

Fetal Infant Mortality Review (FIMR) and Healthy Start: Expanding Opportunities For Collaboration

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JOHANNIE ESCARNE: Good afternoon. My name is Johannie Escarne from HRSA's Division of Healthy Start and Perinatal Services in the Maternal and Child Health Bureau. On behalf of the division I would like to welcome you to this webcast titled "Fetal Infant Mortality Review (FIMR) and Healthy Start: Expanding Opportunities For Collaboration." Before I introduce our presenters today, I would like to make some technical comments. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentation. You don't need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. A 12 second delay typically provides optimal performance for the audience. We encourage you to ask the speakers questions at any time during the presentation. Type your question in the white message window on the right of the interface, select question for speaker from the dropdown menu and hit send. Please include your state or organization in your message so that we know where you're participating from. On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider which you can access by clicking the loudspeaker icon. Those of you who selected accessibility features when you registered will see text captioning underneath the video window. At

the end of the broadcast the interface will close automatically and you'll have an opportunity to fill out an online evaluation. Please take a couple minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support.

We have several presenters with us today, and I will allow Commander Madeline Reyes, Senior Nurse Consultant with the Division of Healthy Start and Perinatal Services, to introduce our presenters. Madeline?

MADELINE REYES: Good morning, everyone. For the past 20 years the national infant mortality review program has been a successful effort between the College of obstetricians and gynecologists and the Maternal and Child Health Bureau. This public/private partnership has been crucial to the overall expansion of the fetal and infant mortality review process. The purpose of the FIMR Resource Center is provide assistance to states and communities setting up or asizeing the process. Share pertinent information among communities and states, develop refinements and new approaches to the FIMR process to make it more responsive, efficient and effective and expand the use of the community problem solving techniques to other mortality and morbidity events impacting the MCH population. I will now introduce our speakers for today.

Our first presenter today is Kathleen Buckley. She has been the program director for the national fetal and infant mortality Resource Center since 1994. She received her

BSN from Cornell university and masters of science in nursing from Yale University. Before becoming the program director of the FIMR Resource Center she worked for 10 years as a nurse consultant and program coordinator for the infant mortality review program and the New York State Department of Health.

Our next presenter is Rosemary Fournier, the state FIMR coordinator from Michigan. She provides consultation and technical assistance to county-based FIMR teams throughout the State of Michigan. She received a Bachelor of Science degree in nursing from Oakland University in Rochester, Michigan. She has medical, clinical background in maternal and child health areas such as anti-partum high risk care, preconception care and counseling. Labor and delivery, postpartum, newborn nursery and neonatal care. She's worked in public health arenas with emphasis on prevention.

Our last presenter is the program director for strong beginnings, one of our Healthy Start projects in Grand Rapids, Michigan, Peggy Vander Meulen. She received her BSN from the University of Michigan and her masters from grand valley state university. Before becoming project direct for for strong beginnings she worked for eight years as the maternal infant health coordinator for three urban clinics. The previous 25 years were spent as an international health consultant for community-based maternal and child health organizations in Latin American, Bangladesh and west Africa and serves on several community coalitions and advocacy groups. Now we will begin our presentations. Kathleen.

KATHLEEN BUCKLEY: Thank you, Madeleine, good morning, everybody. I wanted to start by thanking the Maternal and Child Health Bureau for this great opportunity to talk about FIMR and Healthy Start and strategies for expanding cooperation. I also want to thank Rosemary and Peggy for coming from Michigan to share their on-the-ground experience with those expanding opportunities. For my little part of the webcast, I would like to first review with you some findings from the national evaluation. And second, I would like to talk to you about some common characteristic or threads of the FIMR process that can make it a good community perinatal systems initiative. Let's start by first of all saying -- next slide.

Once again that in FIMR is a Resource Center for the 200 plus FIMR programs all over the United States and it is a collaborative partnership between ACOG and the Maternal and Child Health Bureau. And 2010 marked the 20th year of that collaboration. So we're so pleased to continue with the bureau and continue to provide support to all the FIMR programs across the country. Just to talk about some of the goals of our presentation, next slide, we want to discuss the characteristics of FIMR that make it a community-oriented perinatal systems initiative. We want to describe the FIMR process. We also want to describe examples of how FIMR and Healthy Start collaboration and action have come about from the Healthy Start sites in Michigan and we want to hear from a local FIMR Healthy Start partnership program on behalf of families to see how that really works on the ground. Now for just -- next slide.

Just a reminder that for those of you who may not know FIMR, you may be thinking well, can this program really work? And thanks to the Johns Hopkins university School of Public Health, national study of FIMR, we know that it can. In fact, the researchers said the FIMR program also creates a setting and a set of concrete activities where everyone has a contribution to make and everyone learns from the process. The case study findings indicate that because the FIMR process extends beyond problem identification to promote problem/solutions, observable changes in practice and programs occur. Things get fixed and participants are inspired to take further action. And I think that's a resounding yes. Next slide.

