Infant mortality has long been a community mirror, reflecting our collective capacity to promote and protect the health and well-being of our very youngest and most vulnerable.

Those committed to protecting the youngest in urban communities see in that mirror entrenched racial, ethnic and geographic disparities whose severity has been mitigated in recent years primarily by perinatal technology that fosters the survival of those born too small and too soon. The public health lesson of over a century of struggle is that no one approach or tool eliminates all preventable infant deaths. Its corollary is that infant mortality is not just one thing, rather it is a complex and variable configuration of risk, missed opportunities, and adverse events.

Achieving measurable, sustainable improvements in newborn survival and quality of life, therefore, requires a strategic mix of proven approaches. Through our collaborative work with public health partners in practice and academe, and with the support of the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration/Maternal and Child Health Bureau, (HRSA/MCHB), and the March of Dimes, we have gained some insights into this strategic mix from a local, urban perspective.

Building sustainable community capacity to translate infant mortality data into effective actions requires strategic interdependence among the three leading edges of the “Data Use Triangle” (Figure 1): clear and understandable data about infant mortality; programs and services that make a measurable and intended difference, and informed policies and ample political will to support systems-level change. Public health leaders accountable for urban maternal and child health now have an array of proven approaches and promising tools to address infant mortality that emanate from the different edges of the Data Use Triangle.

There are several tools which emanate from the data and analysis edge of the Data Use Triangle whose aim is to achieve greater shared knowledge and understanding of the causes and consequences of infant mortality. Examples include Fetal and Infant Mortality Review (FIMR), Perinatal Risk Assessment, Monitoring, and Surveillance (PRAMS) systems, and more recently, the Perinatal Periods of Risk (PPOR) Approach. Other tools from the programmatic edge of the Triangle use specific interventions to address known preventable components of overall infant mortality. The American Academy of Pediatrics’ (AAP) “Back to Sleep” campaign and the March of Dimes Folic Acid campaign promote public awareness and community engagement through education to prevent SIDS and neural tube birth defects, respectively. More policy-driven initiatives embrace the Triangle’s third edge of political will by promoting federal, state and/or local approaches for broader systems change. The HRSA’s current championship for “100% Access and 0 Disparity,” and the Surgeon General’s Healthy People 2010 Initiative both include infant mortality in their measurable goals for a healthier nation. And then there are comprehensive approaches like the federal Healthy Start Initiative which tried to reduce infant mortality by 50% before the end of the last decade through varying local mixes of all three edges: better data, new programs and more political will.

Given the range of choices from each leading edge, the public health challenge is twofold: understanding the potential contribution of each tool and strategically aligning those tools with greatest promise to maximum impact within a given community.
Child Health Forum 2000 Participants Share Strategies to Combat Infant Mortality

More than 175 community leaders, health and human services administrators, policymakers, faculty and students met in Omaha on May 18 for Child Health Forum 2000 to address “New Approaches to An Old Foe: Infant Mortality.”

“We all came together to learn from each other and share ideas about how to prevent babies from dying before their first birthdays,” said Magda Peck, ScD, Professor of Pediatrics and CEO and founder of CityMatCH. CityMatCH cosponsored the forum along with the University of Nebraska Medical Center’s (UNMC) Community Partnership.

The forum featured a panel discussion, moderated by Peck and Bill Sappenfield, MD, MPH, a CDC epidemiologist on assignment to CityMatCH at UNMC, and was comprised of public health leaders Gail Bridges Harris, MPH, BSN, Durham, North Carolina; Kathy Carson, RN, Seattle, Washington; Llamara Padro Milano, BSN, RNC, Syracuse, New York; Larry Sands, DO, MPH, Phoenix, Arizona; and Carolyn Slack, MSN, RN, Columbus, Ohio.

As the panel discussion came to a close, Lynne Wilcox, MD, MPH, Director, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, CDC, Atlanta, Georgia offered commentary focused on the need for synergy between science, practice and policy to promote the health of mothers and babies.

Next, in-depth roundtable discussions offered participants a chance to hear about and discuss first hand success stories and proven approaches in other cities across the nation.

