NC Child Fatality Task Force
Perinatal Health Committee Meeting
February 10, 2016

MINUTES

Dr. Sarah Verbiest called the meeting to order at 1:00 and explained that this is the last meeting of this committee before the short session. She introduced herself as the Director of the UNC Center for Maternal and Infant Health and Clinical Associate Professor at the UNC School of Social Work. Dr. Verbiest Co-Chairs this Committee with Belinda Pettiford, who is the Branch Head for Women's Health with the Division of Public Health. Dr. Verbiest asked those present to introduce themselves.

Attending in person: Janice Freedman, Kelsey Kemp, Sarah Smith, Amy Hendricks, Starleen Scott Robbins, Meghan Kennedy, Melissa Godwin, Kate Menard, Kate Berrien, Matt Zerden, Sydney Atkinson, Nancy Henley, Ida Dawson, Michaela Penix, Debbie Farb, Steve Kandall, Susan Robinson, Pamela Thompson, Laila Bell, Tamika Williams, Katherine Bryant, Abby Liberty, Tom Vitaglione, Eric Naisbitt, Kweli Rashied Henry, Kella Hatcher, Rep. Paul Stam, Judith Johnston Hostler, Sally Herndon, Denna Suko, Robert May, Sharon Foster, Cal Hayslip, Sarah Smith, Marty McCaffrey, Camie Tomlinson, Karmel Choi, Sen. Don Davis, Rita Dorry, Belinda Pettiford, Sarah Verbiest

Attending by phone: Erin McClain, Sarah McCracken, Craig Horn, Kim Andringa, Leslie DeRosset, Gerri Mattson

Approval of minutes from meeting on November 4th – motion to approve as written was made by Susan Robinson, and a second was made by Steve Kandall. The motion to approve passed unanimously.

Dr. Verbiest explained that the committee today would be finalizing its recommendations to present to the full CFTF. She said that the first set of speakers was addressing the topic of Long Acting Reversible Contraceptives (LARC). NC has been a national leader on advancing the use of LARC.

Family Planning and LARC in Perinatal Health – Matthew Zerden, MD, MPH, WakeMed Health and Hospitals, UNC School of Medicine [See online presentation "Zerden Perinatal Task Force 2.10.16"]

Dr. Zerden explained that he recently finished a fellowship in family planning and so has been working directly on LARCs (Long Acting Reversible Contraceptives). He explained that there are two kinds of LARCs, the upper arm implant and the intrauterine IUD.

Nationally, the unintended pregnancy rate is 50%. Half of these women who have unintended pregnancies are attempting to use contraception. The way this relates to perinatal health is that a large body of research has concluded that the optimal interval between pregnancies is between 18 months and 5 years, and that by achieving this interval, preterm births can be reduced, particularly in populations at risk for preterm births. 38% of US pregnancies have short intervals. LARC studies have been demonstrated to reduce rapid, repeat pregnancies. Statewide data in California showed improved ideal birth spacing with LARC.

Dr. Zerden showed a chart with tiers of effectiveness for different types of birth control methods. LARC is on the same tier of effectiveness as sterilization. Reasons LARC is preferred include; no daily, monthly, weekly, or time specific actions – use is always "perfect." Dr. Zerden explained the difference between "perfect" vs. actual effectiveness. With most forms of birth control, the effectiveness can be very different depending on how perfectly it's used.

A slide was shown on the popularity of different types of birth control in the US, with LARCs at a much lower rate than several other methods, although the expectation is that LARC use will increase. (see slide 11) Dr. Zerden explained the different brands of LARC available (slide 12).

LARC IUD's are 99% effective and have a duration of 3 – 10 years; he explained the contraindications and said that there are relatively few. The LARC implant is 99% effective and the duration of use is 3 years; he explained the short list of contraindications.

There have been two fairly large studies that demonstrated the impact of LARC. The CHOICE project in St. Louis involved 10,000 patients who were able to get LARC for free with good education for both providers and patients, and the result was a 75% uptake in the use of LARC. The other main study from Colorado was where a private foundation funded more than 30,000 LARC devices, and the result was a 40% reduction in teen births.

