

How to Use the Perinatal Periods Of Risk Approach

ELLEN HUTCHINS: Hello. I'm Ellen Hutchins, Chief of the perinatal women's health and HRSA's maternal and child health bureau. I want to welcome everyone to our webcast today. Today's topic is perinatal periods of risk. This is a topic we think will be of great interest to Healthy Start and other projects joining us today. Our speakers are Jennifer Skala and Dr. Magda Peck both are with CityMatch. Dr. Magda Peck is the director of CityMatch and Jennifer is managing coordinator of education and training. Both are located in Omaha. The speakers will discuss Perinatal Periods of Risk and how it can be used as a tool in understanding infant mortality in cities. Before we get started, I just want to go over some webcast introductory remarks. The slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speakers' presentations. You do not 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.

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Please take a couple of minutes and fill this out. Your responses will help us to better plan future broadcasts in this series and improve our technical support. At this time I will turn the presentations over to Magda Peck.

MAGDA PECK: Well, good morning or good afternoon, everyone. Thank you so much for taking time out of your day to learn, because we want to be in a position to provide for you greater information and tools to strengthen the work you're all doing at Healthy Start for healthier babies. We're going to make a certain series of assumptions in the time that we have today, which will go about 90 minutes. The first is that the reason that we're here is because of a growing partnership between CityMatch and the maternal and child health bureau of HRSA for the Healthy Start initiative. So CityMatch can bring tools that are working in a number of urban communities in the country that Healthy Start can bring to do a better job in saving baby in promoting the health of women in strengthening families (technical difficulties) about which we're going to talk about and fetal infant mortality review another tool available for Healthy Start sites around the country. And so consider this a second step of several that we hope to take together to provide for you the background technical assistance for ways and means to do your job even better.

So we're going to make a third assumption and the third assumption is that you don't know very much about the perinatal periods of risk approach and so we're going to aim this at a very basic level. And we've also gotten feedback that if you're here the first time it's interesting and the second time we begin to get it better. So if some of this is repetitious it's intentional. It's been said that adults need to hear stuff six times before they will be able to communicate it clearly to others. So consider this round two overall. So where we at CityMatch. And by now we hope that most of you are Healthy Start partners are familiar with the organization. We hope that you've cruised our website at <http://www.uic.edu/sph/cade/mchepistach.org> but the thing you should know is we're a national public health organization that we've been around for over a decade trying to strengthen the your bans communities based an academic center at the university of Nebraska medical center where m staff and I also serve the community of Omaha and our greater state and region.

So given there's a Healthy Start right here in our town we know very well what is possible when we work together, and that we do great things. We work to sustain communication across the different parties of partners working to improve maternal health in communities. We try to build communities, which this webcast is all about. Identify best practices and policies so we can all work from a common best knowledge base that will serve us well as we serve others. Because we're all about a mission. Our mission is to improve the health and well-being of women, children and families, strengthening public organizations and leaders in their communities. Every health start site is part of that public health infrastructure, that fabric that's strengthening our women and children. Some of you may

come from more rural areas and we'll tell you that this tool is not designed especially for rural communities but the concepts and approaches will definitely be applicable. So we're hoping that all of the Healthy Start communities can find benefit in understanding and using the approaches of Perinatal Periods of Risk.

What we expect to do in this webcast, well let's give you a very brief overview of our time together. We're going to do this in three-part, consider it aligned with trimesters if you to recognize a beginning middle and an end. We'll spend the bulk of our time actually right up until about the 12:05 understanding one on how to get started on using this approach. We're going to make sure we have the last part of our time together to reinforce the top five things you should take home, what's the most important things to remember as you get started using Perinatal Periods of Risk and then we want to tell you about what we're going to be doing in partnership with you and with the support of the Maternal Child Health Bureau. And the information we've already received from the centers of disease control prevention and from the March of dimes and university of Nebraska medical center. We'll talk about level one, level two and things we can do together after this particular broadcast. So let's get started and I will start with a graph, a very simple graph, that many of you have generated and seen in your communities. This is a graph from my community. I wake and work and worship in Omaha, Nebraska, centrally located to many of you. I'll tell you that for many years the state and local health department has been generating infant mortality statistics that tell us about overall white and black and infant mortality.

So this graphic shows the transitions and trends in infant mortality from 1990 through 2002 over the last 12 years, shows us a general stable pattern, not a whole lot of improvement over a decade of time. And extraordinary variability, a lot of bouncing around of the numbers for the smaller population of African Americans that we have, about 13% Omaha's community. When I look at this graph I say to myself, okay, I think I understand that. But what do I do with this? What does this tell me about where we should put our efforts? It's as if as the cartoon indicates in the next slide that there's something missing here. You know we get these complicated vital statistics that are disseminated and poured on and rained on community to community to tell us about our infant mortality rates, post perinatal rates and neonatal rates, whites versus black. But all in all we've found there's something missing in between all the data and somehow we expect a miracle to occur that should lead us to an exact right answer. Well, what we can tell you is that we have found a different way of looking at the number. We call it the PPOR map. And in that map you will find, as we explain how to do this later on, that it uses a different set of data. It focuses on a different cut point in low birthweights.

It includes fetal death and it allows us to look at birthweight and when the baby died at the same time. These are enhancements. Now what we're going to show you today and review with you over the next, oh, say, hour of the first part of our presentation, it's not new epidemiology. It is not new vital statistics science, but it is a new framework for being able to gather with all of our community partners, to look at information, to filter it, to be able to see where the greatest gaps and to be able to focus our efforts on those gaps. Because PPOR is about three things that make us different. The first is we want to add

and combine tools. We want to help bring those new tools to solve a very, very old problem. And we also know that we want to get some data to action. We've been looking at the data for a long time. We need to get past the data and it's not just data, but we need to know what to do based on the data. And then finally this may involve some communities that do not have the foundation community collaboration in many Healthy Start communities has been extraordinarily robust. We're talking about the way we do business. PPOR is about changing communities. So let me tell you that also this is a six-step approach. We're going to walk through each of these six steps together. It takes a while to get through this.

We're not going to give equal time on each of the six steps. But we're going to try and highlight the fact that it's not just data. If anybody comes to you and says well we did PPOR, we have this map, we have this pretty colored graphic, I would say to you we have not done Perinatal Periods of Risk. You might have heard some of the analytic reference to part of the approach. But it takes the full six steps that can take a community between 12 and 18 months to get fully through and process and say this is what we know, this is what we know together and this is what we're going to do. And it all starts with community. Now that's one of the joys of starting with the Healthy Start audience because you already know that. You already know it's about bringing a community together as partners for support and consensus and to be able to do the work together, every Healthy Start has a consortium.