This is from the same source as the slide before but one of the things that we learned early on is that there can be a synergy between FIMR and other perinatal systems initiatives. In fact, the national evaluation suggests that a community where FIMR and Healthy Start were both present could achieve as much as nine times more than progress in systems improvement for pregnant women. Here is a great benefit of FIMR Healthy Start collaboration. These enhanced results, I think, are worth striving for and worth every effort we can make to make that happen. Next slide. Now I would like to talk about just some threads that run through FIMR that can make it a good community partner. Next slide.

We always say confidentiality is key. FIMR cases are deidentified so the names of families, providers and institutions are confidential. The FIMR focus is not on improved -- is on improving systems, not assigning blame. We're not looking for bad apples.

We want to raise the system up so that good perinatal systems become better. The average become good and the sub part can move up to average. As we do that over time, the systems improve and families benefit. Next slide.

Now I like this slide. FIMR focuses on systems. Each FIMR case review provides an opportunity to improve communication among medical, public health and human service providers, and developed strategies to improve services and resources for women, children and families. We can get so boxed in in our own agency or institution it's hard to think outside the box or what could be new and improved? But when a group of people come together suddenly ideas just pop up and new ways of thinking enlarge and we're able to break out of those straight jackets of just thinking and really come up with some great ideas. So that's something that is a real benefit. Next slide.

FIMR includes a family perspective. The FIMR process includes a home interview with a mother who has suffered a loss if she agrees. And the mother's de-identified story is conveyed to the team members. A home interview is unique to FIMR and a special part of all of our programs. The interview reveals the mom's perspective on her infant's death and provides a window into her life in the community. The interview provides community-specific information that the vital statistics or medical data can never give us. And the home interview also provides a much -- can provide a much-needed bereavement support and a telling of the story of what happened to the mom's baby can really be therapeutic because sometimes no one will listen to the mom's story or let her talk about the death of her baby. And also, her story is presented to the

teams in a way that can't be denied or disparaged. And has to be seen as a crucial part of understanding why a baby died. Next slide.

FIMR promotes broad community participation. FIMR is actually a community coalition that can and should represent all ethnic and cultural community views and becomes a model of respect and understanding. You know, when FIMRs come together they come from all different viewpoints and missions and agendas and they're not sure why everybody else is in the room, either. After a couple of years it's very common to see a change in the dynamics of that group. They're very together, they're very supportive of their mission to improve services for women and children, and they have made a transition from perhaps none cooperation to wonderful collaboration and it is a type of team spirit that can spread throughout the community and make a difference for everyone. FIMR is action oriented, next slide.

There is all the men in the boat. They probably should be rowing in different directions. FIMR leads to multiple -- [inaudible] For five or six, for example, they might be working on improving SIDS risk reduction messages or improving services for moms who present with signs and symptoms of pre-term labor or perhaps working on ways to prevent teen pregnancy. There are lots of entry points where someone who would be interested in any of the activities of FIMR to become involved. And so I see that is a real advantage for partnerships. So just to recap, we've talked about five threads that run through and define the FIMR process. Confidentiality, a focus -- a primary focus on changing systems, the home interview as an integral part of

understanding infant mortality. Broad community participation and action-oriented activities. So these are things, I think, that show us how FIMR can contribute to overall community efforts. And I wanted to talk about them first. Rosemary will talk a little bit about the nuts and bolts of implementing FIMR and give you more information. Next slide.

If you would like more information about the fetal and infant mortality review process or contact us, our information is right there. We'd love to hear from you and we'll help you in any way we can. If you're interested in starting a FIMR. Thank you very much. And now I would like to hear from Rosemary.

ROSEMARY FOURNIER: Thank you, Kathy and thanks to Madeleine for the very warm welcome and introduction and I would like to add my thanks to the Maternal and Child Health Bureau and FIMR partners for this opportunity to get together and discuss the ways that fetal infant mortality review can work with Healthy Start programs to help them understand and address the local factors that contribute to infant mortality and I would like to thank my Michigan colleague Peggy for agreeing to join this program. She is here to represent a local Healthy Start start and local FIMR program which is truly what FIMR is about, a locally owned, action-oriented process that increases care for women, infants, children's and families. As Kathy has discussed the FIMR process is an intense data gathering system. It starts with gathering about a woman's care, the hospital care during and after delivery and infant care and all of this information is collected and compiled and presented in a summary to our community case review