The American College of Obstetrics and Gynecology as well as the American Academy of Pediatrics have said that LARC should be a first line of contraception recommended by providers as a most effective method. There are opportunities for increased access to LARC. One such opportunity is postpartum in the hospital prior to discharge. Patients typically have coverage at this time and it is a safe time to place the IUD, plus not all women come to postpartum visits as they are directed to do by their physicians. Another opportunity is a public/private payment arrangement whereby Liletta has said it will not charge over $50 for an IUD. A third opportunity for increased access is through addressing current barriers: providing good information to providers who may not understand what makes a patient a good candidate for LARC; patient education about LARC, and elimination of cost barriers.

Dr. Zerden provided additional detail related to increasing access through postpartum LARC (see slide 19). He emphasized the importance of reproductive life planning in improving unintended pregnancy rates and focusing on those with a history of high risk pregnancy. LARC is a powerful tool for reproductive health since it is highly effective and has high patient satisfaction with few contraindications.

Division of Medical Assistance perspective on LARC – Dr. Nancy Henley, Chief Medical Officer for DMA

Dr. Henley stated that DMA covers all types of LARCs described by Dr. Zerden, and DMA is enthusiastic about working with providers to make sure that patients who want that type of contraception have access to it. The current problem, however, is that the rates that are available to pay providers in the outpatient setting for the IUD device or for the implant device are frozen, and have been frozen for some years due to legislation that froze rates in the outpatient drug program (physician's office). So, one of the things that the DMA is hoping to do is to bring forward a request to unfreeze the rates to reimburse physicians in the outpatient setting. In the hospital setting, LARCs are covered under the DRG (Diagnosis Related Group).

Dr. Henley explained that it needs to be clearer from a policy perspective that IUDs are covered in the inpatient setting. DMA is looking at options for rate setting that would clarify this policy. She noted that physicians were also paid for their services for IUD insertions. Some beneficiaries get LARCs via family planning services, some through Medicaid for pregnant women, and some through regular Medicaid. North Carolina did have a family planning waiver, but has now switched to regular Medicaid.

A question was asked about whether rates were frozen at the state or federal level, and Dr. Henley answered state level. Dr. Hayslip commented that at his hospital, the impression is that LARCs postpartum are not covered and that associated costs would have to be paid by the hospital. Dr. Henley confirmed that LARCs are in fact covered in the hospital postpartum.

Rep. Stam commented that although you [Dr. Henley] say the rates are frozen, basically all Medicaid rates are lower than costs, so are the rates for LARCs especially low? Dr. Henley replied yes, and for example, the reimbursement rate might be $600 where the market price might be $800, so a physician may have to purchase

an IUD for $800 but only be reimbursed $600, and physicians don't want to take a $200 loss. Dr. Henley explained that Medicaid also reimbursed separately for the physician's services for insertion, but that reimbursement was appropriate in terms of rates.

Rep. Stam said it would be helpful to know what the physician is paid for the services, because there are times when one could be reimbursed for services enough to make up for the loss on the up front purchase. Kate Berrien commented that she doesn't know for sure the reimbursement rate for services but she thinks it is around $135.Kate Berrien explained that there is an alternate approach with obtaining LARC in the outpatient setting, where they are obtained from a pharmacy via prescription. The disadvantage of this is that the patient has to come back after it's obtained from the pharmacy and if they don't, the device can sit on the physician's shelf unused since something prescribed can only be used for that individual.

Janice Freedman asked if there was a co-pay for LARCs and Dr. Henley said no. Kate Menard commented that physicians across the state are hearing that LARCs are not covered so they are discouraged from using LARCs, and that there are other states who reimburse this device outside of the DRG. Nancy Henley said that in NC, all hospitalizations are paid for under the DRG and there is not a lot of flexibility with this. DMA has been working with the Hospital Association on this and they know that LARCs are covered under the DRG.

