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Megan: Hello, everyone, and welcome to this "Hear from Your Peer" webinar, "Fetal Infant Mortality Review" or FIMR and "Healthy Start, Strategies for Partnership on Preventing Infant Death." I'm Megan Hiltner with Healthy Start EPIC Center. And on behalf of the EPIC Center and the Division of Healthy Start and Perinatal Services and the wonderful planning committee for this webinar, we welcome you to the event. This topic is a priority for the division, and we have Dr. Madelyn Reyes here from the Division of Healthy Start and Perinatal Services to provide a few...more remarks on that topic in a moment. But before I turn it over to her, I have a couple of housekeeping announcements for you.

We have approximately 90 minutes set aside for the webinar today. It is being recorded, and the recording, along with the transcript and slides, will be posted to the EPIC Center's website following the webinar. That website is healthystartepic.org. We want your participation today, so at any point in time, if you have questions or comments, please chat them into the chat box at the bottom left corner of your screen. We will only be taking questions through the chat box today, but we will be taking questions throughout each of the speaker's presentations today. So please keep those questions and comments coming in. We also have time set aside at the end to take some more questions and comments.

Last thing, we want your feedback on this event, so please take a moment following the webinar to complete a survey that will pop up right after the event.

So, first, you're gonna hear some opening remarks from Dr. Madelyn Reyes, and then, I wanna briefly introduce the other speakers for today's webinar. They'll provide you a little bit more background on who they are when they provide their remarks. But first, we will have...let me move to the next slide here. First, we will have the FIMR Director with the National Center for Fatality Review and Prevention, Miss Rosemary Fournier. And then you'll also hear from four Healthy Start grantee programs, and you'll hear stories from each of them. The first program you'll hear from is the University of North Texas Health Science Center, you'll hear from Misty Wilder. You'll also hear from Dallas Healthy Start, you'll hear from Miss Karla McCoy and Miss Alexea Collins. You'll also hear from the Indianapolis Healthy Start Program, Miss Yvonne Beasley. And then you'll hear from Miss Lo Berry at REACHUP, Incorporated. I'll now turn it over to Dr. Madelyn Reyes for her opening remarks. Madelyn.

Dr. Reyes: Thank you, Megan. Good afternoon, everyone. We're very excited to hear from our panelist today, beginning with Rosemary Fournier, who again is FIMR Director at the National Center for Fatality Review and Prevention, who will provide us with an overview of FIMR and how it fits into the larger, more maternal and child health system. We're also gonna hear, as Megan stated, from four Healthy Start Programs across the country, who will also share their stories and the many benefits of collaborating with FIMR, such as reporting to inform their community action network, and also the creation of media campaigns to educate and prevent infant death. So we're very excited about our webinar this afternoon, but without any further delay, I would like to now turn it back over to Megan to begin our presentation. Thank you.

Megan: Great. Thanks, Madelyn. And right before I turn it over to Rosemary, I do wanna note that I did include the typo on this slide. The third group down here listed at Dallas Healthy Start, Miss Karla McCoy. Miss Niccole McKinley was on our planning committee. So she is, I wanna acknowledge her, but your presenter today will be Karla McCoy and Alexea Collins. So I wanna make note of that typo and acknowledge that. So I'll correct that, and when we post them to the website, it will have that correct information.

So with that, I'm gonna now turn it over to Rosemary to begin our presentation. Rosemary.

Rosemary: Thank you, Megan, and thank you so much, Madelyn. Just to briefly introduce myself, I'm with the National Center for Fatality Review and Prevention. This is a HRSA-funded resource center that supports both Child Death Review and FIMR, the Fetal Infant Mortality Review program, but we're the data and resource center and my role there is doing technical assistance, training, and just support in any way that I can, to help you all to be more successful. So again, I'm really excited to be with you all today on this webinar. And basically, our objectives are giving a FIMR overview to folks who may not be as familiar with the FIMR methodology, to explore the benefits of Healthy Start and FIMR partnership, and then discussing how FIMR fits in with the larger maternal and child health system.

So, as we start off our presentation, just to keep everybody on the same page, we'll define infant mortality as the death of any live born baby before his or her first birthday. And indeed, we often view infant mortality as the most sensitive index we possess of social welfare and well-being.

A quote from Julia Lathrop of the Children's Bureau, the very first director. "Fetal mortality, or stillbirth, is the death of an infant before extraction from its mom or the product of human conception, but this is a baby that does not show any signs of life. This would be a child that doesn't have a heartbeat or any breathing, voluntary movement of muscles." And so we are reviewing in our FIMR process both stillbirth or fetal mortality and our infant deaths that are babies under the age of one.

So, we're highly in the U.S. In 2015, we had just a little bit under 400,000 live birth, 8.1% of those births were low birth weight, babies less than a pound and a half, and 9.6% were pre-term, born less than 37 weeks gestation. Unfortunately, neither of those are going in the right direction when I did this slide a whole year ago, for 2014, the pre-term birth rate was only 9. So we're definitely unfortunately still having a lot of work to do in that area.

In that same year, we had 23,455 infant deaths. These are our live born babies that didn't survive till their first birthday. And so, we usually express that in terms of how many deaths per 1,000 live births. So that would give us a rate in the United States of 5.89 deaths per 1,000 live births. Our stillbirth rate, and this is actually for 2013, because we don't have a complete set of matched birth and death certificates for years beyond that, and these both come from the National Center for Vital Statistics reporting, and our stillbirth rate is very close to that infant death rate, 5.96 deaths per 1,000 live births.

In here, you can see what those trends look like on a graph. The red line being our infant death, live born babies, and the blue line being the fetal death. A lot of progress has been made since 2000, but we still have rates that we know we need to work on. And then more clearly alarming trend is that we're not seeing a huge reduction in the disparities. Our big challenge in the United States is that non-Hispanic, Black infant mortality remains higher than our white, non-Hispanic infant mortality in many communities, three and even four times higher than the rate of their white counterparts.

So, why FIMR? To look at these, you know, we've looked at Vital Statistics a few moments ago, but when Vital Statistics really cannot tell us the story or give us the full picture, that's when I believe communities turn to FIMR, to tell us really why and how babies are dying. The FIMR process resembles kind of an ultimate quality improvement cycle, ultimate CQI, we call it. The FIMR process begins with data gathering.

Our nurses and social workers and team members extract charts and gather the medical records. They include a maternal interview in that process. And then they put together a de-identified case summary that goes to a case review team. That case review team looks at all of these deaths and tries to learn from that particular case what we might be able to do differently, or how could we improve our systems of care and services for moms and families. And then a community action team will take those recommendations and implement them, translate them into action, and ultimately, that will, we hope, result in changes in community systems of care.

