

Family Medicine Perinatal Planning Meeting
Monday September 21, 2009
Executive Summary

Purpose:

The participants in this meeting all have a shared passion for caring for women and infants. The overarching goal for this meeting is to determine how to apply that passion and skill toward a greater impact on women's and children's health.

- 1) **Network** - Family medicine practitioners who provide perinatal care are scattered across the state and may not know each other. There are other partners who work in perinatal health and share similar goals but may not be well known to family medicine practitioners.
- 2) **Share ideas and initiatives** underway in our various clinics, communities, and state
- 3) **Develop a plan for next steps** - What do we want to accomplish? How are we going to go about doing this? Where will we meet next? Who is going to do what?

Current Health and Care of North Carolina's Mothers and Infants:

Slides for this presentation as well as for the keynote address and presentation on data sets are available at www.mombaby.org in the yellow section. An update on the state of infant mortality and morbidity was given, using the newly released 2008 data. Overall there were not many significant changes in terms of adolescent pregnancy, early access of prenatal care and so forth. The infant mortality rate in North Carolina declined, with the state posting the lowest infant mortality rate for minority infants in its history. Unfortunately, there is still a greater than two fold disparity in infant mortality between white and minority babies. The update also included information about women's health in North Carolina. Data was also presented that looked at the numbers of family medicine practitioners who provided prenatal care and delivery services. Finally, recommendations developed by the Perinatal Health Committee for reducing infant mortality from a primary, secondary and tertiary prevention perspective were discussed.

Key Perinatal Health Initiatives and Advocacy Resources in North Carolina:

Perinatal Quality Collaborative of North Carolina

This collaborative was formed a few years ago, initially driven by neonatologists. Neonatology has the distinct quality improvement advantage of access to the Vermont Oxford Network database – an international database that allows for consistent data collection and benchmarking among centers both in North Carolina and beyond. At the present time they are focused on hospital-based interventions. The collaborative includes a leadership group of consumers – families of NICU infants. The group recently received support (via the NC Division of Medical Assistance) as one of 5 state collaboratives to be funded by the Federal Centers for Medical Services. They are now expanding into maternity care with the launch of the 39 week initiative. This project is focused on reducing late preterm birth by eliminating elective deliveries (inductions and c-sections) prior to 39 weeks gestation. Currently almost half (40) of the hospitals that deliver infants in North Carolina have signed on to the initiative. Jan Beste and Richard Hudspeth represent family medicine on the PQCNC board, although they have not yet fully been able to connect with this group. The next board meeting is in October and they plan to attend. The next PQCNC meeting that is open to everyone will be held on December 3rd at the Friday Center in Chapel Hill. For more information about PQCNC go to their website at www.pqcnc.org.

The Perinatal Outreach Program

This program, formerly known as the Perinatal and Neonatal Outreach Educators and Trainers, was begun by the General Assembly in the late 70s as part of the national movement toward regionalization of perinatal care. The program focused on regional issues relating to the delivery and care of high-risk infants and the care of pregnant women. At the time of regionalization in North Carolina, there was a statewide perinatal council, which helped to create regions, generally grouped around tertiary centers. There were also regional perinatal advisory committees, staffed by very experienced perinatal and neonatal nurses. The focus was to develop a system of care of which communication and education were the cornerstones. When system issues arose, the local councils would step in to provide support and enforce decisions that supported regionalized care. Over time the councils disbanded and the program evolved into largely providing training and technical assistance in the regions, with a particular focus on smaller hospitals and health departments. Areas where the regional nurses have been particularly active include: neonatal resuscitation, fetal monitoring, breastfeeding, and smoking cessation. They have also assisted in training when there are new mandates such as HIV and STI screening protocols and laws. The Perinatal Outreach Program's nurses are employed by a variety of institutions around the state (through contracts with the Division of Public Health) and their specific outreach has traditionally focused on the needs within their region. Two years ago, the program experienced a major shift when Medicaid began to fund a larger share of the program. This shift included a new focus on quality improvement with measurable outcomes. This year as part of this shift the Perinatal Outreach Workers are providing technical assistance to hospitals in their region that are part of the 39 week initiative. They are also partnering with the NC 17P Project to conduct a quality improvement initiative in 54 sites across the state representing private practices, health departments and high-risk tertiary care centers. For more information contact Joe Holliday or Kate Berrien.

Community Care of North Carolina

During the mid '90s with managed care sweeping the nation North Carolina visionaries came together to create a different kind of managed care. They built this on the principle that if you improve quality the cost savings will follow. Essentially this is a CQI model with a very wide reach. They began working with asthma patients first then went on to work with Medicaid consumers with diabetes and chronic disease including congestive heart failure. CCNC is a system in every single county, in many family medicine and pediatric practices – some internal medicine, a few OB/GYNs and very few nurse midwifery practices. CCNC provides case management for consumers with Medicaid but they know that physicians who take care of Medicaid take care of other patients as well. So changes in practice and management benefit everyone in that practice. For example, their asthma action plan is often rolled out for a whole practice even though CCNC only provides case management for Medicaid patients. Another benefit is that they have case managers embedded in practices working as close members of the care team. Their largest funder is Medicaid using a per member per month fee (\$2.5/member/month - \$5 for chronic). The May/June 2009 issue of the NC Medical Journal focused on CCNC. To read the issue click here <http://www.ncmedicaljournal.com/May-Jun-09/toc0509.shtml>. The CCNE website is www.communitycarenc.com or contact Richard Hudspeth.