LARC and Pregnancy Prevention in NC – Debbie Farb, Women's Health Branch, Division of Public Health [see online presentation "LARC CFTF final DFarb 2.10.16"]

Ms. Farb began by explaining what LARC is. She explained that LARCs are significantly more effective than other methods of birth control, they are used longer and more consistently, and women are more satisfied with them compared to other methods of birth control. Most women can use LARCs, including teens and postpartum mothers before they leave the hospital after delivery.

In 2012, the American College of Obstetrics and Gynecology issued an opinion that "with top-tier effectiveness, high rates of satisfaction and continuation, and no need for daily adherence, LARC methods should be first-line recommendations for all women and adolescents." In 2014, the American Academy of Pediatrics recommended that "the first-line contraceptive choice for adolescents who choose not to be abstinent is a Long Acting Reversible Contraceptive (LARC). . . The past decade has demonstrated that LARCs, which provide 3 to 10 years of contraception, are safe for adolescents."

Ms. Farb showed graphics illustrating trends for use of LARC in NC (see slides 17, 18, and 19). IUDs are more popular than implants for adult women, and implants are more popular for teens. Pills and injections are much more popular than LARCs in general. In terms of national trends, NC rates for use of LARC are a bit higher than national (see slide 22).

Ms. Farb referred to the St. Louis CHOICE project that Dr. Zerden had addressed previously, and said that with optimal counseling and access to LARC, NC may be able to improve LARC uptake rates. Ms. Farb talked about teaching and counseling patients about LARC, and the CDC recommendations on counseling for family planning (see slides 25-27).

With respect to barriers and solutions to LARC in NC (slides 29 -33), some providers are hesitant especially with teens, are not always using the best practice approach to counseling, and so need more education about LARC related to national guidelines. There are some financial barriers to stocking LARC for same day insertion, so need to encourage stocking LARC and to secure stable funding for clinics to purchase; there is a lack of funding for all patients who desire LARC, so clinics should seek grant opportunities and we should encourage Be Smart enrollment when eligible. There are Medicaid reimbursement challenges – esp. immediately postpartum, so NC should collaborate with other states who have resolved this issue and support current work on this issue by NC

DMA and the Hospital Association. Ms. Farb concluded by saying that in NC we should congratulate ourselves for having a higher LARC uptake rate than the national average.

Kelsey Kemp commented that with teens, one issue is that pediatricians need training on inserting LARCs and not all are trained with this. Steve Kandall asked how long LARCs have been studied. Dr. Zerden answered many years with no long term consequences shown.

Rep. Stam commented that in remembering this is a Child Fatality Task Force and not a general health task force, he wondered if intended and unintended pregnancies are mutually exclusive categories or if some who are categorized as unintended were not exactly unintended. Also, since short birth spacing is only one of many factors impacting preterm birth, does anyone know whether if we doubled the LARC rate we might be able to avoid X number of infant deaths or X number of preterm births? Because for every strategy we look at to reduce infant deaths, there is a countervailing issue of costs, and not just financial costs.

Ms. Farb said that there have been studies showing that if you can get to about 1.5 or 2 years of use with LARC, it equals the expense of other birth control methods. Dr. Zerden said that Rep. Stam's point related to whether a pregnancy is actually unintended is well taken, as there are women who don't really have a plan and those may be counted as unintended, but the point is that those women need to be engaged in reproductive life planning discussions. Birth spacing is one of a number of conditions that can impact preterm births, and with reproductive life planning discussions, providers help women address behavioral and health factors that would increase their chance of having a healthy pregnancy.

Rep. Stam said that if you focused this effort with LARCs on populations who were more at risk for preterm birth or low birthweight births rather than just everyone, you would have a lot more efficacy without the unintended costs. Also, if for example a women elects to have an IUD because she doesn't want to get pregnant for two more years but then it ends up being 8 years later that she gets pregnant just because of inertia, the result is that she has children at a much older age which has its own negative consequences.