teams and hopefully then the recommendations lead us to community action, which results in true community change in systems and care. The next slide, please. The FIMR process again brings together a multidisciplinary community team to truly examine these confidential de-identified cases of infant death and to better understand the local factors that contribute to fetal and infant death and identify areas where systems of care can be improve. Where barriers can be broken down and to really improve community resources for women, children and families. Next slide, please. Again, I want to emphasize that FIMR differs from other review processes in that it's a two-tiered process. We heard a pretty good explanation of the case review system. The multidisciplinary team but the second tier is the community action team where the cats are made up of community members who are invested and have tremendous political will and hopefully the fiscal resources to bring about these broad systems changes. Next slide, please. Very brief history in Michigan to give you an idea. FIMR started up in 1991. We were fortunate to have two sites funded from the original eight grantees and Saginaw and battle creek were the recipients of the grant. Next slide, please. Today we have 14 active projects in the State of Michigan and I think the important thing is that we have a FIMR presence in the communities that account for approximately 65% of all the state's infant mortality and closer to 90% of the African-American infant mortality. The next slide, please. Here you can see that there is tremendous overlap, the 14 FIMR projects overlap with the six federally funded Healthy Start starts. Each of our Healthy Start does have an active FIMR. Now again we want to emphasize that FIMR truly is an action-oriented, community-based quality improvement system. Is a process that continually monitors and looks at addressing

barriers to care and all of the different areas where we can better relate to infant and fetal mortality especially in low birth rate and racial disparities. Next slide, please.

There are three components of the FIMR process that I truly think are especially valuable to the Healthy Start. The first of those the very diverse community partnership building. Kathy already mentioned how it's very common when you get folks around a common table to do problem solving there are natural partnerships formed. Good examples of that in Michigan is that we now have local law enforcement talking pretty regularly with child protective services and the whole Maternal and Child Health arena. Those are very diverse partnerships that can result. It can't be emphasized enough the home interview of moms who lost babies are critical to get the stories of the moms and their experience with the healthcare system. The last are outcome interventions that are driven by and based on the findings of the review team. The community members and families who live, work, play and worship in the local communities so it truly is a locally-owned process and that is a component that I truly think FIMR can contribute to the Healthy Start process. The next slide, please. I now want to give just a few quick examples of some of the ways that Michigan's Healthy Start programs have taken some of the findings from their FIMR teams and translated those into action at the local level. Next slide, please. I'll start with an example from Saginaw county. The Saginaw county FIMR started in 1991, one of the first eight original grantees. And they are currently reviewing all the deaths of infants born live and do not survive until their first birthday. Next slide, please. The Saginaw Healthy Start program, great beginnings, started in 1998. They were funded in 1998 and annually serve close to 1,000 mothers, infants and children. Next slide, please. One

of the issues that Saginaw FIMR tackled early on. They found a large number of their infant deaths were associated with heavy substance abuse, smoking and illegal substance use. On the left side of this slide you can see of 228 infant deaths reviewed, about 42% of the moms who had lost an infant did disclose smoking during pregnancy. 16% used illicit drugs and 14% were using alcohol during pregnancy as opposed to the right of the slide that shows you what we know from the vital statistic data in that community. That was quite a bit lower. There is such value in giving the quantitative as well as the qualitative data for our reviews. The next slide, please.

What the community decided to do is form a community leadership team. They had 14 individuals on this leadership team who they actually sent for very intense training to the children's research triangle in Chicago. And a comprehensive community approach to substance abuse was developed. Comprehensive screening, referrals and treatment. The next slide, please. We worked closely with the hospitals to revise and develop protocol for universal drug screening. The community adopted a four Ps approach. If you aren't familiar, it stands for preconception, present drug use, parents and partner drug use. They assessed a woman's risk for using, smoking and drinking during pregnancy and tailored to the individual community. Training for our prenatal care provides provides and a visit by the doctor was able to community present to the community action and review team. Held a physician OB Grand Rounds on substance abuse. Did intensive training with substance abuse treatment providers in this community and culminated the village with a large community Town Hall Meeting which was very successful. The next slide, please. Briefly some of the results, Michigan now passed legislation that ensures public buildings, meeting and gathering

spaces stay completely smoke-free and there has been a decrease in current smoking moms of childbearing age in the community but the most impressive is a significant decrease in heavy drinking and binge drinking among women of childbearing age in this community. We truly believe they're the results of some of the actions by FIMR. The next slide, please, the Kalamazoo program began reviews in January of 1998. The next slide, please. Kalamazoo's Healthy Start was funded the year before. So actually preceded FIMR and serves about 385 families annually. In the Kalamazoo program they found a large majority of the infant deaths reviewed were due to prematurity and low birth rate. One of the significant findings they continued the find and through their home interviews is that moms felt they really didn't understand some of the symptoms and signs of preterm labor and often delayed seeking care or contacting their physician or primary care provider when some of those symptoms arose. A very unique partner developed between pharmacists and the FIMR community action team. The pharmacists actually agreed to put Brittany onstickers of all of their pre-natal vitamin bottles, every time a mom picked up the bottle it would give her information. And it truly was a constant reminder to the women of what were some of the signs of pre-term labor and to call their physician or provider early. And this also pointed to some unique refrigerator magnets and other nice ways to increased indication in the community. It is an older example but a good one of FIMR findings translated into action on the local level. The next slide, please. On the Kalamazoo FIMR program and Healthy Start adopted an ABCs of FIMR. A addressed a lot of the preand intercon sention issues. Avoiding unplanned pregnancy. Care for ones, before pregnancy being healthy and well cared for before you conceived. Decreasing stressors in a