So, where are we today? FIMR does have a presence in 28 states, the District of Columbia, and Puerto Rico. There's a little over 175 local programs, and we do have tribal associations that actually partake in FIMR in Wisconsin, Wyoming, and in Michigan. So, on this slide, you can see where those programs are. And excuse me, I also would love to clear a typo. In the last slide, I said 28 states, it's actually 29, so we have 175 FIMR programs in 29 states, District of Columbia and Puerto Rico. And then you can see some states have a very high presence. Florida, for instance, has eight local projects, California with 16, and then some states only have one FIMR program. So, we know we can grow, we can continue to have more. But as I've mentioned, the FIMR process brings together a multidisciplinary community team, and their goal is to examine confidential and de-identified cases of fetal and infant deaths. They not only look at those medical issues that might have been involved but examine the social, economic, cultural, safety, health, and systems factors most importantly that are associated with mortality. And then the other goal is to design and implement community-based action plans that are based on the information we obtained from the reviews.

One of the key elements of FIMR is that confidentiality. We do purposely de-identify cases. We take off the names of the families, the providers, the institutions. We want the community review team to feel very free to participate without focusing on any blame. We're not looking to find fault with our systems, really focusing on improving them. So that confidentiality is quite key to the process. And the other thing that sets FIMR so uniquely aside from any other process is that maternal interview. For each case that we are going to review, we've attempted to go out and speak to the mom, or in some cases, other family members, fathers, grandparents, whoever the caregivers might have been. But this process really gives us insight incident moms experience before her pregnancy, during, during her delivery, even during the life of the infant if they went home. So that it conveys that mom's story to us. And quite

frankly, tells us about, what were their encounters with us like? How did she encounter the local service system and delivery of care? Maybe there were receptionists in the office that were not very pleasant, or she didn't come back for prenatal care because of a bad experience. So we really rely on that maternal interview to help us learn more about what, again, we can do better to improve the next family's experience.

So FIMR is a two-tiered process. We have both a case review team and a community action team. And that case review team is usually made up more of the medical personnel, so our physicians, we look for OB-GYNs, pediatricians, nurses, discharge planners, dietitians, social workers. You might find that at that case review team is a little bit more medically heavy. Whereas the CAT team, the community action team is usually made up more of those community members who have fiscal resources and actually the political will to see that systems changes do occur. And the community action team is gonna be crucial for sometimes prioritizing the recommendations and making decisions on which things they should implement. So, just for an example on my case review team, I'd probably invite, you know, the head nurse from labor and delivery, but on the CAT team, I would invite somebody more like the CEO of the hospital because again, that is the person that has more clout in the community and fiscal resources.

So the role of the case review team is actually reviewing those cases. Of course, they are going to be looking at sometimes sentinel event. In a case, this would be something that is a huge, glaring warning system. You know, we don't need 10 of these cases to tell us we have a problem in the community, but more frequently, they might be seeing trends over time. So over a whole year of reviews, they may be understanding that, "Oh, 90% of the families, or 90% of the moms, are not entering prenatal care until their second or third trimester." So they're looking at those kinds of trends. And then incidental findings, as the things that I kind of describe as, "Well, we never set out to find that, but they did pop up in the review process." A very good example of that was how frequently domestic violence or abuse has become an issue in mom's care. So we really weren't looking for that in the beginning, but incidentally, cases where mothers were physically abuse began to pop up. So it really makes that community understand, "Wow, you need to have resources in that area. We'll really have better services for those moms." And then the second role of the case review team is developing those initial recommendations around what they found through the review.

So, again, we're multidisciplinary. I urge communities to have their case

review team really look like and represent the community, so represent them racially, as far as ethnic background, gender. Generally, our meetings are one to two hours, and FIMR is a close process. We don't invite other people to that process. Again, because of that confidentiality and the anonymity, so there are occasions, of course, where we'll welcome students or others who might be substitute for a committee, but in general, we consider this a closed meeting. And then, generally, in a one- or two-hour meeting, we can get through three to five cases, and I would say, on average, that our case review teams are made up of between 12 to 15 members. But certainly, we do have teams with greater membership and participation.

That community action team, again, is a little bit different. I've mentioned that they're the folks with political will and fiscal resources, and their responsibilities are really to look at some creative solutions to improve the services and resources for families and then to prioritize those interventions. We stress diversity, we stress having members who will have influence, commitment. We want our members of both the case review and the community action teams to at least be able to say, "I really wanna stay with this process for minimally a year." And then we do have FIMRs that include consumer participation. We probably, more frequently, see that on the community action team side, but it's not unheard of to have a local FIMR with a mom who has formerly lost an infant or someone who has been a recipient of services, such as Healthy Start, to be a consumer participant.

So ultimately, I do believe that FIMR is community empowerment. It's through this process that the community becomes the expert in their local service delivery systems. I can tell you that, you know, FIMRs around the country identify very community-specific problems that may not be the same in other neighboring local sites. Again, FIMR is ultimately a wonderful public health model. You can just view the steps outlined here, the cases of fetal and infant death are selected, the maternal interview is conducted, our records are extracted and summarized, and those would include the medical records, prenatal care, the hospital labor and delivery record, infant pediatric records, immunizations, just every service that touched the life of that mother and infant. Then our case review team reviews it, makes recommendations. Community action team prioritizes and takes action. And then our last two steps are improvement in the system services and resources for family, as well as ultimately an improved health in the community. So basically, FIMR is surveillance. It's the ongoing systematic collection and analysis of data about a specific health problem that leads to action and

taking controls to prevent the problem. Again, an infant death is a sentinel event that triggers surveillance activities.

So as a wrap up, the ways that I think FIMR can be a very effective partner with Healthy Start and with other maternal-child health initiatives. Often, FIMR will provide data for regional and state assessments and planning. So for instance, for Title V, FIMR is often looked to for information and data. It is truly sometimes FIMR findings that drive our perinatal initiative to local communities. Way back, in my early days, when I was doing FIMR locally in Saginaw, Michigan, it was our FIMR findings that spurred us to actually apply for a Healthy Start branch back in the early and mid '90s. FIMR gives voice to those local families who have lost a baby. Again, no other process or review process really allows the mom to tell her story, and so the healthcare providers to hear firsthand from our mothers and families what contributed to the loss of their child. And then, ultimately, prevention. We are looking at better healthcare for women, children, and families. I think that, again, as a partner, FIMR enhances the abilities for communities to work together. It often brings those players to a common table who don't usually sit side by side. It enhances communication among our health and human service providers. Sometimes police and social services and healthcare never sit together at a common table, but that may happen at a FIMR review. And then again, I'll just mention that very hallmark to FIMR is providing that community-specific information about the changes in the healthcare system. It helps us monitor what is happening.

