Exploring how Title V can use fatality review to improve maternal and child outcomes in communities

State/Federal Maternal and Child Health Partnership Technical Assistance Meeting
Skill Building Workshop – 10/17/17
About the National Center

• The National Center for Fatality Review and Prevention is a resource and data center that supports child death review (CDR) and fetal and infant mortality review (FIMR) programs around the country.

• Supported with funding from the Maternal and Child Health Bureau at the Health Resources and Services Administration, the Center aligns with several MCHB priorities and performance and outcome measures such as:
  – Healthy pregnancy
  – Child and infant mortality
  – Injury prevention
  – Safe sleep

The Center is funded in part by Cooperative Agreement Number UG7MC28482 from the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

The National Center for Fatality Review and Prevention
MCHB’s vision for the center

• Through delivery of data, training, and technical support, the Center will assist state and community programs in:
  – Understanding how CDR and FIMR reviews can be used to address issues related to adverse maternal, infant, child, and adolescent outcomes
  – Improving the quality and effectiveness of CDR/FIMR processes
  – Increasing the availability and use of data to inform prevention efforts and for national dissemination

Ultimate goal: improving systems of care and outcomes for mothers, infants, children, and families
Facebook and Twitter

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NationalCFRP
Workshop learning objectives:

• Provide an update on the prevalence and current trends of fetal, infant, and child mortality in the US and the Pacific

• Report on the current status of CDR and FIMR teams
Describe the CDR and FIMR methodologies: to serve as an effective systems intervention and public health strategy

• Describe how State Title V and fatality review program interaction can be mutually beneficial.
Infant mortality

- Definition: The death of any live born infant prior to his/her first birthday.

- “The most sensitive index we possess of social welfare . . . ”
  Julia Lathrop, Children’s Bureau, 1913
Infant mortality in the United States

- 3,988,076 births in 2014
  - 8% were low birth weight (less than 5.5 pounds)
  - 9.6% preterm, (born less than 37 weeks gestation)
- 23,215 infant deaths
- Rate of 5.82 deaths per 1,000 live births

Fetal mortality

• “Fetal death”, or still birth, refers to an infant born without signs of life, generally after 20 weeks of gestation

• 5.96 deaths per 1,000 live births

• 5.96 deaths per 1,000 live births
  – early (less than 20 completed weeks of gestation)
  – intermediate (20–27 weeks of gestation)
  – late (28 weeks of gestation or more)

US fetal and infant mortality trends

Deaths per 1,000 Live Births

- Fetal Deaths
- Infant Deaths

The National Center for Fatality Review and Prevention
Disparities in fetal and infant mortality rates

Deaths per 1,000 Live births

<table>
<thead>
<tr>
<th>Population</th>
<th>Fetal Deaths</th>
<th>Infant Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic Black</td>
<td>10.53</td>
<td>11.11</td>
</tr>
<tr>
<td>American Indian or Alaskan Native</td>
<td>6.22</td>
<td>7.61</td>
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<tr>
<td>Hispanic</td>
<td>5.22</td>
<td>5.00</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>4.88</td>
<td>5.06</td>
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<tr>
<td>Asian, Pacific Islander</td>
<td>4.68</td>
<td>4.10</td>
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</table>

Data Source: https://www.cdc.gov/nchs/nvss/linked-birth.htm
State rankings for overall infant mortality

Three Year Average, 2011 - 2013

<table>
<thead>
<tr>
<th>State</th>
<th>Rate</th>
</tr>
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<tbody>
<tr>
<td>Mississippi</td>
<td>9.25</td>
</tr>
<tr>
<td>Alabama</td>
<td>8.57</td>
</tr>
<tr>
<td>Louisiana</td>
<td>8.35</td>
</tr>
<tr>
<td>Delaware</td>
<td>7.64</td>
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<tr>
<td>Ohio</td>
<td>7.6</td>
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<td>Arkansas</td>
<td>7.41</td>
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<tr>
<td>DC</td>
<td>7.33</td>
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<tr>
<td>South Carolina</td>
<td>7.23</td>
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<tr>
<td>North Carolina</td>
<td>7.2</td>
</tr>
<tr>
<td>Indiana</td>
<td>7.19</td>
</tr>
</tbody>
</table>
States with highest Black Infant Mortality

