Minutes
Commission on Improving the Status of Children in Indiana
Wednesday, September 17, 2014, 10:00 a.m. – 2:00 p.m.
Indiana Government Center South, Conference Room C

Members Present: Mary Beth Bonaventura, Director, Indiana Department of Child Services; Mike Dempsey, Director, Division of Youth Services, Indiana Department of Correction; Senator Travis Holdman; Lilia Judson, Executive Director, Division of State Court Administration; Representative Rebecca Kubacki; Larry Landis, Executive Director, Indiana Public Defender Council; Susan Lightfoot, Chief Probation Officer, Henry County Probation Department; Kevin Moore, Director, Division of Mental Health and Addiction; David Powell, Executive Director, Indiana Prosecuting Attorneys Council; Representative Gail Riecken; Glenda Ritz, Superintendent of Public Instruction, Indiana Department of Education; Chief Justice Loretta Rush, Indiana Supreme Court; Ryan Streeter, Senior Policy Director, Office of the Governor; Dr. William VanNess, Indiana State Health Commissioner, Indiana Department of Health; John Wernert, M.D., Secretary, Indiana Family and Social Services Administration.

Commission Staff Present: Amber Holland, Indiana Supreme Court; Anne Jordan, Jane Seigel, Angela Reid-Brown, Indiana Judicial Center; Ruth Reichard, Mike Commons, Indiana Supreme Court, Division of State Court Administration.

1. Other Business. Chief Justice Rush presented Senator Holdman with the "Champions of Justice" Award given to him by the Indiana Judges Association on September 10, 2014. Representative Kubacki announced that she and Chief Justice Rush were honored by the Indiana Association of Resources and Child Advocacy (IARCA) on September 16, 2014. She said they accepted their awards on behalf of everyone working for children. Representative Kubacki reported this will be her last meeting and that she will remain involved with the Commission through the Educational Outcomes Task Force. Dr. Streeter reported this will also be his last meeting. He said that Sean Keefer, the Governor's Deputy Chief of Staff for Executive Branch Agencies will take his place and serve as Chair of the Commission next year. This is also Mike Dempsey's last meeting.

2. Welcome. Chief Justice Rush welcomed everyone to the meeting. She thanked the *Indianapolis Star* for covering every Commission meeting and thanked Indiana Public Broadcasting for attending the meeting today.

3. Approval of Minutes from the July 16, 2014 meeting**.** The minutes from the July 16, 2014 meeting were unanimously approved.

4. Infant Mortality and Child Health, Indiana State Department of Health Presentation.

    a. **William C. VanNess, Jr., M.D., State Health Commissioner, Indiana State Department of Health.** Dr. VanNess thanked the Commission for focusing on Infant Mortality. He said the top three priorities for the Indiana State Department of Health (ISDH) are reducing infant mortality rates, reducing adult obesity rates, and reducing adult smoking rates. In Indiana, infant deaths make up two-thirds of all deaths of people under age 18 years. Half of those infant deaths involve babies less than 28 days old.

    Dr. VanNess explained infant mortality is defined as the death of a baby before its first birthday, and the Infant Mortality Rate (IMR) is the number of infant deaths for every 1,000 live births. Infant mortality is the number one indicator of health status in the world. In 2011, Indiana had 7.7 deaths per 1,000 and ranked 45th worst out of 50 states and the District of Columbia. Indiana

has consistently been one of the worst states in the US. In 2012, Indiana had 6.7 deaths per 1,000, but researchers are not sure if this is an anomaly.

In 2012, the top five causes of infant mortality were 1) perinatal risks (pre-term birth, low birth weight, very low birth weight); 2) congenital malformation; 3) SIDS/Accidents (SIDS, accidental suffocations, other accidents); 4) assault/neglect; and 5) other causes. From 2009-2012, the leading causes of death to infants and children 18 years and younger were conditions originating in the perinatal period (1,168); other (693); congenital malformations, deformations and chromosomal abnormalities (676); unintentional injuries (587); malignant neoplasms/cancer (71); assault/homicide (65); suicide (93); Influenza/pneumonia (20); diseases of the heart (19); septicemia (12); meningitis (3); and, cerebrovascular disease (2).

