DR. MENARD: I was unable to grab this, so I might ask you to resend this, and we'll be able to share this the whole group from notes to this meeting as well. That'd be great. How about Kristen?

MS. ZYCHERMAN: Hi, everybody. Apologize, still sick today, but still happy to be here. I am a CMS ex-officio member and I work in the Division of Quality and Health Outcomes. As many of you know, we are an adult and child course that are housed with our Medicaid CHIP Adult and Child course, I'm sorry. Measure sets are housed within my division, as well as the quality improvement work.

And the child core sets, as well as the Behavioral Health Adult measures on the adult core sets are beginning with our beginning mandatory reporting and we will be requiring stratification in several different ways for those measures and one of the ways we'll be looking at the stratification for those measures is rural and urban. And so, we're excited to have that new dataset to be able to draw from in our quality improvement work.

We've done a lot of work within CMS with workgroups and such on rural maternal health and it's definitely a top issue, as specially as noted on the call

yesterday related to that 30 minutes of decision to incision, so it's definitely a tricky issue that we want to address from our perspective, so any way that I can help and anything I can take back to my leadership I'm happy to do so.

DR. MENARD: Kristen, I'm also delighted that you've joined. There's going to be a lot of different levers, potentially, and CMS is going to be an important one of those, so thank you for joining us. How about Zach, Zach Shultz?

MR. SCHULTZ: Sorry, yes, hi. My name is Zach Schultz, I'm listening in just from a sort of outside organization perspective for clients who are interested in rural maternal health.

DR. MENARD: Okay. How about Diane Tanman?

MS. TANMAN: Yes, hi. My name is Diane Tanman. I work at HRSA, Maternal Child Health Bureau, and I'm your notetaker today.

DR. MENARD: Thanks, Diane. Appreciate that. How about Diane Pilkey?

MS. PILKEY: Hi. Yes, my name is Diane Pilkey. I also work at the Maternal Child Health Bureau in the Division of Child, Adolescent, and Family Health, primary, with our injury and violence portfolio, which includes our suicide prevent program and our Fetal Infant Child Death Review Program, as well as our Core Safety Network, who is currently

implementing Safe Sleep, -- prevention learning collaborative with state Title V programs. All of them work on safe sleep related and infant mortality related efforts. And I'm here mainly to learn and I have experience working in rural states and I recognize the incredible challenges that states are facing, so I'm interested in learning more about where HRSA's going to go on this.

DR. MENARD: Shauna, Shauna Shell?

MS. SHELL: Yes, good afternoon, everyone. Can you hear me okay?

DR. MENARD: Yes.

MS. SHELL: Good. I joined by my phone, obviously, and I just wanted to make sure I completely unmuted myself. So, yes, my name is Shauna Shell and I'm one of the nurses on the Women's and Children's Health Team at Care Sources and we're a managed care organization in Ohio.

In my region, I have a lot of the Appalachian counties, so continuing to just really have concerns with our moms and babies in those Appalachian counties and definitely am anxious to hear what the workgroup has to say today to help our members in those areas.

DR. MENARD: Okay. Thank you. Thank you for joining us. How about Steve Calvin?

DR. CALVIN: Hi, Steve Calvin. I'm a maternal fetal medicine physician in Minnesota working with midwives

at the Minnesota Birth Center, but also with a family history background of being born in a rural area and I am quite interested in how we can improve the access to care and the care delivered in rural areas.

DR. MENARD: All right, let's see, Michael Warren, Dr. Warren?

DR. WARREN: Good afternoon or good morning, Michael Warren. I'm the Associate Administrator here at the Maternal and Child Health Bureau. Like others have mentioned, I have a personal interest in this, having grown in rural eastern North Carolina and trained at a medical school where rural primary care was a large focus and then having spent about 15 years in Tennessee working a lot in public health where we had predominately rural areas across the state.

I think our primary interest -- well, I shouldn't say our primary. One of our key interests right now in this space is thinking about what opportunities do we have as HRSA to leverage all of our various assets around the changing landscape of service delivery, particularly in rural areas. And so, when we think about hospital closures or hospital that have remained open, but have discontinued labor and delivery services, how do those impact the populations that are already at risk for worse outcomes and what resources do we have to be able to address that.

So, one of the things that we are interested in thinking about is as a sort of band aid is how do we think about this concept of readiness for obstetrical emergencies and making sure that wherever a person presents that the facility is able to appropriately triage, stabilize, transfer, get them to definitive treatment and what resources are there, so I'm interest in hearing from you all and learning more about what you all are doing and thinking.

DR. MENARD: Well, thanks, Dr. Warren, for joining us. We're really glad to have you here, and we're just in the beginning, so we've got a process in front of us. How about Diana Ramos?

DR. RAMOS: Hi, good morning. I am Dr. Diana Ramos, OB/GYN, California Surgeon General. And you may be wondering, well, why is somebody for California on this workgroup, but we have a lot of rural areas in California and I'm very anxious to learn about innovative ways that others in the country are doing the work in terms of meeting the needs of those in the rural communities, so thank you for allowing me the opportunity to listen in.