Three Year Average, 2011 – 2013

<table>
<thead>
<tr>
<th>State</th>
<th>Three Year Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas</td>
<td>14.2</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>14</td>
</tr>
<tr>
<td>Ohio</td>
<td>13.6</td>
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<td>Michigan</td>
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<tr>
<td>Utah</td>
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<tr>
<td>Alabama</td>
<td>12.9</td>
</tr>
<tr>
<td>Illinois</td>
<td>12.9</td>
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<tr>
<td>Indiana</td>
<td>12.9</td>
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<tr>
<td>Delaware</td>
<td>12.8</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>12.7</td>
</tr>
</tbody>
</table>

The National Center for Fatality Review and Prevention
Black/White disparities in infant mortality

Three Year Average, 2011 – 2013

- Kansas: White IM Rate = 5.5, Black IM Rate = 14.2
- Wisconsin: White IM Rate = 5, Black IM Rate = 14
- Ohio: White IM Rate = 6.3, Black IM Rate = 13.6
- Michigan: White IM Rate = 5.3, Black IM Rate = 13.1
- Utah: White IM Rate = 4.8, Black IM Rate = 12.9
- Alabama: White IM Rate = 6.9, Black IM Rate = 12.9
- Illinois: White IM Rate = 4.8, Black IM Rate = 12.9
- Indiana: White IM Rate = 6.5, Black IM Rate = 12.9
- Delaware: White IM Rate = 5.6, Black IM Rate = 12.8
- Pennsylvania: White IM Rate = 5.2, Black IM Rate = 12.7

The National Center for Fatality Review and Prevention
States with highest American Indian infant mortality rates

Three Year Average, 2011 – 2013

- North Dakota: 13.2
- South Dakota: 11.5
- Minnesota: 11.3
- North Carolina: 10.6
- Oregon: 10.2
- Montana: 9.8
- Michigan: 8.9
- Washington: 8.7
- Arizona: 8.5
- New York: 8.3

The National Center for Fatality Review and Prevention
American Indian/White disparities in infant mortality

Three Year Average, 2011 – 2013

<table>
<thead>
<tr>
<th>State</th>
<th>White IM</th>
<th>Native AM IM</th>
</tr>
</thead>
<tbody>
<tr>
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<td>5.5</td>
<td>13.2</td>
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<tr>
<td>South Dakota</td>
<td>5.7</td>
<td>11.5</td>
</tr>
<tr>
<td>Minnesota</td>
<td>4.3</td>
<td>11.3</td>
</tr>
<tr>
<td>North Carolina</td>
<td>5.4</td>
<td>10.6</td>
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<tr>
<td>Oregon</td>
<td>4.7</td>
<td>10.2</td>
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<tr>
<td>Montana</td>
<td>5.3</td>
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<tr>
<td>Michigan</td>
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<tr>
<td>Washington</td>
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<td>8.7</td>
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<tr>
<td>Arizona</td>
<td>4.7</td>
<td>8.5</td>
</tr>
<tr>
<td>New York</td>
<td>4.0</td>
<td>8.3</td>
</tr>
</tbody>
</table>
US Cities with the highest Infant Mortality Rate

- Cleveland – 13.5
- Detroit – 13.4
- Milwaukee – 11.3
- Memphis – 10.5
- Baltimore – 10.2
- Jacksonville – 9.6
- San Juan – 9.5
- Philadelphia – 9.3
- Indianapolis – 9.2
- Fresno – 9.2

Infant mortality in the U.S. affiliated Pacific Basin jurisdictions

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>2004</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marshall Is.</td>
<td>25.3</td>
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<td>FSM</td>
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<tr>
<td>Palou</td>
<td>9.6</td>
<td>20.1</td>
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<td>CNMI</td>
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<td>4.0</td>
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<td>Guam</td>
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<td>Am. Samoa</td>
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<tr>
<td>United States</td>
<td>6.8</td>
<td>5.8</td>
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</table>

