85.

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Working Together Pregnancy Spacing and Planning for Success

- Birth Spacing Improves Outcomes
- Extend Medicaid Benefits for 2 years Postpartum
- Title XX Efforts to Prevent Teen Pregnancy
- Title X for Pregnancy Planning and Primary Care

Planning for Success: A Public Health Perspective

A national evaluation of Medicaid family planning waivers conducted by the CNA Corporation along with the schools of public health at Emory University and the University of Alabama at Birmingham, under a contract with CMS, has provided important evidence of the impact of the waivers.⁴³ According to the study, all six of the programs studied resulted in significant savings to both the federal and state governments. Moreover, the researchers found evidence that some of the programs expanded access to care, improved the geographic availability of services, expanded the diversity of family planning providers and resulted in a measurable reduction in unintended pregnancy (see Figure 11).

Evidence from the California Experience

By comparing the contraceptive methods used prior to Family PACT with the methods obtained through the program, researchers estimate that in calendar year 2002, Family PACT prevented 213,000 unintended pregnancies, 45,000 of which would have been to teenagers. By preventing these pregnancies, the program helped women in California avoid a total of 82,000 abortions, 16,000 of which would have been to teenagers.⁴⁸

Figure 11
Impact of State Medicaid Family Planning Eligibility Expansions

State	Year	Births Averted	Net Savings from Expansion Program		
			Total	State Share*	Federal Share
Alabama	2000-2001	3,612	\$19,028,783	\$6,981,721	\$12,047,062
Arkansas	1997-1998	2,748	\$15,524,056	\$5,199,426	\$10,324,630
	1998-1999	4,486	\$29,748,208	\$9,411,954	\$20,336,254
California	1999-2000	21,335	\$76,182,694	\$64,314,302	\$11,868,392
New Mexico	1998-1999	507	\$1,334,435	\$652,918	\$681,517
	1999-2000	1,358	\$5,009,165	\$2,037,590	\$2,971,575
	2000-2001	1,528	\$6,510,909	\$2,650,439	\$3,860,470
Oregon	2000	5,414	\$19,756,294	\$11,077,646	\$8,678,648
South Carolina	1994-1995	2,228	\$13,634,174	\$4,135,453	\$9,498,721
	1995-1996	3,151	\$19,615,968	\$6,201,946	\$13,414,022
	1996-1997	3,769	\$23,066,926	\$7,403,462	\$15,663,464

Source: Edwards, J., Bronstein, J., and Adams, K., "Evaluation of Medicaid Family Planning Demonstrations," The CNA Corporation, CMS Contract No. 752-2-415921, November 2003.
* State share of savings calculated by The Alan Guttmacher Institute, based on the total savings and the federal share of savings in the final report by the CNA Corporation.