DR. MENARD: Thanks for joining us. I know you'll have some great insight to offer. How about Wendy DeCourcey, am I saying that right?

DR. DECOURCEY: Yes, pretty close.

DR. MENARD: Set me straight.

DR. DECOURCEY: Hello, sorry to be a few seconds late. I had a little linking issue. I'm from the Administration for Children and Families. I'm one of the ex officio members on board. Rural service issues and support issues are a broad concern for the Administration for Children and Families with the Office of Head Start, Office of Childcare, Early Head Start, and we support all sorts of interventions and supports for at risk families. So, I just think that I have a lot of questions and I'm hoping to hear innovations and ideas while working with you guys- over this period.

DR. MENARD: Well, thanks, Wendy. And I am just hopeful that Diane is helping me capture all of this strength and talent on the group so far. How about Veronnica Thompson?

MS. THOMPSON: Hi everyone. I'm so happy to be here. I am a senior policy associate at the National Academy for State Health Policy, and we are doing a lot of work in the maternal space and really interested in growing out our work and particularly in rural areas, so really appreciate the opportunity listen and learn from you all.

DR. MENARD: And Dawn, Dawn Levinson?

MS. LEVINSON: Good morning, good afternoon. My name is Dawn Levinson. I'm the deputy director for the Division of Healthy Start and Perinatal Services in the Maternal and Child Health Bureau and I look forward to

listening to the conversation. Thank you.

DR. MENARD: Thanks for joining us, Dawn. And there's someone behind the ACNM Zoom unidentified, and Belinda. We all know Belinda. I'm glad you're joining us, Belinda.

MS. JEFFERSON: I'm so sorry. It's Karen Jefferson, the director of midwifery practice from ACNM. I can't find my button. Am I okay to attend this subgroup?

DR. MENARD: Yes, you're welcome. You're certainly welcome. Thank you.

MS. JEFFERSON: Okay. Thank you so much.

DR. MENARD: I think you'd be a really important contributor, I know, so thank you.

MS. JEFFERSON: Okay. Thanks.

DR. MENARD: Belinda, do you want to introduce yourself and tell us why you picked this workgroup today?

MS. PETTIFORD: Sure. I am Belinda Pettiford. I am the current chair of SACIMM, but I also in North Carolina I'm head of Women, Infant, and Community Wellness here within our Department of Health and Human Services. So, North Carolina is a very rural state. We have a combination of urban/rural, but we are probably more rural than urban.

Similar to Michael, I grew up in eastern North Carolina. I actually still live near eastern North Carolina. But these are issues that we've been talking about in our

state with Kate and others for quite some time as we're having conversations around hospital closures, levels of care, maternity deserts, how do we support our families, our individuals of reproductive age.

I'm actually going to go between the workgroups. I will not be here the entire time, so don't take it personally when I drop off, okay.

DR. MENARD: We're delighted you came first. And I see Anne, Anne Walaszek, who just joined. Would you like to introduce yourself and tell us why you chose to come to this workgroup?

MS. WALASZEK: Good morning. It's morning here and I'm just really trying to hear how everything is going in the community and really appreciate the leadership in perinatal health, and especially in our indigenous communities. So, I'm really hoping to hear a little bit more also about, just, access issues around prenatal healthcare and services, so that's why I'm here.

DR. MENARD: Okay, great. Well, I'm going to take a step back, and since we got some folks that haven't been part of the earlier conversations and just reiterate, I said as we opened the Zoom meeting. And our charge for this group is to work on looking at issues in rural health and health disparage related to that, but also certainly in the context to help the disparities that continue to plague us between

the Black population and others.

So, that's the overarching issue and we've got these three workgroups, one of which is the rural health focus. Well, I think about it a lot. As Belinda said, I live in a state that has a big rural population, but I've also done a lot of work thinking about systems of care and how systems of care can potentially support rural hospitals and so that theme will -- with my input be folded into this, but I certainly value the perspective of other things.

So, that's our overarching charge, but what I thought we would do for an agenda would be first think together about what information we have and what information we need in terms of data, whether it be qualitative data or quantitative data. Danielle's offered to provide for us what's she's able to through Vital Statistics and I know that many on this call are well versed with the literature, so we think about what we have, what we need for data.

And then, think a little bit together about what we need in terms of literature. What are the problems out there that are resulting in hospital closures? Like Dr. Warren said, we need to dig into that, whether it be finances, whether it be workforce, whether it be opportunities in telehealth, those sorts of things. What literature do we need to inform those questions as we take forward recommendations that we hope will be evidence-based,

will be practical, and will be good use--of what is always limited dollars.

And then, I think we should do a canvass too of what are the current programs that are in place. We don't want to put out recommendations that are redundant to things that are already happening, so it'd be good to make sure our workgroup really knows what's out there in some depth.

So, that's what I thought we could start with in thinking about that together. And then we can have a conversation about priority areas, which we're going to have to narrow things down eventually to some priority areas, but what are those things right now that are bubbling to the top. We should also think about our workgroup and our membership, we have the opportunity to bring subject matter experts in to speak with us so that we can learn more about these areas of priority. And we can bring in other members as acting members of the workgroup as well.