Kate Berrien said that LARCs give physicians an opportunity to get mom's medical conditions under control before she gets pregnant. There would be cost issues if for example there was payment to insert LARC and another payment to take it out only 6 months later, but when this issue has been looked at, they found that with more than 75% of users LARCs were still in after two years. So, there is a reasonable return on investment in addition to the health benefits. Dr. Verbiest commented that it's important to note that women are very satisfied with this method and all women should have access to a method they are most satisfied with.

Duke Endowment work on LARCs – Tamika Williams

The Duke Endowment funds in both North and South Carolina, and one of their funding areas is Child Care. They primarily focus on children who are in out-of-home care settings, so they work to help these children; they also focus on prevention and early intervention to avoid out of home care.

The way they got into teen pregnancy prevention was seeing that many of the children they were serving were children of teen mothers, and while they had been focused on efforts with the family after the child was born, staff began to think about funding further upstream – helping to prevent early pregnancy; specifically those born to teen parents. In 2010 and 2011 they began working on teen pregnancy issues. This led them to conversations with South Carolina (SC) because they were doing a lot of work with reducing teen pregnancy, including LARCs.

The keys to success in SC with LARCs fell into 3 categories: infrastructure, a payer source, and a convener/connector. In terms of infrastructure, SC has state-funded clinics located across the state. To generate a payer source, they looked at Medicaid related births and the costs of those births, the use of the NICU, and adverse health issues and realized they needed to focus on reducing unintended births to manage costs and

improve birth outcomes. (This became known as the Birth Outcomes Initiative.) They were able to de-couple for separate billing with postpartum insertions. SC issued a Medicaid bulletin in 2012 that explained how to bill for LARCs in the hospital, along with offering some webinars and guidance. They also increased their LARC reimbursement rates.

With respect to having a convener/connecter, local clinics were reluctant to be the lead for this conversation due to negative stereotypes related to LARCs. However, the SC Campaign to Prevent Teen Pregnancy had lots of partnerships across the state with groups focused on this issue of reducing early pregnancy. The SC Campaign to Prevent Teen Pregnancy was well- positioned to convene and connect local groups and help facilitate conversations about LARC. They also worked to inform the state legislature about teen pregnancy issues. This organization had a positive reputation in the state, so having them step in to do work and to provide research as well as training and technical assistance was critical.

Ms. Williams said that having executive leadership on this issue was critical in SC, and they had good state leadership interested in spreading the message. Also critical was a commitment to change and acknowledging that they needed to do better. For clinical work, they realized they needed to involve coding staff, administrators, and providers to understand the billing issues. Also, they needed to figure out the best ways for providers to partner with teens to help them receive regular care, and to be able to address health issues such as STDs. They also recognized the importance of community engagement, and education related to modern LARCs. They knew the conversation they needed to have with the community was not about pushing LARC but about providing teens with good care, education about contraceptive choices, and access to whatever method they chose.

Rep. Stam said that the prices on the internet for IUDs are way lower than what has been cited here today, one internet figure is $325 to $400, one is $175 to $600, so what is the actual cost? Ms. Williams said she did not know the actual costs, only the reimbursement rates in SC. For example, the reimbursement rate for one device used to be $588 but now is $717 (she cited other rate examples).

Dr. Verbiest said that one potential recommendation for the committee could be to unfreeze the Medicaid rate for reimbursement for LARC. Rep. Stam said that for the full committee we should try to get to the bottom of the cost issue. Dr. Verbiest agreed that we need to be clear about the cost issue and about data that links this to birth outcomes. Kate Berrien said that for example, Mirena cost is $810 but that rate is frozen at $745; Liletta cost is $600 and the Medicaid rate is $650. However, when 25 are bought at once, the price is reduced.

Dr. Verbiest said that with the caveat that we will provide cost information and information on linking LARC to birth outcomes, is there a recommendation that the group wants to put forward? (Dr. Verbiest then explained the 4 levels of support the CFTF could elect.)