mom's life minimizing mom's reaction to those stressors and eliminating risky behaviors such as unprotected sex, alcohol and drug use. Next slide, please. A third example comes from our Genesee county FIMR, a group that formed in 1999 and they review a pretty close to 1/3 of all of their infant deaths. They do a sampling of their deaths because they have large number. They found that a very large number, 41% of the deaths they were reviewing, were post neonatal deaths and truly SIDS and suffocation deaths involved infants being placed in unsafe sleep environments presented a large number of the 41% of all the deaths reviewed. The next slide, please. The Genesee program started in 1998 and they serve close to 725 clients. The next slide, please. The action that resulted from many of their reviews were that FIMR engaged community partners. Their council for child abuse and neglect, ready, set, go and passports. The priority children to launch a large stay safe sleep campaign. Some of the components of the campaign included a crib giveaway. Getting pack and plays to give to families with no other resources for safe sleep for their babies and a grant provided funding for this from their local foundation. They were able to get a safe sleep educator who could give away the cribs and do a tremendous job in educating the mom on use in the crib and place their babies to always sleep in a safe environment. They had Post-It notes to make sure everyone who was a caregiver of their child. Finally, I think a very creative thing that came out of their campaign was developing a stamp for pediatric charts. That reminded the pediatric provider that every time they saw a mom and encountered the baby in their office it would remind them to ask this new mom about safe sleep. The next slide, please. This is what that looked like, a checklist important the provider to ask mom. Is baby always sleeping on

back and alone in their crib, to fluffy or loose bedding and mom is teaching all other caregivers the same techniques for safe sleep. The next slide, please. Results in this project were that 928 clients attended the safe sleep class and over 900 pack and plays have been given to expectant parents and the large decline in infant mortality in this community. It's decreased over this time period from 13.1 deaths per 1,000 live births to 8.1 deaths per live births. And it's declined from 4.3 deaths for 3.1 deaths. The actual number of postnatal deaths has gone from 33 to 19. Some very promising results from the community action. The next slide, please. A fourth example comes from our Detroit FIMR, this is one of our projects that is a city projects rather than a full county project and the Detroit FIMR ran for three years in the early 1990s and resumed activity in 2001. They currently review a sampling of their infant deaths and Detroit has been one of the Pilot projects for two unique expansions of FIMR demonstrating how the FIMR methodology can be expanded to study other events such as prenat -- looking to mother to child transmission of HIV. I'll speak more about that later. The next slide, please. Detroit's Healthy Start was funded in 1992. And serves about 1,800 clients annually. The next slide, please. A project that came out of many of Detroit's FIMR projects is their life groups. They found continually in reviews that women needed a more thorough understanding and planning and preparing for pregnancy as an essential step to reduce racial disparities and created life plans that included reproductive life planning and decision-making tools for family. The primary goal is to improve pre and interconception health. It's a program in progress. The next slide, please. My final example comes from our Native American FIMR. Their FIMR started in 2003 and they are a very good example after partnership because they

actually meet in conjunction with their Healthy Start consortia. They meet twice yearly and uses many members of their consortia to be their community action team. The Healthy Start project in Michigan for the Native American was funded in 1998 and serves 530 clients annually. The next slide, please. A problem that the Native American FIMR addressed head on was like Genesee, identifying large numbers of infants dying in unsafe sleep environments. They've launched a community awareness campaign and updating and revising client brochures to be very culturally relevant to the Native American population. Materials for discussion are being developed for their groups and community conversations are being initiated with local tribal communities and tribal leaders and ways to support prevention efforts better in their communities. The next slide, please. Before I leave the local examples I just wanted to mention that FIMR what actually been instrumental in bringing about legislation in regard to safe sleep and suffocation in Michigan. After hearing a presentation a local legislator introduced house bill 52.25 which was public act 179 in Michigan that mandates investigation and autopsy by local county medical examiners in cases where infants have died unexpectedly under the age of two and it has helped the state with the accuracy in how they determine infant cause of death in the county examiners. The next slide, please. Before I leave this part of the presentation, I did say that I would mention very briefly the expansion of FIMR to another methodology and that is our FIMR HIV prevention methodology in Michigan. This really shows excellent ways the FIMR model and methodology can be adopted to other events such as FAS and HIV transmission to infant. The goal is to improve systems of care by identifying systems that can be approved using the FIMR process and the community

action process to help us identify ways we can prevent perinatal transmission of HIV. Identifying system strengths and missed opportunities are the goals of this project and ultimately to prevent mother to child transmission of HIV. The next slide, please.