And then, finally, I'd like to talk a little bit about the timeline for the project, which Belinda, when she got together with the workgroup leads, put out there that we're hoping to have some recommendations drafted and available for our Committee by January 2024.

Belinda is looking at me like is that what she said. She's nodding. You're muted right now, Belinda, but I'll give you a second to talk. And then how, we, as a

workgroup, going to get to that point? I'd like us to set our pace for getting to that goal. Belinda, did you want to add anything?

MS. PETTIFORD: I was just stating that we hope to have final recommendations by January 2025, not 2024.

DR. MENARD: Oh, excuse me. Of course.

MS. PETTIFORD: I don't want people to have --

DR. MENARD: No heart attacks. Sorry, 2025. So, we have a year and a month. We have a year and a month to get the work done, okay? Sorry about that.

Every year when I say the next year for the first time it hits me, so now I got it. So, how does that sound to other people? Thoughts on what we should cover today. We have an hour and 10 minutes to go through that agenda. Any other thoughts, things we should add and things we should delete.

DR. INTERRANTE: So, I didn't get a chance to introduce myself, so I --

DR. MENARD: Oh, I'm so sorry.

DR. INTERRANTE: That's okay.

DR. MENARD: I should've asked. I apologize.

DR. INTERRANTE: That's fine.

DR. MENARD: You're a real important addition.

DR. INTERRANTE: So, I was invited here to serve as a subject matter expert, but name is Julia Interrante.

I'm a health services researcher and epidemiologist and also the statistical lead at the University of Minnesota Rural Health Research Center. So, my research has really focused around the causes and consequences of rural obstetric unit closures.

We also have done a lot of work around disparities in maternal health outcomes, looking at the intersection of rurality, race and ethnicity, and income. So, a lot of our work was really focused around those areas and also a little bit on some of the financing around obstetric services and particularly postpartum care as well.

DR. MENARD: I told you she was going to be a great addition. She's got expertise in really so many of the areas that we're needing, so thank you Julia. Sorry for the oversight by not having yourself earlier. And I think at one point there will be times where we may call on you or colleagues to present more formally on specific topics within your area of expertise, so thank you for that.

So, let's start with epidemiology. What are, as a workgroup, what do we need to understand in terms of what's going on in the country, if there might be areas of affect or emphasis, what's the data we need? Julia, you actually touched on it just in your introduction, but do you want to articulate that when we're making recommendations about the overarching goal and our specific goal related to rural

health, what data would inform that?

DR. INTERRANTE: Yes, are you talking about data that exist that we should do something with, or data that doesn't exist because those are definitely two --

DR. MENARD: If it exists already and we don't need to redo it, that's great. If there's data that we need and we need to see trends or changes, that sort of thing that is essential that we need to ask to see if we can get.

We have a limited amount of time. We're not going to be able to do everything, so I think yes, yes, available data that we should all become aware and well informed about or things that's not available that we should try to get.

DR. INTERRANTE: So, I think some of the financial aspects around, like keeping obstetric units open and some of what that looks like that's where I think data could be better examined and collected. I know a lot of the sources available out there look at hospital finances as a whole, but don't slip it by service areas, specifically for obstetric services.

I will say a lot of the data out there is not analyzed intersectionally and I think that's another area that could be a focus is making sure to cross some of the maternal health outcomes by some of those things I mention, looking across rurality and race and ethnicity and income because all those things are contributors.

I don't know. I think it depends on what specific area, right? Like if it's a huge area of maternal health and access services and care. One thing I often push for too is to look outside of just childbirth care, looking at prenatal, postpartum, and preconception care. I know there's another group that's looking at that as well, but thinking of what in the world space, especially these rural areas are losing access to childbirth services they're also losing some of these other essential services to ensure healthy in maternal health outcomes.

DR. MENARD: Now, my frame of reference tends to be maternal health and not as much infant mortality. I think we've got, to the degree to which we will be looking at both would be helpful. Diana, did you want to comment?

DR. RAMOS: Yes. No, in terms of data that I would like to see, or I think that would be helpful would be an overlay of the maternal health deserts with the maternal morbidity and mortality in those areas where the births are happening. Somebody commented yesterday that even though you stopped doing OB services, you're still going to be doing OB services and I think that would be so powerful to look at the morbidity, the mortality. Are we really seeing a higher number in those rural areas? I think that would be a big impetus to focus and implement changes if we are seeing that correlation.

And I don't know and maybe I've missed it, but if there that data already with that overlay, I would love to see it again.

DR. MENARD: I may ask Danielle if she could comment. I went looking for that to the best I could, Diana, looking for that overlay of deserts in both infant and maternal mortality and brought altogether into one visual. I didn't find it, but Diana, what do you think? Danielle, is that something we could --

DR. ELY: So, one of the issues that you're going to run into, and it's an unfortunate truth that comes with rurality, in general, is because if you're trying to overlap with the deserts, the care deserts, because the number of maternal morbidities and deaths are going to be so small it's going to violate our PII assumptions around whether we can even show that for rural counties. And I know we hate to say that, and this is one of the issues we run into with small groups in terms of race and Hispanic origin and anything like that. Unfortunately, I'm not aware of that being out there and available. That doesn't mean it isn't or can't be done because obviously we have maternal mortality data. I'm not involved with that, but I can talk to people who are. And we know where the deserts are, so I'm sure there would be a way to do that.