Planning for Success: A Public Health Perspective

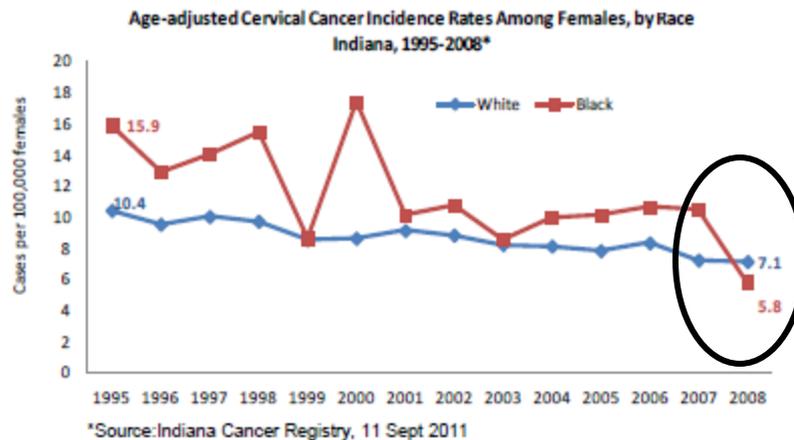
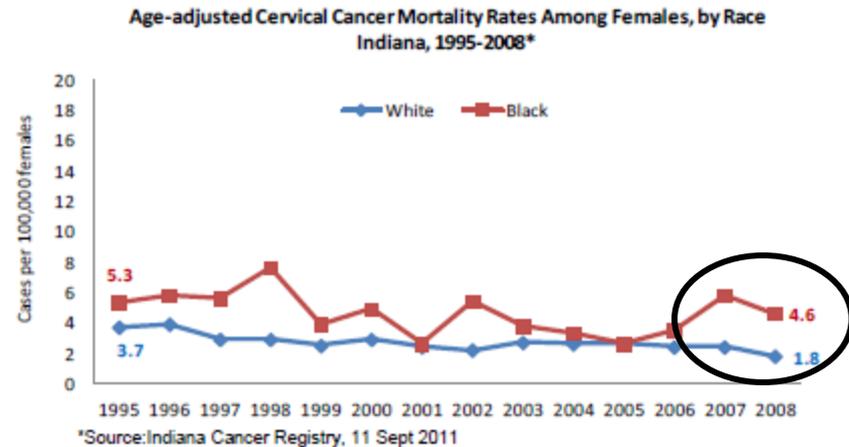
- DHHS Title XX Programs / IFHC
 - Encourage adolescents to postpone sexual activity until marriage
- Unintended pregnancies often result in late or no prenatal care, and an inability to address issues (diabetes, high blood pressure, substance abuse, depression, domestic violence) that lead to prematurity
- DHHS Title X Programs / IFHC and 12 delegate agencies
 - All FDA-approved birth control methods, pregnancy testing
 - Includes breast exams, Pap smears, screening/treatment for STI's and infertility prevention, patient education and counseling
- Inconsistent use of birth control accounts for 44% of unintended pregnancies and 54% of abortions
- For every \$1 invested to help low-income women prevent unintended pregnancies we save \$4 in public expenditures

Who is at Risk for Cervical Cancer Death in Indiana?

CERVICAL CANCER

Mortality Rates:

Significant decrease for whites between 1995 to 2008.
(Numbers for blacks not high enough for reliable conclusions)



Incidence Rates:

Significant decrease for whites between 1995 to 2008.
(Numbers for blacks not high enough for reliable conclusions)



Cervical Cancer Free Indiana



Welcome to the Kristen Forbes EVE Foundation

The Kristen Forbes EVE Foundation is a non-profit 501(c)(3) corporation based in Indiana.

Our Mission Statement:

To support educational, vaccine and other healthcare programs to reduce the incidence of cervical cancer.

Our Vision:

Cervical Cancer: **Educate. Vaccinate. Eradicate.**

Why:

A month after graduating from college, Kristen noticed her right ankle was starting to swell for no apparent reason. The idea for the Kristen Forbes EVE Foundation was born when Kirk and Brenda Forbes lost their 23 year old daughter Kristen Forbes after a year long battle with cervical cancer. Read about Kristen's

[Newsroom Home](#) > [Indiana University Media Relations](#) > [News Release](#)

Last modified: Thursday, December 2, 2010

Grant launches Cervical Cancer-Free Indiana Initiative



[Print this page](#)

FOR IMMEDIATE RELEASE

December 2, 2010

INDIANAPOLIS -- Indiana will join a multi-state program focused on cervical cancer prevention thanks to an unrestricted gift from GlaxoSmithKline Pharmaceuticals to the Indiana University School of Medicine, in partnership with the Kristen Forbes EVE Foundation.

Cervical Cancer-Free America (CCFA) is an initiative designed to raise awareness, increase screenings for cervical cancer and increase rates of human papillomavirus (HPV) vaccination with the ultimate goal of eliminating cervical cancer. HPV is the primary cause of cervical cancer. Initial funding for this initiative was through a \$1 million unrestricted educational grant by GlaxoSmithKline to the University of North Carolina Gillings School of Global Public Health. The CCFA program has since spread to Alabama, Kentucky, California and Indiana and will probably be initiated in other states in the



Gregory Zimet

[Print-Quality Photo](#)

HPV Vaccines Don't Cause Autism or Mental Retardation



You are cordially invited to

Raising the Grade in Women's Health

A celebration of the **transition**
of **Project INFLUENCE leadership** to the
Indiana University

National Center of Excellence in Women's Health

This year's emphasis: Cervical Cancer

• Education • Prevention • Screening
Partnership resources for communities wishing
to join the effort will be announced.