Factors in Indiana that lead to infant mortality include prematurity and other low birth weight causes (smoking, obesity, elective deliveries before 39 weeks gestation); limited prenatal care; unsafe sleep; socio-economic conditions; and, limited breast-feeding. Some of the ISDH initiatives to reduce infant mortality include the "Birth Certificate" bill, which reduces the timeframe to submit a birth certificate from 4 years to 1 year; the Medicaid "hard stop" policy on preventing elective deliveries prior to 39 weeks gestation; the neonatal abstinence syndrome bill; institutional remedies to help save Hoosier babies; grants; a sustained statewide infant mortality public-relations campaign; learning from other areas/ regions/states that have been successful in improving their infant mortality rates; a safety program; a statewide, strategic breast-feeding plan; and, and home visiting.

Representative Riecken asked how smoking effects children. Dr. VanNess responded the baby does not get enough oxygen. Chief Justice Rush asked if anyone is tracking the number of children who are born with drugs in their system. Dr. VanNess responded that this is a big problem and ISDH wants to start tracking this. Dr. VanNess reported the 2014 Infant Mortality Summit is Thursday, November 13, 2014, at the Indiana Convention Center. Dr. VanNess announced this would be his last meeting and thanked the members of the Commission for their work. He is stepping back into retirement, but will remain involved with the Commission through the Infant Mortality and Child Health Task Force.

b. **Deana Haworth, Senior VP & Director of Account Services, Hirons & Co**. Ms. Haworth presented information on "Labor of Love," the ISDH infant mortality public information campaign. Hirons conducted six focus groups around the state, which detected some confusion among expectant parents about the effects of smoking and drinking while pregnant, the normal length of a full-term pregnancy, breastfeeding, and sleep safety. Ms. Haworth also indicated that they discovered a lack of understanding of the first year of life and babies' needs and behaviors. She found that parents are not co-sleeping because of a lack of cribs, but because of their breastfeeding practices. The statewide campaign, branded "Labor of Love," is expected to launch in November 2014 and will include television (broadcast and cable), radio, digital (online, mobile, video, and tablet), transit, and ethnic media. The campaign strategy is to educate all Hoosiers that too many of Indiana's babies are dying before reaching their first birthday. The goals of the campaign are to raise awareness of the problem of infant mortality in Indiana, to encourage support for education and prevention efforts, and to educate Hoosiers that everyone has a role to play in ensuring our babies reach their first birthdays. There will be focused campaigns on specific issues addressing behaviors that heavily contribute to infant mortality. Outreach efforts will include smoking cessation, drug abuse (prescription and street drugs), elective early deliveries, safe sleep, breastfeeding, and level of hospital care. The

marketing budget for the campaign is $1.3 million dollars. In response to a question from Rep. Kubacki, Ms. Haworth noted that the mothers of young mothers would be one of the target groups for the campaign.

c. **Maureen Greer, Indiana Perinatal Quality Improvement Collaborative and Managing Director, Emerald Consulting**. Ms. Greer presented information on Institutional Remedies to Improve our Ability to save Hoosier Babies. There are 200 stakeholders involved in this initiative. The purpose of the initiative is to improve outcomes for high-risk pregnant women and newborns. Ms. Greer stated that while reducing infant mortality is a priority, we also want to reduce infant morbidity. To further that objective, the initiative seeks to create a certification process that establishes consistency in the level of care designation for all birthing hospitals; to implement standards for maternal-fetal and neonatal inter-facility transport; and, to establish Perinatal Centers of Excellence that build on existing hospital networks and their affiliate hospitals.

In 2004, the American Academy of Pediatrics (AAP) defined levels of care in three categories: Level 1-basic care; Level II-specialty care; and Level III-subspecialty care. Published literature between 1978 through 2010 demonstrates improved outcomes for very low birth weight infants and infants with less than 32 weeks gestation who are born in Level III hospitals. Very low birth weight infants born at non-Level III hospitals had a 62% increase in odds of neonatal or pre-discharge mortality, and the risk of death for very low birth weight infants born in Level I or II facilities remained higher than those born in level III facilities. Ms. Greer stated there is a need for every level of hospital. The 2012 AAP levels of care guidelines include Level I well newborn nursery; Level II special care nursery; Level III neonatal intensive care nursery (NICU); and Level IV regional NICU/subspecialty intensive care.