Every Healthy Start is founded on the basis that it's not some data analysis in some cubical in a stat local health department. It starts with bringing the community together. Our intention bringing you the Perinatal Periods of Risk is so that you as your community partners have one more tool to strengthen the partnership and the way you do your business. We have learned however from a variety of other sites that we're working with, and we're working with dozens of communities across the country, and in many states, and not all of them are Healthy Start sites. What we found is that not every community is ready to do Perinatal Periods of Risk. So we have introduced as a tool to bring to this, bringing communities together, working within your coalition, the concept of community readiness. And we have a whole workshop that we can do on this. I just want to give you a taste of it, and one of the examples that I will talk about the overall Perinatal Periods of Risk approach.

We start always with community and we don't run to do the maps or go to do the analysis until everybody gets it and is ready to move ahead. You see, in doing this approach, we have recognized that any community partnership relies on strong leadership and on commitment and ability to make change happen. What we've done is introduce as part of the suite of tool sets that you have for PPOR something which will help you raise the test on readiness. We'll ask you to ask what shape is your test. You see, the community readiness tool allows us to do five or six things. It allows us to engage our partners and reach consensus on a couple of really key issues to get started. It allows us to know what are the strengths and aspects we already have together. It allows us to identify where we need to shore up our tent and allows us to be strategic in being able to bring and blend

Perinatal Periods of Risk into the larger work that we're already doing to address fetal and infant mortality. To get to the heart of this testing approach, we have constructed a manual book. We call it a tent.

In this tent we ask you to raise or lay five different dimensions or stake poles. As you can see in the graphic, the bottom of the stake pole is about reasoning and this is very much about making sure you know what it is and why you really want to do this. And the other floor of our tent is about results. If you decide that you want to take on Perinatal Periods of Risk what are the concrete deliverables. How is it going to make a measurable difference? The set up pole we approach is always about resources. Yes, that includes money. But it also includes the people who have the will to be able to see the implementation of this tool set into fruition, and the side poles we talk about are roles, who is going to do what and making sure you recognize that there are trade offs between risks and rewards for doing this approach. What we will give you when you come to train with us further is a whole tool set on how to lay your tent on Perinatal Periods of Risk and how we can help you calibrate different periods of time where your tent might be sagging. Let me share with you one example from Louisville Kentucky, which is a Healthy Start site.

We started working a number of years ago in 2001 with Louisville.

We asked them to construct based upon the tool set we'll share with you at a later time after this broadcast, for technical assistance, we had them work in the community team together with their Healthy Start project to draw their tent. This is what they came up, which was a reasonable start. We actually call this a sunrise sunset where we show them

where is this community to start out with and where can it grow over time and over the 18 months of working together with Louisville Kentucky we were able to be much clearer collectively with a broader set of stakeholders, why they want to do PPOR and what we say they're going to get and they're able to sustain or increase their resources because of that. Widening their base is a very good thing, because that means when winds come along you don't fully fall apart. So tool set of activity readiness. We want to make sure you know that CityMatch can work with you to make sure that your community is ready to take this on as another way of strengthening what you already do. Let's go to the next step of the Perinatal Periods of Risk approach, the six-step approach. This one we go to our analytic phase. The analysis itself is about once your community is ready to receive the data, ready to be part of analyzing the data, this is not about how the help partner at the university goes and crunch numbers and to tell the truth to the communities. This is actually about everyone understanding the data together. When we generate a new way of looking at infant mortality data, which we call mapping fetal and infant deaths, and we map them by two dimensions: birthweight and age at death. Let's take a look at how that is constructed.

When you build the PPOR on that, you start with two dimensions. One way you look at how much does the fetus or infant weigh at the time of birth. Whether it was a live birth or fetal death and that's a dimension we split in two categories. It's another defining Hallmark of the Perinatal Periods of Risk approach. We make the cut of either it being a very low birthweight, if 500 and 59 grams, under 3.5 pounds, or being greater than 1500 pounds. And we only make those two distinctions as opposed to the 2500 cut birthweight.

So in the Perinatal Periods of Risk, our first question is very low birthweight or is it all other births. And then we talk about the question of age of death. We've gone to very traditional parameters. The first is looking at fetal death and we'll talk in a minute, but we restrict our fetal death to 24 weeks or greater gestation. The neonatal period, which is the first 28 days of life, after a live birth, and the post neonatal period, meaning after the first month of life. Now, let's be really clear about what data are going into those cells and what's missing, because we've excluded a lot of information that we know is available in your communities. Fetal deaths included or restricted to 24 weeks or greater gestation. And we have just found by looking at national data sets and working with individual communities that the quality of data a, the validity of the data under 24 weeks, is not yet good enough to be able to rely upon.

And you in your community have terrific quality data, 20, 24 weeks of fetal death, wonderful. But we are not finding that experience nationally in our CDC states. In addition, we include early live births that are greater or equal to 500 grams. You may have 400 gram infants that live after birth in your community. We have found that when you have less than 500 grams, whether it's fetal deaths or infant births, live infant births, it's not as reliable as we need to be with a robust tool to do this kind of analysis. And then we want to be very clear that either induced or spontaneous abortions are not included in this analysis. When you put all those factors together, you get a template, a map that has four colors. It's the shape of a rectangle. It starts by differentiating all of the fetal deaths, the neonatal births and deaths and the post neonatal births and death in what we call one whole category, the first one is the blue box. And it's for all of those from which the

birthweight, the 500 to 1499 grams. In other words, very low birthweight. And then we distinguish three or what we call three periods of risk. We have one which is later, larger stillborn, meaning those weighing more than 1500 grams that are fetal deaths. Newborn, the yellow box, which refers to those babies that died after being born live whose birthweight was above 1500 grams and died in the critical first 28 days or four weeks of life. And then in the green box, the infant health area, it includes all of the live births that subsequently die who weigh more than 1500 grams who died in the second (inaudible) month of life.

Let me just show you before we move on to the next slide, a very classic way that you can show this to those that don't necessarily get the numbers. And I'm going to show this to the folks on the webcast and hopefully you can see that. When we talk about the blue box, which we've labeled maternal health and prematurity, we're talking about babies that fit in the palm of your hand. This is the very low birthweight infant. This is the very low birthweight fetal death, and this is the critical area that needs to be distinguished from all other areas of fetal and infant mortality. So we ask the question, is it these babies. The second level we say in the pink box, which we called maternal care, we talk about it in terms of women whose babies died in utero, in the womb after the first six months of life. Then we talk about the babies that were born weighing more than 1500 grams for which you need to put both palms of your hand together. That's 5.5 pounds. These babies are bigger. Did they die in the first four weeks of life, that would be the yellow box, or did they die in the second and the third and the sixth and the ninth all the way up to blowing out their first birthday candles. Why do we distinguish between four colored boxes and these

maps we generated together? What we do is we link into action. And that action that we link it to is critical. If I know that the majority of the problem in my community is in maternal health and prematurity in the blue box, then I'm going to concentrate my efforts for further investigation and intervention and prevention around the questions of preconception health. Women's health before they were pregnant.