Some components of FIMR that I think are very valuable to Healthy Start, building that diverse coalition and community partnership, again, the inclusion of home interviews with moms who have lost their babies, and then the fact that our outcome interventions are based on the findings of these review teams and the community and the families who live there. The ways that I see FIMR and Healthy Start working together across the country, often FIMR findings will spur a community to apply for a Healthy Start grant. Healthy Start can fund FIMRs in whole or parts. I do believe that there's strong recommendation on HRSA's part for level two and level three Healthy Start to look at participating in and collaborating with FIMR. Often, FIMR will ask the Healthy Start Coalition to act as their community action team. So your Healthy Start can and actually be the CAT. And Healthy Start members may also serve on the FIMR, both review and community action team, so that across working together, you know, members of Healthy Start should sit on FIMRs, members of FIMR sitting on the Healthy Start hand are very important ways to collaborate and work together.

So, last December, we did a very quick needs assessment of our FIMRs, of the 175 FIMR programs. We did get responses back from 130. So this slide just shows you how they responded through the questions on whether or not they are already collaborating with their Federal Healthy Start. So, about 50% said, "Yeah, there's unfortunately no Healthy Start in my community or nearby areas." But in those that did identify that there was a Healthy Start project in their community, 33% did report collaboration, and others said, "Yes, there is a Healthy Start in my community, but no, as we know, there's no coordination or collaboration." So, my goal is really to go after those 15% to say, "How can we help support you," to either participate on your Healthy Start or to have them participate in FIMR. FIMR's an important part of other maternal-child health initiative. So, you know, we started with Vital Statistics, but I also want to acknowledge that PRAM, our Pregnancy Risk Assessment Monitoring partners, Child Death Review, Maternal Mortality Surveillance, and many of you are familiar with Perinatal Periods of Risk. We frequently use PPOR to help us do case selection in FIMR. If we know where our excess infant and fetal mortality is, in which of the cell, we may sample more heavily some of those cells to brings those cases to our FIMR review teams. And then lastly, the behavioral risk factor survey systems. All of these are other maternal-child health initiatives that FIMR can help supplement.

FIMR really helps augment population data. It is not population data itself, but it helps supplement and augment population data. The FIMR support that you can really help drive for Title V, National Performance Measures, I believe are advancing equity, especially to our inclusion of the maternal interviews. We will frequently hear from moms and families ways that they may have felt that their care may not have been as good as their white counterparts. They also help us understand and analyze assessment skills, building and sustaining partnerships, certainly the data that we get from our case reviews and data management, implementation, and then lastly, I do believe FIMR helps support leadership and systems improvement. So, those are some of the very specific ways that we can enhance Title V, National Performance Measures. And lastly, FIMR does contribute to those five Healthy Start core functions, including women's health, by identifying ways we can improve the care and services for women, quality service delivery, we've talked a couple of ways about how FIMR is that CQI process, quality improvement and evaluation, and then really getting at family resilience. How can we learn from our families and from the loss of that one child, how we can prevent that from happening to another family and

achieving collective impact?

So, ultimately, I'll leave you with this, that the death of an infant is a community problem, way too multidimensional for responsibility interrupting anyone's life. And that is why I believe our FIMRs really, really help partner with Healthy Starts and contribute to our understanding and prevention of infant mortality. Thank you.

Megan: Thank you so much, Rosemary, and thanks for sharing your contact information here. We do have one question that I'll post to you and then we'll move the presentation along. Does the case review team have to be medical or clinical based?

Rosemary: Oh, absolutely not. There are members in the case review team that might be clergy. They could also be part of law enforcement. I've certainly seen successful teams that are composed of, you know, even city council and political folks. I did not mean that the only participants in the case review would be medical. It was kind of just a characterization so that many of the teams do end up a little bit more heavily medical, but certainly, inclusion of many other disciplines is welcomed and encouraged, and that's a great question. Thank you.

Megan: Thank you. Okay, keep your questions coming if you have them, if they come up throughout the rest of the presentation, folks, for Rosemary. But we're gonna move the presentation along, and now, here comes some stories of how some Healthy Start Programs have worked with FIMR. So, I'm gonna turn it now over to Misty Wilder with the University of North Texas Health Science Center. Misty, over to you.

Misty: Hello, everyone. As Megan has said, my name is Misty Wilder with UNT Health Science Center, Healthy Start Program, and I am the program manager for the project, and we are here in Fort Worth, Texas. And so, to give you a little history about our FIMR here in our country, which is Tarrant County. We have our Infant Health Network which serves as our CAN and our Healthy Start and lay legislative efforts to establish FIMRs in Texas. So prior to the Healthy Start being here at the university, it was at a social service agency for many years prior to this grand cycle. And so that, in the Infant Health Network, along with that Healthy Start, work together to leave some efforts to establish FIMRs in Texas. Also, during that time, the Healthy Start also have been the community review team, so the review team meetings were held at Healthy Start side at that time and continues on, to this day, that we now have a similar role and been very active with working and been a part of

the review team as well. So, that's just a little history on our site.

So, our current partnership structure is the Tarrant County public health has the FIMR and then our CAN Infant Health Network, it is a subcommittee as part of the community action team, and then our Healthy Start side has the leadership for the community action team. And so, we all fit in and work together with our public health department, and so we're constantly always in talks with one another. We host our meetings...the review meetings now have been moved over to the public health department, and we host the community action team meetings at our university. And so, we work together in partnership with the health department in our agency as well, as a subcommittee as part of our CAN.

And so, each year, we put out findings of what we have found in the cases that we have reviewed and it's presented during our Infant Health Summit. Each September, we bring an update on some of the findings that we have seen, or trends that we've seen through the review process. And so, during our September summit each year, we will present those findings and also talk about the recommendations that have been made from the review team. And so, we make sure that the community is aware of the recommendations. We give this everybody that is in attendance to our summit, we make sure that they leave with a copy of this report, and we give them the report and tell them what the recommendations are and invite people that want to be a part of the community action team to be a part of that team as well to move the recommendations forward. And some of the recommendations that we've had, we make sure that we use those to guide some of our initiatives that our project works on. And we host some of the community education sessions, and things like that, to broaden awareness based on what the report has said.

So, one example is we saw a trend in our report that when the reviewers worked out during the interviews was stated that the lack of sensitivity from the chaplains and from the medical providers after a loss. And so, we hosted a seminar in the evening time, bringing the community together, and we talked to the healthcare providers, along with chaplains and other community members. We had someone with lend experience to kinda talk about what they experienced, like what they wish that have had happened during that process while they were in the hospitals. And so, we were able to begin that conversation with healthcare providers, chaplain, and the community of what they would have liked to experience during that process and how they felt that the providers were

not being sensitive to the needs of just after having experienced a loss. And so, that's just one example of how we've taken the report and some of the recommendations, and our Healthy Start project has hosted things, educational things in the community or we have made different adjustments within our project as we offer services to our participants.