Michigan's project is a state-led but locally focused project and a collaboration between the Division of maternal, child and community health and the Division of health, wellness and disease control, HIV/AIDS prevention and intervention section of MDCH and our Ryan white partners are critical to this program. We're one of two state projects funded and one of nine total projects around the U.S. and again it's a national collaboration with center match, the city for disease control and prevention. The mortality review program and ACOG. The next slide, please. So just to summarize how FIMRs and Healthy Start may work together. FIMR findings have urged a community to ask for Healthy Start when they've identified systems issues. It has been an impetus to say we need the health and support of a Healthy Start program. They may fund FIMRs in whole or part. They may ask the Healthy Start consortia as example in our Native American project to act as the community action team and there are many cross over members that Healthy Start start review teams as well as their action teams. The next slide, please. Because I opened the door and mentioned funding and applying for grants this is an old slide but I use it to illustrate how well one local community was able to use FIMR data and findings to apply for a plethora of other grants. Federal and state grants. In the 10-year time period the Saginaw community had obtained quite a bit of assistance both Federal and state and as that process continued you can see how the infant mortality rate dropped from 53 deaths down to 21 in that time period. The next slide, please. I am very grateful to close now

and turn this part of the program over to Peggy Vander Meulen who will bring us examples of the local community and how the Grand Rapids and east county Healthy Start programs have taken FIMR findings and translated them to action.

>> Thanks, Rosemary, very glad to be here. Thanks for inviting me to join this wonderful team. Great to be here and share some of our story with you. Before I start, I wanted to take just a minute to honor and recognize Dr. Joseph Moore, who among many, many other things was our FIMR medical director. He died shortly after Christmas. He is greatly missed. He was a most gentle soul but the most passionate advocate for women and children you can imagine. We were honored and blessed to have him in our community and will continue the legacy that he started there. Honor Dr. Joseph Moore. Next slide, please. Start with just some background, history, how we came about and then gave an overview in the ways our local Healthy Start has worked with FIMR and end with a specific project with started in response to a FIMR recommendation. We have an entity called healthy 10 2020. One of the teams is the infant health implementation team. The I team. Back in around 2000 the I team consisted of 15 volunteers from eight or ten different agencies struggling to develop activities to address the huge racial disparities in infant mortality we had in Kent county. We had a sense of what some of the national research was showing about the causes of infant death but we wanted to drill down and learn more about the local situation and what was contributing to the inequities in infant death. The infant health team with spectrum health was instrumental in bringing it to the county in 2001. Next slide, please. So using FIMR findings, perinatal periods of risk analysis, input from 2000 residents. National research health teams identified three key areas that we

thought would have the greatest impact in reducing mortality. These were preventing unintended pregnancies. Access to quality care. Not just care but care that would address all the social determinants of health and racism. Next slide, please. So that package to activities to address those three issues was called strong beginnings. In 2003, when Grand Rapids had the unwanted distinction of being the city with the highest black infant mortality in all of Michigan at 22.4 black infant deaths per 1,000 live births we decided to apply for a Healthy Start grant. We were funded in 2004. And continued the work to address African-American infant mortality through the program of strong beginnings, the Federal Healthy Start. In the meantime the infant health team has grown to be about 65 or even 70 members now from 30 different agencies with 12 committees many of them created because of FIMR recommendations. I want to point out, too, since 2003 Grand Rapids has gone on to improve its black infant mortality. We're down now from 22.4 down to 17.5 so that is improvement. We have a long ways to go yet but we're going in the right direction. Next slide, please. So the infant health team serves as our strong beginnings Healthy Start community consortium for local systems level work, for developing that local Health Systems Action Plan that all Healthy Start projects are required to have. The infant health team also serves as the community action team for implementing FIMR recommendations. And you can notice a few other roles, the advisory board for our nurse/family partnership. Next slide, please. Just shows the structure of the infant health team with the executive committee at the top. Strong beginnings at the top there and then the different committees. You don't need to really look at this. Just to show you there are a lot of different groups working in different aspects related to