2004 data from: Region IX Office of the Regional Health Administrator, HHS. 2014 data from The Status of Maternal Child Health in the U.S.-Affiliated Pacific Islands, Dr. Haley Cash, Regional NCD Epidemiologist for the USAPIs, PIHOA
Infant mortality in the Atlantic jurisdictions

http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_09.pdf
Fetal and infant mortality review (FIMR)

The Cycle of Improvement

Data Gathering → Case Review

Case Review → Community Action

Community Action → Changes in Community Systems

Changes in Community Systems → Data Gathering
The FIMR process

FIMR brings a multidisciplinary community team together to examine confidential, de-identified cases of infant deaths.
FIMR goals

- To examine significant social, economic, cultural, safety, health and systems factors that are associated with mortality
- To design and implement community-based action plans founded on information obtained from the reviews
The maternal interview

- Gives insight into the mother’s experience before and during pregnancy
- Conveys the mother’s story of her encounters with local service systems
Confidentiality

• FIMR cases are de-identified so that the names of families, providers and institutions are confidential – the FIMR focus is on improving systems, **NOT** assigning blame.
FIMR: a public health model

1. Fetal and Infant Deaths Selected
2. Maternal Interview Conducted
3. Records Abstracted & Summarized
4. FIMR Team Reviews & Makes Recommendations
5. Community Action Team Prioritizes and Takes Action
6. Improved Systems, Services & Resources for Families
7. Improved Health of the Community
FIMR: A two tiered process

CRT

Case Review Team

CAT

Community Action Team

The National Center for Fatality Review and Prevention
Through the fetal-infant mortality review process, the community becomes the *expert* in the knowledge of the entire local service delivery systems and community resources for childbearing families.
What is child injury

- Often referred to as an “accident”
- Manner of death
- Considered normal part of childhood
- Best described as unintentional
### Child mortality in the United States

#### 10 Leading Causes of Death by Age Group, United States – 2015

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Rank</th>
<th>Cause 1</th>
<th>Cause 2</th>
<th>Cause 3</th>
<th>Cause 4</th>
<th>Cause 5</th>
<th>Cause 6</th>
<th>Cause 7</th>
<th>Cause 8</th>
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</tbody>
</table>

**Data Source:** National Vital Statistics System, National Center for Health Statistics, CDC. 
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS.™
## Child injury in the United States

### 10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States – 2015

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>&lt;1</th>
<th>1-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>3</td>
<td>Unintentional Fire/Burn 191</td>
<td>Unintentional Motorcycling 131</td>
<td>Unintentional Motorcycling 123</td>
<td>Suicide Suffocation 2,461</td>
<td>Suicide Suffocation 2,510</td>
<td>Suicide Suffocation 3,119</td>
<td>Suicide Suffocation 2,139</td>
<td>Suicide Suffocation 2,263</td>
<td>Suicide Suffocation 2,404</td>
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</tbody>
</table>

**Data Source:** National Center for Health Statistics (NCHS), National Vital Statistics System.  
**Produced by:** National Center for Injury Prevention and Control, CDC using WISQARS™.
US Injury Trends in Children

2008-2014, United States
Death Rates per 100,000 Population
All Injury, Unintentional, All Races, All Ethnicities, Both Sexes, Ages 0-17 Years
Annualized Crude Rate for United States: 8.06

Maps show:
- The United States, showing death rates per 100,000 population for selected categories.
- The color legend indicates the death rate range:
  - 2.74-5.72
  - 6.73-9.00
  - 9.01-11.40
  - 11.41-18.02

Reports for All Ages include those of unknown age.
* Rates based on 20 or fewer deaths may be unstable. States with these rates are cross-hatched on the map. Such rates have an asterisk.

Produced by: the Statistics, Programming & Economics Branch, National Center for Injury Prevention & Control, CDC
Data Sources: NOES National Vital Statistics System: for numbers of deaths; US Census Bureau for population estimates.