And then, the ways we partner is that we have a long-term relationship as I've stated at the beginning, predating our current Healthy Start. So we were...most of the people that are here working already was active in the FIMR prior to our current cycle of Healthy Start. And so, we already had relationships built and things like that prior to this grand cycle. And so, as I've stated, we also align our Healthy Start activities with the FIMR findings and make sure that all of our staff are aware of the FIMR findings and the recommendations. Healthy Start is one of the key partners at the table for the review and also for the community action team, and then we're always constantly in talks with the FIMR staff at the county on an ongoing basis. We share our resources. So we wanted a book that was printed of how the community could help and work towards reducing infant mortality in our community, which was brought up from our FIMR. So, we offered some printing services from some funding that we had that could allow that to happen. We use resources, our space a lot of times. We can offer space for meetings and things that we host out in the community, which would be free, and we've received very good feedback from those type of resources being given. If we host something out in the community, we have a heavy presence. We make sure that our participants are aware of the community events, in making sure that they're a part and that they have a strong voice when the community events are held.

And so, lastly, we have assumed the leadership for the community action team. So our Healthy Start project is the leadership which guides the community action team, which meets monthly. We meet out in the community, that's one meeting that we make sure that is out in the community. We make sure that the community members are involved in the process as we begin to look at their recommendations from our review team and looking at the FIMR report. And so, currently, we're expecting the new FIMR report for our county to come out next month at our summit, and so, in October, we will convene everybody to share the recommendations, look them over, and see how we can leave some action to the recommendations from our FIMR. Thank you for your time.

Megan: Thank you, Misty, so much for that presentation and the sharing of tangible examples of how you worked with, partnered with FIMR

through your Healthy Start work. There are no questions in the hub right now, but if some come up, folks, please chat them in. Thanks again, Misty. And so next, folks, we're gonna move along in our presentation. And now, I'm gonna turn it over to the Dallas Healthy Start team, Miss Karla McCoy and Miss Alexea Collins, to continue our presentation.

Karla: Good afternoon, everyone. My name is Karla McCoy. I'm the community programs administrator for Dallas Healthy Start, of which our FIMR program is one of our components of our Healthy Start Program. And I'll turn it over to Alexea to explain our FIMR program.

Alexea: Good afternoon, everyone. Like Karla said, we are part of the Dallas County FIMR, serves as assistant program coordinator. And we will go ahead and begin. I wanna take the time to thank the center for considering us as a presenter, and we will go ahead and get started. So, here, I have both the Dallas County FIMR mission and the Dallas Healthy Start mission, kinda just to show how our work aligns with the overall action of reducing infant mortality in Dallas County. And then I have listed the current staff. Karla McCoy, serves as our community programs administrator. I am the program coordinator, and then we have Jennifer Andrade as our maternal interviewer and records extractor. And I'm actually happy to report that we are in the process of hiring another maternal interviewer to help Jennifer out with some of those cases and, of course, reach more families and women in the community.

So, we have a short brief overview of some of our historic points with the Dallas County FIMR. So in 2011, FIMR was initially funded in December of 2011 through the Healthy Start Babies Initiative. Following that, in 2012, we conducted our first time interviews and presented case summaries to our case review team. And then following that, in 2013, we shared our first preliminary report, which was compelled from data collected within the first year of operation, those first cases that we covered. And then moving forward, in 2014, National Healthy Start programming transition, and at that point, it was required for level two and three programs to have a FIMR as a program component. And I'll add that we already had a FIMR established, of course, so that transition wasn't as difficult and we just had to kind of segue and change some things up to align with the programming for Healthy Start requirements. And then, moving forward to 2017, currently, I'm so happy to report that we are in the very early stages of initiating a formal report that is expected to be completed by fall 2017. So we are working hard and diligently with that and looking forward to present that information to

Dallas County.

And in here, just our FIMR methodology overview. We have this wonderful graph, like the cycle of improvement I've stated on from other presentations today. What we're looking at, the process of FIMR and what that looks like for our program. Of course, the data gathering portion, we're conducting the maternal interview and looking at different medical records and extracting that data. And being, at that point, forming a summary that we present to our case review team once a month. Typically, we cover two to three cases a month, and currently, we're in the process of looking at all of our data over the last few years and compiling that formal report that we would hope to then push to the community action network so that we can elicit some changes in the community.

So, over to the right, I've listed just some of the primary objectives of Dallas County FIMR. Of course, we want to unite key members of Dallas County Maternal-Child Health, maintain relationships that we already have within our CAN partnership, and again, work in collaboration to focus on the recommendations that the FIMR brings along. We're reviewing individual cases of fetal and infant death, of course, and identifying some of the potential factors that may or may not be associated with the cases. Later in the presentation, I will focus on how important the maternal interview is to Dallas County FIMR. I'm aware that FIMRs all over the country kinda do work differently and I'll zone in more on why maternal interview is a very important piece of our work here at Dallas County. And then moving forward, we determined those factors that we look at represent individual system or policy level issues that we may or may not identify as needing a change that we can push forward in the CAN. And then, those recommendations will hopefully help to guide us to work at that change on the community level. And then here, as I segue into the importance of the maternal interview for Dallas County FIMR, this quote I found kinda just really zones in on the importance of those maternal interview, and even though it is from a FIMR interviewer based out of California, Miss Patt Young, I thought that it really closely align with what we do here at Dallas County FIMR. We're looking at giving these moms and these families a voice, somewhat advocating for them and giving them the opportunity to share their story so that we can then provide education and resources and referral base to elicit that change in the community again.

So, here, we're looking at the importance of the maternal interview. For Dallas County, our overall purpose is to identify the mother's

experiences before and during the pregnancy, and then we wanna look at the community assets and deficits that may have affected the mother's life during pregnancy, birth, and the death of her baby. Again, I mentioned, this is a very integral part of our process. All of the cases that we cover in our monthly case review team meetings include a maternal interview. And here, I'm gonna shift over to the role of our maternal interviewer, and that is to accurately summarize and convey the mother's story based on her pregnancy and encounters with local service system through our FIMR case review. And then they are also responsible for facilitating the grief and bereavement process, and providing appropriate referrals. So this is a big piece of the maternal interview process as well.

Of course, as health professionals, we want to guide our clients and our participants to the appropriate resources that can help them process their loss and also just provide education for future pregnancies if they wish to become pregnant again. And then finally, we wanna access the family's needs and provide culturally appropriate referrals as needed. We have a very diverse staff and we serve a very diverse population here in Dallas County. We have a high Hispanic and African-American population, and I believe that our staff represents that, and we are able to cater to our participants and our clients because of that. And then, I'm going to shift to the importance of the community action network. That is one of the four components of Dallas Healthy Start, and our overall purpose with the CAN is to focus to reduce disparities in perinatal outcomes through cross-sector information sharing, collaboration, and linkages. And what that looks like for our CAN currently is, of course, we, you know, we wanna collaborate and bring people to the table that have a common interest in reducing infant mortality, whether that's through their own individual jobs, I would say maybe even work within the community, they do on a volunteer basis. We're all here for the same reason, which is to work at reducing infant mortality. And the recommendations carry through the FIMR to the CAN, help us to translate that action on a community level.