The health behaviors of women and early access to additive perinatal care. If I find the problem is in the pink box around the maternal care, which is our later larger still born, then I'm going to really ask questions about adequate perinatal care and whether or not there's appropriate timing of referral of high risk delivery and whether the obstetric care has been there. Then I'm going to look at the yellow question I'm going to ask questions about the availability of pediatric surgery to address birth defects or newborn care, the neonatal intensive care unit the receiving end on these larger babies and I want to know about perinatal management. If the deaths are occurring and you have the data in the green box then I want to ask about Sudden Infant Death Syndrome, SIDS, ask about injuries and those could be the cause of death later on in the first year of life. Let me walk you through an example of showing how it works in one community. I'm not going to spend a lot of time. These other graphs you can click on at the CityMatch website that will tell you exactly how other communities have calculated this. But how would you generate the map? Well, I know that in my county, which is about 400,000 people in our population, that about 30,000 total fetal deaths or live births occur each year. I know there's actually 301 for the period 1999 and 2002, there was a combined fetal death and infant death number for that four-year period, 301.

And if I were to sort them about how much the baby weighed and when the baby died, I could partition that 301 into each of these four periods of risk. 124 in the blue box. 69 in the maternal care. 50 in newborn care and you can see how we add these up to get the total numbers. So those are the numbers but many of you know numbers are hard to compare and there may be a lot of variability from year to year. So let's talk about calculating weight. In terms of fetal infant mortality rates it's similar to the number we do for standard infant mortality rate but we include those fetal deaths our numerator in this case would be 110 fetal deaths which occurred greater than 24 weeks and greater than 500 grams. And I add to that the 191 infant deaths. So I'm getting a total of 301 we saw before. And divided by the total number of live births plus fetal deaths and it generates a rate. A rate per one thousand live births and fetal deaths, of 9.9. So it's similar in magnitude to our infant mortality rate, but it's actually higher than Omaha's infant mortality rate overall, which is about 8, 8.5 depending on the year you look at.

Including those fetal deaths we're elevating in many cases and increasing the baseline fetal infant mortality rate. You can see if I have an overall rate of 9.9, how does that partition out into each of my periods of risk? I can generate a maternal health and prematurity fetal-infant mortality rate. That component is 4.1. 2.3 is the fetal-infant mortality for the component of maternal care. And I can do that similarly for my yellow and my green boxes. And they add up. Essentially, it's blue, what, pink, plus yellow and green gives you the overall. This helps me to know the greatest driver, the largest component of my fetal-infant mortality rate and these fetal deaths and infant deaths and

whether it's neonatal or post neonatal, all very low birthweight is driving my problem in my community. It's almost half of the overall fetal-infant mortality of 9.9. It's driven not by low birthweight but by very low birthweight and it allows us to truly focus the work we're going to do. But how do we focus that work? Then we continue to the next step. But up until now this is the basic PPOR map. What we're going to do next is give you a look at that map through a couple of different questions. And we're going to focus in on the overall rate so that we can understand what's going on overall in my community. I

f I look, and this would be for those who have printed the PowerPoint, it would be slide No. 23 is where we're at now, if I look at my map of fetal-infant mortality and I look at contiguous periods of time, 1991 and 1994 and '95 to '98, and then in 99 to 2002 and please note that we at Omaha need to put together four years of data, because we're a mid-sized community. We want to have an ample enough number that we have not a lot of variability with coming up with too small numbers. You may be in a much larger urban area that can combine one or two or three years, and some of you may need to go to five. We do not encourage collapsing more than certainly not more than five years of data. Now, if I look at the trend over time at three points in time, I know that my overall fetal-infant mortality in this community was 11.7, and then it went to 10.3, 10.2 then it went to 9.9. But if you look at the components, and then ask, what has been the progress of very low birthweight infants? And the answer has been absolutely none. It still is the largest driver. But in fact the only areas with significant improvement is the green box of infant health and we have done some further work to understand that the back to (inaudible) campaign and affecting Sudden Infant Death Syndrome is the only thing to make a

difference in the past decade in fetal-infant mortality in Douglas County, Omaha, Nebraska. So to accelerate the progress, to allow us to see where we're not being able to make progress. Another way to express that, that you can do, this trend over time, you can take each of the four components. And we've mapped it out over the next periods of slides.

You can see the progress of essentially the lack of progress of the old and over time of this ten-year period, and what we've done here actually are four-year rolling averages. It allows us to make sure there's more stability as we smooth this trend over time, that that blue line had not such and it's been the largest component for over a decade. You can see that the progress we've made in infant health in the green line really was only up until mid decade, and we've had no progress since that time. So it allows me to get trends overall for my community and ask which component is making the greatest contribution. Now, I could look at the same kind of approach that we just looked at in trends over time by rate. And then in this community I'm going to look at the comparisons between black fetal-infant mortality and white fetal-infant mortality. We have only reached a thousand births to the Hispanic population just in this year. And so we have not had sufficient numbers to do this analysis for other communities of color. But I encourage you, whether you're in Honolulu or Tucson or Phoenix, whether it's a much larger community and other communities, that you try to do this where the numbers support being able to do the work. This would be a good time to mention that to do the Perinatal Periods of Risk approach, you need to have at least 10 events in each of the four steps and 60 events over all.

So you need at least 10 in each of the four boxes of deaths, and you need at least 60 deaths overall. You need to be sure pickup have enough to make sure you have a valid analysis. We can do that for black deaths but we can't do those numbers for our Hispanic deaths yet in our county. Look at the boxes. You can see where the great disparities are. Extraordinary disparity clearly in the area of maternal health and prematurity. The blue box, but the greatest one is in the babies who weigh more than 1500 grams who died after the first month of life, and that we have been tracking. It was greater than four to one. It's coming down a small amount. We hope because of some of the things we're doing. You can also look at the lap over time for all races that we've just looked at earlier to see what changes are common, what we've seen in slide 26, that's a repeat of what we looked at before, but why do we look at those trends over time by weight, it's slightly differently than you'll see in slides 27 and 28, which will be my last examples of looking at the data for Omaha. I can partition out now for my community the Perinatal Periods of Risk component, the blue, the pink, the yellow, the green, and I can see the trends over time to see that in fact I have some real concern about white infants, about what's happening with these larger stillborns. That pink one is very troubling in my community and it's something we've never looked at before. The attitude here has been it's not a problem or adults don't want to talk about it, all of which are fallacies that we're beginning to address locally.

