

## **MCHB/ DHSPS October 11, 2005 Webcast**

### **Using the PPOR Approach to Implement New Policies and Programs**

JOHANNIE ESCARNE: Good afternoon, my name is Johannie Escarne from the Maternal and Child Health Bureau. I would like to welcome you to this webcast. Before I introduce our presenters today I would like to make a few technical comments. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentations and you do not need 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.

We encourage you to ask the speakers questions at any time during the presentation. Simply type your question in the white message window on the right of the interface, select question for the speaker from the dropdown menu and hit send. Please include your state or organization in your message so that we know where you are participating from. The questions will be relayed onto the speakers periodically throughout this broadcast. If we don't have the opportunity to respond to your question during the broadcast, we will email you afterwards. Again, we encourage you to submit questions at any time during the presentation. 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 have 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 the opportunity to fill out an online evaluation. Please take a couple of minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support. We are very pleased to have four speakers with us today who will discuss various aspects of the PPOR approach.

The first speaker is Magda Peck, senior advisor of CityMatCH. Magda will discuss the objectives of this webcast and the six steps of the PPOR approach. Our next presenters are Mary Balluff chief of the health and nutrition community services at the Douglas County health department and Judith Hill. Mary and Judith will address an action plan using PPOR. Our final speaker is Carol Brady executive director of the northeast Florida Healthy Start Coalition and discuss the link between PPOR and the fetal and infant mortality review. In order to allow ample time for the presentations we'll defer questions to the question/answer session at the end of the presentation but send in your questions by email at any time during the presentation. Please identify which speaker the question is for. Without further delay we would like to welcome our presenters and audience and begin the presentation. Magda.

MAGDA PECK: Well, thank you so much. We're delighted to spend time with all of you via the webcast to tell you about perinatal periods of risks in action. We want to be able to accomplish today in our ob -- objectives so that you have an overview to the Perinatal Periods of Risk approach. We'll focus on two communities where Healthy Start is active

and present to talk about how they have been able to use Perinatal Periods of Risk to get some data to action. And then finally we're going to learn about some strategies to be able to strengthen partnerships because Perinatal Periods of Risk is best done in collaboration and partnership with the essential community players that Healthy Start is such a major part of. And that will move us to new policies, new programs and strengthened action.

Next slide. We're doing this in the context of being part of the CityMatCH family. We've been working with CityMatCH and the Maternal and Child Health Bureau and the Healthy Start program for a couple of years now. And our mission, as you can see on this slide, is resonant with what Healthy Start is all about as well. We have the opportunity with supplemental funding from the Maternal and Child Health Bureau to be able to train over 75 Healthy Start sites about the Perinatal Periods of Risk approach. This is not brand new to most of you but it is about achieving this mission for healthier women, children and families in urban communities of the United States and in larger communities as well.

Next slide. Let me start first in this very brief overview that I'm going to give you to talk about why PPOR. What is the difference about adding this particular tool? We've identified six value adds that might be useful in your work in Healthy Start. We know that infant mortality is not one thing. And so there is no one thing that we can do to reduce and prevent babies from dying in the first year of life. What PPOR can do is to provide a common framework for communities to understand a very complex issue like infant mortality. It allows us to take very old data, existing data, and express them in new ways to allow us to prioritize our actions. It allows us to have a value-add that builds on other

existing community efforts and allows us then with this new way of looking at data together with our partners to figure out more clearly where are the gaps and what can be some very key ways for us to target some explicit resources to fill those gaps? Targeting is the key. It's so big and it's so much. How with PPOR help us to be specific, targeted and strategic and how can we mobilize communities to action? That having been said PPOR has been around for a number of years in the U.S. setting.

Many of you know it came from a World Health Organization setting and was applied by CityMatCH in partnership with many other organizations, including CDA and HRSA and March of Dimes and where CityMatCH is located to put it as a six-step approach. If there is one thing to leave you with today it is not just about data. It is about transferring that data into action by following the success which aligns with the community planning process that many of us know in the Maternal and Child Health program. Let's focus on steps one and two in my part knowing when you hear the stories from our two communities they'll be the illustrations for steps three, four, five and six. In step one it's all about assuring analytic and community readiness. The data don't come first, the community always comes first. Because we are those who must understand and interpret this information so that it can be translated into action. Let me start with the issues of community readiness.

Next slide. What do we mean by having a community that is ready? Ready to utilize PPOR and ready to go beyond what has already been done especially in a community where Healthy Start is active and vibrant? We need to have champions and leaders who

are adequately trained professionals who can understand and articulate the complex problem of fetal and infant mortality and understand how data leads to a work plan. We need folks committed to be able to put the resources where action tells us to go. We need to make sure there are adequate community resources to get us beyond collaboration and move us to action, strategic actions. People need to make it a priority.

Readiness is critical up front and next slide, CityMatCH has developed a series of tools that can help us form and facilitate the conversation about readiness. Now, on the website we have, as you can see where it says community readiness from tools, concepts and tools we have developed a package, a toolkit that you can work with each of your communities to try to feel that understanding about how ready are we? We build this off of the concept and organizational change in the literature about leadership, partnership and commitment and we've developed what we call the community readiness based on five basic principles that you can assess and read consensus upon in your own communities. I'll articulate them. You need to know why you want to do PPOR, the reasoning. You need to know the results that you want to get. You want to be able to be very clear about the roles that people will play. You need to be able to understand the risks and rewards for taking on those roles, and mobilize the resources to allow you to move from data to action.

Next slide. In step two of perinatal periods of risk we focus with assumption of essential and adequate community readiness on the data themselves. As you can see in this slide take any urban county, we've been following the white and black infant mortality rates for years looking at them as trend lines on being able to see how information can be

translated but the lines themselves rarely tell us what to do. And we have found in many communities that these kinds of traditional ways of looking at data are necessary but insufficient.