DR. MENARD: And maybe not at the county level,

but perhaps at least at the regional level. My experience in North Carolina is we can divide it into six, but we can't get granular to the county because of numbers. Maybe that's something that we could consider. It would certainly illustrate where the disparities and outcomes are the greatest as they correlate with states, if not at the county level. I like that thought. Let's hear what Steve - --Steve's had his hand up.

DR. CALVIN: I was just going to say I'm glad that Julia is attending the meeting too. I notice too, Julia, the interview that you had with Daily Yonder, I think it was in May giving the kinds of information and the various aspects of it.

Julia, are you familiar with Harold Miller and the stuff that he's been doing with the finances of the hospitals? Is that something you're familiar with from the Center for Healthcare Quality and Payment Reform?

DR. INTERRANTE: A little bit. That'd be helpful to read some more of his stuff as well, but do they go into like obstetrics units specifically?

DR. CALVIN: Yes, he does. He's really detailed, and he's done a lot of stuff on maternity units and standby payments and trying to sort it all. And I've been connected with him for about 10 years, and he has a lot of resources, so he'll be someone I think we should invite to a future

meeting because it really does come down to that. And you and your colleagues at the Rural Health Study Center, of which there are only, what, less than a dozen, nationally, that you have the resources and the connections with data.

But just in informal discussions with people around the State of Minnesota and I also have connections in Arizona, it's usually about finances, but then we also can talk later too about standards that are put up. When Jeff Strickler was talking about a decision to incision standard of 30 minutes can kind of submarine any rural maternity care, so we have to discuss that. But anyway, I think we should include Harold at some point because he really knows the details of the finances.

DR. MENARD: Dr. Warren? Thanks, Steve.

DR. WARREN: A couple of thoughts. One, to the question that was raised by Diana, I think this notion of mapping things out. So, we have a maternal, infant health mapping tool at HRSA with data down to the county level. As Danielle note so well that there is a number of limitations into what we can provide at the county level and in some cases we've said, well, we can't do that at the county level, but we could do that at the state level, so that tool already exists and it's publicly available and so we could think about that as a backbone resource, moving forward. And I'll put the link to the chat in just a minute.

A few data pieces that I think would be helpful. One is not even having the data visible but having a shared understanding of what do folks call a birthing facility in terms of like counting that, so we have a sense of what the denominator is. And I know when I was in Tennessee, we came up with a number based on birth volume and said these are the places we're going to focus most of our effort on for folks who are like routinely delivering babies, but what does routinely mean? How many a week, for example, versus folks who are at a level it's very incidental, it's on an emergent basis, those sorts of things. So, I'm not aware of a standard definition around that, but I wonder if that could be helpful. And I think it relates to broader concepts around levels of care, and so is there a way to look at the landscape around states, jurisdictions that have done level of care assessments to understand what those look like. I know that's voluntary. It's often folks are not interested in sharing that, so is there anything we can glean from that work that's been done.

And I know in the neonatal literature there are a number of studies that look at levels of care and outcomes, particularly like for very low birth rate babies. And not only was the very low birth rate baby born at a level 3 or 4 facility, but do the outcomes differ when you're at a Level 3 facility versus a level 3 facility that's really a level 2,

but the self-assessment was a 3? Like Illinois has done some nice work around that.

So, I don't know if the maternal literature in that space is there or is as robust, but I think it helps make the case when we can understand what the landscape is, in terms of the distribution of those levels of care and then outcomes.

And then just lastly, to the extent that there is a source that give us more real time date on closures I think when we often look at maternity care desert reports, we're looking at reports that are a year, a year and a half, two-years-old and when we think about programming and policy decision, you're really working form behind when you've got that kind of data. So, is there something that's more real time, real time being relative, about the current state of OB services?

DR. MENARD: Thanks, Dr. Warren. That's all so important and helpful. Does anyone on the call familiar with a source that's real time or relevant real time, as you said. Maybe Julia does. Go ahead.

DR. INTERRANTE: So, we've done a lot of work around this and there is none, which is probably the problem. And I think that would be a big area if that was something that could be developed in terms of collecting data. So, all these measures rely on American Hospital Association annual

survey, which, of course, there is a delay with that.

We've published our algorithm that we use for identifying hospitals with obstetric units and obstetric unit closures and we did a validation against where we actually reached out to rural hospitals and asked and compared it to what the dataset within AHA and the CMS provider of service files and those are both fairly inaccurate in terms of if you're trying to figure out when an obstetric unit actually closed and to find that out quickly.

So, I would definitely argue that having something more real time would be very useful. So, when we use those, we end up having to look on hospital websites and also look at news stories about where obstetric units have closed and that's a very time-consuming process and not -very - not- the most efficient because there is nothing else that exists for that.