This yearly Child Health Forum coincides with the CityMatCH Annual Business Meetings. While in the city, visiting public health leaders are tapped for the Forum, giving local participants the opportunity to benefit from their knowledge, skills and experiences.

“Both the (Nebraska) Governor Johann’s Blue Ribbon Panel on Infant Mortality and the Omaha Healthy Start Initiative’s General Council attended, thus assuring that two of the State’s leading representative bodies against infant mortality could hear first hand of success stories and proven approaches in other cities across the nation,” noted Peck.
Eliminating Racial and Ethnic Disparities in Infant Mortality

In a radio address on February 21st, 1998, President Clinton committed the United States to an ambitious goal by the year 2010: Eliminate the disparities in six areas of health status experienced by racial and ethnic minority populations while continuing the progress that has been achieved in improving the overall health of the American people.

National commitment is necessary to identify and address the underlying causes of higher levels of disease and disability in racial and ethnic minority communities. The Department of Health and Human Services agreed to broaden and strengthen its partnerships with State and local governments, with national and regional minority health and other minority-focused organizations, and with minority community-based organizations, i.e., those who have the greatest access to and knowledge of the communities.

Goal One of this initiative is the elimination of disparities in infant mortality rates. The near-term goal is to reduce infant mortality among blacks by at least 22 percent. Reducing infant mortality rates among American Indian and Alaska Natives, and Puerto Ricans will also be addressed.

Although substantial progress has been made in reducing infant mortality in the United States, our nation still ranks 24th in infant mortality compared with other industrialized nations. Additionally, infant mortality rates vary substantially among and within racial and ethnic groups.

The public health community, health care providers, and individuals must focus on modifying behaviors, life-styles, and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, other psychosocial problems (e.g., stress, domestic violence), lack of prenatal care, medical problems, and chronic illness in order to further decrease infant mortality.

Healthy People 2010 is a national health promotion and disease prevention initiative bringing government agencies at all levels together with businesses; communities; and individuals; nonprofit, voluntary, and professional organizations to improve the health of all Americans, to eliminate disparities in health, and to improve years and quality of healthy life.

Healthy People 2010 objectives will be directly related to the Race and Health Initiative goals, targeting race, health and infant mortality. These goals and objectives were launched on January 25, 2000, including a component of activities to support the development of State and community coalitions in 18 states to develop projects, whose purpose is to enable communities to mobilize and organize their resources in support of effective and sustainable programs which will eliminate the disparities.

For more information, contact the CDC at (770) 488-5426 or visit their website at <http://www.cdc.gov>

OpportunitySnapshots

The Health Resources and Services Administration launched the "100 Percent Access 0 Health Disparities" Campaign World Wide Web site, which provides access to HRSA’s Bureau of Primary Health Care’s "Models That Work." This searchable database is located at <www.bphc.hrsa.gov/campaign.htm>

The 128th Annual Meeting of the American Public Health Association (APHA) will be November 12-16, 2000 in Boston, MA. The Conference theme is "Eliminating Health Disparities." For more information contact Edward Shipley (edward.shipley@apha.org (202)777-2478) or visit the APHA web site at <http://www.apha.org/meetings>.

The Centers for Disease Control and Prevention (CDC) released a state-by-state report entitled "State-Specific Prevalence of Selected Health Behaviors, by Race and Ethnicity-Behavioral Risk Factor Surveillance System, 1997," which documents racial and ethnic disparities in several areas. This report is located at: <http://www2.cdc.gov/mmwr/mmwr_ss.html>

Reach 2010: Mobilizing Communities to Reduce Infant Mortality

The Centers for Disease Control and Prevention (CDC) is coordinating a major component of activities to support the President’s Initiative to reduce racial and ethnic disparities. In September 1999, CDC awarded $9.4 million to community coalitions in 18 states to develop community-based demonstration projects addressing the six identified priority areas of health disparities.

The Racial and Ethnic Approaches to Community Health 2010 (REACH 2010) Demonstration Projects are two-phase projects, whose purpose is to enable communities to mobilize and organize their resources in support of effective and sustainable programs which will eliminate the disparities.

Demonstration Projects will examine science-based, community level interventions, with the goal of replicating their successes in other communities.