Next slide. So if we're going to employ the PPOR way of looking at our data, we need to make sure that we now are also analytically ready. That means having access to fetal death information and not just infant death. There are so many events beyond infant death that we can look at. In fact, in many communities we're missing half the picture if we look at infant deaths alone. We must have access to fetal death certificates for those deaths that occur after 24 weeks gestation and the infant death certificate, if the death occurred greater -- before the first birthday. Most importantly for PPOR analysis we need to link those. You need to have a link tile which puts the fetal death and infant deaths together with the birth certificates as well. We need to have a critical number of events overall and in each of the cells that I'll talk about and you need to have a good understanding realistically how good your data are. What are the data that you're missing? What are the quality of the information you have at hand? Information about analytic appears on our website.

Next slide. Now, this is the famous map that many of you have seen. Our four-colored approach to mapping a combined fetal and infant death according to the two most powerful predictors of who will live and who will die. The first is a predictor of the age of death. When did death occur? 24 weeks gestation through to the first birthday and we've partitioned this off into fetal, neonatal and infant and post neonatal periods as we do in

traditional analysis but we do something unique in PPOR. We focus on the point of 1500 grams and that means that we're looking at very low birth weight as the major part of low birth weight. I like to show what I've learned from a person who helped with the PPOR approach and talk about babies that can sit in the palm of your hand under 3 1/2 pounds. Our tiniest babies. By doing this grid that partitions off when babies died and how much did they weigh when birth occurred we create these four periods of risk which we've known. Prematurity, maternal care and infant care. For communities that have trouble with the language because it sounds technical we've given them colors. In some communities you may say what is happening in the blue box, our pink box, our yellow box, or our green box? These cells form the framework that allow us to sort when death occurs and what we can do about it.

Next slide. PPOR is about action. It's about taking what happens in each of these boxes, finding out where the greatest problem is and targeting and focusing our intervention and follow-up analysis so we can prioritize and so you have suggested areas in this slide about the efforts that we'll take on.

Next slide. Some folks think that this is what PPOR is about. Well, you have some data and you link it, you sort it and say oh, we have a problem in our blue box. I would tell you that's a good start but only the beginning. Because the essential part of the initial analysis with perinatal periods of birth is looking at disparity. And we have defined disparity in somewhat new ways. So you will see in some of the examples that follow with our communities that you'll hear about today, Omaha and Jacksonville that it is critical to look

at black, white and racial disparities. We defined disparities differently and try to identify what the gap is between the infants who already have the best outcomes and where your community or part of your community is already at. We estimate the gap for disparity using a comparison of the best possible outcomes groups. Nationally we've identified this to being babies born to women who have more than a high school education, who are 20 or more years of age and who are white, non-Hispanic of their racial and ethnic origin. We've found nationally that this is where the best results happen. Where the lowest death rates occur. By comparing your community, or a part of your community, with this comparison group, you can see what the gap is. Not a gap necessarily in terms of 2010 and where we would like to be. Some infants and their mothers already are. In fact, what I love about the perinatal period approach is that it's a social equity. It is a social justice approach to ask the fundamental question, why can't all of our infants have the same results and good outcomes that some already are?

Next slide. PPOR also fosters integration. It is not about a stand-alone we have our PPOR project. No, it must be integrated with other key efforts in Maternal and Child Health. As such it will be an essential linkage for fetoinfant mortality. PPOR can help you identify which cases to review or which cases more you would like to review. Maybe you would like to target and review under 1500 grams deaths that are occurring or maybe you want to focus on later, larger deaths. It allows you to filter. It needs to fit with other assessments you've already done. This is not a brand new assessment. It has to fit with other surveillance that is happening. It is a beautiful fit for PRAMS or other surveys. It's not just about debits. And other evaluations you've done. It is way for you to integrate this into

your planning for Healthy Start and this is what we also have learned and will hear stories about.

Next slide. So PPOR in summary is a six-step, comprehensive, data-driven, but not just data approach that follows the Maternal and Child Health planning cycle. It starts with community readiness and ends with community investment. As a new way of framing and looking at data, of combining data, of integrating data. Of strategically targeting some of our follow-up assessments and allows us to then say, what part of the very complex problem are fetal-infant mortality should we focus on for further intervention and further investment in our communities? That's it in a nutshell. That's how it works and a lot more information can be had. Training opportunities are on the website. I'll talk more about that toward the end of the webcast with you. But let us now turn in the slide that looks at the success to steps three, four, five and six. Developing targeted prevention strategies, strengthening existing and launching new preventional initiatives. Monitor and evaluating our stakeholder work and approaches and getting that stake hold investment and political will to see the long-term sustainable solutions in action and to do this let's start by talking with some folks in Omaha where CityMatCH is located who believe we can go around the country but if it doesn't work in your own backyard you're not really being accountable. We have a fabulous local health agency working in partnership with a terrific Healthy Start project.

Let me tell you the headline news of this next slide. It created incredible partnerships that weren't there before. Let me reintroduce Mary Balluff the chief of the nutrition health and

services of the Douglas County health department from Omaha, Nebraska and her partner in prevent, Judith Hill from Charles Drew Health Center of the Omaha Healthy Start project. Let me ask them to both tell their story from Omaha.

MARY BALLUFF: Thank you, Magda. I'll start at the beginning of the story. I'm going to start in the beginning of the story. The first and most important thing is who came to the table and how did we get started? As you can see by the first slide, we had several partners at the table. I'm going to give you a synopsis of who these partners were rather than reading the names to you because I think it will be more informative. Both federally qualified health centers and university institutions along with the health department. Our local physicians' medical society, Health and Human Services, which many of you may be familiar with and an organization which was our healthier communities initiative, along with CityMatCH, which is the pediatric department also represents the pediatrics department. The visiting nurses association also joined us in this effort.

