ADVISORY COMMITTEE ON INFANT
AND MATERNAL MORTALITY (ACIMM)

Systems Issues in Rural Health Workgroup Meeting

Health Resources and Service Administration Building
5600 Fishers Lane
Rockville, MD 20857

Thursday, June 27, 2024
1:15 p.m. - 2:45 p.m.

00:00:49:11 - 00:00:52:18

Sarah Meyerholz

For those of you online. Can you hear us?

00:00:52:20 - 00:00:53:20

Scott Lorch

Yes.

00:00:53:22 - 00:01:08:13

Sarah Meyerholz

Great. Give us just one second. We're getting set up here in the room. I just want to make sure we have the right camera. Perfect. I think we're good to go. Okay.

00:01:08:15 - 00:01:11:14

Steve Calvin

Are we in the rural one, or where are we?

00:01:11:16 - 00:01:13:21

Kate Menard

We are here in the rural.

00:01:13:23 - 00:01:19:15

Steve Calvin

Okay, fine. I see Jacob there, so I know I'm in the right place.

00:01:19:17 - 00:01:24:18

Jacob Warren

Sorry I couldn't find the link. I had it, but then I lost it.

00:01:24:20 - 00:01:33:13

Kate Menard

This plane is going to the rural health work group. Please fasten your seatbelts.

00:01:33:15 - 00:01:49:07

Kate Menard

So we'll go ahead and get started. Yeah. I think that there might be a couple more people to drop in. Well, good afternoon everybody. We've had a packed full couple of days, and now we're going to have a packed full hour, I think, with our work group. So thank you all for joining.

00:01:49:09 - 00:02:06:21

Kate Menard

And what I thought we would do -- Jacob and I kind of put our heads together on how to structure this meeting. Thought we would begin with introductions, introductions, and then, you know, kind of the focus of what we want to do with this. Now, what will be an hour, we've got from now till 12:45, right?

00:02:06:21 - 00:02:28:17

Kate Menard

Yeah. an hour and a -- 2:45, so an hour and a quarter. So, we have a couple of goals that I'll go over with you. And I think we're going to be able to get a lot done. So, anybody have any questions before we start? Let's start with introductions, then. I actually have the, for those of you that have not met me, there's just a couple on here that have.

00:02:28:17 - 00:02:48:11

Kate Menard

I'm Kate Menard, and one of the ACIMM committee members and co-chair of this work group, and I'm a maternal fetal medicine specialist I have the pleasure of -- I want to introduce our, the new face on the screen, to us. And we're privileged today to have a community member with us for our work group today.

00:02:48:13 - 00:03:13:00

Kate Menard

Divine Bailey-Nicholas, you can see her in the -- at least on my Hollywood Square. She's a front of the left hand corner. She's affectionately known, I'm told, as Divine, which is lovely. And so, she's the founder and CEO of the nonprofit organization Community Birth Companion, which was started in 2012 with the goal of lowering infant and maternal mortality rates in the Landry Parish.

00:03:13:02 - 00:03:38:21

Kate Menard

She hails from Louisiana, right? Yeah, good. She's also a certified lactation counselor, midwife apprentice, trained doula and traditional herbalist. Currently, she's a member of the Healthy Saint Landry Steering Committee and local ambassador for the National Perinatal Task Force. Divine is a leader of the Cafe Au Lait breastfeeding circle in --

00:03:38:23 - 00:03:41:21

Kate Menard

I'm not going to say this right. Opelousas, Louisiana.

00:03:41:21 - 00:03:42:17

Divine Baley-Nicholas

Opelousas.

00:03:42:17 - 00:03:59:19

Kate Menard

Thank you. Where she lives with her husband and four children. All babies deserve to celebrate their first birthday, and by helping mothers and families, Community Birth Companions works to make that a reality. So welcome, Divine, we are very, very happy and privileged to have you with us.

00:03:59:21 - 00:04:01:00

Divine Baley-Nicholas

Thank you so much.

00:04:01:02 - 00:04:06:20

Kate Menard

I’m going to have the others introduce themselves. Would you like to add anything?

00:04:06:22 - 00:04:24:07

Divine Baley-Nicholas

I'll just say I've added that, now is five children. So recently we just had another baby, and she made one month today. So, just glad to be here and able to share with y’all.

00:04:24:09 - 00:04:32:11

Kate Menard

Lovely, lovely, lovely. And, so I'm going to kind of go around and ask others to introduce themselves.

00:04:32:11 - 00:04:37:23

Kate Menard

Let's start let's start with the screen and then we'll go -- Jacob, would you like to go ahead, please?

00:04:38:00 - 00:04:53:14

Jacob Warren

Sure. Hi, everyone. I'm Jacob Warren. I'm a health equity epidemiologist with a particular focus on rural health and maternal child health, particularly maternal mortality. In a previous life, I was Dean of a School of Health Sciences, helping to build workforce.

00:04:53:14 - 00:05:17:17

Jacob Warren

And before that I ran two rural health centers, one at the Mercy University School of Medicine and the Wyoming, currently with the Wyoming Rural Health Institute and then previously Rural Health Research Institute at Georgia Southern. I also am a previous Healthy Start grantee, and a current MHI grantee. So, it's just a real pleasure to have everyone here and looking forward to continuing to move forward with some recommendations to help improve outcomes in rural areas.

00:05:17:19 - 00:05:21:19

Kate Menard

Jennifer.

00:05:21:21 - 00:05:30:02

Jennifer Vanderlaan

Thank you. I'm Doctor Jennifer Vanderlaan. I am a nurse midwife researcher at UNLV, and I attend as a subject matter expert.

00:05:30:04 - 00:05:33:16

Kate Menard

Thank you. Angie.

00:05:33:18 - 00:05:44:03

Angie Rohan

Hi, I’m Angie Rohan. I'm the team lead for the Maternal Health and Chronic Disease Team in the Division of Reproductive Health at CDC, and also attend as a subject matter expert.

00:05:44:05 - 00:05:50:17

Kate Menard

Kristen.

00:05:50:19 - 00:06:04:14

Kristen Zycherman

Hi. Sorry. My internet is kind of wonky today, but I'm Kristen Zycherman. I am the ex-officio member from CMS, and the lead of the Maternal and Infant Health Initiative there.

00:06:04:14 - 00:06:14:21

Kate Menard

Okay. Jackie.

00:06:14:23 - 00:06:17:16

Jackie Wallace

Sorry. Kate, you mean me, Jackie Wallace?

00:06:17:18 - 00:06:18:15

Kate Menard

Sorry, I should say last names.

00:06:18:16 - 00:06:27:15

Jackie Wallace

Okay, so I'm actually here. Even though I can't change my name, it says CDC, I am here as a member of the public, so I'm just going to stay on mute. Thank you.

00:06:27:15 - 00:06:32:23

Kate Menard

Thank you. Okay. Scott.

00:06:33:00 - 00:06:41:16

Scott Lorch

Hi. Scott Lorch, Professor of Pediatrics at the Children's Hospital Philadelphia, and, Chief of the Division of Neonatology at the Children's Hospital, Philadelphia.

00:06:41:16 - 00:07:07:21

Scott Lorch

I'm a perinatal health services researcher. I think, and I'm a new member of ACIMM, or ACIMM, I can't really figure out how they're pronouncing it. And, I have an extensive portfolio in perinatal regionalization, perinatal health care policy, and

hospital closures and their impacts on health outcomes. So, I'm here as a new member.

00:07:07:23 - 00:07:14:08

Kate Menard

Excited to have you. Thank you for joining the group. Marilyn.

00:07:14:10 - 00:07:45:01

Marilyn Kacica

Hi, everybody. I'm Marilyn Kacica. I am a pediatrician and a public health physician with the New York State Department of Health. We oversee maternal child health, the Title V program. I also lead the efforts with the Perinatal Quality Collaborative. Hi, Jackie. Our Maternal Mortality Initiative and the MHI Initiative, currently in New York, and we also oversee the regionalization, which we have extensive programs.

00:07:45:03 - 00:08:06:10

Marilyn Kacica

And although -- New York has very, a lot of rural area, surprisingly upstate. And we're dealing right now with a lot of these issues as far as hospital closure, midwifery issues, expanding service. And so, and I'm also a new member.

00:08:06:12 - 00:08:13:01

Kate Menard

Welcome again. Excited to have you. Charlene.

00:08:13:03 - 00:08:27:10

Charlan Kroelinger

Hey, everybody. I'm so glad to be here today. I'm Charlan Kroelinger, the Chief of the Maternal and Infant Health Branch. and I'm one of the ex-officio members representing, the Division of Reproductive Health and CDC.

00:08:27:12 - 00:08:30:12

Kate Menard

Steve.

00:08:30:14 - 00:08:39:13

Steve Calvin

Hi. Steve Calvin, a maternal fetal medicine specialist. I'm nearing the end of my -- it turned into more than four years because of Covid, my time on the committee.