In October 2010, the ISDH's Division of Maternal and Child Health initiated the Hospital Levels of Care Task Force. The goal of the Task Force is to ensure that higher risk mothers and newborns deliver at appropriate level hospitals. Previously, Indiana hospitals could self-declare their levels of care, which led to inconsistencies among hospitals. The guiding principles of the Task Force are to achieve the best outcomes for mothers and babies; to comply with, but not exceed AAP and other national standards; to require that all standards be grounded in solid evidence; and to produce a visionary document.

The Indiana Perinatal Hospital Standards were finalized in 2012 and endorsed by the Governing Council in January 2013. A gap analysis survey was sent to each birthing hospital. Eighty-nine of the 92 hospitals completed the survey. Hospitals were sent findings with identification of components that were inconsistent with the standards. Too many very low birth weight infants were found to be in the lower-level hospitals, which resulted in poor outcomes. The study also found that while there has been an increase in NICUs across the state, they are not certified to the national standard of care, and there is much duplication of services. There is also much networking of hospitals, which does not necessarily lead to a higher quality of services.

Inter-facility transport is a critical component of ensuring risk-appropriate care for high-risk pregnant women and newborns. Nationally, inter-facility transport is largely unregulated and has wide variations in staffing, orientation, quality assurance activities, and policies and protocols. In Indiana, there are more regulations that govern the transport of animals than the transportation of pregnant women and children. The goal is to develop standardized procedures for the stabilization, consultation, and transport of high-risk pregnant women and neonates in

Indiana. The Indiana Department of Homeland Security and Emergency Medical Services helped develop the transport standards.

Ms. Greer stated perinatal coordinated centers of care are needed in order to provide risk-appropriate and timely care for women and infants; to decrease isolation for referring providers; to decrease maternal, fetal, and neonatal morbidity and mortality; to pool and share resources and to reduce redundancy; to improve perinatal outcomes; to provide education for affiliate hospitals; and, to monitor outcome data for resource allocation. In response to a question from Chief Justice Rush, Ms. Greer explained that infant morbidity is a problem because those babies are likely to end up in special education or have a high long-term cost to society. She stated that we have a shortage of risk-appropriate care in Indiana, and the most high-risk mothers cannot be treated appropriately in their current geographical districts. In some parts of the state, women can cross state lines and seek treatment in Cincinnati, Louisville, or Chicago.

d. **Maria Del Rio Hoover, M.D., Newborn Services, St. Mary's Hospital for Women and Children.** Dr. Del Rio, a neonatologist, reviewed the medical definition of Neonatal Abstinence Syndrome (NAS). NAS is a drug withdrawal syndrome that presents in newborns after birth when transfer of harmful substances from the mother to the fetus abruptly stops at the time of delivery. NAS is most frequently due to opioid use in the mother, but may also be seen in infants exposed to benzodiazepines and alcohol. Fetal exposure usually occurs for one of three reasons: 1) the mother is dependent/addicted to opioids, either prescribed or illicit; 2) the mother requires prescription opioids for another disease process; or, 3) the mother receives methadone therapy to facilitate safe withdrawal from addiction to prescription or illicit opioids. Nationally, the cost of health care for infants diagnosed with NAS rose from $190 million in 2000 to $720 million in 2009. During this same period, hospital stays for newborns shortened, but the average hospital stay for babies with NAS stayed the same.

   Senate Enrolled Act 408-2014 describes NAS as "the various adverse effects that occur in a newborn infant who was exposed to addictive illegal or prescription drugs while in the mother's womb." The bill mandates the ISDH to meet with specialists and representatives of various associations to define NAS, develop a uniform process for identifying NAS, and identify and review data reporting options.

   The Indiana Perinatal Quality Improvement Collaborative (IPQIC) NAS Task Force will assist the ISDH with the completion of the work and report mandated under SEA 408. The IPQIC NAS Task Force will review national guidelines, current practices from other states, and relevant literature, and identify promising/best practices for the identification, treatment, and follow-up of infants with NAS.