The pattern for our black infants is quite different as you see in the next slide, which shows not only is the prematurity of maternal health the driving force, as it is with the white community. But it has, it goes up particularly in the last year which may just be the numbers. It's terribly disturbing to see how much higher it is because the scale to the left

on the X-axis, goes from zero to 10 versus zero to 6 in the previous slide. And it shows me that our greatest concern that we need to look at in the black community is infant health, along with maternal health and prematurity. That in fact the contributions of maternal care, the stillborns and the infant care, I'm sorry, the newborn health is not, the yellow, it's not driving it. When we talk with our African American community and we talk about how it starts we talk about making a difference in the blue and making a difference in the green. And folks, whether they know a lot of the statistics or not can get that. And that's the beauty of being able to present this. Because if we bring it back once again they're saying so if it is the blue box and we want to get some data to action. You will see that the things that we need to ask questions of, particularly in our Healthy Start target site, which is predominantly the African American community in Omaha, we had to talk about women stuff. We had to talk about preconception health. We had to talk more the extent to which there's quality and access to quality perinatal care. And we need to talk about what's happening to the larger baby that died later in the first year of life. And we have been able to see that the SIDS campaign, it never got translated to the African American infants.

And if you go to many of your sites and go to the association of SIDS infant mortality programs and we can find out where our best practice is that we in Omaha can draw from to make a culturally competent specific program targeting African American babies. Now, that's a whole lot of stuff and it's about 11:30 and this is a time when a pop up may appear on your screen. We're hoping that you can tell us as you look at this about questions that you may have. This is a chance for you to type in those questions that you have, and I'll

turn it over to Ellen Hutchins to send us the questions. Those who are watching it by webcast you'll get a pop up. If you could give us your name and PPOR if you could answer the question the pop up will disappear. I'll turn it back over to Ellen. Are we getting any questions from the folks in the audience because you're the one who gets to be my translator?

ELLEN HUTCHINS: We have not gotten any questions yet, Magda.

MAGDA PECK: That's because I talk so fast like an East Coast city girl. This would be a good time if any of you would like to send any questions, I'll make a few side comments here. We've allotted about five minutes here for you to be able to say does this make sense.

ELLEN HUTCHINS: We just got one, from the Missouri Boothill Healthy Start project. They want to know how to download a copy of your slides.

MAGDA PECK: How to demo a copy of the slides. I'll turn my colleague Jennifer Skala and actually it would be great if you could ask questions so Jennifer can answer questions as well. Where are the slides available that people can download? This is the technical piece. Because Jenny is the one that helps with the technical assistance at the site.

JENNIFER SKALA: Currently there's no way to download the slide they're with UIC and just available through the webcast. However, Gail Davis has them through e-mail as well

as does our CityMatch office, and you can call them and refer to 561-7500 and they'll be able to e-mail them to you. And then after this we'll have them available to you as well.

MAGDA PECK: They're not available today but if I led you on, I apologize. But they're available through UIC webcast. And I hope that answers the viewers' questions. Other questions that we have? (No response.)

MAGDA PECK: Hearing none, let me just say that for those of you who are on the webcast, we love questions. You've got to know that CityMatch actually demands questions, because unless you ask, we have no idea whether or not we're getting things across. So the other thing you can do is if you want to get any feedback to us as well, as I say yes, that's okay, and we're doing good or we understand that would also be welcomed in that text box if you can type. But we actually would like to know if there's any questions you have, please do not hesitate. I am going to move ahead.

ELLEN HUTCHINS: There's more questions.

MAGDA PECK: All right. I love questions. Go for it.

ELLEN HUTCHINS: From Leroy Koetz, I'm not sure where he's from, it doesn't say. But Leroy would like you to explain the boxes again and what times do they define, he asks Jennifer Skala explain the boxes one more time.

MAGDA PECK: Let us go back then in the boxes and let us go back, I'm assuming that the caller wants to know about what, how to construct the actual map again. I'll review it one more time. And it is on -- I'm going to start with slide No. 15. If we could go up to there and then we're going to jump ahead to slide No. 17. So I want folks to know so they can know where to follow. What we've done in the analysis part of PPOR is to take existing vital statistics. So take the birth death file forfeit tall deaths for a given period of time. We take all of those events and take in particularly the question of where and when do the deaths occur. And this map is based upon this construct on slide No. 15 which lists that age of death and when, how much the baby weighed at birth at the same time. And through a series of analysis we've done statistically, we can fast forward to number 17, we are able to collapse these six cells into the PPOR standard map. And this map has the capacity to differentiate between four different periods of risk four components. The first one is called maternal health and prematurity. And it refers to all fetal deaths and infant deaths, which weighed less than 3.3 pounds or less than 1500 grams. As I explained before, the births that are this size to fit in one hand.

We were able to collapse what was originally cells one, two and three because regardless of when the death occurred, the etiology, the causes, the background reasons for why that death occurred are similar, even though the clinical treatment may be very different. So some of you may actually come from a clinical audience. Physicians are used to doing direct clinical care sometimes pause at our ability to collapse boxes one, two and three. But from a prevention standpoint, very low birthweight has similar prevention strategies for at least that for which is known. The pink box, which is maternal care, is all the deaths

which occurred, that weighed more than 1500 grams but died in the womb. Either stillborns or fetal deaths, the baby was not alive when birth occurred. And these are greater than this size-- either this size or greater. The yellow box are all of the now infant deaths which occurred and the infant deaths which weighed more than 1500 grams at birth, or alive but subsequently died in the first four weeks or 28 days of life. And then finally, the green box, the infant health box, are all of the infants that were born alive, weighing more than 1500 grams, who subsequently died in the second, third, fourth, fifth, up to the 12th month of life.

Essentially any time after the first month of life but before being able to blow out the first birthday candle. This is a starting grid. These four components are periods of risk allow us to then, if we can just remember that the slide I think that follows that one right afterwards has action. And so one more slide ahead of that for the folks in Chicago, you'll be able to see if I know my problem is predominantly blue, that I have certain questions and strategies I want to follow. Similarly, I want to be able to again link the problems in green to a very different set of strategies and interventions. Bottom line, infant mortality is not one thing so there's no one thing that we can do. This allows us to figure out what the leading components are of fetal-infant mortality, and tell us what we might want to do next. That's the question. Any other questions before we move on.

ELLEN HUTCHINS: I submitted about three more, Magda. The first is can you combine data from multiple years to reach 6 deaths?