Kate Menard asked whether this group could do anything related to hospital availability. Pamela Thompson asked whether at the postpartum stage, providers are more likely to recommend a more or less expensive device. Dr. Zerden said that it's important for the patient to have information about all of her options so that she and her provider can come to the right decision.

Janice Freedman made a motion for the committee to recommend support for unfreezing Medicaid reimbursement rates for LARC, the motion was seconded by Cal Hayslip, and the motion passed by a unanimous vote.

Dr. Verbiest said that this committee could make an administrative recommendation related to the postpartum barriers issue. Belinda Pettiford noted that there are parties already working on this issue. Dr. Verbiest made a motion that the CFTF administratively work with parties already working on challenges related to postpartum insertion of LARC in the hospital setting.

Sen. Barefoot asked when the conversation about LARC happens with the mother. Kate Menard said that conversations should be taking place repeatedly at prenatal visits. Sen. Barefoot said that with the many women who don't get prenatal care, and asked when would that conversation take place? Dr. Hayslip said that the conversations including risks and benefits would be taking place whenever a woman is seen by her doctor. Sen. Barefoot asked whether it would be possible for this to be done in the hospital without ever having had discussions previous to delivery at the hospital. Dr. Zerden said that it is important for physicians to make sure a patient is informed, understands the risk factors, and is able to give informed consent. Sen. Barefoot asked if in the circumstance where there has been no prenatal care and a woman's delivery is her first time to see the doctor, is there a certain amount of profiling that take place or will the doctor ask every patient they have whether they want one of these devices? Dr. Zerden said that for any woman who comes in for care, you may have that conversation, and it may depend on previous conversations. Dr. Hayslip said that before the postpartum mother is discharged, contraception is part of what is supposed to be discussed by the clinician – it is a clinician responsibility for this to be discussed.

Janice Freedman commented that much of this is about public education and provider education, and we should look at what South Carolina did.

Rep. Stam said that most teens who give birth are actually 18 or 19 year old adults. Also, we should concentrate our efforts on those women who are at high risk for having a premature or low birth weight birth.

Dr. Verbiest asked that the committee go back to the motion that was on the table that was administrative in addressing challenges in the postpartum setting. She said it is important that the committee continues to learn more and discuss who is getting LARC, who is not getting it, how the conversations are taking place in NC, and that we keep this as an issue we want to continue to study.

Rep. Stam asked for clarification on the postpartum issue, and Dr. Verbiest said that the issue is for the postpartum mother to be able to access LARC as conveniently as possible so that we don't miss the window of opportunity we have to support her contraceptive goals and plans; being a new mom is a challenging time in life and we want to facilitate her decision.

Sen. Barefoot said that if this is a challenging time and the conversation was not started early on, that's an issue. Belinda Pettiford said that the issue is making sure there is informed consent – it still has to be her choice. Kate Berrien said that hospital administrators in SC spent time making sure there was informed consent prior to making LARC available postpartum in the hospital. Ms. Berrien said no one wants a patient to have LARC without informed consent.

Sen. Barefoot said that his next question would be what is informed consent in this situation? How much time should the patient have to make this decision? Sometimes a mother is in the hospital briefly.

Dr. Verbiest said that these are very important conversations that should be continued. She asked the committee to go back to the motion for administrative work that was on the table. Dr. Hayslip made the motion, Steve Kandall seconded the motion, the motion was approved by a unanimous vote.

Belinda Pettiford explained that the next presenters were here to share information about a Wake County prenatal care initiative.

A Wake County Prenatal Care Initiative – Dr. Sharon Foster, pediatrician and member of Wake Human Services Board; Ida Dawson, Wake Human Services [see online presentation "WCHS Dawson 02-10-2016"]

Dr. Foster said that in 2012, Wake took the challenge that they wanted to become the healthiest capital county in the U.S. and currently Wake is #4. One of the priorities the public health committee of the Human Services Board

took on was decreasing low birth weights and the infant mortality rate. Ida Dawson, who is head of the perinatal clinics, made a presentation to the Wake County Commissioners as to their plan, and the commissioners voted to fund an expansion of the clinic. Dr. Foster said they see this as an opportunity for counties without prenatal care to learn from their program.