   Before November 1, 2014, the ISDH, in consultation with the IPQIC NAS Task Force, will report to the Legislative Council the appropriate standard clinical definition of NAS, the development of a uniform process for identifying NAS, the estimated time and resources needed to educate hospital personnel in implementing an appropriate and uniform process for identifying NAS, the identification and review of appropriate data reporting options available for the reporting of NAS data to the State Department, including recommendations for reporting NAS using existing data reporting options or new data reporting options, and the identification of whether payment methodologies for identifying NAS and the reporting of NAS data are currently available or needed.

By December 31, 2014, the task force will make recommendations regarding the feasibility of the ISDH establishing one or more pilot programs before June 1, 2015, with hospitals that consent to participate in the pilot program to implement appropriate and effective models for NAS identification, data collection, and reporting under Ind. Code 16-19-16, the section of the Indiana Code that deals with neonatal abstinence syndrome (NAS). Recommendations should include the definition of NAS, indicators to be collected, strategy for development of data collection system, personnel resources necessary for maintenance of data collection system, cost of implementation, and plan for ongoing collaboration with IPQIC.

The recommended obstetric protocol requires at the initial prenatal visit that the primary care provider, as part of a routine prenatal screening, conduct one standardized and validated verbal screening; and one toxicology screening (urine) with an opt out. At the discretion of the primary care provider, INSPECT and/or repeat verbal and toxicology screenings may be performed at any visit. The protocol also requires when the labor woman arrives at the hospital for delivery, hospital personnel is to conduct a standardize and validated verbal screening on all women, conduct toxicology screening (urine) on one with positive or unknown toxicology screening results, conduct toxicology screening (urine) on women with a positive verbal screening at presentation for delivery, and conduct toxicology screening (urine and meconium) on babies whose mothers had tested positive for unknown toxicology screening results.

The recommended NAS definition is babies who are symptomatic, have two or three consecutive modified Finnegan scores equal to or greater than 24, and have a positive toxicology tests or a maternal history with a positive verbal screening or toxicology tests.

5. Teen Suicide. **Dr. Thomas W. McAllister, M.D., Albert E. Sterne Professor and Chairman, Department of Psychiatry, Indiana University School of Medicine**. Dr. McAllister presented information on suicide in children and adolescents. According to national data from the Centers for Disease Control and the Prevention (CDC), suicide is the third leading cause of death among persons between the ages of 10 to 24, with approximately 4600 deaths per year. According to the Risk Behavior Survey administered to high school students nationally, in the prior 12 months, 16% of students seriously considered suicide, 13% created a plan, and 8% attempted suicide. In Indiana, suicide is the second leading cause of death among persons between the ages of 15 to 34, and the 11th leading cause of death in Indiana overall. Suicide consistently outnumbers homicide deaths in Indiana, for example in 2012 there were 935 suicide deaths and 344 homicide deaths. Serious suicide attempts are reported by 1.9% of high school students nationally, but in Indiana, the rate is 3.9%, double the national rate.

   Twenty-nine percent (29%) of students in Indiana reported feeling sad or hopeless almost every day for two weeks or more, resulting in behavior change. Nineteen percent (19%) seriously considered attempting suicide in the past 12 months, and 11% of students reported that they attempted suicide in the past 12 months. The risk factors for youth suicide include depression, substance abuse, stressful life events (grief/loss), trauma (psychological and biomechanical), environment, genetics and family history, prior attempts, incarceration, and easy access to lethal methods.

   The idea that suicide comes "out of the blue" is incorrect. Once an individual has a plan, the problem is in an "escalating phase." Therefore, Dr. McAllister emphasized that prevention is very important; it is critical to reach people before they have a plan, and especially before adolescence. It is also important not to separate suicide from mental health in general. Dr. McAllister reviewed the

relationship of suicide in adolescence to psychiatric illness. Based upon a study published in the Journal of the American Medical Association (JAMA) Psychiatry, the estimated lifetime prevalence of the representative sample for suicide ideation is 12%, suicide plans is 4%, and suicide attempts is 4.1%. Ninety percent (90%) had a psychiatric disorder and only about 55% had received treatment prior to the suicidal behavior.