For more information, contact the CDC at (770) 488-5426 or visit their website at <http://www.cdc.gov>
Every Child Deserves a Healthy Start

The Federal Healthy Start Initiative

The cornerstone of the Healthy Start Initiative (HSI), is the philosophy that community-driven strategies are necessary to reduce the causes of infant mortality and low birth weight, especially among high risk populations. Innovation, community commitment and involvement, increased access to services, service integration, and personal responsibility guide the Initiative.

Healthy Start, which began in 1991 as a demonstration project, is committed to implementing innovative community-based interventions to support and improve perinatal delivery systems in project communities. HSI focuses primarily on perinatal and infant clients and their families; strives to assure that every participating woman and infant gains access to the health delivery system and is followed through the continuum of care; and provides strong linkages with the local and state perinatal system.

Development and mobilization of coalitions of consumers, local and state governments, private sector, schools, providers and neighborhood organizations to address infant mortality reduction within communities is a hallmark of Healthy Start. HSI seeks to improve health care access and outcomes for women and infants, promoting healthy behaviors and combating the causes of infant mortality.

Those initial HSI demonstration projects created community-based strategies to reduce infant mortality which were implemented in areas with high incidence. From this first demonstration phase, nine categories of community-driven infant mortality reduction strategies emerged. These included eight service intervention models and an organizational model. The service intervention models are: community-based consortium, care coordination/case management, outreach and client recruitment, enhanced clinical services, family resource centers, risk prevention and reduction, facilitating services, training and education, and adolescent programs.

In 1997, Healthy Start expanded in a second phase to support additional communities seeking to adapt or replicate successful Healthy Start strategies in conjunction with individual programs already underway. Currently there are 94 HSI sites.

HSI awarded funds for infrastructure building and program planning at the community level to assess community needs, resources and capability to adapt Healthy Start models. Twenty projects from Phase I were provided grant funding for continued support of successful strategies and interventions, and peer mentoring of new Healthy Start communities and health care providers, including managed care organizations.

Phase II of the Initiative directly addresses the Healthy People 2010 goal related to eliminating health disparities, and in particular, the objectives related to maternal and infant health.

Additional information is available at <http://www.healthystart.net>

The National Healthy Start Association

The National Healthy Start Association was formally established in the Spring of 1998 to promote community-based maternal and child health and the reduction of infant mortality and low birth weight.

The Association intends to be a voice for the education and promotion of community-based solutions to those problems. Membership in the Association is open to any organization with a focus on community-based public health, but, initially, is comprised of project directors and chief executive officers representing the federally-funded Healthy Start Programs across the country.

The Mission of the National Healthy Start Association is to promote the development of community-based maternal and child health programs, particularly those initiatives addressing the issues of infant mortality and low birth weight. As part of this mission, the Association supports the expansion of a wide range of activities and efforts that are rooted in the community and actively involve community residents in their design and implementation.

The goals and objectives of the Association are to: educate its members, the public at large, federal, state and local policy makers and elected officials on the need for and effectiveness of community-based programs to reduce infant mortality and low birth weight; provide a nationwide communication and technical assistance network for the exchange and dissemination of “models that work;” increase public awareness concerning the needs of pregnant women, infants, children and families; identify common factors impacting maternal and child health status and develop strategies to sustain Healthy Start and other community-based maternal and child health programs; collect and analyze data and publish reports on evaluation findings and lessons learned from Healthy Start Programs.

The Healthy Start National Resource Center (HSNRC) is housed at the National Center for Education in Maternal and Child Health (NCEMCH), at Georgetown University.

The Center provides national leadership to the maternal and child health community in three key areas--program development, policy analysis and education, and state-of-the-art knowledge--to improve the health and well-being of the nation’s children and families.

For more information, contact: HSNRC at the National Center for Education in Maternal and Child Health (NCEMCH) Georgetown University 2000 15th Street North - Suite 701 Arlington, VA 22201-2617 Tel: (703) 524-7802 Fax: (703) 524-9335 Email: HealthyStart@ncemch.org on the Internet at <http://www.healthystart.net>
Back to Sleep: Reducing SIDS Risk

The National Institute of Child Health and Human Development (NICHD), part of the National Institutes of Health, launched the "Back to Sleep" campaign in 1994 to promote the message that back sleeping can reduce the risk of Sudden Infant Death Syndrome (SIDS) and save lives. Major partners in the campaign, besides the NICHD, include HHS’ Health Resources and Services Administration and the Centers for Disease Control and Prevention, the AAP, the SIDS Alliance, and the Association of SIDS and Infant Mortality Programs.