MAGDA PECK: Absolutely, easy question we include multiple years because it gives you more stable numbers. We encourage you to try three years and see if that works. Some very large states can do two years. But we found three years is a good way to combine. We at Omaha do four. Some states stretch to go to five. If you go to five so much can happen from year to year that it begins to lose its strength. If you're going to do it much after combining years, give us a call and we'll talk about it. You may also want to look at the city limits. You may want to look at the county limits. You may decide to combine counties. Here's a little adage to remember, the unit of analysis, the geographic unit of analysis is the unit of change. So if you're doing business in a metropolitan approach, in a metropolitan area and this is where your boundaries are, then you may be able to go to combined counties to give you a more metro approach. But if you've got very different solutions and you won't be able to cut it to cut it by two geographic communities, don't go there. Two more questions quickly.

ELLEN HUTCHINS: How do you calculate the weight at death? This is from Kristy from the Boothill project.

MAGDA PECK: The weight at death is recorded on death certificate. But the most important thing is that the parameter of weight is not the weight at death. The parameter we're using, the measure we're using is the weight at birth. So the question leads me to think if someone is thinking somehow we want to know how much did the baby weigh when the baby died. We want to know how much did the baby weigh when the baby was born, whether the baby was born alive or not. And so birthweight is the parameter. And

that birthweight appears on the birth certificate and it appears on the fetal death certificate. And we just use the data that are reported in vital statistics. One more.

ELLEN HUTCHINS: Can you review?

MAGDA PECK: Then we'll move on and make sure we can add more questions later on. Next question is from Barbara Joseph from north Louisiana. Can you review why low birthweight is not included and why it's grouped with normal weight?

MAGDA PECK: The question again is? Jennifer Skala why is low birthweight not included and why it's grouped with normal weight.

MAGDA PECK: Very good question. We could have had an original model that we developed this from, which I give attribution to Brian McCarthy which was with the WHO collaborating center for CDC health. The original model has 16 cells, not six cells, and we can go back and give this, if you pass on this particular questioner's information we can follow up and give you back-up information about this. We were able to from an eat logic perspective, through a series of analysis, collapse the above 2500 gram births together with the 1500 to 2500 grams for the use of this model. But please remember that we had originally not six but 16 cells. And by doing a series of statistical analysis, we were able, and (inaudible) analysis, we were able to combine different cells in the six which we then collapsed into the four. We found a 16 cell model, while statistically was the most accurate from an action perspective, was not pragmatic or practical, because the numbers

in the cell became too small to be able to do much with. So conceptually we were able to finally reach the four cells. Let me suggest in the interests of time that we keep moving ahead, because we've only got started. And if you have additional questions, we'll make sure that they get sent to us and we will be in a position to answer that question after the webcast through additional assistance. And at this point we're going to, for those who wonder where we are, we'll move on to what will be slide 31, which is mostly for the folks at UIC to know.

When you print it out later you'll be able to see that. Let me remind you we've been doing a good job of being able look at the overall PPOR map. But we're in phase one of our analysis. And in phase 1 we're only getting started and only having this map is necessary but not sufficient. The real thing we need to ask is where are the gaps? What I'm going to talk about over the next five minutes is probably the critical heart and soul of the Perinatal Periods of Risk approach. What distinguishes it even more than the data being different and a different lens to look through of the pretty boxes, this concept that I'm going to lead with next is really what sets it apart from standard infant mortality review that we have and shown the statistical analysis in the past. You see, what we want to ask is: Which babies are already doing the best? We're not asking which are the best babies, but where are there already optimal outcomes? Where do we find the lowest death rates among our women and infants? Where is that? We want to ask that. I know that there are some within our communities whose babies are not dying and others whose babies are. So we want to assume that all of our babies all infants can enjoy the same outcome. If we've already achieved that success within our community or elsewhere in the nation, why can't

we demand that we should achieve similar success for all of our infants? ? So we need to choose a comparison group, because comparisons is the heart of Perinatal Periods of Risk.

It asks us if we know the fetal-infant mortality rate for a given group, we want to compare to the group that's doing the best and look at the gap between and ask why is that gap there, where is the gap, and how can we target further questions and interventions on the gap? And we have a calculation that we will show you how to do now that will tell us what the magnitude of that gap is overall. So let's go back to Douglas County. Let's come back to Omaha where we're doing this webcast from. And remember the PPOR rate being 9.9 overall, and remember how it broke down into the four different periods of risk. I'm working with my team in the Omaha area, entities that are involved in the question of eliminating infant mortality and racial disparities. We asked ourselves a couple of strategic joint questions. We have to ask it as a community. Should we set the bar, should we set that comparison group internal to Omaha? Should we find out what is the best possible outcome within our community? Or should we identify some group outside of Omaha and other urban areas or states or the U.S. as a whole to compare our fetal infant mortality rates too? If I am going to choose an outside of Omaha group, which outside group should I use? If I'm going to use an internal group to Omaha, what should that look like? Let me start with the outside look first, because one of the things that we all may want to do is to take a certain external standard, which women in the United States as a whole have the best birth outcomes?

And we know from examining national center for health statistics data that it is women who are 21 years of age, 13 or more years of education who are non-Hispanic white women. These maternal characteristics combine to give us the best and the lowest fetal-infant mortality rates in the community. This is for all U.S. resident mothers at the time of birth. If we do that calculation and calculate the fetal-infant mortality rate as we did for Douglas County, in our example earlier, we end up with a national external and comparison group. Its national U.S. PPOR rate is 5.9 divided into 2.2 in maternal health, 1.1 in newborn care and 1.1. So still all at the 5.9, the very low birthweights continues to be our driver of who lives and dies and our lowest component is in infant health in the larger babies that die later in the first year of life. So we had a previous reference group that we have used. And some of you have been using an earlier reference group that's shown in the next slide. We just want to show you that when we use the earlier reference group, when we started this methodology, it was based upon 12 cities data. Now we've gone to all U.S.A. in those that are resident that have infant maternal care characteristics. What's interesting whether you're talking about 95 or 97 for external comparison and our current that we just calculated for '98 to 2000, it is essentially the same for those of you who have done this previously. So in Omaha, I could use that. I could use the 5.9 and compare my 9.9 to 5.9 and the gap is four. Four per thousand. That's huge.

That's an almost half my weight if Omaha was doing as well as the nation as a whole for women with similar characteristics who are residents. But what if I want to look internally? What if I wanted to have an internal reference group to compare with? Women with the same characteristics, 20 more years of age, 13 more years of education, who are non-

Hispanic white women. Well on the next slide you'll be able to see, you can see that that rate is 7.0. And you can see again the largest contributor is still fetal maternal health and prematurity in the blue box. But I would tell you that there are higher rates in Omaha's internal group than there is for the nation as a whole. So what is the gap? Is the gap between 9.9 and 7 or is the gap between 9.9 and 5.9. Where do we decide to set the bar identifies where our gap is. That's why I started a statistical decision. It's a community decision about what should be the definition of best outcome. Now, some communities have looked at both. We wanted to show you an example of what would happen if we looked at both together. And in slides 41 and 42, the next two slides that you would look at, we can go and calculate out across each of the periods of risk what our overall would be. And we've just taken our boxes, our graphic and displayed them in with a consolidated format that we read across the ropes. You'll see the total, which leads to 9.9. You saw that before.