Suicidal behaviors generally begin to start around age 10 and the time between suicidal thoughts, plans, and attempts is about one year. Suicide is a marker for several different psychiatric disorders. Half of all mental health conditions start by age 14; however, the average lag between symptoms and treatment is 10 years. There is evidence to suggest that early identification and intervention can be effective. Early identification and intervention will not eliminate or cure the disorder, but it will alter the trajectory in a significant way.

In Indiana, one in five youth have mental health needs. Nine to 13% have significant functional impairments associated with the mental illness, and 5 to 29% have serious emotional disturbances. There are greater needs in certain populations. For instance 50% of children and youth in the child welfare system have mental health disorders, and 67 to 70% of youth in the juvenile justice system have a mental health disorder.

Medical costs for patients with mental health and/or substance use disorders are 2 to 3 times higher than those without. Only 14% of people with insurance are receiving treatment of mental health or substance abuse issues, but they account for over 30% of total health care spending. We are paying the price for mental illness, but not for treatment of mental illness. Ten years ago, 13% of mental health care dollars were spent on those under the age of 21. This means the system is devoting more money after the illness has come to fruition.

There are gaps in treatment and treatment capacity. About 20% of those needing treatment received treatment in the past year, and 50% of those needing treatment have never been treated.

American Hospital Association data shows that nationwide, psychiatric inpatient beds dropped by 30% from 1995-2009. In Indiana, beds dropped from 257.5 beds to 19.3 beds per 100,000 population, which is half of the ideal number. There is also an unequal distribution of available beds. There are 52 shortage areas in Indiana. There are also psychiatrist shortages. Indiana is the 41st lowest in the nation in psychiatrists. There is only one residency program currently for child and adolescent psychiatrists, and the training slots are half of what they were 20 years ago. There is an economic disincentive to enter the field, it is the fourth lowest paid specialty.

The big picture is that suicide is a big problem worldwide. Several metrics suggest Indiana is an outlier. Suicide is strongly associated with psychiatric illness. The funding of psychiatric treatment has resulted in severe treatment capacity deficits. There is also a mismatch of resource allocation to the size of the problem. There is no single solution to the problem but prevention or mitigation of risk factors and improving access to care are two options to consider.

In response to a question from Rep. Kubacki about whether suicidal youths share their plans, Dr. McAllister stated that they sometimes do. More commonly, though, they are uncomfortable talking about it. He reminded the group that only 50% of youths who need treatment ever receive it. There are other clues indicating suicidal ideation, but those around the youth have to be attuned to them. The most important factors (but not the only factors) are major depression, substance abuse, and psychiatric disorders, with major depression being the most significant factor.

Dr. McAllister highlighted a few approaches being tried in other states and countries. These approaches include the integrated collaborative care model in California, the Australian "Headspace" integrated care model, the Minnesota school-based approach, and the Massachusetts child psychiatry access project. The Minnesota and Massachusetts programs began with grants, not legislation, Dr. McAllister noted, when answering questions. In response to a question from David Powell about the shortage of psychiatrists in Indiana, Dr. McAllister agreed that telemedicine might be a good short-term help, but it cannot replace personal connections. It is important to build local capacity to offer services.

6. Infant Mortality and Child Health Task Force. **Jane A. Bisbee, Co-Chair, Deputy Director for Field Operations, Indiana Department of Child Services; and Arthur Logsdon, Co-Chair, Assistant Commissioner, Health and Human Services Commission, Indiana State Department of Health**. Ms. Bisbee reported that the Task Force has primarily been focusing on infant mortality issues but plans on looking at child suicide and injuries to children in the future. Chief Justice Rush requested the Task Force minutes be approved and posted to the website within ten days.