00:08:39:15 - 00:09:03:22

Steve Calvin

I'm really honored to be with this whole group. I'm currently at the University of Arizona in Phoenix, but spend a lot of time in Minnesota. So I'm really interested in the rural stuff, in both states in particular. Also glad to see that Jackie Wallace has joined us. She's the lead author of a paper that has an awful lot to say about the,

00:09:03:22 - 00:09:18:09

Steve Calvin

the benefit of midwifery care for low-risk mothers. So I'm just really happy to be part of this group of very everybody's got some really interesting backgrounds and things to offer.

00:09:18:11 - 00:09:22:12

Kate Menard

Right. Anne Driscoll.

00:09:22:14 - 00:09:36:18

Anne Driscoll

Hi. Sorry, my camera does not work. I am a demographer statistician at the Division of Vital Statistics and National Center for Health Statistics at CD. and focus on infant mortality and natality trends.

00:09:36:20 - 00:09:47:04

Kate Menard

Okay. And I think we have some other, public listeners, on the screen. So welcome. We're glad you're here. Let's going to move to kind of move to the room. Sarah.

00:09:47:09 - 00:10:01:18

Sarah Meyerholz

Oh, sorry. No voice after, full week. Yes. Hi. Sarah Meyerholz here, I'm with NCHB, the ACIMM program lead. So if you need anything, feel free to shoot me a message. Just here taking notes.

00:10:01:20 - 00:10:06:10

Kate Menard

Do you have a microphone? Here?

00:10:06:12 - 00:10:10:11

Carey Zhuang

Oh. Hi, everybody. My name is Carey Zhuang. I'm from the Federal Office of Rural Health Policy.

00:10:10:11 - 00:10:14:16

Carey Zhuang

And I'm one of the program leads for the RMOMs program.

00:10:14:18 - 00:10:37:07

Kate Menard

Does your mic work?

00:10:37:09 - 00:10:45:05

Scott Lorch

Kate, we don't have audio online right now. I don't know if anyone’s speaking.

00:10:45:07 - 00:11:00

Kate Menard

Were you not -- are you able to hear me through the microphone? Okay. It's just a matter of, I think, speaking into the microphone, then. Okay. Okay. Well, let's, let's just well one of our advanced specialists. So she's here with us, I think.

11:01-11:08

Stacey Penny

Can you hear me talking? Okay. It might have.

00:11:16:20 - 00:11:37:21

Stacey Penny

Can you hear me now? Yes. Hi, everyone. This is Stacey Cunningham Penny and I oversee the National Network of Perinatal Quality Collaboratives at NICHQ, the National Institute for Children's Health Quality. And here as a subject matter expert and part of the public. Great to be here.

00:11:37:23 - 00:11:46:17

Kate Menard

Okay, so, thanks everybody for that for those introductions. I think it demonstrates kind of that we've got a breadth of representation here, so that’s wonderful.

00:11:46:17 - 00:12:11:10

Kate Menard

Our goals today are going to, and this is Belinda's direction. We're going to come up with a rough draft of recommendations. It seems like oh wow, here we are already. But given that we're on a timeline and we need, you know, we need to have a robust and then consolidated list, this will be a process of going through, putting all our sort of getting our ideas down, adding to them, and then consolidating them over time.

00:12:11:14 - 00:12:30

Kate Menard

So today, we'd like to start with the rough draft. We'd also like to think about, criteria to consider for evaluation of those recommendations. So we're going to get a really long list. And then how are we going and what decision factors are going to go into, you know, what we really kind of move forward, in the end.

00:12:30 - 00:12:45:18

Kate Menard

And then if there are things that we need to identify gaps in our learning thus far, topics, you know, that we want for our future meetings, these precious couple meetings that we'll have in July and August and September before we have a draft recommendations to bring to the meeting in October.

00:12:45:20 - 00:13:05:00

Kate Menard

We want to use that time well, so let's talk about that and who else we want to bring to that work, or is it just us where we really kind of need to be thinking together? So that's kind of thought -- that's our thoughts for what we'd like to be able to do in this hour. It's a lot, but I'm optimistic.

00:13:05:02 - 00:13:22:22

Kate Menard

First I'm going to, what -- this was this was Jacob's idea, was to kind of take themes that we've identified so far and consolidate them. We've talked -- we had a sort of our foci, but then there were really themes within those that I think he can, you can tell about the process, [inaudible],

00:13:23:01 - 00:13:28:19

Kate Menard

I'm going to let him kind of take us through that of, drafting a list of recommendations.

00:13:28:21 - 00:13:34:06

Jacob Warren

Great. Do you all have a monitor there in the room where you can see if I share-screen?

00:13:34:08 - 00:13:35:01

Kate Menard

Yes.

00:13:35:03 - 00:13:46:22

Jacob Warren

Okay. Great. Yeah. Get this shared.

00:13:46:24 - 00:14:04:13

Jacob Warren

Okay. We’re all seeing the mirror tablet. Okay, great. So also, along the way, I'll try to speak really quickly for the the new members of the subcommittee. Welcome so much to you. Just to give you a sense of how we landed where we are, because we will have a lot that we're going to go through.

00:14:04:13 - 00:14:35:02

Jacob Warren

So I mentioned earlier that we have four areas that we've been working on. So what I'll do is go through each very briefly, and particularly focusing in on where we seem to thematically have landed. So in the discussion of MCH workforce, some of the questions that generated where we ended up going, we're looking at the availability of training programs in a variety of fields, looking at the diversity of the workforce and how we can help to overall diversify that.

00:14:35:02 - 00:14:56:19

Jacob Warren

We've had a lot of discussion about that over the past couple days of what can we recommend, particularly in rural, where sometimes that's even more of a pressing issue. We also talked

about the various disciplines that we think we need to be considering when we talk about workforce. And so that includes midwifery, labor delivery, nursing, general surgery, family medicine of doulas, community health workers, really across the spectrum.

00:14:56:19 - 00:15:30:04

Jacob Warren

These are the different worker types that we've been discussing. Another element is retention and advancement, so how are we going to continue the folks that are practicing in rural, and then looking at specific pipelines. So some of the questions that came up along the way, as we discussed that is issues of liability and toward particularly in low volume areas, looking at other HRSA workforce programs that intersect with rural, and other programs overall, such as RMOMS that are working specifically in the rural maternity space.

00:15:30:06 - 00:16:02:04

Jacob Warren

And then we heard some about this yesterday, which is great. And that was, you know, what the Bureau of Health Workforce funding opportunities are to support midwifery, in particular. So what this all distilled down to is really these areas of recommendations. So these are written in form of, you know, pretty policy wording or anything like that, but just sort of the theme that sort of came through is looking at, are there recommendations we can make surrounding providing funding specifically for FMOB residency or fellowship training?

00:16:02:06 - 00:16:25:01

Jacob Warren

Right now it's kind of hit or miss in how locations are able to either implement an add-on fellowship or incorporate this into their core curriculum in an FM residency. So that's one element

we've discussed. Another is looking at innovative payment models for team-based care. And so really looking at risk-appropriate levels of care and how we can support that through payment models.

00:16:25:01 - 00:16:45:21

Jacob Warren

And are there specific recommendations we need to be making in that area? Some of the discussion that came up here is, you know, for instance, I used to partner in the Healthy Start program that I ran with a local FQHC that had a nurse practitioner that provided initial prenatal care. And then they were transitioned up to another FQHC for longer term OB care.

00:16:45:21 - 00:17:03:12

Jacob Warren

I knew I had to transition them to another FQHC to receive MFM care, and the payment model just did not support that, in any way. Another is looking at ways to mitigate legal liability for providers and hospitals practicing in rural areas that are frequently seeing higher acuity patients later in their presentation. So how were we able to do that?

00:17:03:12 - 00:17:23:13

Jacob Warren

Because that becomes a workforce barrier. If people feel that they're not going be able to practice successfully the area because of liability issues, that's something that we need to be looking at. If we could address then looking at opening codes or ensuring the applicability of codes, billing codes for midwives, doulas and community health workers for MCH care.

00:17:23:15 - 00:17:46:21

Jacob Warren

you know, one example that happened recently, if you work in the CHW space is, you know, Medicare opened up some new codes that allow for community health worker billing under other providers. Those currently aren't open, of course, in all states for Medicaid. So are there things that we need to support in that area that would help with this workforce that we know impacts health inequities in a very positive way?

00:17:46:23 - 00:18:04:23

Jacob Warren

And others looking at training and see opportunities for maintenance of skill providers. How are we training folks at ERs that are in catchment areas that do not have labor and delivery services, but quite often are ended up having to deliver? So how are we making sure that those skills are up, in those. So that was -- I'm sorry.

00:18:04:23 - 00:18:29:19

Jacob Warren

I'm going to talk a lot and then we're all going to talk. That was in the overall workforce component. Those were the recommendations that we looked at. When we looked at regionalization of care, some of the initial thoughts that came up -- we're looking at midwife led birthing centers, using telehealth to support regionalization, how to incentivize those regional partnerships, how to support across systems of care, which we encounter frequently in rural.

00:18:29:19 - 00:18:50:23

Jacob Warren

You're not working all within one health system. So how do we cross those lines? And then a real repeated theme that came up is the issues of bundled payment approaches and how that's

really affecting the way that we can have regionalization. So I'm so glad we have new folks in the room that can speak much more eloquently about regionalization, but those were some of the things that that issues that arose.