I would also urge some caution around the maternity care deserts measure that March of Dimes does because some of that measure they look at the number of OBs and certified nurse/midwives providing services per area, but they don't include a measure of family physicians who do childbirths, which are a huge proportion of the providers rural areas, so just wanted to flag that as well as we're talking about that specific measure.

DR. MENARD: Yes, that's helpful, Julia. I know my

experience in North Carolina is they say, no, some of the counties don't have obstetric providers, but we know where they are, we know who's billing Medicaid for maternity services and we know where the services are happening.

Do you have a suggestion in terms of—our team seems to be focusing on the hospital and the hospital closures. Is there, in your mind, a best wage to gauge? Workforce is important, workforce follows hospital closures, hospital closures follow workforce. I don't know. Do you have a thought on how we should look at availability of access in your work? That may be too much to ask for the moment.

DR. INTERRANTE: That's tricky. Without having OB, like some kind of reporting around when a hospital closes an obstetric unit there's a government agency that gets reported that information and keeps track of it. Like I said, we're doing the best we can at our Rural Health Research Center with a staff of four people working on maternity care projects.

I know the Sheps Center in North Carolina tracks hospital closures, but again, it's a lot trickier when you're looking at a specific unit just closing without that being something that's regularly measured or reportable.

DR. MENARD: Another area that Belinda and I had talked about needing information on is the childbearing

population by race, ethnicity. It occurs to me when I look at some of the frontier states it may not be the Black by disparity issue may not be there, right? In fact, the rural population may be predominately white and there might be higher rates in certain counties. Is that mapped for us anywhere? I haven't really seen that. Again, overlaying that potentially on underserved areas or deserts.

DR. ELY: I'm not aware of it actually be mapped, but I do know that the data would be available from the census. That might be an issue of pulling that data.

DR. MENARD: And that might even be available in the data that Dr. Warren was referencing to. I just haven't done the hard work of figuring that out yet, but anyway, I think another variable that we should consider when we're thinking about the areas of most need.

Okay, what about workforce? What data do we need related to the maternal health workforce that inform our recommendations? I can say that I recently worked with the MHLIC Team in preparing a maternal health playbook and assisted with the chapter on workforce and that might be a starting place, but it's not everything that we need, I know, in my review was there. Steve, do you have thoughts?

DR. CALVIN: Sure. And I'd be interested too in what Karen Jefferson has to say. It's not just about CMNs, CM or CPM. Earlier this year this legislative group called

ALEC, which is kind of right leaning-, they asked for a presentation on midwifery at their national meeting and I basically called them out saying many of the red states are the ones that have the worse outcomes and have the least likelihood of having midwives attending births all the way from one or two percent of births in Arkansas. I mean it's not always the case. I mean, Alaska has, I think, 40% of births attended by midwives, but just as a, you know, a totally convinced that midwifery has got to become a bigger part of our future. And it's not that midwives are physician extenders. It's a mutual relationship and I would even say that physicians are midwife extenders. So, I'd be interested in the ACMN perspective on that.

I think there're 37 training programs and I've been involved in a number of them, but I just recently found out the State of Arizona has 80,000 births per year and many of them are Hispanic and out of that state with 80,000 births there are, I think, only 200 plus certified nurse/midwives. I mean we are totally upside down.

As Kate, and those of us who are obstetricians know that the workforce as well for obstetricians is shrinking. So anyway, I believe workforce is a huge issue. And also, having been the beneficiary of a National Health Service Course Scholarship a long time ago, that was a very instrumental part of leading to where I am now and what I'm

doing, and even being part of this.

MS. JEFFERSON: Kate, can I have a minute to expand on what Steve was saying?

DR. MENARD: Certainly, go ahead.

MS. JEFFERSON: I don't know that it might be helpful to this committee, but ACNM is wrapping a two-year workforce study and so may have some better data than has been available before about the CNMCM workforce and the density of midwives by state and by county and where we're located.

Steve, you mentioned certified professional midwives. ACNM doesn't represent certified professional midwives, but they're a part of the system of care for attending births and taking care of people. And it would be great to be able to track them too. It's quite challenging to track the midwifery workforce because midwifery is not a profession recognized by the Bureau of Labor Statistics.

Nurse/midwives are categorized as advanced practice nurses and so it would be quite a challenge to find the CPM workforce, so perhaps that's where our data may be helpful.

DR. MENARD: We'll count on that, Karen. That's great.

DR. INTERRANTE: I just want to second what both of them said. I think that's really important. I actually

just had a baby five months ago with a CPM attending my birth, so I love them. Yes, on the data side of it, I think looking at some of the scope of practice laws around midwifery practice by states and how that limits a lot of the ability for midwives to attend birth. And I think that's, again, especially important in rural areas where you do have a lot of workforce shortage issues.

I would also add around the data for family physicians who do their obstetrics fellowships too I know that there has been discussion; this isn't my area of expertise, but I know that there's been a lot of talk around the number of family physicians who take on obstetric fellowship has been declining. And I think looking at some of that will be important going into the future too, especially as we're talking about in rural communities who's actually providing childbirth services and the majority of those not being obstetricians.