Next slide. The next thing we looked at and perhaps the very first thing was we began to do the work around our own PPOR work to find out what our rates really were. Your rates may look very similar to ours. Our overall rate is 10.3 but you can see we have higher rates in the blue box, the prematurity box. Surprising to other organizations that we've looked at in most other cities our pink box, maternal care box was also high, along with our infant -- let us go to the next slide.

We wanted to look a little further in depth at our own results and what we found were that it wasn't just about where our disparities were in comparison to other women but also in comparison to our black and whitish e -- white issue in our community. Our African-American rates are twice that of our Caucasian rates and particularly high in the blue box and also you can see that they are almost three times higher in the infant health box. Those gave us moments of pause trying to decide what that meant for us and what we would do. So we moved on.

Next slide, please. To looking at where our excess was. As you remember, Magda talked about the fact that there are reference groups to tell us where we are -- who is doing the best and where we are different. The reference numbers are about half of ours. In other words, their total overall was 5.8 and Omaha's is 10.3. The rates, if you look by the boxes, turned out to be very different in terms of the blue box and the prematurity and the pink box, maternal care. Again the reason for our concern. If you want to look overall that means if we could improve the rates of those women who were doing the best we could have 131 fewer deaths per year.

Next slide, please. Another part of this evaluation is to look at a process called the Kitagawa analysis. It tells you for those babies that are born small, in blue box, the prematurity box, whether that box is large because of just the number of overweight babies we have or if there is some other factor. Perhaps something called birth weight specific mortality that tells us once these babies are born some babies don't do as well as other babies. In most cases or in many other cities that we have looked at, this is about a

90% of those babies all in the birth weight distribution and only about 10% fall in the birth weight specific mortality. So Omaha, again, had some difference. We have about a 1/3-2/3 split.

Next slide. We wanted to look for carefully at the green box, the infant health box. This box we tried to find out among the larger babies that were dying later what was happening and we wanted to look at cause of death. What we found was an overwhelming incidence of SIDS. That to us was very concerning. SIDS in many other cities in the nation was reducing at rates that were out of range for what we were looking at. And, in fact, we had 33 deaths. We could reduce our deaths by 33 by reducing the number of SIDS death.

What did all this tell us? It told us first and foremost if we wanted to impact all these things we were going to need more partners at the table. We also decided that being the Omaha perinatal collaborative meant very little to most people so we spent some time trying to figure out who we were and what we wanted to achieve. We became Baby Blossoms and you can see in this slide the logo that we now use trying to make sure that every Baby Blossoms. We also, as you can see, went to look for more partners. We looked at our hospital systems, we also looked at our Chamber of Commerce, we moved beyond that to our minority health, to the governor's office, to the mayor's office.

We also looked to human service agency such as salvation army and the united way of the midlands. Many of those joined us in this area initiative. I want to talk for just a minute about our findings. We had four findings that we thought we needed to address. One was -- we've talked pretty specifically about this -- about our prematurity. We had too many

little babies being born and it was the overall driver of our infant mortality in our community. We also remember when we looked at whether it was just too many little babies or how they did, how they survived beyond that, we found that our ratio was different than other communities and we needed to do something to make sure that all of our babies, once born, could survive. Remember our pink box also was out of line, the larger still borns. We needed to understand what that was. Interestingly in some further analysis we found out that was being driven by our white population. So we needed to understand better what was coming from that.

And lastly, we were concerned about our infant health. The larger babies that were dying later and remember, the SIDS issue came up there. From there we built a blueprint for action. It was to look at four issues, one was to look at our perinatal system. How was it working for all women? Was it working for all women in our communities and what did it look like? What were its strengths and weaknesses? We also decided that we needed another set of information. We wanted to specifically know about each of those deaths, or at least those deaths in our target areas, the blue box, perhaps the pink box but most assuredly that green box. We also wanted to find out more about those very low birth weight babies and why they were not doing as well as provided. And lastly we wanted to begin an effort across our community regarding SIDS.

Next slide, please. This slide is pretty complicated but I'll try to give you the essence of it. You can see in the middle those four areas I just spoke of. Our primary areas. We knew that the overriding group to work on this was Baby Blossoms but we knew we would need

a lot of coordination and crosstalk among all those organizations to make this work. If you look down in the far right-hand corner, what you can see is that the perinatal periods of risk was going to be the driver to lead us to those things but we knew that we would need more information. And we needed to make sure the information we had was of the best quality. This was the same work that we used to help drive us to our next decision.

Next slide, please. Talking about action step one the first thing we wanted to work on was our perinatal system. We used a process called appreciative inquiries, asking mothers to tell us about the very best experience that they've had and when they had seen it work best. We received a small grant from the March of Dimes to help us in that and we had a group of women in focus groups specifically high risk women, tell us their stories. Their stories created for us a mother's journal. We collected all those positive experiences and then we asked if it can work for some, can't it work for everyone? We also then began to learn from those stories about what kinds of things women thought would help them the most. We developed something called the preconception health slip book. It was a tool to help all women understand what would work best for them. We took the book and made it accessible to many of our other participants in our community. They've translated it into other languages. We looked at the implications of it and made cultural shifts to make it appropriate for our Native Americans. And lastly we had it translated into Spanish to help us teach that part. Judith will talk about how Healthy Start helped us move this forward.