Tuesday, August 23, 2011

at

The Tobias House
5 E. 71st Street, Indianapolis IN
5:30 p.m. - 7:30 p.m.

• Appetizers • Networking
• Tour of the Women's Wellness on Wheels (WoW) bus



- Community coalition mini-grants (CoE/ACOG)
- Deployment of WoW bus
- Rx by Dr. Larkin:
 - Get vaccinated
 - Get screened
 - Reduce risk behavior

Tobacco & Women's Health

- Cancer: cervix, lung, throat and bladder
- Cardiovascular disease: heart attack, stroke, peripheral vascular disease
- Lung disease: bronchitis, emphysema
- Reproductive & endocrine problems: infertility, bone loss
- Obstetrical complications: Preterm birth, LBW, stillbirth, SIDS
- Secondhand smoke in children: more illnesses, wheezing, coughing, ear infections, asthma

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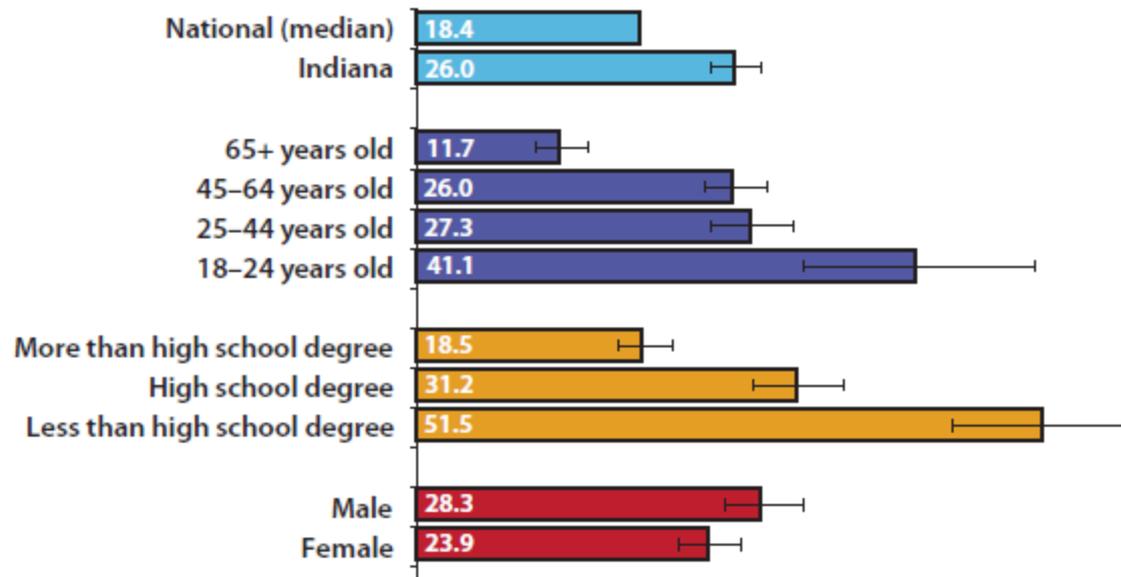
Monitor

In Indiana, 26.0% of the adult population (aged 18+ years)—over 1,247,000 individuals—are current cigarette smokers. Across all states, the prevalence of cigarette smoking among adults ranges from 9.3% to 26.5%. **Indiana ranks 50th among the states.**

Among youth aged 12–17 years, 11.8% smoke in Indiana. The range across all states is 6.5% to 15.9%. Indiana ranks 35th among the states.

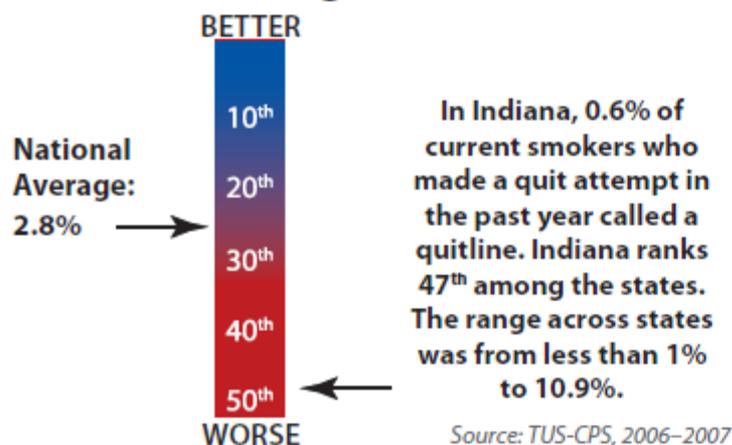
Among adults aged 35+ years, over 9,700 died as a result of tobacco use per year, on average, during 2000–2004. This represents a smoking-attributable mortality rate of 308.9/100,000. Indiana's smoking-attributable mortality rate ranks 43rd among the states.