DR. MENARD: One of the ways we quantify this in North Carolina was charge through Medicaid, who was billing Medicaid, yes, so we could find the family physicians. This was in the context of Pregnancy Medical Home Program and that those that were providing obstetrics care were billing Medicaid for OB care and we could find out, you know, who was doing what. OB fellowships are that prevalent, so I didn't find another way to do that.

I'm just wondering if that's something we could get help from -- I guess it's state by state, though. We wouldn't be able to get that nationally, I suppose. I don't have other ideas about how we could really capture that, but it's important, right? Anybody else have thoughts on that, how we could find the family medicine workforce who's delivering babies. Think on that. We might come back to it.

DR. CALVIN: We could talk with our colleagues in HRSA's Bureau of Health Workforce. They have lots of provider projection data. I don't know that it is down to the level of who's delivering or not. Certainly, they've got the data by specialty, but I'm happy to take that question back to them and see what assets they might have for that.

DR. MENARD: Yes, thanks. Okay, good. All right, anything about tele-health that we want to learn, that we want to think about with respect to the rural health concerns, rural health systems? I'm hearing lots of enthusiasm for looking at the closure thing with the finances, looking at things that are driving that, some enthusiasm for workforce. I just want to open up to other ideas of things that people might be interested in us pursuing. Diane, you have another thought.

DR. RAMOS: Yes. And this is oftentimes a barrier, is the type of telehealth that's being delivered, whether it is video, is it -Internet based, is it a phone

call, is it a hub-and-spoke type of model that patients go to a facility, and they're then connected. Are there any wearable devices that are being used and the reimbursement- for all that is so critically important?

DR. MENARD: Other thoughts from others about us potentially pursuing the telehealth as a way to support rural communities? Steve?

DR. CALVIN: I mean what we heard yesterday from the RMOMS thing in the Bootheel of Missouri. Having gone to medical school in St. Louis, I visited a few times the Bootheel and it's quite an interesting place. And I think they were pointing out the decreased travel and that by itself is an economic problem for many of the patients that would be seen, so I do think we do have to - and I know there's a lot of information regarding broadband access. I think that's, I think, a focus of the current administration and that's incredibly important. But then, just what Diana said too of what exactly is the telehealth modality that you're using because some of them can be not very good at all. But anyway, just being able to access something, some information, and some consultation that decrease travel time and sometimes pick up life-threatening- problems.

DR. MENARD: Okay. So, we've talked about closures. We've talked about workforce. We've talked about telehealth being a potential focus. Is there any other kind

of big bucket areas you think we should explore as a group? Julia.

DR. INTERRANTE: I just wanted to add one more around the tele-health piece. I think a lot of the discussion - and some of it was the hub-and-spoke -and some of it was patient to- -provider, but even the provider -to -provider telehealth, so like rural practitioners who need to be able to have a connection with a childbirth provider in an urban area that can handle a higher level care and have that support that way too, I think there's less literature around the provider-to provider telehealth, but I do think that's another important area for connection for rural communities on the provider side.

DR. MENARD: Yes, that's a good point, Julia. I do think that correlates well with the concept of levels of care, too, right, where the tertiary-care centers are connected seamlessly with the level 1 and 2 centers which tend to be rural areas. But with that line of communication is first name basis is the idea and the ideal. Other thoughts?

I'm looking in the chat real quick because I haven't been able to monitor that too well. A recent New York Times about Alabama's loss of birth centers due to restrictions like requiring a physician to be available at the birth center in an emergency at all times within 30

minutes to the hospital.

A lot of hospital privileges require distance from the hospital, require their medical staff members to be a certain distance to the hospital. I think ACOG is blamed for this 30-minute rule, but my understanding is that's been taken out of pretty much all of their literature, but I could be wrong on that. So, it lingers from days gone by.

MS. ZYCHERMAN: This was saying that the birth center needed to be within 30 minutes of a hospital, which then in rural areas is a real issue because in these deserts nobody's within 30 minutes of a hospital, so putting a birth center there is impossible.

DR. MENARD: This would be a freestanding birth center. Yes. The organizations that certify birth centers there's a lot of standards there that the certifying bodies put in place fairly evidence-based in my review of that work most recently. So, Virginia has a high telehealth maternity program. Yes. And there are a number of those in rural states that have more and more sophisticated telehealth programs, I think, since COVID. We learned a lot. Diana?

DR. RAMOS: I just wanted to maybe pull on and see if folks have heard of any other innovative models for providing the care, especially for high-risk moms. Some of the models that I heard in China is that what they end up doing for those that are in remote health deserts and the

moms are high risk is that they actually house the moms near the hospitals. And that's something that in California we're looking at because there's so many vacant state-owned, government-owned buildings to be able to convert them, not into hospitals, but to facilities where moms can be cared for and can be close enough and perhaps arrange it so that the family is there with them and it's not so inconvenient. Like just looking at alternative models, innovative models of care that provide the family around the mom, and really in the long run are a lower cost. I think that would be really important to look at.