00:18:51:00 - 00:19:30:21

Jacob Warren

So these two are the recommendations down here that we've sort of been reducing this down to. So one is looking at recommendations around payment structures. and then another is looking at the potential of enhanced reimbursement, to support regionalization. I'm sure there's more there. But that's what we sort of came to in those areas. In the third area of rural hospital closures and maternity deserts, you can see we had a lot of preliminary thoughts in this one because there's it's just a huge, huge thing, everywhere, but particularly in rural. One repeating theme, and I mentioned this earlier in the meeting, is this concept of labor and delivery unit stabilization.

00:19:30:21 - 00:19:53:18

Jacob Warren

Not just hospital stabilization, because frequently what happens in hospital stabilization is they close the labor delivery unit and they close the E.R. that's how they stabilize the hospital. So how are we looking at models that can stabilize labor delivery units themselves, not just the hospital overall? We also talked about OB readiness and how we can build that within staff at hospitals that might have low volume.

00:19:53:20 - 00:20:19:03

Jacob Warren

This particularly becomes a factor if, in a positive way, we're able to reinforce and support labor and delivery units with lower volume. Then we have to make sure that we're also

preserving readiness, due to the low volume that that would be supporting in those facilities. A lot of thoughts about how to support hospitals and communities without labor and delivery services, how we can provide support to hospitals that are at risk of losing labor and delivery.

00:20:19:05 - 00:20:37:01

Jacob Warren

We talked about birthing readiness designation. Is there a way to support and enhance that? And then also looking at this is a great idea that we came up with at our, I think, our most recent meeting. There are some models in states where part of that stabilization is by opening up provider sources that typically aren’t open to the public.

00:20:37:01 - 00:21:01:05

Jacob Warren

So for example, in rural frontier areas there might be a military base. Is there a way to partner with the services provided on the military base to continue L and D, or overall prenatal care services and then payment models we could spend 30 years talking about, but, you know, Medicare policy is great. But when we're talking about reaching half of births in the US, we're talking Medicaid, which is state by state.

00:21:01:05 - 00:21:31:22

Jacob Warren

And so what could we potentially recommend about raising some of those minimum standards or creating other type of payment models? One in particular that we've talked about quite a bit is standby payment models as a way to, to stabilize some of those labor and delivery units with lower volume. So the recommendations are kind of distilled down from there are looking at how to incentivize rural hospitals to participate,

and perinatal quality collaboratives, birth and family designation and how to enhance the AIM bundle rollout.

00:21:31:24 - 00:21:52:20

Jacob Warren

Looking at the potential for a critical access labor and delivery hospital designation, that kind of mirrors the enhanced reimbursement that you can get off -- as a critical access hospital. Looking again at standby payment models, looking at how to increase Medicaid payments to rural hospital, labor delivery units. and then you see that some of this already overlaps with systems and workforce.

00:21:52:20 - 00:22:12:00

Jacob Warren

So we're already starting to weave together some of the recommendations. And last one I'll talk about very briefly, because we don't have a lot on this front yet. And that is telehealth, something that we all talk about with rural, something that the history of it originated in rural. But the uptake and maintenance is not as high, unfortunately now in rural.

00:22:12:00 - 00:22:44:23

Jacob Warren

We're seeing a bigger drop off now, as the presenter talked about yesterday. But, you know, looking at OB readiness bill, there were some, there's some discussion of how do you telehealth receive MFM services, and then how to in particular expand access to maternal mental health and rural by utilizing telehealth methods. So the recommendation there, you can see we have the very technically worded something related to -- so we'll hopefully come back to that sort of going back to the report out and say, yeah, something related to mental health.

00:22:45:00 - 00:23:06:05

Jacob Warren

Those are the big domain areas. One other cross-cutting theme is we've, and I apologize, I'm getting on my soapbox. I talk about this all the time, is data. And the issue that we face in trying to even evaluate the impact of these types of programs in rural areas because of the data suppression issues. So, you know, we don't know that we have a specific recommendation.

00:23:06:05 - 00:23:23:18

Jacob Warren

And Kate and I talked a little bit about we might want to partner with the other working groups because we all seem to be having data consideration. So we might have more of an omnibus data recommendation that would cut across all of the themes that the working groups are working on right now. Okay, that's way more than I'd like to talk.

00:23:23:18 - 00:23:44:13

Jacob Warren

So, I'm gonna stop there, but for those that have been a part of the discussions, did those kind of thematic recommendations seem to hit on what you've been discussing? Have we missed anything? You know, really want to look for some feedback on that as we try to distill some things out to present later today.

00:23:44:15 - 00:24:09:22

Kate Menard

I welcome you all to put up your hand on the screen or electronically or whatever works. We're eager to hear from everyone. I mean, let me just make -- if I might, may just, a couple of other observations that Jacob mentioned this

overarching thing about data. I mentioned this to Belinda at lunchtime, that this was at this cross -- and it seemed to be cross-cutting all three of the priority areas that we've, that the committee has focused on.

00:24:09:22 - 00:24:35:08

Kate Menard

And she was really supportive of having a cross-cutting kind of approach to that. True also for the workforce issues. But I mean, I think it's the special needs of the rural area I think is something we should still, you know, develop really well. But, that's the other thing. She -- it was, it was a theme in all, you know, in all three of the presentations that all the three of the folks here, that we've learned more about today.

00:24:35:10 - 00:25:04:20

Kate Menard

So, the other thing that Jacob tipped to, but when we when we have these four areas and he and I started talking about the four areas, there was very natural overlaps of what goes in what bucket. It's not really, there are -- and maybe there's going to be themes that are overlapping that. Our recommendations on, for example, most of you know, one of my strong areas of interest is in regionalization of maternal care.

00:25:04:20 - 00:25:30:15

Kate Menard

Early part, I learned a lot and worked a lot in the area of neonatal care. Maternal care is part of that. And we can really improve both quality improvement through PQCs and through -- in regional systems. If there's quatinary care centers and tertiary care centers support these rural hospitals. Right. So implementation of PQCs, I think, fell in the bucket on, hospital closures that supports them, right?

00:25:30:15 - 00:25:56:07

Kate Menard

But it also falls in the bucket of training, right? And so it, of the workforce. So these things are -- they're not discrete, I guess is the point here. But feel welcome to put them anywhere and then we'll figure out, you know, how we end up talking about it down the road.

00:25:56:09 - 00:26:00:20

Kristen Zycherman

Marilyn, you have your hand up first, and then Scott and then Charlotte.

00:26:00:22 - 00:26:27:01

Marilyn Kacica

I think that's very comprehensive and a lot of great ideas and a lot of things that we talk about. I want to caution, too, though. I run the Perinatal Quality Collaborative. It's a great model for improving care. However, these hospitals on the verge of closure that are so small are some of the toughest ones to reach because they just don't have the resources or staff in order to participate.

00:26:27:03 - 00:26:40:01

Marilyn Kacica

So you can recommend it. But, whether they can do it without funding or extra help, it's just a wish.

00:26:40:03 - 00:26:50:17

Jacob Warren

Thank you for bringing that up. I think I failed to mention I was doing the quick pass through. Part of that was, how do we make it where they have that bandwidth? Because it's easy to say implement all these bundles, just take it on unfunded mandate.

00:26:50:17 - 00:26:56:16

Jacob Warren

So thank you for bringing that up, it’s very important.

00:26:56:18 - 00:27:01:22

Scott Lorch

I guess I’m next. How do you want to do this? And I'm coming in in the middle.

00:27:01:22 - 00:27:15:07

Kate Menard

You know what, Scott? Let's take a minute or a few minutes and hear about your work and, and, you know, kind of the depth of your thinking on this area so far. We can take some time to do that now.

00:27:15:09 - 00:28:00:13

Scott Lorch

Okay. as a background, I probably have four hour long talks on topics that relate to these areas. I think when I think of this question, I think it's almost like three, three phases of patients and issues and then both workforce and hospitals kind of intersecting along those lines. There is obviously the interconception pre-, peri-, antipartum and constantly postpartum aspect of care because we do see areas that just that can support that but don't have a local delivery partner to work there.

00:28:00:13 - 00:28:25:04

Scott Lorch

That's obviously gone down in, in numbers and sizes over time. But there is that kind of workforce piece. There is the delivery of the patient, which we have data for, suggesting one that risk appropriate care for rural patients is horrible and does not usually get done in a in both either a timely or efficient pattern.

00:28:25:06 - 00:29:00:07

Scott Lorch

And there's a growing body of work that suggests that you have really two sets of hospitals that are delivering these patients, the local community-based community, hospitals located, localized in a rural community. But there's also a larger subset of urban hospitals that have a large rural component to their delivery services. and it's unclear whether they have the appropriate resources to support those patients who are traveling moderate to long distances to, for their care.

00:29:00:09 - 00:29:40:13

Scott Lorch

And then we have the newborn side, which is kind of a different piece to the puzzle. And when we think about delivery services, I think it's really important to have not only who's taking care of the pregnant patient, but you also have the skill set -- have to have the skill set of handling the newborn after they've delivered, which in many cases is trying to assess who's got the requisite skills to resuscitate in that kind of golden hour after delivery of the patient, when it may happen one time of year, and what resources that you need to have in place to when those unexpected, particularly if you've done an appropriate, risk-appropriate triaging of patients.