The Back to Sleep Campaign strives to increase public awareness about various ways to reduce the risks for SIDS. NICHD experts define SIDS as the sudden death of an infant under one year of age, which remains unexplained after a thorough case investigation, including performance of a complete autopsy, thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history.

The Back to Sleep Campaign raises awareness among parents and health care providers by producing and distributing brochures, posters, print public service announcements, and informational videos.

The campaign has also spurred the development of state SIDS campaigns, developed a Back to Sleep internet website (http://www.nichd.nih.gov), and established a toll-free phone number -- 1-800-505-CRIB.

Recently, the AAP issued a statement reinforcing their recommendation that infants be placed on their backs to sleep to reduce the risk of sudden infant death syndrome (SIDS). The AAP stated that since they began to promote this important message, the ‘frequency of prone sleeping has decreased from <70% to ~20% of US infants,’ and the SIDS rate has decreased by <40%. The new statement reviews evidence about prone sleeping, and other risk factors, and makes recommendations to further reduce the risk of SIDS. Included in the statement is a list of modified and expanded strategies intended for healthy infants. The complete list is located on the web at <http://www.aap.org/policy/re9946.html>.

Collaborations and creative communications strategies are helping ensure that the message be heard. For example, Gerber Products Company is placing the Back to Sleep message on its cereal boxes, in mailings to new parents, and on its toll-free information number.

Get the "B" Attitude: Preventing Birth Defects

Lethal birth defects of the nervous system account for about seven percent of all infant deaths due to birth defects. The most common group of birth defects are neural tube defects (NTDs), affecting the spinal column (e.g., spina bifida, meningocoele, meningomyelocele) and brain (e.g., anencephaly, encephalocele). The March of Dimes has focused national attention on the many periconceptional and other health benefits of daily folic acid intake and has promoted the message that healthcare providers can and should play a vital role in promoting the use of folic acid. MOD conducted several recent surveys which indicate that more public and provider education is needed, and that providers want more resources to educate their patients about the importance of folic acid. They are working to facilitate change in these areas.

In 1998, just 13% of women of childbearing age knew that folic acid can help to prevent some birth defects, and only seven percent knew that folic acid must be taken prior to conception to achieve the benefits. In addition, although CDC-sponsored focus groups have shown that patients want to learn about folic acid from their care providers, the 1998 March of Dimes-sponsored Gallup Poll of women of reproductive age demonstrated that fewer than one out of five women who knew about the importance of folic acid identified their healthcare providers as the source of the information. This was compared with at least one-third who obtained folic acid-related information from independent reading of newspapers and magazines. Providing information does not guarantee behavior change and sustained change is what is needed to reach fortification levels high enough to achieve the health benefit.

Find out more by visiting the March of Dimes website at <http://www.modimes.org>.
CityTools - Data to Action

National Fetal and Infant Mortality Review (FIMR) studies fetal and infant deaths to learn how to improve community systems and resources for other young families.

The process begins with abstracting data from medical and other health/social services records and continues with a personal interview with mothers who have lost an infant. This information is presented as a confidential, de-identified case study to a small multidisciplinary panel, the case review team. Recommendations to improve systems are developed by the case review team and forwarded to a larger group composed of key local and regional leaders, the community action team, for implementations.

Overall objectives of all FIMR programs are:

- To examine significant social, economic, cultural, safety and health systems factors associated with fetal and infant death through review of individual cases.
- To plan interventions and develop policies to address these factors.
- To participate in implementation of community-based interventions and policies.
- To assess the progress of the interventions.

By forming partnerships, FIMR programs operating in major cities address the issues identified through the process.

Improving Community Systems

The following stories from select sites highlight the different approaches that can be taken to make use of this tool.