So, typically, we have members that have political will and physical resources to create larger scale system changes. So we definitely have important people at the table that have a sense in the community that will help us push that change through. And then, how we do that, we developed new and creative solutions to improve services and resources for families. We have a very tight-knit resource base. We share a lot of information. A lot of our partners, we've had relationships with them for years, and I think that's just a part of how strong our CAN

is currently. And then, secondly, to enhance the credibility and visibility of the issues related to women, infants, and families, like I mentioned earlier, all of the people at the table pretty much have some interest in improving women and infant health in Dallas County to some extent. And then from there, we determine if community needs are changing, and as we know, Dallas County is a very big population, things are always changing as far as what our population needs, what we're referencing, and what we need to do to move forward. We proceed to partner with the community to implement interventions to improve services and resources, like I said, that's an ongoing process, looking at recommendations and seeing what needs to change, what can stay the same, and what needs to be implemented to enforce some of those changes. And then finally, safeguard successful system changes that have been implemented.

So that's the basic overview of our community action network. We meet once monthly. We are based with subcommittees that all deal with maternal-child health and pushing those recommendations out in the community again, as I mentioned earlier. And then finally, looking at collective impact in community action. A formal Dallas County community health needs assessment was completed in October 2016. Infant mortality was listed in the top five priority areas in Dallas County. I'm happy to report that. Our implementing agency also included infant mortality in its top three health issues. So, infant mortality is definitely on the map in Dallas County. It is something that is very important. And of course, Dallas Healthy Start represents that importance and we are the key individuals responsible for pushing out that change in the community. So, we're doing some good work and we'll continue to do so.

Currently, the Dallas County FIMR is in the preliminary stage of formalizing a report. The recommendations included in the report will be presented to the CAN and other MCH entities to implement change on the community level. Through this collaboration, Dallas Healthy Start will strive to work at reducing infant mortality by ensuring that our initiatives are translated into local action. All right. Thank you so much again for the opportunity to present, and we will take any questions, if there are any.

Megan: Thank you so much, Alexea. And there are no questions at this moment, but folks, as questions come to your mind, please chat them in. And again, thanks again, Alexea, for highlighting, especially the work, how you're integrating you CAN into all of this. I thought that was great

that you shared that as well. So, moving here along, folks, I'm now gonna turn it over to Miss Yvonne Beasley with Indianapolis Healthy Start, to share how they are working with FIMR in their Healthy Start Program. Yvonne?

Yvonne: Good afternoon. This is Yvonne Beasley. I'm Director of Maternal and Child Health here at the Marion County Public Health Department and also the Project Director for Indianapolis Healthy Start. Indianapolis is an urban city. We have a population of almost a million people. We have major industries of auto, life sciences, and transportation. We are a level two Healthy Start project, and in the late 1980s, Indianapolis had the highest infant mortality rate, one of the highest infant mortality rates in the nation. As a result of that, the Marion County Public Health Department, which is a grantee for the Healthy Start grant, and the Healthy Babies Consortium, they began a FIMR program. A total of 2,209 cases were examined and 187 cases were used for analysis. The reviews were completed in 1997 and the preliminary results were published that year. The final results were published in a document, "Healthy Babies in the New Millennium," in 2000. The findings informed the interventions for improving services and system changes within Marion County that would improve the health and well-being of mothers, infants, and families.

... In 2000...there was a lapse in having a FIMR program from 1997 to 2004. We had hired FIMR coordinators, however, a couple two that were hired were not able to get the program going. And so, in 2004, we hired our current FIMR coordinator, who is Teri Conard, and the program has been going continuously for the last 13 years. Indianapolis Healthy Start was the leader in getting our PPOR team up and running. Our project manager identified technical assistance provided through CityMatCH, and so, not only Healthy Start but other leaders in the community were trained through CityMatCH. We attended FIMR PPOR workshops, the FIMR Chart review team was launched, and the Healthy Start community assessment of MCH high-risk populations and identification of a catchment area was obtained.

We were really pleased with PPOR because PPOR directs evaluation. The use of PPOR investigations allows for a comprehensive look into the fetal and infant mortality, it looks deeper into the causes behind the problems, and it provided us with the guidance to develop solutions. Directly aided us in systems changes, allows for the targeting of specialized messages to those in the community that need them, and it aids in resource allocation. PPOR is data-driven, and we're really

interested in having this data and making sure that we respond to what our data is telling us. So, PPOR provides the big picture for community efforts. It's a catalyst for the development of more data-oriented community. PPOR allowed us to focus on where we were having our excess deaths, and so, we looked at our areas where maternal health prematurity, what interventions could we link to make in that area, pre- and interconceptional care was identified, health behaviors, prenatal care, public education campaigns with an intervention, reproductive health plans, mentoring programs, better control of chronic diseases and obesity, expanding Medicaid for family planning and interconceptional care, mental health and substance abuse programs, prenatal care coordination. In the area of infant health, it was identified that the interventions should be safety issues, breastfeeding, and family and parenting issues. So, safe sleep and a home safety education was initiated, breastfeeding was stressed, long-term care coordination services, substance abuse screening and treatment.

Initially, Healthy Start was funded here in Indianapolis in 1997. So, from 1997 to 2004, we really tried to serve all of Marion County, enforce Healthy Start services with more concern, and that was just too much of a monumental on taking. So, in 2004, we had a needs assessment done of Marion County and we've found that there were seven high-risk ZIP Code areas at that time that had women living in those areas that were at high risk for adverse birth outcomes. So we started concentrating on those seven ZIP Code areas. In 2010, we did another assessment and we added three additional ZIP Code areas because they were also identified as having women at high risk for adverse birth outcomes. So we concentrated our services on the 10 ZIP Code areas.

Infant mortality awareness activities that had been formed through FIMR and PPOR in Marion County have been...Healthy Start has been able to provide support for death scene investigation training. Healthy Start provided dolls for death scene reenactments by deputy coroners and help finance sudden unexplained infant death training. And this is a picture of a reenactment of a death that was caused by strangulation. Professionally, we've been able to support and work together as partners on professional and parent education. In 2009 and 2010, Indianapolis Healthy Start was able to award a stipend of $1,500 to each of the six hospitals in Indianapolis that provide labor and delivery service. Indianapolis Healthy Start was also able to provide SleepSacks for the infants admitted to the nurseries at this chart. And in September of 2010, the six hospitals reported on the accomplishments achieved as a result of the collaboration, including modeling safety practices by

placing newborn infants in the HALO SleepSack used to swaddle newborns instead of blankets, and the purchase and display of "The Seven Steps to SIDS Reduction" DVD, purchase of dolls to demonstrate safe sleep and breastfeeding positions for use in prenatal parenting classes, development of safe sleep displays, and the purchase of materials and bags for grandparent education. Each hospital has institutionalized the use of HALO SleepSacks in the newborn nursery, and some had made HALO SleepSacks available for purchase in their hospital gift shop.