maternal and child health. So the executive committee for the I team includes myself, the Healthy Start director and Sara McDonald the FIMR coordinator. The executive committee sets the overall strategic plan for systems work and each of those 12 committees is responsible for creating their own action plan and members of the I team sit on both of those committees to ensure coordination. Next slide, please. So both the FEMA coordinator and Healthy Start director sit on the executive team. Three of our community health workers sit on FIMR's case review team and some of our community health clients or program participants so they are able to provide that consumer and community level perspective to the review team. Several of our partner agency staff also sit on the case review team. I would like to mention right now that strong beginnings is a community partnership. We have six partner agencies that we collaborate with that forms strong beginnings. Those are the Kent county Health Department, the Grand Rapids African-American health institute. Arbor circle. The community mental health provider. Cherry street health services and metro health. Next slide, we bring FIMR recommendations at the monthly I team executive committee meeting. So far she's brought us 40 recommendations, most of which we either have implemented or in the process of implementing now. Then the I-team executive discussions how to implement those recommendations, which could be adding them onto existing committees, forming new committees to address a specific issue, adding them to the greater overall strategic plan or in some cases deciding they don't apply to the interest fant health team. One recommendation would have medical records in the hospital. So that is kind of out of our arena. We don't address every single one of the recommendations we get. Next slide, please. So in order to

executive committee the infant health team meets as a broader membership every month and a report on FIMR updates is a standing agenda item at each of those meetings. Sara presents at each of the meetings. One of the I-team's subcommittees is the Maternal and Child Health program. A visiting program for pregnant women and infants on Medicaid. Every two months the FIMR coordinator also presents her findings, recommendations, we have discussions with the MIHP providers. Next slide, please. So the FIMR coordinator and medical director come every year to one of the strong beginnings advisory board meetings as well as to the full I-team meetings and present their annual report. I get an overview of what has happened over the past year, where we are with infant mortality and what recommendations are being implemented. At the same time the I-team members and our advisory board members provide feedback and suggestions to FIMR. Next slide, please. Another way that we've collaborated with FIMR is through funding. In the first couple years of our grant we did include FIMR as part of our funding to support and expand FIMR. Unfortunately we have not been able to continue that, as you know, flat funding, increase in program costs, we have not been able to continue funding FIMR. However, we did help them obtain separate funding for the past few years. At the same time, FIMR findings have helped us obtain Federal and local grants. Just one example, FIMR did a factor analysis and found that mental health issues, depression and multiple stressors were involved in 42% of our black infant deaths in Kent county. Using those data we were able to go to a local foundation, the Grand Rapids community foundation and obtain funding to expand our mental health program. Next slide, please. For several years, I was the supervisor for the FIMR coordinator. One of the recommendations that the infant

health team had made to FIMR is we wanted to expand from reviewing only African-American infant deaths to review all infant deaths in Kent county. So we had no money to increase the staff so we sat down and tried to identify where the bottlenecks were in the process. And once we had done that, we found -- developed ways to streamline the process so that it could move along more quickly and efficiently and increase the number of cases reviewed. In 2006 we partnered with FIMR to obtain an additional \$100,000 grant for FIMR and these two streamlining processes and the additional funding FIMR is now able to review all infant deaths in our county and up to 50 to 75 per year. Next slide, please. Not only does FIMR give the infant health team recommendations, we also give -- make some recommendations to FIMR, which they have adopted. For example, we know that periodontal disease can be a factor in premature to low birth weight and we asked them to add that information to their interview. Access and utilization of birth control and the experience of discrimination based on race, ethnicity or social or economic or insurance status. So FIMR has incorporated all of those questions into their interview providing us with very valuable information. Next slide, please. You may know that both HRSA, the Maternal and Child Health Bureau and the Michigan Department of Community Health have adopted the Life Course perspective as their framework for action to reduce infant mortality. Our Kent county FIMR also adopted the Life Course perspective as their framework for making recommendations and documenting implementation of those recommendations and it's based on Dr. Michael's 12-point plan. For example, to provide interconception care to women with a prior adverse outcome. To improve the quality of prenatal care and to eradicate racism. All FIMR recommendations and the

community action team's actions are framed within those 12 points. Next slide, please.

From beginning Healthy Start and FIMR also collaborate by doing a lot of joint education. The FIMR coordinator has done many presentations to our lactation consultants, pre-natal educators. One recent example a couple months ago our strong beginnings educator and FIMR coordinator did a joint education on safe sleep to 50 workers with the Department of Health, Human Services who are involved in child protective services giving them information and some education on safe sleep. Next slide, please. We've also created and done a number of joint presentations. For example, coming to the FIMR state coordinator's meetings to present some of the work on prenatal and screeners we developed in Kent county. We did a joint presentation at the CDC preconception health conference in California. The CityMatCH conference in 2009 and right now Sara and I are in the process of writing an article together that we hope to submit for publication this year. Next slide, please. These are some examples of activities that the infant -- the results of FIMR recommendations. Past pregnancy had a poor outcome -- we have 100 -- [audio coming in and out] So we think that has been very successful. Disorders -- next slide, please. Fatherhood coalition, we have hosted home-based preconception health parties for more than 200 women. We worked with 13 regional hospitals who develop a standardized policy on safe sleep so that what patients were being told in the hospital matched what we were teaching in the community. All the hospital staff were trained and they developed patient education materials. Next slide, please. I'm going to give you just one example of just one program that we conducted based on FIMR's recommendations to reduce unintended pregnancies. As you know, this is a major factor in infant mortality and we

did a number of activities around this. Created a pregnancy prevention committee. We had to send an intern to pharmacies to find out which were wanting to pass on contraception and pocket cards and know where to go if they needed it. We created a community outreach program. That's the one I'll talk about now. Next slide, please.