DR. INTERRANTE: So, I do know Alaska does that in some areas too. The model that I'm aware of there it's only the birthing person and so that's, I think, a big area that's challenging when they're not able to bring their family support partners. I mean, again, there's also economic issues, right, if you are losing time from work and childcare coverage and things like that, but I think those other models are interesting and good to look at.

DR. MENARD: We can certainly learn from them and see what we might choose to try incorporate, at least take a look.

Well, I think we've put a lot on the table, and I think I'm seeing things and I'm hearing what people have enthusiasm for. I'd like to think about who's not here that

we really think that we should bring in as a workgroup member, or at the very least as a subject matter expert to come and talk to us. So, I've heard a number of times now that it's Harold Miller. I think that's- somebody we should certainly invite.

I was intrigued by some of our speakers that we had in our -- it was kind of rapid-fire information that we got yesterday, but if we can take just a few minutes and reflect on the folks we heard from that we might potentially invite back for some more in depth, pointed questions potentially. Danielle talked with us about data. We had Community Voices from the RMOMS Program. How might that inform the work we're doing?

It occurred to me that one of the things that we learned made the report the, the last the Committee did on American Indian and Alaska Native is the stories is what made it come alive. Do we want to get some stories that might make our paper, or our recommendations come alive in such a way, just a thought. Hospital Association, Megan Cundari caught my interest in a lot of things, Office of Mental Health, RMOMS, more from CMS. What do you want, what's your wish list for people that we could bring direct to our work group meetings or to the Committee?

DR. CALVIN: So, I would just add hearing from Julie Wood and what they're doing in family medicine, and

also Jeff Strickler. It was encouraging to hear about how many people had taken the advanced life support obstetrics training. That sort of training is very valuable.

DR. MENARD: Well, that's a good idea, Steve. I think for sure if we could learn more about the also who's doing it and has that been evaluated in terms of effectiveness and that sort of thing. I think that's a great opportunity. I think that's partially being funded by federal sources now, but to the degree to which it is I don't know. Okay, what else?

DR. WARREN: We may want to invite our colleagues from HRSA's Federal Office of Rural Health Polices. We heard about RMOMS yesterday. There are a number of initiatives they've got going on. I mean their whole charge is to focus on rural health issues and so it may be helpful just to have them come and talk about the work they've got going on in this space.

DR. MENARD: I'm going to ask a naive question, Dr. Warren. They're HRSA as well, right?

DR. WARREN: So, they're like one of the bureaus within HRSA, so just like we've got Maternal and Child Health Bureau and Bureau of Primary Healthcare, there's the Federal Office of Rural Health Policy.

DR. INTERRANTE: They fund our center. Yes, they fund our center and other rural health research centers.

DR. MENARD: So, when we come with recommendations, we're coming out with recommendations to MCHB. We're coming to recommendations to entire HRSA, right? Is that right?

DR. WARREN: So, the last few sets of recommendations have been broadly to HHS. So, the charge to ACIMM is to advise the Secretary of HHS and all of the HHS components, CMS, CDC, NIH, FDA. The place where we've got the most direct levers with this Committee are HRSA, but the Committee can certainly make recommendations more broadly. And within HRSA, you can make recommendations for MCHB or Federal Office of Rural Health or any of the other bureaus or offices as well.

DR. MENARD: Got it. That's helpful. Thank you. I had to understand that. Thanks. So, do you have specific questions we should bring to them in mind, and we can think about this offline if it's better, but inviting them back to spend some more time I'd like to come up with specific things that we would ask them to address in addition to what they did with the bigger group.

DR. WARREN: I wonder if there's the opportunity to talk more broadly about their approach with RMOMS. You've heard from the Bootheel grantee but are there other questions the group has about RMOMS or feedback that you all would like to share on RMOMS because I know that time was limited

yesterday. They also work with the State Offices of Rural Health and do a lot of work with critical access hospitals, rural health clinics. So, just thinking are there any opportunities to engage those entities in this work and they also are just a wealth of knowledge around rural health issues and so just getting their perspective on some of these challenges.

DR. MENARD: And I'll say I confess that I'm not real well versed on how critical access hospitals are funded. I know pretty much how they're defined and funded, so that might be something that others would want to learn more about as well. Would that be a resource for that?

DR. WARREN: They could help with that, and I think Kristen and our colleagues at CMS could probably help us with that as well. Let's put Kristen on the spot.

DR. MENARD: Okay. And they fund Julia's organization, and several organizations like yours, right? Yours has within it, I guess, a particular maternal health focus that isn't there for some of the other funded sources.

DR. INTERRANTE: There are cooperative agreements between the rural health research centers and FORHP, so we go back and forth with research projects that we do every year, but we are pretty consistently funded on maternal care projects because that's what we've done for a long time.

DR. MENARD: Yes, got it. Okay, are there

lingering questions from the hospital association that folks really would want to bring the hospital association folks back to our group to learn more? I have to go back to notes and I had so many questions after yesterday, but if things are burning in your minds let me know and we'll see what we do. CMS, I think, is going to be able to inform us in important ways.