JUDITH HILL: First let me start out by saying wow, what a wonderful process. It was about two and a half years ago we began participating in the initial phase of this process. I miss

tell you that as a representative for Healthy Start it wasn't always easy to understand what these young ladies have shared with you this afternoon. But over time it became apparent to me and Healthy Start that this was a process that we couldn't just sit by and listen to but that it said to us we had to find a way to make certain that the information that was being shared, the data we were taking a look at, was going to be of benefit and be utilized within our program to reduce the infant mortality rate in our community. As we sat through the process, the thing that became very clear to us very early on is that the two areas that we had to be most concerned with was that blue box, which was very surprising to us because we really had always focused on just infant mortality. We really hadn't thought about maternal health. We knew we had to begin immediately to look at our program and to determine if we were doing more than just talking about the health of that unborn child and that child directly after birth or were we also talking to moms about their health prior to conception? And then, of course, we were not surprised at the data that reflected the high infant mortality rate in that green box.

We knew SIDS was an initiative we needed to continue to pursue, to promote more active in our community. That was one of the good things was to know that our initial work in the SIDS area was being supported by our PPOR data. As we look at our slides, one of the things we did, having been involved in the process from beginning we adopted baby blossom as our 2005-2009 local action plan. You talked about the slide that talks about the Maternal and Child Health providers that are partnering in this process. Clearly that's where our effort needed to be and it was simply a no-brainer as to what our local Healthy Start action plan would be. We'll be looking to get our other staff involved in some of our

subcommittees and we've even talked with our consortium about getting our consortium members involved. It is not enough that we as providers understand this process, we have to make sure those individuals whose lives are being most impacted are also involved in this process. This preconception health flip chart is wonderful.

The women who come into our program every single day absolutely love it. It allows them also to begin to look at their lives in a different perspective. Not just valuing themselves in the terms of what happens to me for those few months when they're pregnant and their life after the birth of their child but starts to ask them to look at their health prior to conception. One of the things we realized was that as a partner in this process we had to do more than sit down, correct the data, take it home and do what we could with it. There were dollars that needed to be invested in this process. One of the things that happened that was so life changing for me is that we had a young lady who gave birth to twins in our program. She had just joined the program. She had transferred from another case management program. And her case manager walked into the office one day and was absolutely devastated because this young lady had lost her twins.

The thing that was most meaningful to me or most disturbing to me was that she absolutely could not understand what could possibly have gone wrong. This is what you would have called an ideal program participant. And that is when my mind went back to the fetoinfant mortality review. In that PPOR process I learned it was a process that could be used to maybe answer some of what appeared to be those unanswerable questions and I immediately made contact with our partners in the PPOR process and said let's see

what we can do as a program to do more than just sit at the table, let's bring some resources that might help us to develop this Fetal & Infant Mortality Review. We developed a feasibility study. I'll let Mary talk with you about the findings in the study. What I can tell you is that Douglas County will join the other communities around this country that have a Fetal & Infant Mortality Review.

MARY BALLUFF: Next slide, thank you, Judith. What we could tell you is we've been in the engagement process for nearly nine months now and we've been in the process, the entire process for a year. Trying to make sure that our community is really ready for Fetal & Infant Mortality Review. We've conducted community trainings. We've begun to develop a contract with the state to make sure that we actually have the legal wherewithal to make sure this process could occur.

Next slide, please. Let us tell you a little more about how we were addressing those issues in the prematurity box, the blue box across the top. It also helps us to address that pink box. We began to look at how we could spread the word about those very low birth weight babies in our community. Our first effort was to do a summit in which we invited over 60 health professionals to come and listen to a national speaker who you'll hear later in this presentation talk about pre-conception health and the importance of having that discussion with women in our community. We'll follow it up again this year in November we will, with another prematurity summit and we'll again talk about pre-conceptive health and having another national speaker, some of you might have met him, come to speak to us about the recommendations for preconception help. We believe this is one of the key

links in making a real difference in our community in terms of changing our prematurity rate. Judith will talk to you about the efforts we've made around SIDS. Next slide, please.

JUDITH HILL: Our action four was to create a unified SIDS initiative in our community.

This is one of the areas I've had the most personal pleasure of being a part of. I have enjoyed the learning process, learning more about SIDS and enjoyed the opportunity to be able to present the back to sleep campaign information in our community. As a workgroup, we felt it was important that we would understand and improve the classifications of SIDS.

I can tell you that in 2005 we've already experienced 15 deaths that have been categorized as SIDS. One of the things we like to say while the deaths have been categorized as SIDS we know there is a lot of work that needs to be done around the issue of whether those were SIDS death or might have been contributed to some other factor but because there may have not been an ought top -- autopsy done. Part of our workgroup is looking at working with our law enforcement and working with our hospitals and better understanding how they classify a SIDS death. We've developed a community and media education campaign.

We've been able to work one-on-one with our childcare providers. There is not a more appreciative group of individuals that come together around SIDS training that our childcare providers. You might ask why? Many of the deaths that occur in our community occur in the homes of childcare providers. We have joined with the State of Nebraska in developing a Douglas County safe sleep initiative and we have a number of subcommittees that work with that area. One of the things that we're finding in the homes

of the moms who participate in our program is that while they may place the children on their back to sleep, they still struggle with the whole issue of co-sleeping and they're still trying to find a way to make that OK.

So we really have the safe sleep initiative training needed in our community. To address the need we had the privilege of participating in a community-wide forum sponsored by our general counsel on September 26 of this year. I must tell you that it was absolutely marvelous. There were over 250 individuals that attended that forum. There were childcare providers not only from our community but from all over Nebraska as well as Iowa. We had individuals that chose to participate from our Spanish speaking community as well as our Sudanese community and Somalian communities. We're so pleased we have had the opportunity.

I'm forgetting to say next slide. Next slide, to that youthful young lady there that depicts to the top left-hand corner that shows you some of the programs that are involved through Omaha Healthy Start with our PPOR initiative.