We have used FIMR information in Healthy Start to inform the community about pregnancy care. We have used the, for preconception health, before, between, and after, signs for informing mothers who might be...women who might be pregnant to contact Healthy Start for a health behaviors that they should adapt during each of those phases. We have used cards to inform the community of folic acid and its importance in preconception health and pregnancy. And this is a...we have partnered with our hospitals to develop the posters that have been used to put around the city regarding folic acid, again. And then we have had safe sleep campaigns that we have used the media of movie theaters, televisions, and billboards to assess the importance of safe sleep. The other focus has been on smoking cessations during pregnancy, and Indianapolis Healthy Start has been, through the Marion County Public Health Department, we have been awarded funds through the Indiana State Department of Health to have the BABY ME and Tobacco Free program at Indianapolis Healthy Start. And we just were awarded a new grant award this month to continue the program from October the 1st, 2017 through September the 30th of 2019.

The other partnering that we do and the advantage of being involved with FIMR, Healthy Start and FIMR, has been to have a FIMR findings inform our infant mortality awareness month activities. And so, this is one of our displays that we had in the Central Library here in Indianapolis and we had our consumers decorated the ones that you see in this infant mortality awareness display. So, these are some of the ways that we have partnered here in Indianapolis with our longstanding pre-FIMR program, and we're looking at...our focus right now is looking at, getting our CAT team up and running, and we're making much progress with that. We've identified our priorities in CAT, which is optimum maternal care and safe sleep. Thank you and I appreciate having this opportunity to share what Indianapolis Healthy Start and FIMR are doing.

Megan: Thank you so much, Yvonne, and congrats on that follow-up award for your tobacco work. And thanks for sharing about the targeted marketing and education work and partnerships. That was great. There are no questions still waiting, so folks, maybe you're just saving them for the end. So with that, I'm just gonna turn it over here to Miss Lo Berry, who's going to close out the Healthy Start stories that we're gonna hear. And then we'll take questions from everyone. So, Lo, I'll turn it over to you.

Lo: Okay. Hi, family, hope everybody is doing well. I'm Lo Berry, President, CEO of REACHUP, Inc., and I always like to remind people that REACHUP, Inc. is a bold 501c3, community-based organization. And we really pride our self in assisting others and ourselves in achieving optimal health, and we do so with a sense of urgency. And I also like to remind people, and myself, that I have the opportunity of working with the best staff this side of heaven and I'm blessed to work alongside with consumers, recipients of services, as well as community partners at large. And as you see before you, we have many things that we can be proud of, and this is one. While we have long ways to go and RU community is happy, we're not satisfied with our clinical outcome, but as you can see, we've been successful in reducing infant mortality and disparity in the communities that we are fortunate enough to serve. So when we first got started, our babies were dying at a rate of 19.2 per 1,000 live births, light babies sent in. In 2015, we have reduced it to 8.3, and so, there's a 57% reduction. So we are proud about that.

And what you see here is a list of not all our partners but many of our partners, particular, there was a home we call lifelong partners. Because most have been with us since inception, since 1998, and we like to say that we partner with everybody, anybody that has anything to do with maternal-child health. We're at the table, invited or uninvited, or not invited.

So, for us, accountability through quality and improvement, monitoring and evaluation with, that's how Healthy Start approach on number five, is critically important in this work that we do. And as Yvonne and others talked about Perinatal Periods of Risk, here's sort of brief overview around that connections to our actions. So, in our community, too, the area that presents the biggest challenge for us is the maternal health and prematurity. And unfortunately, our moms are sick or unhealthy before they even get pregnancy. So a big focus for us is definitely preconception health, health behaviors, and perinatal care, and maternal care, prenatal care, referral systems and high-risk OB care that

we'll focus on, and with our newborn care, is perinatal management, referral systems, and NICU. And in the infant health is our sleep position, breastfeeding, and injury prevention.

So, now you have heard of the wonderful presentations prior to mine, but we are basically saying the same things, that the benefits of using FIMR and for us, too, it's PPOR. And so, here's the advantages that you see before you so I don't have to go into any detail on each of them you see, but I really wanted to highlight health leverages resources because that's critically important when we look in that sustainability and, you know, how we tell our stories effectively and being able to do so with data really helps us leverage funds. And for us, we have leveraged that since due for 2009, but total leverage of funding, yeah, since 2009, yes, that's correct, is $23 million. But that's what local state and national funding. And so, the bottom line is that having the ability to translate this data into practice really enables us systemic change for perinatal health. And moving this data to actions is one of the things that we are most proud of with our Healthy Start community consortium and the example that I wanted to share with you all is our BIHPI, Black Infant Health Practice Initiative. And in 2007, we were successful, our community consortium and our community action team and CRT, we were successful and champion House Bill 1269 in Tampa, and that was what we termed Black Infant Health Practice Initiative. And we were able to get these funding through relationship and partnership with one of our senators, Senator Arthenia Joyner, and the bill called House Bill 1269. We were able to focus statewide on the disparity in the state and what was the reason for the disparity. And so, leveraging our data from our FIMR and our PPOR really was instrumental in us getting a statute created so that we could actually have a practice collaborative statewide to examine our racial disparities and infant mortality disparities. And I'm really proud to say that these activities and strategies live on even today since 2007 in regards to decreasing the disparity and closing the gap.

So, I sort of already talked about this, and the one of the things that I do, one's you'll see and you'll hear a little bit more about it later, is that in the BIHPI findings, we were able to have what we call primary and secondary gains. And here before you are listed the primary gains because we've got a lot of momentum statewide to really do some activities in our various communities around the preconception and interconception care, doing cross-training with our case managers across the state, and also some really specific activities and strategies around recruitment and performing focus groups to actually come up with qualitative and creative strategies to close disparities around the

state.

So, for us, we have had the opportunity to have many strategies and interventions created as a result of our FIMR. And so, I wanted to share a few with you. The Bed for Babies in our community, at the time that we did, this was a little more than six years ago, but it's still a project that's continuing now, we have 40% of our SIDS death review had co-sleeping as a risk factor. And so we started this Bed for Babies campaign, and the hospital actually took the lead, wherein that they provided beds for our babies that was going home and we knew that they didn't have a bed to sleep in. And so, they were given materials from the hospital about safe sleeping. In order to get a bed or crib, they had to agree to have the in-service by either our program, which is the Federal Healthy Start or either our local Healthy Start program. And we were also able to link our information together from the home visitation programs in the community so that we could really get a look at who was in need of a bed and how we can get those beds to families from our Healthy Start system and our Healthy Family system. And one, two years' time, and this data just reflected our initial year of distribution, we had 1,020 cribs distributed.