00:29:40:16 - 00:30:15:05

Scott Lorch

But they still, childbirth is not a benign 100%, low-risk procedure and either for mom or for baby. And so having the having the resources for to handle emergencies is really important on both sides, whether that's L&Ds, emergency rooms, etc.. So I think we can probably add in some recommendations as it goes.

00:30:15:07 - 00:30:38:11

Scott Lorch

One I think separate piece is the funding, which is, I think, a very important piece. I mean, we've shown in our work that, as people have said, the first thing to go when a hospital is in some financial difficulties is typically maternity services. That's one of the lowest hanging groups to go. Second is pediatric care.

00:30:38:13 - 00:31:09:07

Scott Lorch

And we have seen kind of an uptick in selective obstetric unit closures within larger hospitals that have remained open. Whereas about 15 years ago, OB closures typically happen in conjunction with closures of hospitals. And that's both urban and rural communities. I think the final piece is really thinking about the finances that's been mentioned before.

00:31:09:09 - 00:31:40:00

Scott Lorch

Many of these hospitals are not wealthy from a resource perspective. and they too suffer from the challenges of the way that obstetric care is funded in the U.S, which is where most people get paid based on delivering the baby, which can lead to some untoward conflicts in terms of when you transfer patients

and who do you keep in, etc.. So maybe some creative ways to think about funding mechanisms.

00:31:40:02 - 00:32:07:15

Scott Lorch

But I do think that if we're going to ask people to have more resources, there needs to be an understanding that they -- we can't have an unfunded mandate because people are just going to close, and that's just what's going to happen with that. So I think all of those pieces kind of have to be thought through. And then the telehealth kind of, with Covid kind of rising up and in a potential option, I would go much further than what you guys have done.

00:32:07:17 - 00:32:44:13

Scott Lorch

There may be much more opportunities to have more formalized recommendations for methods to support both delivery when there's unexpected complications during the delivery, as well as unexpected complications during the -- for the newborn. and there's examples in particularly Canada where most of the delivery services are near the U.S. border, but they are maintaining care for patients that may be five, six, 700 miles away.

00:32:44:19 - 00:33:12:24

Scott Lorch

And how they're usually utilizing telehealth services to, augment care for those patients while they're trying to get out to benefit from the newborn side. but also from the maternal side. Very, I'm sorry, scattered amount of stuff. But I think as we can kind of think through, there's probably some ways to kind of things that we kind of our experts on in terms of thinking about where we could add to some of the recommendations

00:33:13:01 - 00:33:23:08
Scott Lorch
from my group and with folks within my research group.

00:33:23:10 - 00:33:25:11
Kate Menard
Yeah. Charlen?

00:33:25:13 - 00:33:29:20
Kristen Zycherman
Charlen, did you want to add -- you had had your hand up.

00:33:29:22 - 00:33:32:20
Charlan Kroelinger
Well, it's hard to follow Scott.

00:33:32:22 - 00:33:36:01
Scott Lorch
Not true. Charlan. Not true.

00:33:36:03 - 00:33:56:22
Charlan Kroelinger
That was a great. And actually I just wanted to follow up on one of the points that Jacob made and his great mapping display, and that is, there was a question about needing more detail about the work on perinatal regionalization, risk-appropriate care from CDC side.

00:33:56:22 - 00:34:11:22

Charlan Kroelinger

So I wanted to follow up on that to ensure that there weren't any missing pieces in that particular bucket, because we do have, Angie Rowan on the call who can provide some more of those details?

00:34:11:24 - 00:34:33:05

Kate Menard

I'll say, I think of the topics that we've worked on just to the -- I think we've had presentations and gotten depth of learning, you know, on the closures and you know, the workforce piece, but we really haven't had the in our workgroup, you know, haven't spent as much time or much time at all, really on the regionalization piece and on telehealth.

00:34:33:05 - 00:34:54:09

Kate Menard

So these are going to be things we'll talk about in the subsequent segment. So Angie would love for you to speak up today and give your perspective. If you feel comfortable, we can also have an opportunity to give a really chunk of time in the next couple of meetings that we have, to enhance this and give, you know, Scott time to think about it and bring those things forward as well.

00:34:54:11 - 00:35:16:21

Kate Menard

And we'll, we actually have a speaker in mind to talk about telehealth for maternal fetal medicine, a telehealth provider who actually gets into the delivery room with during obstetric emergencies. And does that work? I imagine that that maybe,

Scott, what you're talking about for neonatal. Well, my you know, doing it for neonatology would might be a, you know, something we could think about for a future session.

00:35:16:23 - 00:35:52:07

Scott Lorch

It's easier, I think, to conceptualize it from the neonatal side because you know that some high-risk delivery is actually happening in a not risk-appropriate, setting. and for those that are clinicians, these would be situations where the baby either unexpectedly, yeah, is not transitioning from being in the womb to breathing here. And many times that requires a fair amount of interventions to just get them over the hump, so to speak.

00:35:52:07 - 00:36:14:19

Scott Lorch

And there's, and there's some interest. We just don't have the data yet on kind of even understanding who's trained in many of these, in these hospitals, which, unlike an urban area where it's a setting where there may be hundreds of people who have the requisite training, in many smaller hospitals, particularly rural serving hospitals,

00:36:14:21 - 00:36:42:18

Scott Lorch

There may be two or three -- so I have a mentee working with the AP now to try to understand what the scope of training in, in neonatal resuscitation is across these hospitals. But, I mean, I think you're exactly right that there's ways to kind of try to overcome those. It's just, it does take some work, funding and policies to kind of support that.

00:36:42:20 - 00:37:14:19

Scott Lorch

OB, it may be a little more difficult, but I think we can do it, but it may be a little more difficult. Because the as many of the folks on the call better serve than I am, things can happen really quickly in OB that may not be expected.

00:37:14:21 - 00:37:18:08

Kate Menard

He didn't hear me because I don't have my microphone on. Steve, do you want to comment?

00:37:18:10 - 00:37:26:16

Steve Calvin

No, I'm just -- I'm grateful for Scott and for Charlan and everybody else, everybody else in this work group. I mean, the main thing is really --

00:37:26:19 - 00:37:28:21

Kate Menard

We're not able to hear you, Steve, right now.

00:37:28:23 - 00:37:31:01

Steve Calvin

Can you hear me okay?

00:37:31:03 - 00:37:32:04

Jacob Warren

Oh, we can hear online.

00:37:32:06 - 00:37:33:10

Scott Lorch

We can hear online.

00:37:33:12 - 00:37:37:23

Kate Menard

Okay. Carrie's in the room. Thank you. I can see you. I mean, that's okay.

00:37:38:00 - 00:37:58:08

Carey Zhuang

Hi. Can everybody hear me? Yes. Great. Thanks. Okay, so, I know we were just talking about some of the training, and also, I think, you know, yesterday we had a side conversation about some of the, like, telehealth elements that, we're seeing, our, RMOM's awardees pilot right now.

00:37:58:10 - 00:38:18:19

Carey Zhuang

I can speak to those initiatives pretty broadly. And just like what I've been seeing this year, doing, some site visits. So I think I could start a little bit with going towards, like the emergent sort of, you know, OB services. One of my awardees, I don't know if folks are familiar with Avira Health Systems.

00:38:18:21 - 00:38:46:12

Carey Zhuang

They have a critical access hospital that has a really interesting model where they have an e-NICU. So they have, like, they were able to get a bunch of grants and funds, and it doesn't necessarily have to be grant funding, but they were able to kind of piece together funding in a way to fund, really, you

know, advanced cameras that they can link even to their emergency department and their labor and delivery department.

00:38:46:12 - 00:39:16:02

Carey Zhuang

So that way they can still offer labor delivery services at this small 25 bed critical access hospital in, like Parkside in, South Dakota, which is very rural. And they were demonstrating like how that works. And essentially like any emergency physician can just kind of beam into, like, press a button and there's, at least an emergency physician on the other side, as well as, like, tele-MFN that's been working out pretty well.

00:39:16:04 - 00:39:40:11

Carey Zhuang

And so, you know, that I think kind of goes towards like that second bullet in the telehealth, recommendations that we're talking about. And I think, you know, they've been mentioning how that's been working out really well for them. as a part of their larger RMOMs work, they are also trying to implement a OB hub, but they've been having a lot of the workforce issues.

00:39:40:11 - 00:40:10:17

Carey Zhuang

So kind of going back to that first issue of like trying to get nurses trying to hire, to staff that, that's been kind of an issue. But eventually they hope to be able to have that so that there's 24/7 access to some OB, you know, services or OB like knowledge, so to speak. And then last but not least, going towards the remote patient monitoring, they are seeing some early success, in their ability to implement that for hypertension control with their patients.

00:40:10:19 - 00:40:36:06

Carey Zhuang

And one thing I thought that was kind of unique was that they were using a sort of almost like a text app called Volt to be able to message each other rather than like sitting at a computer doing like the EHR messaging among providers. And that seemed to be, you know, really effective in their ability to communicate, you know, quickly to resolve some of these issues.