Current Smoking Among Adults by Demographic Characteristics



Offer

Percentage of Smokers Calling Quitline



Best Practices estimates 8% of smokers could access quitlines each year. In Indiana, 0.6% of current smokers who made a quit attempt in the past year called a quitline.

The Medicaid fee-for-service program in Indiana provides full coverage for tobacco dependence treatment. Indiana's Medicaid policy provides coverage for both bupropion and varenicline. Indiana's Medicaid policy provides coverage for individual and group counseling but not telephone counseling.

Medicaid Coverage for Counseling and Medications

Nicotine Replacement	Varenicline	Bupropion	Counseling
✓ Yes	✓ Yes	✓ Yes	Partial

Source: MMWR 2009;58(43):1199-204

Protect

Indiana does not have a statewide smoke-free law that provides adequate protection against exposure to secondhand smoke in public places.

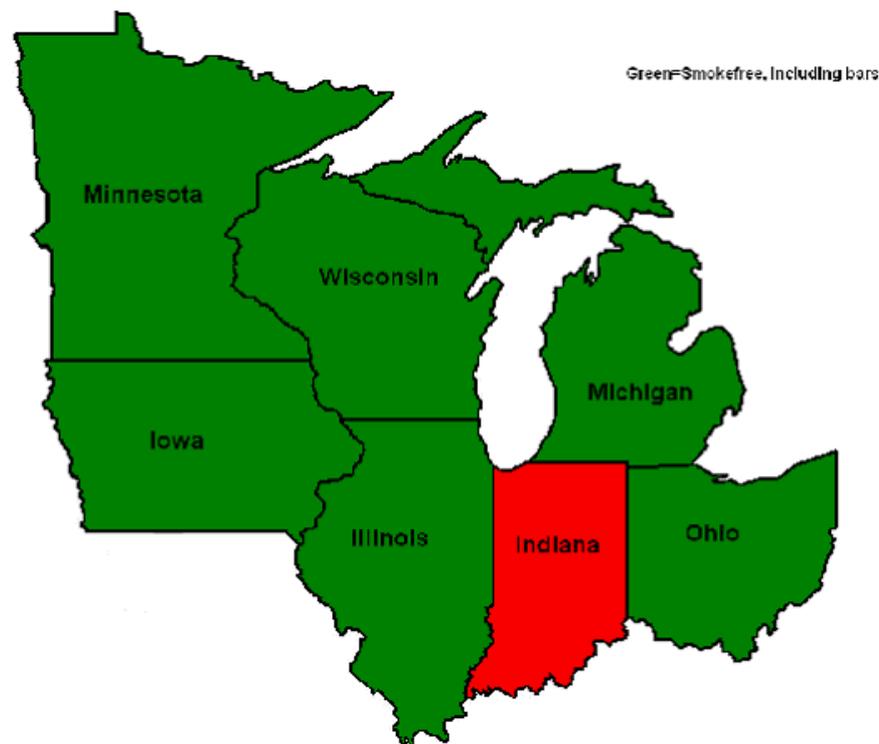
State Smoke-Free Policy		
Smoke-Free Workplaces	Smoke-Free Restaurants	Smoke-Free Bars
No	No	No

Enforce

Indiana preempts local regulation of tobacco industry promotions, sampling, and display of tobacco products in commercial establishments.

State Allows Local Advertising and Promotion Laws		
Display	Promotion	Sampling
No	No	No

Source: STATE System, 2009



States in **GREEN** Ban Smoking in All Public Places



NATIONAL CONFERENCE ON Childhood Obesity



Confronting the Epidemic through Nutrition Research and Policy

Thursday, June 18 to Friday, June 19, 2009

Washington, D.C.