Another project that we were able to have in our community was called Zero Exposure Project, and there was an initiative led by our Healthy Start Coalition of Hillsborough County, which is what we call State Healthy Start, but we are a partner with Healthy Start Coalition. And so, we found that there was use of alcohol, drugs, and tobacco present in our FIMR cases. So the imposition was to be one of the most difficult areas to address and get in contact directly with some of our physicians' offices to do the marketing or do the media or do the dissemination of information. So, we decide to create our own marketing training activity and we received funds by our local Children's for the Hillsborough County. And what we decided to do was to go and do our own presentations in all our provider offices in our area, and we developed a formal resource guide for the providers. We created a resource and information exchange. And then it was mandatory for the leads on the Zero Exposure from both projects to participate in what we call the ZEP Conference, which is the Zero Exposure Conference. And we were successful in getting funding initially from the March of Dimes grant, and this has been an ongoing program as well in our community and still continues today.

And then, the one that I have great sense of pride in is the Hillsborough County jail pregnant women, and reason being is because this particular

effort really was heightened by our community consortium and in focus groups, getting information from some of the women who had exited the jail or who is in transition from going to the jail. So, for us in our community, the FIMR cases saw that we also had history of homicide and that homicide was a problem in our community, and we were averaging 30 to 40 pregnant women in jail each month. The other thing was the HIV positive women being released three days and not having appointment, or even not having medications, and then there, of course, the issue of lapse in prenatal care when they were once released. And so, what we learned from the focus groups was the women were saying, one of the biggest issues for them was that before they even leave the property, they also sign themselves sometimes back in trouble or incarcerated because they were soliciting, some of them, in order to get their affair back to their perspective residence, or where they wanted to go. So, one of the programs and one of the activities that was created by this focus group's recommendation was this providing care vouchers for the women when needed, so that when our person go to the jail to do the training around Healthy Start that they would then provide the moms with care vouchers when they know that they were exiting the jail site.

And so, another program that we wanted to share was Let's Talk About It, and because, of course, for us, the maternal-child health piece and women being unhealthy prior to birth and delivery and the added stress in their lives for many reasons, we started doing this Let's Talk About It sessions with some nannies from Allegany Franciscan Ministries. One of the other findings for us in our FIMR was when there was problems with the co-sleeping, we had a high rate of babies suffocating because of co-sleeping. One of the things that we note is that there were also a pattern of obesity with the moms who were co-sleeping. So, our CAN decided to focus in on stress and obesity. And so, this was the first beginnings of our Let's Talk About It in actually dealing with health-work-family relationships, nutrition, social circles, finances, overall stress. And addressing racism and effects of racism on pregnancy was also a part of the theory.

And then, the Save Our Babies Community toolkit came about as well, when our community action team needing someone reviewing our data and taken a look at what was missing from our initial toolkit. And what we felt was missing, one of the things that was really missing was in choosing a safe caregiver category, we didn't do enough emphasis on male inclusion or create activities and workshops and sessions for men to be involved and included in choosing a safe caregiver. So, we tried to perfect this community toolkit and the topics in this toolkit and the

training in this toolkit includes shaken baby syndrome, choosing a safe caregiver, safe sleeping, and the baby's environment. And so, this toolkit is used around the state, but it is for educational purposes only.

And the last program that I wanted to share with you was the Reach Up For Life. Again, as we advanced from the initial stress group, we created another four to six-week monthly program group, and it was entitled...and it is Reach Up For Life. And again, this focuses in on the healthy lifestyle of the mother and nutrition and education, physical activity, stress reduction, and the one that was added that was not in the one prior to was sleep hygiene and education, the importance of good sleep hygiene for family and family members. And I just...I just want to end with a lesson learned, and I think this captured really well by a FIMR committee in our Florida Department of Health FIMR annual report. And this is her quote, she said, "But these death happen, and only when we face this squarely and look at everything from a multidisciplinary perspective, can we begin to solve the puzzle. When we identify the possible causes, we can begin to change the healthcare system and improve the care we offer families." Thank you.

Megan: Thank you so much, Miss Berry, for your passion and for the programmatic examples that you shared. So, everyone, we have 15 minutes left in the webinar. If you'll chat in your questions or comments, please do so in the chat box for these programs. And I wanted to also let you know presenters that you have received some kudos in the chat box already for some appreciation for the great examples that you've already shared. So, I wanna acknowledge that right now. One of the question that we received was that they wanna know, or this person wants to know a little bit more about how to...she's interested in replicating some of the programs that were shared around safe sleep and exposure to alcohol and tobacco. So, if any of the presenters shared programs on those topics wouldn't sharing for a minute or two about, how did you, specifically, actually start up this type of work based on the FIMR recommendations that you received? How did you actually begin some of this work that you have done in that area?

Lo: This is Lo. For us, again, a lot of these recommendations came in as a result of creating focus groups from our community action team and our Healthy Start consortium. And so, as we had conversation... First of all, let me back up and say, we also had looked at the data as well and see what were some of the reason or predisposed factors for birth outcomes that really hadn't been addressed a lot. And so, in the conversations with the family members in some of the areas that we

work in, the risk for safety is really high. And so, they're in neighborhoods where you really can't woke definitely dusk or at nighttime, and some are because of financial constraints. The babies sleep with the mom because that's the only safe place for the baby to sleep. But as they were having these conversations, they started talking about how much sleep they don't get because they are preoccupied, both consciously and unconsciously about the safety of the family, and they find themselves getting up and down throughout the night from fear that something may happen. So they were saying they were averaging probably three to four hours a night. And so, we begin to talk about ways in which to increase that sleep. And then, as we did more research around the sleep issue, we learned that there was a direct correlation with obesity and sleep as well. And so, that came right out of one of our FIMR piece because of a focus that we were doing on the co-sleeping piece and tried to dig deeper about why were there's so much still co-sleeping even after the education piece.

Megan: Thanks, Miss Berry, for that. And I feel that you kinda, with that piece, you kinda dug into the piece around sleep hygiene. There was a question around that. So, you kind of got into what you meant by sleep hygiene with that example you just shared. That's three hours of sleep. Goodness, yeah. Did someone else, one of the other presenters, have something to share on that?

Yvonne: This is Yvonne, and we have been fortunate here in Indiana that, since 2013, that our governor had made infant mortality a top priority. There were three top priorities, there was infant mortality, obesity, and smoking cessation. Well, as part of that, we were ready to apply for, to submit our grant application for the BABY ME and Tobacco Free grant, Marion County, the grantee organization was. And we were able to implement that within our Healthy Start Program. The first year that we were funded, Healthy Start managed the grant. The second year, because we wanted to increase the number of women who would have the opportunity to enroll in the program, WICK was the initiator of the application, and Healthy Start worked with them on...continued to work with them on recruiting clients, etc. So, this year, we're back with Healthy Start getting the application because we feel that we applied to have a full-time health educator. We had been working with a part-time health educator, and we found that they didn't have enough time really to do the recruitment and to encourage the retention that was needed. So, because, you know, smoking cessation is a priority of the state and there is some money, there are applications available through the state to apply for assistance with smoking cessation. We have been receiving

that additional support.