Next slide, please. The community action plan. As I mentioned earlier we're looking to make this -- we have already adopted baby Baby Blossoms for our action plan for the next project period. We're training our general counsel. Our consortium on PPOR, preconception health, safe sleep and other areas. We've begun to identify women and men in our program that will join us in serving on many of our Baby Blossoms committees and then last but not least we'll continue all of our efforts around SIDS training, education

and just making certain that all that we're learning as an organization through this process, that we're doing what I believe is our responsibility. That is to make certain that our community is educated as well.

MAGDA PECK: We'll take a picture over here and thank you so much, Judith, for being able to share with us who the core strategic partners have been that have worked with you so hard to be able to make not only Baby Blossoms come to life in our town but with the incredible strong backing and partnership of Omaha Healthy Start. We're humbled by the stories in our own towns and about how PPOR has catalytic with other efforts to leapfrog and get out of the entrenchment of being stuck with old infant mortality issues. If there is a community in the nation we've turned to time and again over the last couple of years, it's been looking at our partners in Jacksonville, Florida, which is our next headline news to bring to you today. Jacksonville is in a state which has another kind of Healthy Start that you're going to hear about in addition to federal Healthy Start. Jacksonville is a place that has already shown us how to do the integrative work between FIMR, Healthy Start, larger community planning initiatives and seizing the moment to break out of old ideas and make things happen. They've done successful integration along with the active support of their March of Dimes for new strategies to prevent feto-infant deaths. To tell the story directly we'd like to introduce you to Carol Brady, the executive director of northeast Florida's Healthy Start Coalition. She also heads the agency which is the grantee for federal Healthy Start. Help us understand how to put the pieces together that leads to a different kind of action.

CAROL BRADY: Thank you, Magda and good afternoon, everyone. If we could go to the first slide, please. In order to tell you the story of PPOR in Jacksonville, I need to kind of provide a little context to how we got involved in this whole effort. Back in, I guess it was 1998, a simple analysis was published by our State Department of Health that compared Florida's 67 counties to the state average in terms of infant mortality and my county, Duval, which includes Jacksonville, was one of three counties in the state that had the dubious distinction of being recognized as having a significantly higher infant mortality rate than the state. You can imagine the response from the Healthy Start Coalition. We were fortunate as Magda said, to have a very strong and active state Healthy Start program that led to the development of 33 community-based coalitions where the community is actively involved in addressing infant mortality. Certainly that community coalition was not at all pleased that we were one of three counties in the state to achieve this recognition. We did the typical analysis that we all do. Actually identified two factors that were contributing to Jacksonville's higher infant mortality rate. First of all, we had among Florida's counties the largest proportion of non-white women in our child bearing population. And second of all, the outcomes among that non-white population were poorer than outcomes among non-whites in other parts of the state. You can see from the next slide the kind of trend data that we were looking at.

We were following in Jacksonville between 1993 and 1996 improving infant outcomes. Starting in 1996, particularly in the black population, we were going in the wrong direction in no uncertain terms. All this led us to a new focus and that focus was on the health of women prior to and between pregnancies. So how did we get to focus on well women,

well women's healthcare? The answer is two-fold. First of all, we discovered -- literally discovered the perinatal period of risk, CityMatCH was doing so work in this country and used information that we had gathered over the years in implementation of our Fetal & Infant Mortality Review or FIMR project. When we did the PPOR analysis we found the greatest disparities in our outcomes occurred in the maternal health and prematurity and maternal care in the perinatal periods of risk. We had two boxes in the PPOR map where racial disparities disappeared.

I'll say that again because it was a shock to our community. We actually had two boxes in the PPOR cells where black and white babies had equal outcomes. I think that was a moment of discovery and hope that, in fact, maybe we could develop interventions that would significantly reduce disparities in our community. When we did the Kitagawa analysis it pointed to the fact that too many of our black babies were being born too soon and too small. Our healthcare system was working in the neonatal area. We had too many babies that were being born at rates that were too small for survival. Then, of course, FIMR. I'll go through these in detail.

The next slide shows a comparison of black and white fetal and infant death rates between 1995 through 1997. If you look at the bottom of that map you'll see a disparity that we are all used to seeing. That is, a two-fold disparity between black and white outcomes. However, if you look at the individual boxes, those disparities are not in any way equally distributed among the cells. The greatest disparities, as I said before, occur in that maternal health and prematurity. The health of the mother prior to pregnancy and we

saw some difficulties occurring with access to care in the maternal care category. The two boxes where there were no significant disparities were in newborn care and infant care.

Next slide. For all that including the confidence -- it was the response of our community but don't be fooled by the numbers. There is meaning behind the numbers.

Next slide. What do all the numbers mean? Well, basically the secondary part of our analysis showed that about 2/3 of the mortality difference between black women and the internal reference group was due to birth weight distribution. As I said, too many black babies being born too small and too soon. And that this analysis led us to the conclusion and the communities to the conclusion that if we were going to focus on anything to address disparities it was going to have to be on the health of women prior to pregnancy. Maternal health and prematurity accounted for 95% of the excess gap in Duval County. The next step that we took, we knew as Magda has described in the earlier slides, about what PPOR says we should focus on based on your findings. What the data tells us that we should be doing. We had again in Florida been fortunate to have a funded Fetal & Infant Mortality Review project before we did this analysis. We had an incredible body of information and analysis on cases that met the PPOR criteria. So we decided we wanted to take a look at this data with an understanding to increase our understanding about what was going on actually in those cells in Jacksonville. We used the ACOG process as part of the FIMR family, the case review team to actually make findings about contributing factors and include family.

Next slide. As I mentioned, we had about 140 cases that we had reviewed through this community review process since 1995. I want to emphasize that FIMR is not an epidemiological tool. It is much more qualitative tool. Our selection was not random but it did provide us with information about actual fetal and infant death in our community.