Ida Dawson explained that Wake is unique in that they are a Human Services Agency, not a typical health department. In 1988 the infant mortality rate was in the double digits, and Wake County opened its maternal health clinic and began providing care to low-risk pregnant women. Ms. Dawson presented a graphic on the infant mortality rates between 1988 and 2014 in Wake and in NC. She pointed out the large racial disparity in rates and the need to address this issue.

Her clinic is the largest provider in the county of prenatal care. The request they made to County commissioners was for 7 FTEs in order to establish maternal care services at their Millbrook location, projecting 4,000 additional visits as a result, and to re-establish 2012 service levels that include some evening and weekend hours, projecting 1,700 additional visits as a result. Looking at statistics, they knew that pregnant mothers were not getting as much prenatal care as they should, not nearly enough prenatal visits, and the ability to have more women seen was critical. When women couldn't access their clinics, the overflow was going to WakeMed emergency departments, as these women did not have other good provider options. It was brought to their attention that WakeMed was seeing an increasing number of women presenting in the second or third trimester without adequate prenatal care.

Most of their patients are medically low-risk but socially high-risk. The goal is for women to get in to prenatal care as early as possible to address medical or social issues. Many women said they did not come to the clinic because they couldn't get an appointment – there were long wait times. Ms. Dawson stressed the fact that they presented data and the ability to show a return on investment to their commissioners to get funding for their initiative, and she also stressed the importance of community advocates.

Sen. Barefoot commented that he wanted this presentation to take place because one area he represents is Franklin, and such things don't exist there. Dr. Foster commented that anyone who takes on the initiative to do this in their health department should partner with hospitals. Keeping just two mothers from presenting at the hospital with early labor by providing good prenatal care can save $30,000, demonstrating cost-effectiveness.

Fetal Alcohol Spectrum Disorders – Amy Hendricks, NC Fetal Alcohol Prevention Program [see online presentation "FASD Hendricks 2.10.16condensed"]

Ms. Hendricks noted the news lately addressing current CDC recommendations for pregnant women consuming alcohol. She explained FASDs as the spectrum of conditions that can occur when a woman consumes alcohol during pregnancy (slide 4). FASD is not a diagnosis rather, how the issues presents is a diagnosis. She passed out dolls demonstrating the types of presentations with babies on the spectrum.

She explained possible impacts of alcohol use (slide 5 and 6). Alcohol is a teratogen, which can cause premature birth, pre and postnatal grown restriction, physical malformations, SIDS, cognitive and behavioral problems. There are multiple critical periods of exposure during pregnancy that not only impact birth outcomes, but can cause intellectual disabilities, learning disabilities and challenges with behavior that will present across an individual's lifespan. Those in the field are very concerned about women who are consuming alcohol before they even know they are pregnant, as damage to the fetus can occur as early as 3 weeks, which may be prior to a woman realizing she is pregnant.

1 in 20 children may be impacted by FASD. SIDS is more likely with a woman consuming alcohol during pregnancy as compared to tobacco or cocaine, both of which also increase risk of SIDS. She showed a graphic illustrating the

impact of consuming various substances during pregnancy (see slide 11). She explained the scope of the issue (slides 12, 13) related to the numbers of women consuming alcohol while pregnant and other statistics.

Ms. Hendricks explained and showed slides on the CDC recommendations (slides 15, 16) for all women and pregnant women related to alcohol, and how no amount of alcohol during any stage of pregnancy is safe. However, women get mixed messages from health care providers. Primary care physicians need to be educated about the importance of educating their patients on this topic. Ms. Hendricks's presentation included goals for prevention and increased awareness, and the charge for prevention (see slides 20, 21).