00:40:36:08 - 00:40:58:24

Carey Zhuang

Some of our RMOM's awardees are piloting, you know, doing tele-, like mental health or, and behavioral health, but it's a little early at this point in terms of, like, being able to have results. And we hope to be able to share something more substantial later on. I hope that was helpful to some degree.

00:40:59:01 - 00:41:11:12

Carey Zhuang

I apologize if it does sound rambly, but I just wanted to share, you know, some of the things that we're seeing right now at this point. Thank you.

00:41:11:14 - 00:41:14:13

Jacob Warren

Great. Thank you so much. Steve. Do you want to --

00:41:14:15 - 00:41:37:04

Steve Calvin

Oh, sure. Yeah. So I was just going to say too, that I mean, I -- it is a balancing of especially the telehealth, telemedicine stuff too. I think that my pediatric neonatal colleagues would say, you know, let's be careful about trying to facilitate or

encourage people hanging on to babies that they really shouldn't be hanging on to because there's that's very real.

00:41:37:04 - 00:42:00:14

Steve Calvin

But obviously, there are also times someone's evaluating a newborn and saying, I don't know if this is concerning, but if they had an immediate consultation by telehealth, they could say, you need to transfer this baby, or you could pay watch overnight and see what happens. So and I go back to and we did have a presentation by Harold Miller from the center for Health Care Quality and Payment Reform.

00:42:00:14 - 00:42:38:24

Steve Calvin

And, you know, he used the terminology, standby capacity payments because we can have all kinds of pilot programs and grants and try and -- but what I think every community is going to try to we need broad kind of a broad framework, but every community is going to have their own unique things. And if we can just guarantee based on I mean, maybe Charlan and the CDC folks can say in these various areas based on the number of reproductive age women, we will know that this is how much you should be paying to provide the standby capacity so that these hospitals aren't stuck with, you know, just low reimbursement and they have to close.

00:42:38:24 - 00:43:14:01

Steve Calvin

And then the last thing I would turn to is just that, the workforce issue. You know, obviously, I'm a huge fan of midwifery and, but then working with family medicine physicians just within the last week, had conversations down in Arizona. they've got, they're trying to develop in Arizona, the first family medicine, obstetrical fellowship or even in a family

medicine residency, being able to do maybe 50, probably ideal is 100 Cesarean sections to be able to be part of a team.

00:43:14:03 - 00:43:34:02

Steve Calvin

One of the hospitals in Arizona I've shown up in the White Mountains is losing. They had five OB doctors. It went down to three. Now it's down to two and one of them is leaving. And so -- and that's a pretty good sized hospital. And it serves the Indian Health Service Hospital up in that area as well. So we have to figure out ways to provide the care.

00:43:34:02 - 00:43:59:19

Steve Calvin

And it's going to involve incentives by having the hospitals have the financial capacity to do that. So it's going to be obstetricians. It's going to be family medicine doctors, obstetrically trained. It's going to be midwives. So anyway, I'm just excited, just seeing what we have on the page right here is, it's the pathway forward.

00:43:59:21 - 00:44:05:20

Kristen Zycherman

Divine. If you're able, we would love to hear more from your perspective.

00:44:05:22 - 00:44:27:22

Divine Baley-Nicholas

Yes. So a few things that we're just, we're seeing here, just to give you an idea about, the landscape of Opelousas Louisiana, where in Saint Landry Parish, which is about three hours west of New Orleans. If anybody's from -- if you're familiar with the

Louisiana, we're about 30 minutes outside of Lafayette, Louisiana.

00:44:27:24 - 00:45:03:13

Divine Baley-Nicholas

We have one hospital. That hospital does not have a NICU. You -- what we have noticed, quite a few years ago, I want to say almost, ten years ago, Opelousas General Hospital became baby friendly, and I was a community liaison during that time. Initially, we had a lot of pushback, from some of the staff there with all the things that went on with that gift, you know, initiative to, you know, the checks that needed to be the boxes that needed to be checked so we could be baby friendly.

00:45:03:13 - 00:45:27:18

Divine Baley-Nicholas

But initially -- but after we did become baby friendly, at this time, we're the only hospital in this area. Meaning that even the hospital that's in Lafayette, Lafayette has more than one hospital. We're the only one that is still baby friendly, and that's become part of their, like, marketing, for families like, hey, we're baby friendly.

00:45:27:21 - 00:45:58:06

Divine Baley-Nicholas

So when I saw on there, or the actual mapping, talking about incentives for rural hospitals and participating in the PQCs or being birthing friendly because that was one of our critiques was that it was a baby friendly initiative. But how can that be baby friendly i they're also not birthing family friendly or, friendly for, you know, moms and their families that are coming up there, to welcome that said baby.

00:45:58:08 - 00:46:31:19

Divine Baley-Nicholas

And so we have seen that it had -- it can be one of those bragging rights for hospitals to say, hey, we have this initiative, we have this, type of, incentive to say this is what we're doing in the hospital. That being said, I think that it has to continually have this community component where they're reaching out to the community to say, how is this working for us?

00:46:31:19 - 00:47:01:03

Divine Baley-Nicholas

You know, are we seeing a benefit? You know, I know you all talk a lot about data. But kind of that boots on the ground, voice from the community saying, like, okay, these hospitals, I said, they're part of X, Y, and Z, but are we, are we feeling it, you know, directly as community members. So, another thing I did see on the -- I don't know if you all have already talked about it when you're talking about midwives.

00:47:01:05 - 00:47:31:17

Divine Baley-Nicholas

We know that across the United States, just as different medications cover different things and different states. We know that different states have different types of midwives that take that into account, if you haven't already. You know, certified nursing wives, you know, certified professional midwives, our community midwives that work at birth centers and home births in different states have different states allow certain just scopes of practice, via this state board.

00:47:31:19 - 00:48:00:18

Divine Baley-Nicholas

For instance, the Louisiana State Medical Board does set out, you know, scope of practices for certified professional

midwives. And how are we making sure that we're including them also into the process of helping these rural communities, because you have these gaps of areas where, you know, especially if the mother may be low-risk, that that may be a way in which midwives can do some type of prenatal care with them before they are transferred to a higher level of care, like an OB and MFM and things of that sort.

00:48:00:18 - 00:48:08:24

Divine Baley-Nicholas

So, and I'll stop there because I'm still kind of listening of what you all have, you know, done thus far. So.

00:48:09:01 - 00:48:16:03

Jacob Warren

Thank you so much.

00:48:16:05 - 00:48:20:22

Kate Menard

Jacob, I see Scott has his hand up. Scott, did you want to comment?

00:48:20:24 - 00:48:42:08

Scott Lorch

I'm sorry, I hit the wrong button to unmute myself. We think I know after 15 -- Divine, can I ask you a question? And this is one that we -- those that think about structuring systems kind of ponder one thing that we don't know in the literature are two questions.

00:48:42:10 - 00:49:13:03

Scott Lorch

One is how far? What's the trade-off between traveling and the improvement in outcomes people get from going from like a local hospital to a hospital with a lot more services? And at least in Philadelphia, which is a very different kind of center -- we're not talking about rural communities because to get rural communities you've got to get like four hours away from here, but there's a lot of them.

00:49:13:05 - 00:49:44:01

Scott Lorch

There is a tension with people even here saying, I want to keep my local hospital open and then when faced with the evidence of, you don't have lactation support, you don't have this type of supports, you don't have these type of services. And really struggling with this aspect. There's almost like a community badge that says we can deliver patients.

00:49:44:01 - 00:49:55:21

Scott Lorch

So we like to have a hospital that does that. Is there some feedback you can give from a -- from your perspective or from the folks that you work with on that kind of question?

00:49:55:23 - 00:49:59:14

Divine Baley-Nicholas

So if I'm understanding correctly,

00:49:59:18 - 00:50:01:01

Scott Lorch

I didn't ask the question well, so I apologize.

00:50:01:01 - 00:50:10:18

Divine Baley-Nicholas

Well, that's okay. What we're seeing is as far as from the community, they may say it, like I said, the nearest city is Lafayette.

00:50:10:20 - 00:50:36:05

Divine Baley-Nicholas

I rather go to one of those bigger hospitals because, my babies come early and they have a NICU, you know, because all we have here is a nursery. So you may have moms that know straight up. I rather go to the bigger city hospital because they're going to have to transfer me anyway. Okay. You do hear people say and look around like, oh, wait, they allow my baby to remain with me.

00:50:36:05 - 00:50:55:03

Divine Baley-Nicholas

So I want to go to a place where I allows rooming in. And so we are noticing that mothers and families are becoming more educated about what they want and are seeking hospitals that have it. And then a lot of times it's a really a default thing. My OB delivers at this hospital. So that's where I go.

00:50:55:03 - 00:51:06:07

Divine Baley-Nicholas

And you see a lot of that as far as what our younger mothers and younger families who are birthing for. That's where my doctor said they deliver so that that's where I'm going to go.

00:51:06:09 - 00:51:17:22

Scott Lorch

Thank you. It's just it's a big tension between some of our work, which is finding that there is kind of a volume outcome association in OB care more and more.