We organized -- next slide -- our FIMR findings according to the four PPOR cells. We looked at the two cells of interest. The maternal prematurity and maternal care. What we found, our experience validated what the PPOR model told us we should be looking at. If you look at the most frequent contributing factors identified in those two cells in FIMR like no Healthy Start screening. Previous poor outcomes. Family planning issues. The general state of the mother's health and poor nutrition. Most of these factors -- in fact, the mother brought to her pregnancy. They were occurring prior to pregnancy. They didn't just happen the day she became pregnant. We took all this information, timing is everything, and went to a number of community meetings to try to figure out now that we had identified a strategy how do we actually make the changes. Jacksonville is no different than any other community in this country in that our focus, when it came to impacting infant mortality, had started the moment the mother presented with a positive pregnancy test.

At that time the federal Healthy Start program had just released an R.F.P. in 1999 specifically to address racial disparities in birth outcomes and we decided to apply for it using the information that we had gained after about a year going through the analysis. And basically we made the case that Florida had a well developed Healthy Start program that provided support to women during pregnancy and immediately following birth. But

what we were lacking is some kind of mechanism to be able to support an intervention to address racial disparities that dealt with the health of women prior to and between pregnancies. And that's what the foundation was for the Magnolia Project which was eventually funded under that R.F.P. but the federal Healthy Start program.

Next slide. Just to give you a little idea of how we approached this through our federal Healthy Start program, the Magnolia Project is implemented in a five zip code area in Jacksonville that at that time accounted for more than half of the black infant mortality in our entire city. There is about 25,000 women age 15 to 44 that live in the project area and it is a predominantly African-American community.

Next slide. We set the Magnolia Project up to really be a community-based intervention. It operates out of a store front site that is located in the target area. We provide services through a collaborative effort that involves our health department, the teaching hospital, the Healthy Start Coalition, as well as a variety of community agencies. Staff is all located at this community site.

Next slide, please. In terms of what we do, we don't do anything that is much different than any of the other Healthy Start projects. The difference is who is the target of our intervention? We've sessionly taken the Healthy Start models developed by the first federal Healthy Start project and adapted them for use with a non-risk population that is not pregnant, but if they were pregnant, would be eligible for Healthy Start services. We were pleased to get continuation funding or refunded in 2005 to continue this work.

Next slide, please. Like most Healthy Start projects, our staff and our approach is very community driven. This is a picture of the staff. I often say I get to travel across the country and talk about this project. These are the people that do the real work. Many of them come from the community and this includes our community council representatives as well.

Next slide. I'm just going to give you a snapshot about what the project looks like based on our 2001/2005 impact report. We served over 3,000 participants during that period of time. Most of them are age 15 to 25. Predominantly single and black. 40% of them have less than a high school education. It is not because of their age. It is because they've dropped out of school. Most interesting, I think, for all of us is 90% of the women that we serve are uninsured. Remember again if they were pregnant tomorrow, we would be all over them with Medicaid and case management services. Right now they have the same risk profile at our at-risk woman only they don't have access to the services that we provide.

Next slide, please. In terms of our eligibility criteria we have two different eligibility criteria based on the type of services that women request. Clinical services, which is essentially well woman care, is available to women of child bearing age who reside in the five zip code area who are pregnant or able to get pregnant and who have not had a health exam in over a year. Case management services are directed at a higher risk population and you can see the criteria there. We want them to be sexually active, not pregnant. I'll point

your attention to the risk factors because they do have to be of higher risk. How we selected those risk factors was based on the findings from our FIMR project.

Next slide, please. This gives you, again, a little bit of information about women that were served over the last four year period. We do provide some services to a small group of pregnant women and a lot of pregnancy -- which turns out to be predominantly negative and a great outreach tool.

Next slide, please. Our clinic services, because we run a small two exam room clinic with a single healthcare provider, we try to tailor to the community and have evening clinics and provide group prenatal care for pregnant moms.

The next slide shows you the birth outcomes among the pregnant clients that have actually received services. Again, we aren't doing a big pregnant woman caseload but I think we're very pleased that, in fact, our infant mortality rate among women we serve was about 6 per 1,000 live births which is pretty good for our population.

The next slide talks a little bit about our case management. Not surprising to all of us who deal in Healthy Start most of the risk factors we're addressing are social rather than medical. We have had a good track record in keeping women engaged for in-services for a long enough period of time that we can have an impact on their risk.

Next slide, please. This provides a profile that I'm not going to go over about the kinds of risk factors that we're dealing with in case management.

Next slide, please. The next slide provides some information about the nearly 250 clients that actually completed and closed the case management services during our last grant period and we were actually able to resolve or manage the majority of risks that were presented to us. That they presented with, rather. We're pleased that we're the recipient, recent recipients of some CDC funding that will allow us to study the outcomes of the next pregnancies of the women that we dealt with in case management during their pre and interconceptionall period. We examined in detail two priority risks in our success in addressing them. I had had to do with consistent use of family planning when the woman did not desire to have a pregnancy, and also repeated STDs. We were highly successful with the interconceptual approach addressing the two risk factors.

The bottom line, next slide, please, what has happened since the initiation of magnolia. We continue to be challenged as a community with our high infant mortality rates but if you look at the top line, the infant mortality rate in our project area and although the number of births makes it jump up and down from year to year, the trend line definitely shows an improving infant mortality situation in our target community. In fact, in 2002 we were ready to really light the candles and celebrate because for the first time that community had an infant mortality rate that was lower than the non-white infant mortality for the county as a whole. Our experience in implementing PPOR in the Magnolia Project

led us to become involved with the CityMatCH national practice collaborative and we joined two other Florida cities.