You have just seen before the internal comparison group 7.0 and the external of all U.S.A. which is 5.9, different components, different expression of what I just showed you. So I have to know where is the greatest gap overall. And that gap, and what we're going to be working on, is different, whether I use an internal or external comparison. And in particular, there is no gap in stillborns, larger stillborns if I use only Omaha's reference group. If I look at an external comparison it's almost 1. So there are big differences and you need to examine this in your community to find out which would be better. If you find that you're about the same as the U.S. overall, perhaps your statewide PPOR rate would be one to use, if that's so different. That internal comparison may be just fine. But in

Omaha's case we have to ask ourselves as we do in the next slide, if I look at the actual numbers that go along with these rates, and I calculate an estimate of how many babies are actually dying, and how much would have died if we achieved the optimal rate, is the gap 122 preventable deaths or is it 88 deaths, and you can see there's a big difference. Then there's a methodology that we encourage communities to use to take their excess deaths and partition them into a series of pie charts, and a number of you have seen in front of you now shows you that for overall, the blue is the driver of all of these excesses, not just all (inaudible) the largest component of your rate but of the excess deaths, of the gaps. This is a way of further refining and confirming where you need to put your efforts.

So overall, compared to the U.S., I know that in Omaha we have to look at maternal health and prematurity as we have very low birthweight whether you're white or black because it's shared by both. But I do know that among white infants that larger component of the pink and the lower left pie chart tells me that I got a real problem with stillborns in my white community that we have never examined before. If you look at the next slide, and we show the comparisons to a reference group that would be only for how well we can view Omaha, the pink disappears. So reference group decision makes a big difference, because it tells us really from data to action. If I've got a problem with that pink box I've got to be able to know it's there and we have to target our questions and solutions to that. Now, here's another one of our times for pause. I'll take one or two questions here if we can, if there are any that have come up so far, in the interest of time, and we'll save the rest to the end of the program.

ELLEN HUTCHINS: I have one from Mississippi. If you don't have data on fetal deaths can you do an analysis with the three boxes on the bottom?

MAGDA PECK: If you don't have data can you in fact do the analysis is the question? The answer to that very clearly is no fetal deaths are an essential part of the Perinatal Periods of Risk. Fetal deaths are available in the specifics and we know that we've been working with them to conduct the Perinatal Periods of Risk and with the technical assistance that we've been able to provide (inaudible) to the CDC either. So you have the data and those who have the data, you should use the data and without having fetal death information, the approach does not have much meaning. One more.

ELLEN HUTCHINS: Just a comment. Wanda from Phoenix says we've been using PPOR for several years and we've been very satisfied with the progress and process derived from it.

MAGDA PECK: Thank you for that endorsement Phoenix. We appreciate it. They've put in an extraordinary amount of work it's a Healthy Start site grounded in the communities. Thank you for that comment. Let me move on and say this comparison piece, this excess death takes a little while getting used to. Once you stop thinking only about overall rates or just differences in overall rates between different white versus black and you shift the attention to estimated excess deaths, if you shift your attention to the gap, then you go to the next step of PPOR, which is to target your further intervention, through your further analysis on the gap, not on the overall. This opportunity gap is really a way for you be

much more efficient and targeted with the limited resources that you have. So in the presentation that was done at the grantees meeting, it was focused on exactly that. How do you integrate fetal-infant mortality reviews to where you have the greatest gap? If your greatest gap is in the blue or greatest gap is in the green but you don't have a lot of excess deaths in the pink or yellow, then look at your fetal-infant mortality review results, specific to the very low birthweight or the larger infant deaths, it allows you to be much more economical and much more filtered in using other tools like (inaudible) the who that don't compliment themselves very well.

There are other kinds of secondary analysis that you may want to do, now that you've been able to get a big picture and find out where your gap is. Let me tell you a couple of what we've done quickly here in Omaha that may give you a sense of how we call this phase two analysis, the analysis of phase one but phase two which a follow-up and targeting further investigation. We asked three questions in Omaha right up front. We wanted to know for just the yellow or the green -- now we've eliminated all the very low birthweight births and deaths but just for newborn care and infant health, just for those two periods of risk what were the causes of death and it allowed us to sharpen the lens on the contribution of birth defects and the contribution of sudden infant death syndrome. We needed to ask in Omaha because Nebraska has a higher rate as a whole than the nation.

It has a higher gestation on trip merits and quad drops elsewhere, perhaps because of the technology-- what about multiple gestation-- how much mortality is related to a lot more of these multiple births that are born small? What we have found is that there are a lot of

multiple births and it is a four percent versus two to three percent in other areas but the mortality is not higher. And most of the deaths that are occurring are happening in the larger, if they do occur, they are happening in greater than 1500 grams with birth defects and others. It's not been a major issue for us. We have a whole template analysis for those who are interested in looking at this. The third thing that we ask, and this is a standard analysis that I'm sure that some of you are going to bore you in the next five minutes of our final part of analysis.

It's something that we encourage every community to do. And it basically has a fancy name called Kitagawa Analysis. It's really a very straightforward question. It's a question we ask about the view, about maternal health and prematurity, about only the very low birthweights, the under 1500 grams, fetal deaths, and infant deaths that occur throughout from the first weeks of gestation through the first weeks of life. We ask the question, is it high because of a whole lot of prematurity. In other words you have a lot of premature births occurring, call it birthweight distribution, or is it because of the issues that once babies are born so small, they subsequently die at a high rate, that all that we do to save them (inaudible) is not optimal. That the sequence, the things that happen as a consequence of being born so small so high are playing out after they're born, and so we differentiate between birthweight and fetal-infant mortality.

To show a difference between the overload and the survival of the thin yes baby. We want with all of the technology to be available and used to the optimal most for our tiniest. I'll show you some quick results out of Omaha as we finish out with an example, with the

understanding we will not have enough time to go through this in detail. But we did learn that in Omaha Nebraska for Douglas County, two-thirds of the excess estimated deaths in the blue box were being driven by birthweight distribution, meaning we have a lot of premature babies being born too small. And a third are attributable to the survival of the timing of babies, this methodology of Kitagawa, using a population attributable risk that use that kind of methodology detail.