**Southern New Jersey**  Perinatal Cooperative’s FIMR found that women with no prenatal care (NPC) who deliver a stillborn baby are lost to follow-up after discharge from Camden area hospitals. These women often had a history of substance abuse and did not routinely use the health care system. No follow-up protocol existed for this group although a strong protocol for NPC women who deliver a healthy baby was in place. To address this problem, the community network team brought together the outreach agency, substance abuse providers and hospital representatives to develop a protocol built upon existing resources.

Each organization formally approved the protocol and trained its staff to implement their component. Substance abuse counselors will provide home visits and, if possible, meet with women before they are discharged from the hospital. Outreach workers, with additional bereavement sensitivity training, also follow up at home.

Contact: Barbara May, Southern New Jersey Perinatal Cooperative (609) 665-6000

**San Diego, California** identified a need to improve pregnant women’s understanding of the signs and symptoms of preterm labor and to reinforce the need to seek medical evaluation when experiencing those symptoms. Based upon FIMR findings and recommendations, the San Diego County Board of Supervisors allocated $150,000 over two fiscal years to develop and test strategies for teaching preterm labor education. One track reaches women in their second trimester of pregnancy at WIC visits, offering information about preterm labor and the importance of getting a medical evaluation when something “feels wrong.”

Another track targets intermediaries - medical office clerical and paraprofessional staff and staff from community based organizations - as educators. FIMR trains these key contact people about warning signs and risks of preterm labor. They can then distribute educational packets to pregnant women and stress preterm labor awareness at every visit.

Contact: Barbara Bonner, County of San Diego, Department of Health Services. (619) 692-8667

**Oakland, California** found that the “Back to Sleep” SIDS risk reduction messages were not reaching some families. To address this problem, the FIMR work group developed SIDS risk reduction binders for hospital staff. Binders contained background information about SIDS, SIDS risk reduction, and unique patient education materials developed for populations with persistently higher SIDS rates.

Key risk reduction points were integrated into information sheets and translated into eight languages. Sets of materials targeted parents, grandparents and people with low literacy levels. The Alameda County MCH program printed and distributed camera-ready materials to hospitals and health care providers.

Contact: Dr. Jogi Khanna, MCH Director, Alameda County Public Health, 1000 Broadway, Ste 500, Oakland, CA 94607

**St. Petersburg, Florida’s** FIMR program found that new mothers needed information about what is "normal" following childbirth and about early infant care. The Pinellas County Florida FIMR project, Healthy Start and area hospitals with OB units worked together to develop a booklet for new mothers to take home following hospital discharge. Built on an existing hospital publication, the MOM’s (Matters on Motherhood) booklet provides answers to commonly asked questions. The Care for Mom section covers nutrition, exercise, managing visitors, carving out free time, breastfeeding and bottle-feeding. The Caring for Baby section covers burping, bathing the baby, care of the umbilicus, signs of illness, sleeping, crying and immunizations.

Contact: Carrie Nero (727) 824-6922 or email at Carrie_Nero@doh.state.fl.us

Opportunity Snapshots

The NFIMR webpage [http://www.acog.org/goto/nfimr](http://www.acog.org/goto/nfimr) contains additional information, state contact people and other FIMR resources. Contact: Kathleen Buckley 202-863-1630 or kbuckley@acog.org

Sustaining the FIMR Program: A Toolkit. This publication discusses strategies to sustain FIMR programs, funding development, strengthening communications, translating numbers into information, using models and examples from FIMR programs. Contact: NFIMR (202) 863-2587.
Would the Perinatal Periods Of Risk Approach Help Your Community?

"The PPOR approach helps policy makers to see that infant mortality isn’t one problem with one solution, that strategies to prevent the death of a 500 gm preemie are likely to be different than those targeted to a normal birthweight infant who dies at four months."

Kathy Carson, Seattle-King County

Based on a strong conceptual prevention framework, the Perinatal Periods of Risk (PPOR) Approach is a new simple analytic method which can be used by communities to prioritize and mobilize prevention efforts around fetal and infant mortality. Through a multi-city learning cluster approach sponsored by the Centers for Disease Control and Prevention and the National March of Dimes Birth Defects Foundation, CityMatCH has worked closely over the last two years with teams from Seattle, Boston and Honolulu to test the validity and feasibility of using this approach in US cities.