00:51:17:22 - 00:51:48:23

Scott Lorch

We're starting to see this. But where that balances between as your point where people want -- where people can or, accessing care is very challenging. It's not it's less difficult in a large urban area where it's a difference of five minutes driving time for, for example, even though it is difficult, I think there... and it is a just -- I think that's the struggle between regionalization or how does regionalized care get operationalize on a perinatal system?

00:51:49:00 - 00:52:22:19

Scott Lorch

And what resources one has access to in a relatively fast fashion. And what's fast, I don't have the answer for I don't think we have it in the literature, but it's just a tension I think we see. And it's a greater tension in some of the states represented here, Wyoming, which is a whole all unique perinatal system, for example, versus, you know, on the East Coast where you drive five minutes to get to another hospital that's delivering a patient.

00:52:22:21 - 00:52:36:22

Scott Lorch

And rural communities are closer to large urban areas than they are in many of the western areas of the US.

00:52:36:24 - 00:52:47:18

Kate Menard

All important. I'm checking the clock now, folks, and I think we probably need to if you allow me, we need to pivot to actually kind of some language for recommendations.

00:52:47:18 - 00:53:09:07

Kate Menard

Now, if you'd like to drop thoughts in the chat, we'll capture those. Okay. For things that come up, feel free to put those thoughts in there. But, Jacob, do you want to kind of take us through how we would go about, you know, just some overarching language for recommendations -- to we've got topics here without language.

00:53:09:09 - 00:53:35:06

Jacob Warren

My controls went away, I couldn't get them back. One thing I do want to mention, just really quickly is, you know, the origin of these three working groups related back to the overall Committee's desire to make recommendations very, very specific in addressing maternal mortality in black and African American populations. So not that everything we recommend needs to reflect that, because some things will address all.

00:53:35:06 - 00:53:58:12

Jacob Warren

But one of the criteria we'll talk about in a minute is what -- how we're ensuring we're addressing equity. So this was something that, you know, we can thank Ashley Hirai and everyone, HRSA, CDC who said that that helped get us the data for this. When we look at where rural Black mothers are giving birth, that's where this map comes out.

00:53:58:12 - 00:54:17:12

Jacob Warren

It's not surprising. It maps very closely to the overall distribution. but I can't remember the exact numbers. But it's something like if you just put Mississippi, Georgia, North Carolina together, it's about half of the rural Black births. So as we think about some of our recommendations, you know, we do think about this specific region that's being impacted the most.

00:54:17:12 - 00:54:54:03

Jacob Warren

And these white x's represent non-expansion states. So one factor we need to be thinking about in our recommendations is that the states that are the hardest hit for the most part are non-expansion states. So that might need to factor into some of the recommendations we're even thinking of. Because if we're talking about interconception care and what happens in these areas where women don't have, access to care across the continuum, and in some states that are even have postpartum after, you know, the 90-day standard period, so just wanted to frame that a little bit as we talk language.

00:54:54:03 - 00:55:30:03

Jacob Warren

So again, these are super draft. But, you know, Belinda has asked us to come back with some type of recommendation schema. So let me share this document again. Okay. So some of these interconnect. You know, I don't if we want to take it at least one by area to start with. To figure out some type of, of starting place.

00:55:30:05 - 00:55:43:00

Jacob Warren

I've heard a lot about, even today with -- I'm trying to highlight some things -- so payment structures.

00:55:43:02 - 00:55:53:02

Jacob Warren

Seems to be something that we continually resonate with.

00:55:53:04 - 00:56:16:20

Jacob Warren

And then, you know, I feel like one thing I noticed in looking back over this, I don't feel like we're capturing all the stuff we had about midwifery, just that we see that is really a crucial element of addressing access to care. So I don't know if there's something in general with midwifery.

00:56:16:22 - 00:56:40:19

Jacob Warren

Midwifery recommendation, a payment structure recommendation. Heard again about the -- we have all these designations, but how do we actually support rural hospitals in attaining and maintaining them. And then, heard energy around this today as well.

00:56:40:21 - 00:56:44:19

Jacob Warren

Yeah. I can get things highlighted.

00:56:44:21 - 00:56:46:21

Jacob Warren

So Steve.

00:56:46:23 - 00:57:06:17

Steve Calvin

Yeah, I was just going to say I mean, you know, we do have, you know, Karen Jefferson and Jennifer Vanderlaan and, you know, Jackie Wallace to us, a physician colleague with a lot of expertise about about midwifery and how it would work. I think we do need to be much more specific. And I think the biggest barrier is it's a state-by-state thing.

00:57:06:19 - 00:57:29:19

Steve Calvin

And some states, unfortunately, many red states, have like 1% of births attended by midwives and other states, not all blue states, but many of them. It's like 35 to 40% attended by midwives. We have to get past that. And that that does need to come from a national level. I mean, I keep hearing physician colleagues say, well, midwives, they're physician extenders.

00:57:29:19 - 00:57:51:18

Steve Calvin

And I just respond by, well, we as physicians are midwife extenders and it's a team. And so, we have we really have to work on that, I don't know, I mean, I'm sure that our midwife colleagues here on the, in the group can maybe come up with some language of saying, here's how we need to lay this out.

00:57:51:20 - 00:57:53:04

Jacob Warren

Jennifer.

00:57:53:06 - 00:58:19:09

Jennifer Vanderlaan

Thank you. Steve, I am happy to work with language, with somebody offline so we don't take up meeting time with it. But one thing I wanted to point out is that here in Nevada, we've started counting the births that midwives log, and we found that the national statistics report fewer births attended by midwives than a single one of our midwifery groups did last year.

00:58:19:11 - 00:58:55:09

Jennifer Vanderlaan

So we are so undercounting midwives in Nevada. And our assumption is it is because it is the hospital policies that do not allow the midwives to admit the patient under their own names. So the hospital clerks default to the admitting physician as putting, responsible for the births. I should have numbers probably by the end of the year to be able to tell you how much it is undercounted, but I bring it up because I am starting to doubt that we have states where there's only 1% of births attended by midwives.

00:58:55:11 - 00:58:56:23

Jacob Warren

Marilyn.

00:58:57:00 - 00:59:28:19

Marilyn Kacica

No, the other nuance to that is that, depending on the data source, sometimes the national data sources will only include certified nurse midwives. We found that out in something that we're doing with our maternal mortality. And so you will have a population that's not a nurse, but as a midwife, who are doing deliveries, but they're not going to be captured because they're not in their database either.

00:59:28:21 - 00:59:51:15

Kate Menard

You know what, Jacob? I'm realizing it's almost 2:30, and I'm and I'm thinking that we need, you know, we need to put some -- we've got a lot of material here, obviously, and recommendations here already, I think to actually kind of wordsmith this. We're not going to get that done today. But we can -- one thought would be to take these three foci areas and frame advance the workforce to you know, enhance diversity.

00:59:51:15 - 01:00:16:04

Kate Menard

And you know the -- you know the about that for each of these four topics, you know, advance our system for regionalized care for both moms and babies. That includes, you know, the elements that exist in the level of maternal care and the levels of neonatal care guidelines that, where quatinary and tertiary care centers support rural hospitals, small hospitals in their region.

01:00:16:06 - 01:00:59:17

Kate Menard

The other one, you know, mitigate hospital closures through -- rural hospital closures through policy advancement in payment structure. Attending to critical access, labor delivery hospitals, that's one thing. And then we can provide more detail later, you know, and then, and one overarching recommendation that crosses all of these things, when I learn more about as I learn more about these things, it's sadly apparent to me that in policymaking, often the women's health aspects and neonatal all aspects, maternal child health aspects of these issues don't come through, as strong as they could.

01:00:59:17 - 01:01:17:23

Kate Menard

So, for example, you brought forward critical access hospitals. They have to have an emergency room, but they don't have to have an L&D unit. Right. They -- and that emergency room is not required to be, you know, to have OB readiness training and all the things that might be necessary to take good care of moms and newborns.

01:01:18:00 - 01:01:40:03

Kate Menard

But there are examples throughout here where the maternal health workforce of the neonatal health workforce hasn't been -- I did some math yesterday when they offered a beautiful presentation yesterday morning about workforce development, and I just did math on the clinicians they had and those that were OB care providers. And it was like 3% if I was if I was getting the math right.

01:01:40:05 - 01:02:13:02

Kate Menard

So there's opportunity really to kind of elevate, elevate maternity care and neonatal care in all the policies it seems to me. But so am I. That's just for sake of time. I wonder if we want to just put if we want to put forward the four, if everyone is still on board with these four foci and then we can work, you know, in-between meetings with language about and propose language about the, you know, specific recommendations.

01:02:13:02 - 01:02:25:06

Kate Menard

I'm imagining we'll have broad recommendations with some subgroup description, you know, that will include a lot of this is kind of the guidance I've gotten so far from Belinda.

01:02:25:08 - 01:02:28:21

Kate Menard

Thoughts?

01:02:28:23 - 01:02:40:18

Jacob Warren

I'm just trying to think about, kind of an omnibus kind of goal, maybe wording that we have within each of those so we can share that out.