What I will tell you overall is that there's no difference when we use the internal and external comparison groups, over the same findings of both reference groups. So the real issue is that that 33% in Omaha is higher than just about any other city. Whether it's claim boosts Ohio 90% would be premature and 10% would be survival of (inaudible) it's a huge flag for Omaha why are our excess deaths are so much more (inaudible) relative to other different communities in the country. So I'll leave with you a few slides at the end, just so you can know what we did with our analysis in Omaha because it's about getting data action. It would be in the next slide to show that there are four major findings. That really it's about the blue box for all women that a higher proportion than we would expect is really due to survival. We've got a problem of white women in terms of stillborns, larger babies still born weighing more than 1500 grams and that there's a huge disparity between black and white infant deaths in our green box. This has led to us collaborating to a blueprint for action. We have our first blueprint of action for eliminating and reducing infant mortality in Omaha in the history of our community and we hope it's going to make a real measurable difference because it allows us to walk through the full six steps of Perinatal Periods of Risk in the last slide I'm going to show you before I break.

And that is after you have targeted, you need to move on. You need to mobilize because this has changed. In Omaha Nebraska as shown on slide 55 we now have the first unified approach to addressing Sudden Infant Death Syndrome in our white and black and other communities (inaudible) that puts everyone on the same page. That would not have happened had it not been how this kind of target approach target to know what they need to concentrate on and it's not rocket science, bringing in what we know in other communities to avail culturally competent and targeted prevention programs right here where babies go to sleep in their cribs. So that's my example. I'll check the time. Not so bad. We're doing pretty well. This is one more five-minute period for questions. We'll leave ten minutes in our time to walk us through what happens next and what we need to remember. So let me breathe, rest here. I'll pass it back to you Ellen. Any more questions come through?

ELLEN HUTCHINS: Not at the moment. We'll give people another couple of minutes while you're taking a slight break, Magda, to see if we can get a couple more questions in before you go on.

MAGDA PECK: That would be great. I think that the key that we want you to remember, which Jennifer will be the one going through some of our next steps of our overview about the top things to remember, is that it's not about the data. It's about what a new way of looking at the data help us to do differently. It's about being able to target, know where

your gaps are and focus your efforts on the gaps and being strategic with limited resources in times of challenge. Other questions, Ellen?

ELLEN HUTCHINS: No, we don't have any more at the moment Magda Peck. We'll give people one more chance. There's always another chance to ask questions at CityMatch. As you know that's our culture. Why don't we in the webcast, why don't we shift to asking Jennifer Skala, who is our managing coordinator for education and training, who is working directly with our colleagues at the Maternal Child Health Bureau to find best ways we can provide technical assistance and bring you on board to know -- why don't we ask Jennifer to tell us a little bit about what are the most important things that we need you to take. And so five take home points, and then we'll take a pause after that to see if there're any questions--one more time. Then she'll tell you about our plan for helping you use this tool, if that's what you decide that you're ready, willing and able to do. So let's take it away, Jennifer.

JENNIFER SKALA: Okay. Hello, everyone. The camera is on. Again we're so thankful to HRSA and MCHB to talk to you about the approach today. Back in September I was able to do that whole in just about ten minutes. I know a lot of people walked away not understanding what the approach is all about. So today now you've heard it all we really want to reinforce at least five things to remember and walk away with in your consideration of if you want PPOR technical assistance in the future. So the first one being PPOR is a comprehensive approach it's used to address fetal-infant mortality. Again, it's six steps beginning with the community engagement and going to systems

change. If you just do the analysis, there's no value added, just the starting point, as in getting it engaged and not the ending point. That's the first thing to remember. Number two- it allows the community to move towards action. It lays out the four periods of risk. It allows you to do those comparisons and focus in on your gaps so that if it is an infant health you know right away that what you need to do to prevent and go to action. You need to look at the sleep positions, breast feeding and injury prevention, for instance. It really is an effective tool to use data to go directly to action. Number three- it fosters integration with other key efforts. Back in September at the grantees meeting we really focused on that critical integration between PPOR, the center and your local help action plan.

Here we want you to realize there's so much quantitative and qualitative information out there that you need to use to take the faces behind the numbers, and PPOR is a way of making sure that integration occurs. Number four- you need to be ready analytically to do this approach. We can't stress this enough. It's not for every community. And we are here to help you make sure that you are able to do this. And a lot of questions have already been addressed to Magda earlier about the fetal death files, for instance. You do need to have access and you do need to look at the quality of those death files. You need to also make sure that those files are linked. That's not a standard practice. That's something that's becoming available as PPOR is being introduced to a lot of communities and states. Again, you need to investigate the unlinked infant death files and also look into your missing data items and the ones that have poor quality. And finally, the last point to remember is number five. You need the community on board and ready. This is like

preaching to the conservative, I know because all Healthy Star communities always have this in place, but this approach really allows the community champions and leadership and the adequately trained staff to understand the fetal-infant mortality problem, to understand the work plan that needs to take place. It puts everyone on the same page. It allows people to commit up front what resources they have to decide into further investigation and also to provide resources so that community collaboration and the action that needs to take place. And finally it gives priority to this effort and champions the initiative.

So finally, things that we've learned- the next slide- is in the last three years it's really about impact and the results. It is still data capacity, first of all. It makes sure to promote effective data use. Again, moving directly from data to action. It strengthens essential partnerships that need to be in place. It fosters integration with other key efforts. It leverages resources and it enables systems change for addressing perinatal health. Those are the five things to remember about the approach. Now that you've been told the story, we know that it doesn't take just once. We're here and we want to talk about what your next steps are if you are interested in receiving this type of technical assistance and giving this approach in your community.

MAGDA PECK: Great. Ellen, this is Magda. Have you had an opportunity to get any more questions in?

ELLEN HUTCHINS: We haven't gotten any questions about the technical assistance, but we got one about do you need to use statewide or community wide death statistics or can you just use Healthy Start recording deaths?

MAGDA PECK: That's a very good question. We strongly believe that it would behoove you to use the denominator, the data that corresponds to what needs to change. Let me give you an example like in Philadelphia, which has used this before. Philadelphia has a large enough population, talking about a city of five million people. It has two Healthy Start sites. It is able to do Healthy Start analysis in the part of Philadelphia, west Philadelphia and north Philadelphia, using, take into account a smaller geographic area to calculate Perinatal Periods of Risk fetal-infant mortality rates. But remember again that the expectation to have ample results is at least 60 deaths overall and at least 10 in each of the four colored cells.