Next slide, please, Orlando and St. Petersburg. As a result of that, in working with CityMatCH over a year period of time, we recognized that Florida had a great foundation with its state Healthy Start program, the FIMR project and a lot of support from the state Title V agency but if we were going to move the agenda toward women's health forward it would require policy changes and we needed to do something at the state level. We successfully applied to the Florida March of Dimes for a grant that essentially allowed us to replicate the national practice collaborative around PPOR.

Next slide, please. The Florida PPOR practice collaborative brought together the seven largest cities in Florida. That together accounted for 60% of the state's births and our objective was pretty clear. We wanted to work together to see what needed to be changed in our state program to address infant mortality in a new way.

Our objectives, next slide, please, as I outlined before, was to try to promote the use of PPOR in our urban communities, to try to use the results to influence decision making, for program and policy development. To really build some data-driven, evidence-based prevention strategy and also to use it as an opportunity to implement the existing MCH efforts in Florida. We have 33 Healthy Start Coalitions. We have FIMR projects and we have five federally-funded Healthy Start projects. We did all this in a year. I look back now

and I'm just amazed by the kind of progress that we had. But again, communities coming together had an incredible amount of momentum.

Next slide, please. These next couple of slides summarize our accomplishments. Title V was with us at the table for the entire year and we certainly had an improved working relationship with that agency, because, as you can tell, PPOR depends on have access to good data and a analytical skills to be able to use it. Five of our seven cities completed phase one. We were able to integrate the PPOR into our community planning process. Both the federal Healthy Start, local action plan and also the local plans that we're required to do as state coalitions. We identified opportunities for actions and launched discussions on policy changes that were needed.

It was pretty clear -- next slide, please, that we needed to move forward as a state to develop strategies to impact a woman's health before pregnancy.

Next slide, please. The PPOR practice collaborative really allowed us to build new partnerships and foster integration among our programs. It allowed us to work with the March of Dimes who was launching the prematurity campaign and gave us support to think outside the box as looking at solutions we hadn't tried before to address this important issue.

Next slide, please. This was kind of a schematic where we adapted the PPOR map to look at interventions at the state and community level that fit into the different boxes. We could look where we wanted to promote our attention.

Next slide, please. We had great results, as I said, as a result of this project. We were able to develop consensus with our Title V agencies and the state Healthy Start program to actually expand the focus of the state program to also include interconceptual health as well as the health of women during pregnancy. We developed guidelines, protocols and interventions that were incorporated in our state Healthy Start program.

We were able to educate -- next slide, please, our MCH partners around the state on disparities and the potential impact on maternal health and prematurity and to really start thinking that this was a new approach and to start thinking moving beyond just pre-natal care and the health of women prior to pregnancy. In fact, pre and interconceptual health was the focus point of one of the summits that the state March of Dimes did helping us to move the agenda forward.

MAGDA PECK: I listen to the Florida story each time and I'm breathless because it shows us the range from a community from a community like Omaha that didn't have the infrastructure like a Healthy Start Coalition, I'm talking about a statewide Healthy Start, did not have a table where everyone was at who was going to address the problem of infant mortality, that did not have a FIMR in place and how in the beginning of the process of PPOR when you do not have lots of infrastructure in place the tremendous effort going on

can be a galvanizing, catalytic and organizing framework to create stronger systems and structures and consensus and partnerships that will allow us to make a difference in perinatal health and the other end of the spectrum like Jacksonville and now in all the urban communities in Florida in strong partnership with their state to be able to see what happens when you put together perinatal periods of risk, feto-infant mortality review. Organizing structures such as the local Healthy Start Coalition together with the partnership of the state and March of Dimes in a time when nationally the shift is finally happening. The tipping point has occurred and now the talk is all about pre-conception health, interconception health and talking about the health of women in and of her own right before she is pregnant. You can anticipate by the end of the year CDC will be publishing guidelines on pre-conception care and preconception health for all women in the United States of reproductive age and places like Omaha and Jacksonville and Healthy Starts are poised to seize the recommendation and put them into action. It has been a catalyst to make the shift in focus before they're pregnant, while they're pregnant, after they're pregnant and beyond. What I call before, between and beyond pregnancy.

In the slide that starts with PPOR is about impacting results let me just bring together in my final minute or two before I pass it back to our colleagues in Washington about what it is about PPOR. If you take it on in your community because of the demands of data, linked data, fetal data, quality information, you will build both your data quality and epidemiologic capacity. It's a catalyst for infrastructure. It is not about the data alone. You do PPOR in your community with other efforts and you'll become effective and more effective data users, not just data generators. You'll do this always in partnership and

PPOR can be a catalyst to strengthen and build the partnerships necessary to make measurable, intended results. In an integrated way that brings together all that we're doing to improve the health of women and infants between, before and beyond pregnancy. What you do will be evidence-based because it is not only about assumptions and intuition and experience, it will be about linking the data to evidence-based action. And you will do as you've heard here already, leverage new resources for political and in-kind as well as new grants and new funding with sustainable results. And all of this -- it's the sixth and final step of PPOR and what we want to leave you with at the end of our webcast. It is not about the data, projects and pilots. It is about changing the way we do business for women and children and families and fathers who live, work and worship in our communities. PPOR is a toolkit.

So the next slide you'll see how you can learn more about perinatal periods of risk. Go to the CityMatCH website and learn more about the tools and information that we have at hand for you. Some of you have already been to some of our training and are part of our urban learning network. We encourage you to stay engaged. More is coming down the pike.

For those of you who would like to get trained and like to join the network go through in the next slides what we require to be a more comprehensive training session. Come join us in Miami, Florida at the next MCH epidemiology meeting when we'll have at the close of those meetings a series of official of training and overall orientation that will allow you to get into level two to be part of the learning network and advance practical things for those

who have been part of our -- particular focus on analytic skills for those of your quantitative partners to do phase one and two to yield better results and more informative information in your community. The information is provided. PPOR is not about doing the business, it's about doing the business better for better babies, healthier women. Over 75 communities so far it is already working. Tell us what your questions are now so we can help make it work for you. I'll send you back to Washington.