01:02:40:20 - 01:03:15:03

Jennifer Vanderlaan

Jacob, for the midwifery piece, I think the language you're looking for is that states should authorize midwives to work to the top of their training or to the full extent of their training, I think is the language we're seeing recently.

01:03:15:05 - 01:03:26:14

Jacob Warren

Okay. Also...

01:03:26:16 - 01:03:30:13

Jacob Warren

Practice and bill. Maybe I'll try and put that in there as well.

01:03:30:15 - 01:03:50:23

Kristen Zycherman

I just want to navigate you to the chat as well. There's lots going on there, and Charlan just suggested a new, yeah, a new ACOG identification and management of obstetric emergencies in non-obstetric settings, resources.

01:03:51:00 - 01:04:14:21

Jacob Warren

That toolkit, is actually in the resource folder that that Sarah showed you earlier today. So you'll be able to look for it there. I put that in there today. Thanks, Charlan. But you know it's great to have that resource. Implementing that is a whole different thing. And what policy lever is there to ensure that that sort of work is, is, is implemented?

01:04:14:23 - 01:04:40:12

Kate Menard

I think that's kind of where we need to take this. So, you know, I mean, even thinking about the levers we have to pull, that we should probably spend the last ten minutes or so of our conversation thinking about which is going to end in about 14 minutes about our criteria. And Jacob and I talked about, you know, kind of highlighting what are the levers that that can be pulled to implement, you know, to, to, to effect change.

01:04:40:14 - 01:04:50:06

Kate Menard

In the context of, you know, the recommendations that we can make. Jacob, are you comfortable transitioning to that question now or?

01:04:50:08 - 01:04:52:19

Jacob Warren

Absolutely. I'm going to be working on some wordsmithing while we talk.

01:04:52:21 - 01:05:14:01

Kate Menard

Okay. Thanks so much. He's the best. He's the best. He's the best co-chair you're going ever have. Okay, so the next, the next thing that I, that I mentioned that we wanted to talk a little bit about was, you know, what are going to be the criteria for, you know, of the recommendations that we'll articulate much more clearly than we've done today.

01:05:14:07 - 01:05:33:18

Kate Menard

But what, what what's going to weigh into our decision as to what we decide to move forward? I, kind of, you know, out of our head, you know, I Jacob and I thought, well, is it novel? If it's done -- it's been done years and years and years and, you know, and we just say, do it again.

01:05:33:18 - 01:05:51:11

Kate Menard

That's not going to -- that's not going to change. It's already underway, right? People are doing it. So we want it to be novel. This is -- these are out of our heads. And we want what's in your head as well. The other would be, you know, he speaks of, you know, potential for positive disruption, you know, change.

01:05:51:13 - 01:06:14:23

Kate Menard

You know, what's working now isn't getting us where we want to go. So what's disruptive, what can make change. And receptivity, you know, if it just won't be, won't be received because of forces that are beyond our control, maybe that's not where we want to spend our capital, potential to enhance, you know, the potential to enhance, the health of Black and African American mothers is our charge.

01:06:15:03 - 01:06:32:17

Kate Menard

So we need to keep that -- mothers and infants as our charge. So we need to keep that in mind. And finally, the other thought we had, is this actionable? So we were thinking about the levers of change. One is CMS's payment strategies. Right? Another, there's going to be a number of different levers that one can pull in policy.

01:06:32:19 - 01:06:45:11

Kate Menard

And what are those levers and keep those in mind in our -- so that's kind of what we came up with. But I'm not showing that to you in print. That might have been in the chat. It's in the chat.

01:06:45:16 - 01:06:48:21

Sarah Meyerholz

I just put it in the chat. And would you mind if I just add something quickly?

01:06:48:21 - 01:07:13:01

Sarah Meyerholz

Okay, okay. Just from the federal perspective, as the person who is trying to track these recommendations, the best that we can write them in a way that that it is easier to track, because that's what I'm finding in previous recommendations is, some of them are so nebulous. They're great, but they're very hard to track.

01:07:13:01 - 01:07:23:02

Sarah Meyerholz

And I think that's a big piece that we want to move forward is accountability to you and accountability to the public on these recommendations.

01:07:23:04 - 01:07:40:12

Kate Menard

That's one thing. One thing I loved about that SAMHSA recommendation, how she went through the tracking process. I was impressed by that. So it's in the list, in the chat. Other thoughts on, you know, when we're deciding what to move forward, what we should be thinking about.

01:07:40:14 - 01:07:45:00

Scott Lorch

Divine. You might, have -- please if you have insight please speak right up. Don't wait for us okay.

01:07:45:00 - 01:07:58:09

Scott Lorch

Kate, can I ask a clarifying point from Sarah? Should we list deliverables or specific, outcome measures that should be tracked trackable in these recommendations, then?

01:07:59:22 - 01:08:04:07

Sarah Meyerholz

I am not allowed to direct you.

01:08:04:09 - 01:08:06:11

Scott Lorch

Okay.

01:08:06:15 - 01:08:09:16

Scott Lorch

Okay, but that answered my question. Thank you very much.

01:08:09:18 - 01:08:16:08

Kate Menard

There you go. Charlan.

01:08:16:10 - 01:08:34:04

Charlan Kroelinger

Thanks. Just wanted to make a point that, Sarah, isn't it true that these recommendations go to the Secretary of the Department of Health and Human Services? So recommendations should be relevant to the work that the Secretary oversees?

01:08:34:06 - 01:08:36:22

Sarah Meyerholz

Yes. That's correct.

01:08:36:24 - 01:08:44:02

Kate Menard

Which is quite broad. Right, Charlan? And it's quite broad, what he oversees.

01:08:44:04 - 01:08:58:20

Charlan Kroelinger

That's right. Kate, I just wanted to make sure that that especially the new members have had that understanding as well

that this -- these recommendations are for the Secretary and all of the programmatic work that falls under the Secretary's purview.

01:08:58:22 - 01:09:10:20

Kate Menard

Yeah. Thanks for clarifying that. Because when I first came on the Committee, I thought, well, we're talking to MCHB. And that's not that's not the case. We are 'yes, and's, right? Marilyn?

01:09:10:22 - 01:09:26:17

Marilyn Kacica

Yeah. I was just going back to the question is how do you monitor these? Because that's always a very difficult thing to do. And I think that one of the ways that has been done, especially in maternal mortality, is who's the responsible party.

01:09:26:19 - 01:09:45:00

Marilyn Kacica

So you task -- this is the person who most likely can affect change in that area. What will they do by what timeframe? And then you have someone to go back to and say, you know what has happened in this area?

01:09:45:02 - 01:10:06:04

Kate Menard

I'm just wanting to be --thanks for that Marilyn and we'll incorporate that. That's more sort of along the same line of tracking, right? And monitoring, yeah. Those I haven't heard, from anybody else? I'm not going to pick on anybody, but, additional thoughts?

01:10:06:06 - 01:10:13:05

Kate Menard

Welcome Deb -- no, I don't think so?

01:10:13:07 - 01:10:22:03

Deb Kilday

Thank you. I'm listening intensely and taking notes, but apologies. I'm traveling so I didn't jump in, but it's all amazing stuff.

01:10:22:05 - 01:10:30:04

Kate Menard

Well, let's let's just say this is all draft, right? And everybody can noodle on these ideas. We'll make sure these ideas are sent out sort of criteria.

01:10:30:04 - 01:10:51:07

Kate Menard

We may refine that on a future call, but please give it some thought. You know, the things you want to add, things you want to modify. And we'll come back to this at a future meeting. So let's turn our attention for now then, if you allow me, to our future meetings. We'll have a couple of meetings between now and October: July, August, and September.

01:10:51:07 - 01:11:09:00

Kate Menard

And we can bring, you know, we can bring some of the subject matter experts to the conversations as we have in the past, or we can work as a team, one that we have planned that I think is

going to be very exciting and very helpful is, you know, the the gap of we haven't had much telemedicine sort of education presence.

01:11:09:00 - 01:11:26:08

Kate Menard

And honestly, it's in part -- it's pretty new, right? So those of this as a clinician, you know, tried and tried to do it before the pandemic, but man, it happened during the pandemic. So people have learned a ton since then. And there's a lot of new newness there that we can bring forward. as an individual who does --

01:11:26:08 - 01:11:49:03

Kate Menard

that I mentioned, that, was discovered through a couple of avenues. Vanessa was a big help and Sarah, in finding us some resources, but there's, who does a lot of maternal fetal medicine telehealth work, and he's actually kind of, you know, policy savvy. His name is, Dr. Sina Haeri, and he's willing to come and talk to us.

01:11:49:05 - 01:12:14:10

Kate Menard

Kerry mentioned a couple of a couple of programs through RMOMs, you know, that that and she's very familiar with their work. And we could bring them forward to talk about this. And now I heard from Scott that there's potentially a Canadian model for neonatal telehealth, that, that we could learn about. Does that sound like something people want to devote time to?

01:12:14:13 - 01:12:23:14

Kate Menard

As subject matter experts to talk with us?

01:12:23:16 - 01:12:29:05
Kate Menard
May be hard to accomplish all that in an hour. But maybe, but --

01:12:29:07 - 01:12:31:23
Sarah Meyerholz
Scott you’re unmuted. Did you have a comment?