Update on Perinatal Quality Collaborative – Dr. Martin McCaffrey [see online presentation "PQCNC at PHC McCaffrey 2-10-16"]

Dr. McCaffrey explained the mission of their initiative (slide 2), the hospitals participating (slide 3), and the initiatives specific to 2015 (slide 4). He explained their work on neonatal abstinence syndrome (NAS): standardizing the protocol within the hospital, standardizing the scoring, finding an optimal room in the hospital, and encouraging breastfeeding.

Dr. McCaffrey showed graphs on the decreases they have been able to achieve for average length of stay for all NAS infants (slide 6), and for pharma treated infants (slide 7). He also showed a graph on NAS infants receiving pharma treatment (slide 8), addressing the potential reasons for the increase in the % of infants being pharma treated (slide 9). A graph was shown illustrating a 20% reduction in NAS infants hospitalized in the NICU (slide 10), and the days to reach a peak pharma dose for an NAS infant. They have seen a 20% increase in infants receiving breast milk (slide 13). They have also seen an increase in maternal use of heroin (slides 14, 15, 16, 17). A summary of their work on NAS was presented in slide 18.

Dr. McCaffrey explained PQCNC's work with managing preeclampsia (slides 19 – 25), estimating that the impact of their work avoids 98 non-indicated preterm deliveries per year (50% reduction) which results in several million dollars in cost savings, plus improved maternal health. Dr. McCaffrey said that for 2016, they planned to continue their work on preeclampsia, and they were picking a new nursery/NICU project.

Dr. Verbiest thanked Dr. McCaffrey and then moved the committee forward to finalize other recommendations for the full Task Force.

Tom Vitaglione provided an update on Medicaid coverage of lactation services, saying that the work group provided comments for the stakeholder period and that it would provide comments during the public period as well. Progress is being made on this issue but there is more work to be done. A motion was made by Mr. Vitaglione to have as an administrative item on the action agenda to continue working on Medicaid coverage of lactation services. The motion was seconded by Dr. McCaffrey. The motion was approved by a unanimous vote.

Belinda Pettiford said that there are other items proposed for track and monitor:

- Medicaid Reform
- Legislation pertaining to substance-exposed newborns
- Licensure for International Board Certified Lactation Consultants (carry over)

Susan Robinson moved for the committee to approve these track and monitor items, Starleen Scott Robbins seconded the motion, the motion passed unanimously.

Janice Freedman made a motion to also track and monitor all of the baby bundle funding items from last year. Steve Kandall seconded the motion, the motion was approved by a unanimous vote.

Belinda Pettiford provided an update as to what is going on in North Carolina to address Zika Virus concerns, and said that this issue is a priority for the Division of Public Health.

The NC Perinatal Strategic Plan – Dr. Sarah Verbiest and Belinda Pettiford [see online presentation "Perinatal Health Draft Strategic Plan 2-10-16 Pettiford"]

Dr. Verbiest explained how the NC Perinatal Strategic Plan has been developed with many important points in time in mind (see slide 2 on life course approach), and they have taken into consideration equity issues. The plan is comprehensive, not just what women and families can do, but what the community and larger society should do as well (slide 4—individual, interpersonal, organizational, community, and public policy realms). Those working on the plan worked with the Equity in Birth Outcomes Council, and many also participated in the federal Collaborative Improvement and Innovation Network (CoIIN).

Belinda Pettiford assured the committee that the plan was about to be released. She explained goal 1 – Improving Health Care for Women (slide 6), goal 2 -- Strengthening Families & Community (slide 7), goal 3 – Addressing Social and Economic Inequalities (slide 8), and the components of each goal.

Ms. Pettiford explained that the plan was being formally released on March 24th, hosted by DHHS Secretary Rick Brajer and Deputy Secretary Randall Williams, and that all CFTF members would be invited. She thanked those in the room who were on the planning committee for their work on the strategic plan.

Rep. Stam wanted the committee to know that Rep. Greg Murphy had just been appointed to the Task Force and was the only physician in the General Assembly, and Rep. Stam expects him to be an asset to the CFTF.

Meeting adjourned.