The community outreach program had multiple components. We trained peer educators who then went on to host group conversations. We conducted neighborhood outreach, made referrals for home planning. Developed risk screening and counseling tools, distributed pre-conception health kits and provided free birth control. Next slide, please. So in 2006 we received state funds to fund this program. The objective was to engage hard to reach African-American women in family planning services. So we started by training 53 non-traditional leaders and members of six community-based organizations. Sororities, church groups, so on. They were trained by planned parenthood and family planning and tomorrow's child. Michigan's SIDS alliance in safe sleep. I'll only talk about the family planning portion right now. Next slide, please. The training on family planning included the benefits of family planning, how to talk about it. What are your birth control choices, how to talk with your partner about birth control. What are the risks of having unintended or closely spaced pregnancies and how to access local family planning services. Next slide, please. So these then 53 peer educators brought in their peers, women and men from their social network, and shared what they had learned on family planning and birth control. And nearly 300 people participated in these small group discussions. Next slide, please. We also had a larger community group education effort for 80 residents and for everybody who participated they showed significant increases in knowledge about

contraception and preventing unintended pregnancy. Next slide, please. Two of these community-based organizations then in the summer months went out and blanketed two of the urban neighborhoods that had the highest black infant mortality rates and they provided education on family planning to approximately 450 urban residents one-on-one, door-to-door. Next slide, please. Through these door-to-door visits, they identified at least 200 women who were sexually active and not currently using birth control and referred them to Planned Parenthood for family planning services. These women said when they showed up for their family planning visit were given a \$15 gift card. Now, the gift card was not to pay them for going to birth control. It was to help cover associated costs such as transportation or childcare. Next slide, please. We then used these funds to cover the costs for physical exams, SDI testing and birth control for one year, 465 of these women who did not have coverage for family planning purposes. The other thing we did was created a screening and counseling tool for women who showed up at family planning centers who had a negative test and who did not want to be pregnant at that time. Next slide, please. We've screened more than 300 women and counseled and we found that at least 90% of these women had at least one risk factor. For example, 93% did not want to be pregnant in that year and nearly half of them were not using any form of birth control. 42% had been treated for an SDI. 30% were screening positive for depression. They were smoking, using and drinking alcohol. Next slide, please. Women who are at risk of having a poor pregnancy outcome if they become pregnant at that time because of the risk factors that had not been addressed at that time. So these women who were coming in with a negative pregnancy test, each one was given a wonderful canvas bag with a cute logo

and a preconception health kit that contained dental supplies, condoms, vitamins, home pregnancy test, farmer's market coupons, health education materials and local resources. We've given out more than 1,000 of these kits so far. Next slide, please. So that's what we've been doing so far. A few examples of our joint work. In this coming year we do have a few other FIMR recommendations that we would like to find ways to implement. For example, one new recommendation is to establish standards of care for women who show up in the emergency room who are pregnant but not active in prenatal care and produce a joint report on the past five years of infant health teams, FIMR, strong beginnings, Healthy Start collaboration and submit that article for publication. Next slide. So I would be happy to answer any questions if you want to have more information at any time, feel free to contact me. I know I can speak for Sara McDonald, our FIMR coordinator who would be happy to share knowledge, resources, information with you. Feel free to contact me any time. Thank you.

>> We now are into the question and answer portion of our webcast. The first question that I received is for Peggy. The question was, you mentioned that FIMR got \$100,000 after Healthy Start funding. Where did that money come from?

>> That was a mental health foundation provided that funding. And the funding was given in 2006 and they didn't spend it all in the first year so that money is still available for ongoing projects and it was used partly to support FIMR's salary but to provide a \$50 gift card to women who participated in a home interview. That takes about two hours, 2 1/2 hours, so this is a way to thank these women for their time so that funding was used for those gift cards and I know they were greatly increase the number of women participating in those home visits as a result.

>> Do we have any questions from the audience in the room?

>> You can speak from there. The mic is right there.

>> I wanted to know from any member of the panel whether you could give some examples of how racism is manifested in practice.