01:12:32:00 - 01:12:46:09
Scott Lorch
Oh, no. Sorry.

1:12:33:00 – 1:12:33:45
Sarah Meyerholtz
With that. Okay.

1:12:34:10
Scott Lorch
I'll just type in. It was in Manitoba that specifically has a program that I know of from Winnipeg, but it was pre-COVID when they talked to me. I’ve no idea what's going on now.

01:12:46:10 - 01:12:50:05
Scott Lorch
Just so you know. I won't put that in the chat.

01:12:50:06 - 01:13:06:22

Kate Menard

Well, if you're all willing, we'll plan on it. But I think, Vanessa, I plan that for July if we wanted to. Let's if you're all okay with this, we'll plan on that for July. The other area that I think we're pretty slim on, at least having heard enough about, is the risk-appropriate care.

01:13:06:24 - 01:13:29:05

Kate Menard

Regional state building systems for risk appropriate care, the regionalization peace building systems for regionalized care. and there's a lot of dimensions to that and how regionalized care can support rural hospitals. Angie, Charlan, you have thoughts on how we can bring that important information forward?

01:13:29:07 - 01:13:52:03

Angie Rohan

Yeah, I can start. We could definitely share some more on our CDC work in the LOCATe assessments and how some examples on how some of our state partners have been able to use that information from the LOCATe assessment to assess what their regionalized system looks like in the state and move on making improvements. So that's one area that comes to mind that at least we could help contribute to.

01:13:52:05 - 01:13:58:04

Angie Rohan

But I'll defer to Charlan for other ideas too.

01:13:58:06 - 01:14:08:00

Charlan Kroelinger

You know, thanks, Angie. I think that would be great. And then I didn't want to put Scott on the spot, but I know Scott has done quite a bit of work in this area as well.

01:14:08:02 - 01:14:18:05

Kate Menard

You all think we could do an hour, a second hour in August with our intern with you -- with Scott presenting his work and the CDC work as well, and just do it as a team?

01:14:18:07 - 01:14:20:14

Kate Menard

Can we do that?

01:14:20:16 - 01:14:23:00

Charlan Kroelinger

Sounds good.

01:14:23:00 – 01:14:23:10

Scott Lorch

Sure.

01:14:23:12 - 01:14:27:01

Kate Menard

Yes. He hasn't even looked this calendar yet, but --

01:14:27:03 - 01:14:30:18

Scott Lorch

Just make sure I'm not at the beach. That's the only thing I have to say, so.

01:14:30:18 - 01:14:35:17

Kate Menard

We'll figure it out. We'll figure it out. You know, I can -- you and I have to talk between now and then for sure.

01:14:35:19 - 01:14:55:23

Jacob Warren

One point I wanted to bring up just real quick -- it just registered, that is, we've been having a very sort of state-centric discussion and a lot of these systems cross state lines. So I just want to be sure we all remember and sort of keep that in mind that, you know, if you're in rural West Georgia, you're getting care in Alabama, if you're in Wyoming, you're getting care in Colorado, you know.

01:14:55:23 - 01:15:02:15

Jacob Warren

So just as we think about regionalization, we also are going to have to think about the complexity of crossing state lines with that care.

01:15:02:17 - 01:15:15:00

Scott Lorch

Jacob, Wyoming is the parent -- such a different system than any other state in the US. No Level three NICUs in the entire state.

0:15:15:00 - 0:15:18:18

With one MFM in the whole --

01:15:18:18 - 01:15:28:01

Scott Lorch

One MFM, I mean, it's a very interesting method of delivering care. Let's just leave it at that.

01:15:28:03 - 01:15:30:22

Kate Menard

And then Marilyn, you had your hand up.

01:15:30:24 - 01:15:47:00

Marilyn Kacica

So I was just going to say too, like for that discussion, New York State has had, regionalization for decades, so it's pretty well mapped out legislation. And we're in the process of updating those, two-year process, so.

01:15:47:02 - 01:16:05:11

Kate Menard

I had the privilege of serving as an advisory person to -- you remember that? To the New York State. It's really quite sophisticated. So that's a good idea to bring their model to the discussion, Marilyn. If not a presenter, the description at least, you know. Charlan, you had another thought.

01:16:05:13 - 01:16:14:17

Charlan Kroelinger

Thanks, Kate. I was also going to add, it might also be nice to bring someone in who's worked in a frontier area like Wyoming.

01:16:14:19 - 01:16:33:07

Charlan Kroelinger

I know Lily Lou, who was a previous state health official from Alaska, has presented before on what it's like to work in a frontier area and to tele-medevac pregnant persons over long distances for critical care.

01:16:33:09 - 01:16:44:16

Kate Menard

If we can capture that name. Yep. Okay. That might be. Yeah. We have to, again have to think about how how much time we'll have at each of these.

01:16:44:16 - 01:16:54:12

Kate Menard

But I think that that would be -- especially with if we get people with experience with that, you know, having experienced the, you know, community members who have experienced that kind of care would be great.

01:16:54:12 - 01:17:02:01

Jacob Warren

One piggyback -- I would thank you for bringing that up, Charlan, is that, you know, a lot of people think of the West and Alaska as frontier also.

01:17:02:01 - 01:17:15:22

Jacob Warren

But in some of these key states that we're looking at there are technically frontier parts of Georgia and frontier parts of Louisiana. So, you know, just, you know, for us to keep in mind that sort of holistic view as well.

01:17:15:24 - 01:17:35:23

Carey Zhuang

One of our RMOMS awardees is serving them on a frontier Montana. So, like Granite and Powell counties and, southwestern Montana, and they are primarily doing a virtual care model for, like, everything because they're relying on Intermountain Health is infrastructure in Utah.

01:17:36:00 - 01:17:41:18

Carey Zhuang

So, you know, perhaps that could be one of our future guest speakers with them, if that's helpful.

01:17:41:20 - 01:17:47:15

Kate Menard

So is everybody willing to meet weekly between now and October?

01:17:47:17 - 01:17:57:21

Sarah Meyerholz

You're joking, Kate, but I was going to say. I mean, this is up to you guys. We have the monthly schedule, but it does not have to stay like that.

0:17:57:23 – 01:17:58:00

Kate Menard

I’m looking for when --

01:17:58:05 - 01:18:22:24

Jacob Warren

I wonder about alternating sort of presentations and planning, because we always have such wonderful presentations and great follow-up discussions that are sort of moving the recommendation piece forward falls, understandably, by the wayside. So if we move to a different cadence, it could maybe be that we have presentation and discussion meetings and then we have planning recommendation building meetings.

01:18:23:01 - 01:18:45:01

Kate Menard

Sarah really likes that idea, she said softly. But I really going to have to poll the group as to whether, you know, we can commit that. I'd be willing to give it the time I'm hearing -- Jacob nodding. I mean, if people can. Yeah. That the in between ones that you can get to it, great, or without really asking too much of people.

01:18:45:03 - 01:18:50:19

Kate Menard

Yeah.

01:18:50:21 - 01:19:11:05

Kate Menard

Okay. So we've got that suggestion. We can massage that a little bit further and see if that we want to go forward with that work meeting in between the presentation, in between the subject matter expert presentations and, yeah, other suggestions of topics that were that are gaps in subject matter, extra kind of needs that we have.

01:19:11:07 - 01:19:36:11

Kate Menard

The RMOMS input is going to be great if we can get that. We just had to think, I don't want to overfill these agendas either. So, okay. I think we've gotten through our today and it's quarter up, so we need to -- any other closing thoughts before we move on to, back to the main room?

01:19:36:13 - 01:19:38:01

Kate Menard

Jacob, do you have anything? I see Jennifer's going to continue.

01:19:38:01 - 01:19:39:18

Jacob Warren

Oh, yeah. Jennifer, I was trying to call on you.

01:19:39:18 - 01:19:56:05

Jennifer Vanderlaan

Thanks. I just wanted to point out that we haven't actually looked at the nursing workforce or the problems that are caused by hospitals because nurses, they don't get paid for nurses procedures, nurses work gets reimbursed is sort of the hospital daily charge.

01:19:56:07 - 01:20:02:15

Jennifer Vanderlaan

And that -- changing that may help.

01:20:02:17 - 01:20:06:03

Kate Menard

Do you have, well that's -- offline. Jennifer, let's think about how we could --

01:20:06:03 - 01:20:07:08

Jennifer Vanderlaan

Sure.

01:20:07:10 - 01:20:23:16

Kate Menard

Bring in to help us more understand the nursing workforce and that a little bit better. Okay. All right. Well, that's lots of ideas. and so let's close, go back to the main room.

01:20:23:18 - 01:20:35:23

Kate Menard

For those of us that are on the Committee and – we'll be with, you know, for the workgroup, we'll be in touch with everybody for, for our future meetings and planning. So thanks, everyone for your time. Really appreciate it.

01:20:36:00 - 01:20:37:17

Sarah Meyerholz

Thank you.

01:20:37:19 - 01:20:40:12

Divine Baley-Nicholas

Thank you.

01:20:40:14 - 01:20:41:22

Scott Lorch

Thank you, Divine, so much for joining us.

1

2