- “Epigenetics” (1942): environmental factors alter the way our genes are expressed, even *in utero*
- “The Fetal and Infant Origins of Adult Disease” (1992)



David Barker, M.D., is a professor of cardiovascular medicine at the Oregon Health and Science University and a professor of clinical epidemiology at the University of Southampton, UK. Twenty years ago he showed for the first time that people who had low birth weight are at greater risk of developing coronary heart disease and diabetes. This is now widely accepted. It has led to a new understanding that chronic adult diseases, including certain cancers, are “programmed” by malnutrition in the womb. Dr. Barker’s work is relevant around the world. In the western world, many babies are malnourished because their mothers eat diets that are unbalanced and monotonous, or because their mothers are either overweight or excessively thin. In the Third World, many babies are malnourished because their mothers were chronically undernourished when they were young. Dr. Barker has lectured and written extensively on nutrition in the womb

CDC Breastfeeding Report Card 2011

State	Ever Breastfed	Breastfeeding at 6 months	Breastfeeding at 12 months	Exclusive breastfeeding at 3 months	Exclusive breastfeeding at 6 months
U.S. National	74.6	44.3	23.8	35.0	14.8
Alabama	56.7	24.4	8.0	19.8	5.9
Alaska	84.2	45.5	25.6	37.7	17.1
Arizona	78.4	52.0	22.3	36.1	12.3
Arkansas	63.9	34.0	16.0	29.9	13.7
California	86.6	59.1	40.0	48.1	25.7
Colorado	80.0	55.6	26.8	46.3	24.0
Connecticut	74.4	47.1	25.0	43.4	16.2
Delaware	71.8	40.7	18.2	31.6	11.4
Dist of Columbia	74.8	48.6	32.4	34.8	17.1
Florida	79.5	39.0	20.2	31.7	12.9
Georgia	71.6	36.7	18.5	27.1	10.1
Hawaii	85.0	52.4	31.2	42.4	20.8
Idaho	84.5	61.2	31.4	49.5	22.1
Illinois	70.6	44.5	21.7	35.3	14.3
Indiana	67.4	31.4	12.8	29.7	11.4





Clinical Preventive Services for Women: Closing the Gaps

*“Knowing is not enough; we must apply.
Willing is not enough; we must do.”*
—Goethe

Committee on Preventive Services for Women
Board on Population Health and Public Health Practice

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Clinical Preventive Services for Women: Closing the Gaps – IOM July 2011

ACA: all insurance plans should cover (without cost):

- Screening /counseling for intimate partner violence
- Full range of FDA-approved contraceptive methods
- Screening /counseling for STI's, including HIV
- Testing for HPV as part of cervical cancer screening
- Well woman visits including preconception care
- Screening pregnant women for gestational diabetes
- Comprehensive lactation support and counseling



Learning Objectives

1. Raise Awareness of Indiana's Performance

2. Identify Evidence-Based

3. Set Priorities for Raising our Grade

If you had to pick one priority area for Indiana what would it be, and why?



10 Evidence-Based Opportunities

Infant mortality/prematurity

1. Improve care coordination
2. Prevent preterm birth

Pregnancy planning

3. Extend Medicaid benefits

Cervical cancer

4. Promote HPV vaccination &
5. Cervical cancer screening

Tobacco Exposure

6. Ban smoking in public places
7. Discuss with every patient

Obesity / diabetes

8. Optimize *in utero* environment
9. Promote breastfeeding

Prepare for ACA

10. Implement Institute of Medicine Recommendations



INDIANA UNIVERSITY



1. Insist on a better standard for the women of Indiana
We can and must do better than 39th place and a grade of "U"
Promote high levels of OB and NN care, statewide coordination
2. Set an example
Promote health in our families, friends, coworkers and patients
3. Hold elected officials accountable
To maintain funding for Breast & Cervical Cancer Prevention, Title X and XX, Medicaid pregnancy benefits
To promote Substance Abuse Identification/Treatment , Breastfeeding, Extension of Medicaid Postpartum Benefits
To BAN smoking in all public places
To not oppose ACA-mandated women's services



INDIANA UNIVERSITY

A FINAL THOUGHT

*"You may be disappointed if you fail,
but you are doomed if you don't try."*



-Beverly Sills (1929-2007)



Only by working together can we help Hoosier women and infants obtain a health status that will make us all proud.