Megan: Thanks, Yvonne, for sharing that example. I do wanna get back here, and maybe, Rosemary, you'd be a good person to ask this question given your big picture take on the work with FIMR. But what type of funding generally supports the work of FIMR?

Rosemary: Thank you, Megan. There's a variety of funding that I see across states and local programs. As we mentioned a little bit earlier, there are certainly Healthy Starts that support their FIMR in part or whole, and many FIMRs turn to Title V. So, if you're a local health department, you can use your Title V block grant funding to support positions in FIMRs, so for instance, a coordinator, a maternal interviewer. There are states that have passive money set aside for bereavement services. And so, under the assumption that when we are doing bereavement, we may also be able to get the maternal interview, that has been kind of a creative way to fund FIMR. Certainly, there are foundations, local and community foundations that support FIMR work. The United Way is one that I'm aware of, March of Dimes. I think the other presenters have other examples of funding for FIMRs.

Yvonne: This is Yvonne, and in Marion County, the Marion County Public Health Department funds our FIMR program.

Lo: This is Lo. In Hillsborough County, and several other counties in Florida, we get money from Title V Block Grant to do the FIMR. As you saw in this screen, what we're thinking was the 18 FIMR projects in Florida and our goal is to get a FIMR project in 32 other coalitions that are in our county that deals directly for maternal-child health services. And so, for us, who has been helpful to get the funds that we do get is the advocacy on behalf of our legislator, which, again, is, for us, was Senator Joyner, who helped us get monies in times of when there's lapsed dollars. We're able to sometimes get additional funds as well for our FIMR activities.

Megan: Thanks, Miss Berry. How about the other two programs? Do you wanna share about some of the ways that your FIMR is funded?

Karla: Hi, this is Karla in Dallas, and our FIMR is funded solely with our grant with our Healthy Start Program.

Megan: Thank you. Misty, would you like to share? She might be on mute.

Misty: Okay, hello?

Megan: Hi, we hear you now, Misty. Thanks.

Misty: I'm sorry.

Megan: That's okay.

Misty: Yes. When it comes...well, again, as I stated in our presentation, we leveraged our community resources to help fund some activities through some of the community partners around the table. Because since we don't actually just own the FIMR, we just have a heavy presence in it, we leverage resources to help fund our activities, our community partners brought different funding to the table to do our programming.

Megan: Great. Well, thanks. I mean, I think that is a great example of how you engage, and so thanks for sharing. So question for you, the Dallas team. Does the Dallas FIMR have suggestion for increasing maternal interview rates? And it sounds like you're able to do that with many of your moms you've worked with. Can you provide some suggestion, or suggestions?

Karla: This is Karla. One of the recommendations that I would have is to have a very good relationship with your Vital Statistics Office because that's where a lot of the data is gonna come from that's gonna drive your FIMR program and that's where you're gonna get the information for the maternal interviews. So, that would be my suggestion.

Misty: This is Misty in Fort Worth, and in Fort Worth, we were...the team was not able to really get interviews, but we have seen an increase. We received some funding from another source and we were able to give "Thank you" gifts, and which included a gift card to say, "Thank you for your interview." And we've seen some increase in being able to get interviews from using that.

Megan: Thanks, Misty. And on that note, just as a great segue, we are looking at including that topic in the next, the bereavement webinar that we focus on in September. So we can dig much more into that specific topic during that webinar. I did wanna follow up with you, Rosemary. You had mentioned you had a potential example of what one of the persons asked before, about an intervention related to substance use

and how to sort of operationalize that based on FIMR findings. Could you please share that?

Rosemary: Oh, I'd be happy to. Thanks, Megan. The team that I was involved with locally, again, Saginaw, Michigan, they had identified a really large number of the deaths they've reviewed that were due to preterm and low birth weight were related to mother's maternal substance abuse, whether tobacco, alcohol, or in many cases, opioids and other substances. So, they sent a full team of like eight people to the Children's Research Triangle. It was an opportunity that came up funded through both the Public Health Department and the Healthy Start. And if you're familiar with Ira Chasnoff's work, he's the Children's Research Triangle director in Chicago, and we were able to device a very community-specific plan for assessment, treatment, and improving the resources for substance-using mothers and families, and that included tobacco, alcohol, and drugs. And so, we worked with Dr. Chasnoff to formulate his tool, the 4P's Plus, and not just, you know, training on how to ask the questions but how do you follow up a "yes" answer, how do you follow up a "no" answer. And then a lot of training for provider around group interventions. So, that included motivational interviewing, there was a whole book that Dr. Chasnoff provided the community, and it was called "Because I Care." So, whatever the answer was, the provider should quickly turn to the Marijuana section and say, "Here are some things I really wanna share with you about using marijuana during pregnancy, and it's because I really care about you and your baby and the outcome." So that was just one good example of the community's response to the FIMR findings that many of the moms who had preemies and low birth weight babies were substance using.

Megan: Thank you. And I did see one point of clarification somebody chatted in, and I think this may be a question, you know, kind of for you, Yvonne, or for you, Lo. But somebody chatted about there were 1,020 cribs distributed, and they wanted to know if that was in one year. Anybody remember sharing that?

Yvonne: That was Lo, I think.

Lo: That was me, and that was one amount that was done in one year. In the Hillsborough County, we have approximately 17,000 births annually.

Megan: Wow. Okay. Well, thank you. So, I'm gonna share this script

wrap up slide with you and then I'm gonna ask the presenter, any presenter, to share any...maybe one closing remark you have, if you have one that you'd like to share with the group, and then we'll wrap up. So we have a couple of upcoming webinars. So in two days, there's a conversation with the division webinar from 1:00 to 2:30 Eastern time on the 17th. Then on the 5th, September 5th, on the topic, there's a webinar from 3:00 to 4:00 p.m. Eastern time, "What are the long-term effects and impacts of fetal alcohol spectrum disorders on individuals and their families." So those two webinars, mark your calendar for, and we will post all of this information and archive all this information on the Healthy Start EPIC Center's website. So, presenters, I'd love to turn it back to you. And do you have any closing remarks for the presenters...I'm sorry, for the participants about your engagement with FIMR? We've heard you echo how important this has been for you, but anything you'd like to share?

Yvonne: This is Yvonne, and I would like to share the fact that Indianapolis Healthy Start, as far as the benchmark for safe sleep, our benchmark was 60% for 2016 and we attained a 91% that our infants, the behavior that we're observing with our parents include infant sleeping on their backs, on clean, firm surfaces, and the absence of smoke, and with no extra bedding, pillows or toys.

Megan: Thank you. Anyone else? ...Well, a huge, huge thank you to all of you, both Rosemary for your sharing and your willingness to engage with Healthy Start Programs and either engage with a FIMR or starting up a FIMR, and to all of you, Healthy Start grantees, for sharing your examples and stories. It has been a pleasure listening to all of you. So, thanks again for this, and thanks to all of you for covering up time in your busy days to participate on this webinar. This concludes the event. Have a great rest of your day.