JOHANNIE ESCARNE: Thank you, Magda and thank you for all of our presenters for a wonderful presentation. We have now entered our question and answer session and I will go ahead and read some questions that I've received via email and if you have some questions, please feel free to continue sending them in. If we don't get to them by the end of this webcast we'll make sure that the presenters get back to you after the webcast. The first question is, how long has Omaha been using PPOR?

MARY BALLUFF: Actually we began in 1999 and we did about 18 months worth of data collection and analysis before the process was begun. It took us 18 months to get off and we're still working on it. We just did our second set of data in the last couple of months.

MAGDA PECK: I have to tell you that we estimate that when a community starts to do perinatal periods of risk it is an initial 18 months investment to go through as many of the first six steps that are there. But it is an iterative process. You should begin with the data and some early action and some results within a year and a half of taking on this process.

JOHANNIE ESCARNE: Thank you. This question is for Mary. This person would like to know if you have any contractual agreement with the partners in the Baby Blossoms collaborative.

MARY BALLUFF: We don't have even memorandums of agreement. Everyone has willingly come to the table mostly being driven by the data that we have. At this point it's consensus that drives us forward. We do have one contractual agreement with Healthy Start which is financial in nature but all the people come to the table willingly and bring their resources.

JOHANNIE ESCARNE: The next question I believe is either for Mary or Judith. It is about the flip charts. Is this given to women or used by health educators? Who distributes the flip charts and how can we get a copy? It's from Indianapolis Healthy Start.

JUDITH HILL: I can certainly speak to how they're used at the Omaha Healthy Start project and then Mary, you can share with us how we can get a copy. In our project they're used by our case management and health education team. As women come into our program for pregnancy testing or other free testing services that we provide or if they're program participants we sit with them either in our office or in their homes and we actually walk through the process with them. At this point we're not providing them a copy of the flip chart itself. Where there are questions or specific areas they would like more information on we either provide them with additional information and brochures and I don't know if I should say this or not but we aren't opposed to making a copy of certain

parts of that information if it's something they would like to hold onto and to utilize.

[Inaudible]

MARY BALLUFF: [Inaudible] Along with the Healthy Start individual . It is available if you'll get in touch through the CityMatCH. [Inaudible]

JOHANNIE ESCARNE: Thank you. The next question is again for Mary and/or Judith. How engaged are they from the mayor's and governor's office. How do you get them and keep them engaged?

MARY BALLUFF: I think it's one of the issues you deal with. Policymakers see this as an issue only at points in time when you have a press release or news conference, something like that. However, we do have our governor's office has an Office of Minority Health and they have been very engaged with us and they really -- help to get the information we share with them. For our health department happens to be a county health department. [Inaudible] our communication is linked mostly to their public relations office. We have much stronger relationships because we have a minor at the health office with our governor's office than we probably do with the mayor's office. The governor's office is - - we have more [inaudible].

JOHANNIE ESCARNE: Thank you, Mary. I believe this question is for Judith. Give an example of the information on the flip chart. Is it used for women who are or have been pregnant primarily?

JUDITH HILL: The information is actually used for both. Both for the women that are in our program that are currently pregnant. We want to begin our process talking very early about what their plans are for the next planned pregnancy. Part of our protocols are that even though they may be now pregnant in the program, it is important for us to begin to talk to them about what are their life plans beyond this birth. We do begin to utilize that flip chart in that process. I can tell you that probably 65% of the time we utilize it, it is with those women coming into our program with children at least one year -- at least one month old and older and again we're using it to begin to ask them to focus on what are their plans beyond this birth. I believe the other part of that question was what is the content? For me -- I have only gone through it once. So I can't tell you that I know it inside out. But the thing that is primarily caught my attention is that it's looking at, first of all, you as a woman. Who are your life plans? What are your life goals? How are you beginning now to look at your health? What are those health risks that you bring into your pregnancy prior to getting pregnant? How are you receiving care? Do you have a primary care provider? If so, are you seeing them on a regular basis? How are you managing those health concerns now? How will they be managed during your pregnancy? What are your family planning goals? If there are contraceptives being used, how are they being utilized? What are your long-term plans for your family, for that child, and for yourself?

JOHANNIE ESCARNE: Thank you for your response, Judith. This next question is for Carol Brady. In your opinion, what caused the infant mortality rates to increase after the sharp decrease?

CAROL BRADY: Well, I think those of us who have been in Maternal and Child Health for a long time have come to recognize, if we didn't know it already, that healthcare and basically there are a variety of factors that impact on Maternal and Child Health. Healthcare is a piece of those factors. But we have a lot of social determinants that also impact on Maternal and Child Health and quite frankly that was the year we implemented welfare reform and Jacksonville was the pilot site in the State of Florida to implement it. So there was a huge upheaval in the safety network -- safety net, if you will, having to do with social support and eligibility for Medicaid and things like that. And I think that, in addition to some changes within our healthcare system, probably contributed to the changing direction of our infant mortality rates.

JOHANNIE ESCARNE: Thank you, Carol. I believe that is the last question that I have received. Unless any others come in. I would like to say on behalf of the Division of healthy start and perinatal services I would like to thank our presenters and audience for participating in this webcast and thank our contractor the Center for Advancement of Distance Education at the University of Illinois at Chicago School of Public Health for helping us make this technology work. Today's webcast will be archived and available in a few days on the website [mchcom.com](http://mchcom.com). Let your colleagues know about this website. Thank you and we look forward to your participation in future webcasts.