The National Center for Fatality Review and Prevention
US Injury Rates in African American Children

2008-2014, United States
Death Rates per 100,000 Population
All Injury, Unintentional, Black: All Ethnicities, Both Sexes, Ages 0-17 Years
Annualized Crude Rate for United States: 10.42

Reports for All Ages include those of unknown age.
* Rates based on 25 or fewer deaths may be unstable. States with these rates are cross-hatched in the map (see legend above). Such rates have an asterisk.

Produced by: the Statistics, Programming & Economics Branch, National Center for Injury Prevention & Control, CDC
Data Sources: NCHS National Vital Statistics System for numbers of deaths; US Census Bureau for population estimates.
Disparities and injury

• New framework being utilized
• Goal to identify disparities within causes of injury
• National collaborations
Fatality review in the US

CDR in 50 states and DC

1350 local and state teams

Dept. of Defense

Guam

Tribes

FIMR in 29 States and DC

175 local teams

Puerto Rico

Pacific Jurisdictions

Tribes
CDR: Where the Good Shift Happens

Tell the story

Collect data

Take action

The National Center for Fatality Review and Prevention
Child Death Review

- Multi-disciplinary
- Telling a story through the sharing of case information from multiple sources
- Focused on improving systems and prevention of deaths; not culpability
- Balance between individual cases and accumulation of fatal and non-fatal data for trends
Prevention

Improved agency systems

Improved identification, diagnosis and reporting

Improved communication

Review
The Web of Reviews

- Child Fatality
  - Maternal Mortality Review
  - Internal Child Welfare Agency Review
  - State Child Fatality Review
  - Citizen Review Panel
  - Fetal & Infant Mortality Review
  - Domestic Violence Fatality Review
  - Military Domestic Violence Fatality Review

- Elder Death Review
  - Regional Child Fatality Review
  - Local Child Fatality Review
Who studies death now

• Health care providers
• Institutions
• Medical researchers
• County and state health officers

*Fatality review complements existing efforts, but takes a different approach*
Fatality review as part of other MCH initiatives

- Vital Statistics
- PRAMS (Pregnancy Risk Assessment Monitoring)
- MMMS (Maternal Mortality Surveillance)
- PPOR (Perinatal Periods of Risk)
- BRFSS (Behavioral Risk Factor survey System)
Surveillance:
The ongoing systematic collection and analysis of data about a health problem that can lead to action being taken to control or prevent the problem. An infant or child death is a sentinel event that triggers surveillance activities.
Case Reporting System

• National, web-based data system
• Comprehensive information
• Addresses many performance measures
• Free to utilize
How fatality review informs Title V

- Assessment
- Action Planning
- Prevention
- Workforce Development
Assessment

• Fatality review can help state Title V programs to prioritize needs, and, based on their data, to select which National MCH Priority areas are most critical for their state

• The recommendations developed by CDR and FIMR teams can help states to establish meaningful performance objectives
Assessment

- CDR and FIMR’s systematic review of individual cases of fetal, infant, and child deaths helps to identify what may be lacking in a community in preventive and primary care services for pregnant women, mothers, infants, and children.
  - Sentinel Events
  - Trends over time
  - Incidental findings
Assessment

• CDR and FIMR can play a unique role in identifying when the death of a child with special needs or disabilities is the result of caregiver maltreatment, or if the family lacks supports needed to keep child with disability healthy and safe.
Action planning

- Fatality Review data and findings can help states select which eight of the possible 15 National Performance Measures (NPM) they will focus on for programmatic emphasis over the five-year reporting period.
- Identification of specific causes and contributing factors in a fetal, infant, or child death aids in the development of evidence based and evidence informed strategy measures.
Action planning

• States need to continue to monitor and assess, on an ongoing basis, the successes and continuing needs that have resulted from the implementation of their five-year Action Plan

• CDR and FIMR provide invaluable information that helps communities understand how changing conditions impact services and resources and affect families throughout the community trying to access or utilize services
• Fatality Review can enhance and create new collaborations around prevention work. Additionally, Fatality Review builds on existing programs.
• Fatality Review teams can be used to disseminate MCH work and plans to local communities.
Work force development