Learn more about the new methodology and what the approach has to offer your community by attending the upcoming September 13th Pre-conference Workshop at the Annual CityMatCH Leadership Conference in Westminster, Colorado.

In the workshop, "Data 109: Using PRAMS Data for Perinatal Prevention" participants will learn:

• The description of the Perinatal Periods of Risk Approach;
• The importance of community involvement;
• The connection of prevention strategies to their infant mortality data;
• The initial results from using the approach for the 64 largest U.S. Cities; and
• The factors needing to be present to implement the approach in your community.

This session is designed to provide skills to help shift infant mortality prevention efforts from broad-based initiatives to more targeted effective strategies.

Using PRAMS Data for Perinatal Prevention

PRAMS, the Pregnancy Risk Assessment Monitoring System, is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.1

In 1987, PRAMS was initiated because decreases in infant mortality rates had leveled off, and little new change was being made in reducing the incidence of low birth weight infants. Research indicated that maternal behaviors during pregnancy might influence infant birth weight and mortality rates.

The goal of the PRAMS project has been to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS provides state-specific data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health.

PRAMS provides data not available from other sources about pregnancy and the first few months after birth. These data can be used to identify groups of women and infants at high risk for health problems, to monitor changes in health status, and to measure progress towards goals in improving the health of mothers and infants. Data can be used by local and state government to plan and review programs and policies. They can be used to identify potential partner agencies that have important contributions to make in planning maternal and infant health programs.

For their 1998-1999 CityMatCH/CDC Urban MCH Data Use Institute (DUI) project, Phoenix, Arizona’s DUI team chose to participate in a PRAMS project through the Maricopa County Department of Public Health. Participants Larry Sands, Sarah Santana and Rose Howe had four goals in mind: to educate the health community about PRAMS; to create public/private partnerships to utilize students/interns from universities and the MCH bureau and to lobby for support. Their experience was a positive one, and they reported a number of important lessons learned. They emphasized the importance of planning, of obtaining and leveraging support, learning from other state’s experiences, evaluation, and never underestimating the power of data.

For additional information, contact Mary Rogers
Nat’l Ctr. for Chronic Disease Prevention and Health Promotion, (CDC) 4770 Buford Hwy., Mailstop K-22, N.E. Atlanta, GA 30341-3724 (404) 488-5613 or E-mail at mjr3@cdc.gov

1 <http://www.cdc.gov/nccdphp/dh/PRAMS.htm>
Urban MCH Leadership Conference 2000
"Many Trails, One Destination"

September 13-16, 2000
at The Westin Westminster Hotel
Westminster, Colorado
in the Denver metropolitan area

REGISTRATION DEADLINE: AUGUST 4, 2000

Congratulations to the Next DUI Class

With support from the Centers of Disease Control and Prevention and the National March of Dimes Birth Defects Foundation, the following eleven cities’ local health departments have been selected to lead community teams in the fourth CityMatCH Urban MCH Data Use Institute:

- Baltimore City Health Department; Baltimore, MD
- Boston Public Health Commission; Boston, MA
- Denver Health Department; Denver, CO
- City of Detroit Department of Health; Detroit, MI
- Arkansas Department of Health; Little Rock, AR
- Jefferson Co. Health Department; Louisville, KY
- Metropolitan Health Department; Nashville, TN
- Douglas County Health Department; Omaha, NE
- Orange County Health Department; Orlando, FL
- State of Rhode Island Dept. of Health; Providence, RI
- Wake County Human Services; Raleigh, NC

Several new features were a part of the selection criteria for the 2000 – 2001 Data Use Institute. This year, teams are required to leverage resources for at least one of the core members and any additional traveling members. Therefore, 22 of the 45 participants are locally supported. The 2000 – 2001 DUI projects focus on MCH issues ranging from asthma to lead poisoning; school health to human services. All are focused on making a difference in the health of women, children and families. The new class will kick-off their DUI year at the September 2000 CityMatCH Urban MCH Leadership Conference in Westminster, CO.

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CityMatCH newsletter is produced and published quarterly by CityMatCH staff and is funded by project #SU93MC00120-09 from the Maternal and Child Health program (Title V, Social Security Act), Health Resources and Services Administration and the Department of Health and Human Services.

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