All right, this gives me some ideas. How about committee members, actual committee members. Julia, we're not going to let you go, if you're willing to stick with us as a committee member. Are there other individuals that you or others would recommend that have expertise and interest in this field that we would want to bring on recurring meetings?

And for those of you who are more in kind of an observer role, not necessarily a committee member, per se, all of these meetings will be open to the public. So, they'll be published when we're having our scheduled meetings and folks are able to listen in.

DR. INTERRANTE: I don't have names off the top of my head right now, but I think if we're going to be talking about disparities and health outcomes, it'd probably be important to have committee members from the most affected communities. There's a few like Black Doula associations out there that do a lot of work around that. I know that there are some Indigenous NIPA free organizations. Specifically,

in New Mexico that's where I grew up, but I know that there's- some work around that there just to get some of those perspectives too.

DR. MENARD: And I'll ask for others for help, but I know of some community advocates that are really -- and one person I'm thinking of, in particular, that had triples and needed a higher level of care and had a hard time finding it. Those sorts of things, those stories I have in my brain, but finding individuals that -- I also have in mind a young physician -- soon to be physician. She's finishing med school, who was born and raised in a rural border county of Texas and talked about this 14-year-old translating for her grandmother when she was ill and the struggles she had.

I interviewed her, actually, for a residency program recently. I was just struck by her life experience with growing up in a rural area in very rural Texas and then finding her way to Stanford Medical School is pretty impressive. Individuals like that, though, that can bring that personal experience to the work I think would be helpful. So, if you'd all give that some thought, we may invite folks to come and tell their story, if they're willing.

Let's then think about our work plan then. As I mentioned, our final product ready in January of 2025, I just thought about we spend a third of the time learning and

gathering the literature and the data and that sort of thing that we need to teach ourselves and bring ourselves up to speed where it's necessary and inform our decisions.

And then, in the second, third perhaps of the time work on narrowing the focus and considering solutions, potentially highlighting models that work. If we wanted to, we could identify those things and elevate those and then give ourselves a couple of months at the end, maybe October, November, December, that sort of thing, for writing up what we wanted and fine tuning it.

This is what I've been thinking about. How does that sound to folks? Reasonable?

(No response)

DR. MENARD: In terms of cadence of meetings, it depends on how many people we want. There will be in between work on this, but depending on how many folks we want to hear from in terms of presentations I think that will give us a meeting cadence. But if folks are willing, and I'm thinking for maybe that first, third quarter or first, third of the months, maybe January through March or April that we have a cadence with presenters of maybe once a month get together with a 35, 45 minutes time of presentations, plural, if they're shorter, and conversation while we're learning.

In the meantime, we're gathering data from other sources and discussing that and some email exchange in

between. And then I think we can probably -it might end up being once a month between now and the end to get the work done the way we want it done to actually get input from all the minds and perspectives that we have. Does that sound onerous? Does that sound like a commitment people can make, those that have agreed to be on the committee, Steve, Julia, and others? Good. Michael? -Okay?

Well, that's what we'll map out and there will be notes from this meeting and I'll probably send out a few ideas and names of folks we could ask to present and then I think I'll get help from the HRSA staff in inviting those people. I don't know how much they're going to do with us for literature review, but I feel fortunate that we've got people here who already have a lot of expertise.

I've done a fair amount of reading myself but boiling it down to the most important is my challenge because I go reading and then I go, I got to read that and read that, and I finally have too much to read. So, those of you that have expertise in that area might be able to help. Any other thoughts, ideas? I think I've got a lot here to pull together for us and I'll count on all of you to help.

All right, I know people are going to be having a lot of ideas and I'm going to put my email in the chat here. So, everybody if you get an idea, you're reading or you're talking to folks and this person would be great for us to

talk to, shoot me an email.

If you're on the call today and you're actually interested in joining the workgroup and being invited on a regular basis, just send me an email and let me know, describe who you are and what you're doing, and we're allowed to bring in subject matter experts to the workgroup. So, if you're interested in doing that and can commit the time, send me a note, and we'll- go from there.

I see that a couple folks joined since we started. Tina, welcome. We're about to wrap up our group, but I'm very, very happy to connect with you offline too and review what we discussed if that would be helpful.

DR. PATTARA-LAU: Sure. I apologize for being late. I had a conflicting meeting, but I just drafting you an email and happy to help.

DR. MENARD: That's great. That's great. Anybody else that joined that didn't introduce themselves, that didn't introduce themselves earlier?

(No response)

DR. MENARD: Okay. Well, I think we can close. Those of you on the east coast that still lunch, you'll have time to do that before we open again at 2 o'clock. And the email is there, use it liberally. Ideas come up and I'll do my very best to pull some ideas together and get people to get back. In terms of timing of our workgroup meetings, I

tend to think if we set a regular time that we can count on over time that works well, but I'll ask the staff, once I have the names of the people who are going to really commit to coming back each time, ask them to find a time that will work for most of us. I appreciate your time, open to your ideas, as I said.

(Whereupon the meeting adjourned.)