And so there are very few communities that are large enough that allow themselves to do the fetal infant mortality rate analysis of PPOR at the neighborhood level. And many have these targets at neighborhood levels. So you need to look to see whether or not you have enough data and the data is good enough quality and complete enough to be able to calculate it in this way. If you can, terrific. If not, it may allow you to or may cause you to need to go to the next geographic unit of analysis which may be countywide. Or maybe metropolitan, depending on which community is speaking with us. So try to get to the lower level. We always suggest you want to get to the unit of analysis, as the years have changed. But there may be ways, much like in other vital statistics analysis, where the

Healthy Start sides have to rely on why countywide data is used and economic status and geography when the numbers aren't good enough or big enough to be able to go to a smaller unit. Next question.

ELLEN HUTCHINS: Next question is from Francesca from Healthy Start, can you use (inaudible) versus aggregate data?

MAGDA PECK: Great question. I'll be glad to follow up. As we look at the trend data over time and give you an example of Omaha-- we did three contiguous periods of time for the full years we put together, 95, 96, 98, 99 and 2002. That will give you very valid snapshots in time. The rolling averages, and particularly doing it as rolling averages aggregates would give you a better view because it has information that will identify if there were changes that happened to happen around the artificially identified contiguous points, you'd be able to see that a little bit more clearly. So the rolling average is probably more accurate. But some folks may have a hard time reading graphs that way. So we calculate it both ways because different people perceive things in different ways. The three snapshots may be more accessible to others. How about one more question before we go to the last piece.

ELLEN HUTCHINS: That's all the questions we have right now, Magda.

MAGDA PECK: That's good timing. I want to make mention of one thing before I pass it over to Jennifer to talk about technical assistance and what we can do for you next. We

had a webcast yesterday through the centers for disease control and prevention through their MCH epidemiology initiative which talked about the availability which we have now been able to achieve at CityMatch in partnership with CDC and the March of Dimes for national PPOR data table. This would be a way for you to go to the CityMatch website and click on PPOR and click on the PPOR data tables. We also have an archive of our, a link to the archive at UIC and the power points from yesterday's presentation will be up on our website for you to get some background on this. We have gone to national centers for health statistics and use data from three periods of time, '89 to '91, '95 to '97 and '98 to 2000. And we've done all the same analysis that you just saw for phase one overall, over time, by race and ethnicity, including Hispanic ethnicity to be able to estimate Perinatal Periods of Risk, rates, be able to give you external reference groups, and to be able to help you understand the issues of multiple gestation. Seven different data sets up on the web, you can then go out and find your state, look up your county, in some cases your cities, it's large enough numbers, to get, according to national data sets, what your data looks like, what your community looks like.

It's not a substitute for your doing it locally. But it can give you a preliminary snapshot of what you look like nationally. So I encourage you to do that now that you may have an orientation on how to interpret the different periods of risk, the different components, and how to look at the trends and look at it at different levels of analysis. We have it for both the state and the U.S.A. as a whole as well, because you want to make sure you are working with your state in moving ahead. This is actually something you can't do as a locality yourself. Because you don't have the data and state partnership is critical to that. I

wanted to tell you that. You can go back in 24 hours and see the webcast. And in addition, we want to tell you about some other technical assistance opportunities that are available. And I'll pass it back over to Jennifer who will tell us about level one and level two opportunities for you. Jennifer.

JENNIFER SKALA: If you will remember back about a month ago, Gail Davis sent out to all project officers and all Healthy Start projects type of well assistance requests. If you're interested it involved level one as well as level two technical assistance. I'm just going to talk about each of them. First of all, I want to make sure you know a lot of comments that I receive back was do I have to be a level one before I'm in level two. And that's not the case. So first of all, level one is just called general communications. And it's similar to what we're doing today. A webcast about what the approach is all about. It's just general information that you would like to have about the approach. Not saying that you're going to use it or form a group of people or a learning piece to put it into effect, but more so about individuals that really want the knowledge about the approach, get best practices, they can receive peer exchange, via electronic communication, and really access the web and know what's out there on our CityMatch website. Those projects thus far are listed below so you know which ones we've actually obtained. If you do want to be part of this technical assistance and you're not on this list, please get in touch with your project officer then they will forward the information on to us. So going on to the level two technical assistance-- this is more for those users of PPOR, the people that really want to implement their approach in their communities. So it's again the learning network we're calling it.

And those communities using or planning to use the approach and they will receive emerging promising and best practices from all those sites and teams and communities and states that are already using the approach. They also receive regular E communications or emails from CityMatch, as well as peer exchange and technical assistance along the way, if they're putting their approach into practice, and also not bimonthly or monthly topical conference calls or webcasts similar to this as well. And finally how to do the PPOR workshop. You'll see on the request coming out from Gail Davis there was level two opportunity for the people to attend the December 12th and 13th workshop in conjunction with MCH conference. Back there, there were the TA projects that were interested that we have heard from, and so if you have any updated information or that you do want to become part of this, again, contact your project officer and they will forward the information on to us. And again we thank you for this opportunity and we can go back to the final comment here. This workshop is for everyone. It's introductory, takes you through all six steps of the approach as well as bringing in lots of information. Those that registered through your project officer, we choose to be part of a cohort of training, so that won't be the only time that we see you. It's just the beginning of the training and we'll have another one offered in April or March or April we're looking at in the spring of 2004 for additional people.

MAGDA PECK: Jenny, as we have found, many in the technical assistance really helps. Everyone starts at level one. This is learning about it. It's through passive communication. You get on the receiving information here what's passing out there. And

level two is an engagement that requires a certain foundation of knowledge and that knowledge tries to get started is what we insist that every community that's part of level two have the opportunity to go through the eight-hour workshop. It lets you to be more participatory, in your own community, allows you to collaborate with others, and gives you this solid basis from which to actually do the work. We have certainly been hearing from those that have been trying to figure this out on their own and we applaud you for doing so. Just make sure that everybody is on the same page and the methods are being used are consistent with national practice and standards are being set.

It is our anticipation that within the coming years, Perinatal Periods of Risk will become an additional approach used to standardize presentations and standard work in terms of community assessment in terms of strategic planning for maternal and child health in communities across the country. So when we look at fetal-infant mortality and the approach which looks at gaps and estimating excess deaths and targeting our interventions based upon where some are and others are not yet, we want to make sure that everyone has an equal opportunity to be solid about what this approach is, how to use it, and how to get the most from it. Bottom line, it's about doing the absolute right thing right for the women and children and families and fathers that we serve. We want to make sure that we can bring to you a Healthy Start time, new tools, to bring new life, life for places who have been do I go this struggle in a long time on a fresh level to make an even greater difference. With that we'll pass it back to you Washington, folks in Chicago in doing the technology, to say it's all yours.

ELLEN HUTCHINS: Thank you very much, Magda and Jennifer, for a very informative webcast. And thank you to the audience for sending in your questions. I hope everyone has found this informative and I hope you'll join us on further webcasts. Thank you.

(Music)