>> I will take a stab at giving a few examples. I do vividly remember interviewing a woman, this was before I was doing state technical assistance and worked in my local project. A woman I was interviewing -- said I had to wear my wedding ring every time I went for prenatal care. As a pregnant woman myself it would have occurred to me. Now my fingers are swelling, I'm taking off my ring. She had to do that so that she presented herself to the provider as I am -- not a mom on welfare having a baby. She felt she was treated very differently. And it was a very vivid example. How your care is perceived. How a provider presents. I do think that's one very specific example.

>> I know we have had many stories, too, of women -- [audio going in and out]

>> They're treated disrespectfully. Oh, I know. Some of them are clients who in the hospital, after they had given birth, were asking for their babies and about breastfeeding and told by the nurse you don't want to breast feed, do you? Just the assumption because you're African-American you're not going to breast feed. We've heard that many times over.

>> And I know that some moms have said to interviewers, if only, you know, if only I wasn't on Medicaid, then maybe my baby would have been alive. So presuming that they weren't getting the same care as everyone else. So that's something, even though -- even though the care may have been very, very good, but it's this whole perception that they're second class. They're second class services are provided.

>> I know, too, there are -- it's not even just one individual example. The way that racism impacts infant mortality is the chronic stress of a lifetime exposure to race, to these daily, you know, being harassed driving, being followed in the store, being snubbed by the receptionist. All of these daily humiliations that build up and then produce measurable physiological changes in the body as you're under this constant stress. Increases in blood pressure, decrease blood flow to the placenta when you're pregnant. Growth retardation. All of these cascade of events.

>> Another question for you, Peggy. What is the Kent county funding for FIMR chart abstractor?

>> The chart abstractor is Sara McDonald. I hope I get this right. Sara McDonald is the coordinator and she does the chart abstracts. Her -- the funding for FIMR comes from a number of entities in Kent county, spectrum health, an employee of there as I am. St. Mary's healthcare, priority health, an HMO, metro health and Kent county Health Department all provide funding for FIMR. And I know there is some reimbursement from the state for some of the cases that are reviewed and the funding goes to the Kent county Health Department and if I understand this correctly, the Health Department provides the grief team that actually does the home interview.

>> That's correct. There is a very small stipend the state can provide to help augment the abstractor's time. It's a small fee per case that is provided.

>> Does that answer the question?

>> This is comment, not a question. For the last three years our division supported a project around the country in which state breastfeeding coalition received training in the use of our kits for breastfeeding and I just wanted to compliment Peggy because

she had applied. It was on a competitive basis. And people had to submit applications and then there was a small committee here that chose them. And Peggy was instrumental, the leader, I would say, in submitting an application from Kent County. Now, in general, we only gave grants to state breastfeeding coalitions, but in the case of Michigan, because of your leadership in applying, we actually provided two trainings. One for the state and one for Kent County and so I just -- I just wanted to thank you for that and compliment you on that. Because I think strong leadership is a major factor.

>> Thank you. That was very kind and yes, we've had a great time implementing the business case, what we learned was an amazing training and I hope that -- I know there has been talk about it coming to life again. I hope that will be the case because it really is valuable training. It's wonderful. Truly, it really is the collaborative that we had. We had that breastfeeding task force, which is one of the committees of the infant health team and working with FIMR, so it really was a true collaboration of many people involved in that. Thank you.

>> Very good example of collaboration in action.

>> Do we have any other questions in the room? Any comments before I turn it over to Madeleine for a couple of thoughts? Question from the audience? We haven't gotten any, sometimes they're furiously typing. Do any of the presenters have any couple thoughts before I turn it to Madeleine?

>> I just want to thank Rosemary and Peggy. Their presentations were absolutely marvelous and it really, really helps us see how FIMR and Healthy Start can collaborate on the behalf of mothers and babies.

>> It was an honor to be included. Thank you.

>> Thank you.

>> We haven't gotten any other questions from the audience. Audience members, if you have a question that comes in after we close I'll send the question to the presenters just in case we miss you. Madeleine, do you have a couple thoughts?

>> I just want to mention that we're happy to report that 88 of our Healthy Start grantees have a FIMR project and strongly encourage those thinking about starting their own program to talk to and reach out to Kathleen Buckley for technical assistance and also to our existing Healthy Start sites and Peggy and our other Michigan sites out there. We really want to dispel the myth that Healthy Start funds cannot be used to start a FIMR program, because I think that was kind of going around for a while and that's really not the case. But I want to thank all our speakers for their great presentation today. And we hope that the audience received some valuable information. Thank you.

>> Thank you, Madeleine.

>> And on behalf of the Division of Healthy Start and perinatal services our want to thank the Center for education at the University of Illinois Chicago School of Public Health for making this technology work. Today's webcast will be archived and available in a few days on the website mchcom.com. We encourage you to let your colleagues know about this website. Thank you and we look forward to your participation in future webcasts.