- Multidisciplinary review leads to collaboration with formal and informal community leaders/groups
- Fatality review brings key stakeholders around a common table for the purpose of improving the care, resources, and services available to families
Skills that CDR and FIMR provide in direct support of the Title V National Performance Measures

• Advancing Equity
• Partnerships
• Implementation
• Leadership and systems thinking skills
Advancing equity

- Fatality review provides valuable qualitative data to use with states’ quantitative infant and child mortality data.
- CDR and FIMR findings can be used to understand mothers’/families’ experiences of racism and how those experiences may have impacted maternal and child outcomes.
- Fatality review assesses the equity of current and proposed interventions.
- Fatality review data may be used to influence and inform policy, program, and funding choices.
Partnerships

- Multidisciplinary reviews foster collaboration with community partners and manages shared challenges.
- CDR and FIMR teams partner effectively in advocacy efforts, including aligning messaging for communications related to each measure.
- CDR and FIMR teams identify and engage with non-traditional partners, and share their perspectives around given performance measures in Title V efforts.
Implementation

• The common mission of CDR and FIMR are to build and support teams to actively guide program design, delivery, and improvement of resources and systems of care

• Fatality Review data guides implementation and systems change effort

• Fatality Review uses data systems to measure progress and guide improvement efforts
Leadership and systems thinking skills

• CDR and FIMR convene public health and primary care professionals to align strategies and communication related to national performance measures

• Fatality Review teams lead and influence without authority, including willingness to challenge cultural norms

• Multidisciplinary case review has demonstrated the ability to scale up successful changes and interventions to larger systems and processes
Examples of how CDR and FIMR have addressed national performance measures

Six Maternal Child Health population health domains:

– Women/Maternal Health
– Perinatal/Infant Health
– Child Health
– Children and youth with special health needs
– Adolescent Health
– Cross-cutting or Life Course.
Fatality review and Title V National Performance Measures (NPMs)

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<th>NPMs addressed by FIMR</th>
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<td>NPM 2: Low-risk Cesarean delivery</td>
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<th>NPMs addressed by FIMR and CDR</th>
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<th>NPMs addressed by CDR</th>
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<td>NPM 9: Bullying</td>
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<td>NPM 10: Adolescent well-visit</td>
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<td>NPM 12: Transition</td>
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Well woman visit

**Problem:** Case review in San Francisco’s FIMR program identified that infant deaths due to prematurity and low birth weight were associated with chronic maternal health conditions.

- More than half of the women with chronic conditions had a pregnancy that was unplanned, and needed a medical home.

**Recommendation:** Encourage preconception counseling and Well Woman Visits, along with interconception counseling for women, so they can plan for optimal pregnancy outcomes.
Well woman visit

- **Action:** The San Francisco Public Health Department designated a 1.0 FTE Public Health Nurse to address women’s health, ensure Well Woman Visits, and encourage preconception and interconception care and counseling to include Annual Exams, (breast and pelvic) nutrition, physical activity, optimal weigh counseling, on substance avoidance.
Smoking cessation

• The Oklahoma City, OK FIMR program identified a high number of premature and low birth weight infant deaths that were highly correlated with tobacco use among pregnant women. FIMR data and FIMR findings have helped them to shape their strategies.
Smoking cessation actions:

• Staff at the Oklahoma City/County Health Department (OCCHD) conducting focus groups with men who smoke in an effort to understand and develop strategic messaging aimed at second and third-hand smoking.

• Messages to educate families on second and third-hand smoke were created (video and print materials).

• FIMR worked with the Healthy Living Grant at OCCHD. The partnership resulted in the creation of 2,000 smoking cessation quit kits to be given to pregnant women and their families, and included the Oklahoma Helpline for pregnant Medicaid members.
Adolescent health

Problem: Lack of providers equipped to work with adolescent patients as evidenced in multiple suicides

Recommendation: Implementation of a teen health literacy program

Result: Teen health literacy program implemented that focuses on teaching physicians how to listen to teens
Infant safe sleep

• CDC Case Registry
• Multiple prevention strategies and partnerships
• Local, state and national implications
• Better quality DSI
Questions?

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