   Mr. Logsdon presented the Task Force Report and Recommendations approved on September 15, 2014. The Task Force has met five times and has heard presentations on the leading causes of death for Indiana children, institutional remedies to improve our ability to save Hoosier babies, the child fatality review program, neonatal abstinence syndrome (NAS), and tobacco control interventions to improve infant mortality in children's health status. The Task Force presented six recommendations to the CISC to consider, which are derived from the presentations and the information contained in the report. The recommendations are:

   I. The CISC support, and the State of Indiana create, a Levels of Care certification program for all Indiana birthing hospitals.
   II. The CISC support, and the State of Indiana adopt, standards for maternal-fetal and neonatal inter-facility transport.
   III. The CISC support, and the State of Indiana establish, Perinatal Centers of Excellence that build on existing hospital networks and their affiliate hospitals.
   IV. Establish written protocols for obstetric and neonatal care.
   V. That a specific definition be adopted for Neonatal Abstinence Syndrome (NAS) and that hospital staff receive prescribed training for NAS identification.
   VI. That all worksites and multi-unit housing locations be 100% tobacco free.

   Mr. Logsdon said recommendations I and IV will be implemented through the Indiana State Department of Health's rulemaking authority, and recommendation II will be implemented by rulemaking either by the Indiana State Department of Health or the Indiana Department of Homeland Security.

   Senator Holdman moved to accept and approved recommendations I, II, and III. The motion was unanimously approved. The CISC agreed not to take any action on recommendations IV and V until the NAS Task Force has completed its report and recommendations and CISC members could receive more information.

   Superintendent Ritz stated she is concerned that recommendation VI is overly broad. She wondered how this relates to infant mortality. Miranda Spitznagle responded that lowering smoking rates

while pregnant would reduce infant mortality. Lilia Judson inquired about the unintended consequences of this recommendation. She supports reducing smoking but does not think this is the right way to do it. David Powell remarked that this would impact the elderly and others who live in public housing who have no chance of getting pregnant. He believes this recommendation is too broad and noted that it does not address e-cigarettes.

Gretchen Martin, Child Fatality Review Coordinator at the ISDH, explained the Child Fatality Review process. The objective of the Child Fatality Review is to accurately and consistently identify causes of death in children. Child fatality review teams look at autopsy reports and death certificates. Teams review any death that is sudden, unexpected, or unexplained; any death being investigated by DCS; or any death determined to be homicide, suicide, accidental, or undetermined—essentially, all child deaths not due to natural medical conditions. Another role of the child fatality reviews is to review risk factors involved in child deaths.

The law requires that child fatality review teams operate in every county or region. There are currently 81 counties participating in teams. All teams use a comprehensive web-based reporting system to collect information on the circumstances involved in child deaths. The information contained in the reporting system will be used to track trends, but is still in the early stages; the Department of Health has been reviewing this information since mid-2013. Local groups around the state have collected such data longer, but without any standardization. Chief Justice Rush said the CISC needs the child fatality review information in order to drive policy within the respective branches of government. Once the statewide report is available, she would like the report shared with the Infant Mortality and Child Health Task Force and the CISC. The statewide Child Fatality Review report is due December 28, 2014.

7. Discussion: Next Steps on Infant Mortality and Child Health. Commission members discussed how to assist primary care physicians address teen suicide; the need for statistics on the number of teenagers who are overdosing on drugs; the need for statistics on the number of children 0 to 18 who are dying, why they are dying, and how to get those numbers to go down; funding for the statewide infant mortality campaign; and replicating successful programs such as WIC and home visiting programs.

8. Open Discussion. Commission members discussed the following:

    - The possibility of expanding the rural family practice program to include psychiatrists.
    - Kevin Powell offered to present information about drug trends amongst kids in Indiana.
    - Dr. VanNess suggesting inviting the ISDH child fatality team to present its report and findings.
    - Rep. Riecken stated that she is interested in obtaining the cost projections for the Infant Mortality and Child Health Task Force's recommendations. They could vary between regions, and the costs might need to be incorporated in agency budgets. She also mentioned that efforts should focus on retaining psychiatrists and nurse practitioners.
    - How to increase funding for psychiatric residents and other strategies to keep psychiatrists in Indiana.
    - Superintendent Ritz observed that there is need for mentors for pregnant teens.

9. Topics for the November Commission Meeting. The topics for the November 19, 2014 meeting were reviewed. There will be presentations on Human Trafficking, an update from Representative

Christina Hale on the underreporting of crimes of domestic or sexual violence, and a report from the Data Sharing and Mapping Task Force.