Action for Children and the Child Fatality Task Force

The vision of Action for Children is to make North Carolina the best place to be and raise a child. Since 1983, Action for Children North Carolina, formerly known as the North Carolina Child Advocacy Institute (NCCAI), has acted as a leader in securing the opportunities needed for all of North Carolina's children to flourish. As a statewide, nonprofit organization devoted to

improving the well-being of North Carolina's children and youth, Action for Children uses highly-credible research, data collection, advocacy and education to influence the knowledge, attitudes and actions of a broad cross-section of people across the state. Action for Children also partners with community leaders to directly influence—in an independent, nonpartisan manner—the attitudes and actions of all people across the state. Their work to educate, engage and influence people has the ultimate goal of ensuring cost-effective policy and changes in practice that benefit and protect our state's children and youth. Their major work focuses on health, safety, early care, education, economic security, child maltreatment and juvenile justice. For more information go to www.ncchild.org

Child Fatality Task Force is a Legislative Study Commission that was launched when North Carolina was ranked last in the nation for infant mortality. A series of child homicides launched broadened the focus of the Task Force to include perinatal health, intentional death and unintentional death. The Task Force also partners with local Child Fatality Review Teams and the State Child Fatality Review Team. The CFTF has 34 appointed members included legislators from the House and the Senate and has automatic entry into the legislative session any time. The CFTF has visibility and leverage which has allowed it to move forward issues such as booster seats, graduated driver license, smoke alarms, carbon monoxide alarms, folic acid campaign, birth defect monitoring, initial PQCNC money, breastfeeding initiatives, 17P, safe sleep and more. The CFTF is available as a resource for ideas that need to be pushed – they will study and then if evidence based will move it forward. Pediatrics more organized and brought lots of issues to this group. Family medicine has not been as organized to date but are welcome to participate and bring ideas forward. The next meeting of the Perinatal Health Committee will be on November 2nd at 1:30pm at the General Assembly. All are invited. Contact Joe Holliday and Sarah Verbiest with questions

March of Dimes

The mission of the March of Dimes is to improve the health of babies by preventing birth defects, prematurity and infant mortality. As a non-profit organization, the March of Dimes has a strong advocacy network which includes an annual legislative agenda (federal and state), an advocacy day and alert/listserv. Through their advocacy, Cystic Fibrosis was added to North Carolina's robust newborn screening, there was increased money for birth defects monitoring program, new smoking legislation, a statewide multivitamin distribution program, and more. Their work with the folic acid campaign has decreased neural tube defects by 40% in North Carolina – by 70% in the western region of the state. They also have a community grant program where they provide large grants (up to \$50,000) as well as smaller grants for conferences and meetings. They are proud co-sponsors of the 39 week initiative. Their website is www.marchofdimes.com/northcarolina. Contact Anna Bess Brown for more information.

Keynote: Steve Ratcliffe and the IMPLICIT (Interventions to Minimize Preterm and Low birth weight Infants through Continuous Improvement Techniques) Network

Introduction: Dr. Steve Ratcliffe has rich experience and leadership in family medicine – through his work at Washington University and the University of Utah residency where he was Program Director of the Residency program and began community health centers in Salt Lake City. He is currently the Family Medicine Program Director at Lancaster General in Pennsylvania and is providing leadership to the IMPLICIT Network. He has a number of publications including the Family Medicine Obstetric Book.

Dr Ratcliffe began his presentation highlighting that he is here to serve as a sounding board for group and wants to be a resource for us. He is not trying to recruit the group to join IMPLICIT but they are open to new groups joining their project. For more information about IMPLICIT and to join up for their listserv / access their materials click here http://www.fmec.net/projects/project.php?project_id=127

IMPLICIT was started in 2003 at the Northeast Region State Family Medicine Meeting with coordination support from the Family Medicine Education Consortium, Inc. The National March of Dimes and leaders such as Brian Jack and Karla Damus were very instrumental in getting the network launched. They agreed to start with a focus on prematurity and began with 10 programs in the network. CQI is the impetus for this program. The sites that already have a culture of QI are doing better overall. HRSA recognizes IMPLICIT as a practice based QI network. They have done some research but as an offshoot of their CQI work. For example, they found that an initial two-question depression screening tool was a quick way to discern which patients were fine and which needed the full Edinburgh. Everything is transparent. The data can be really confounded and messy which makes research a challenge. They have about 3,900 patients in their network, 100 faculty and 200 residents. Their various practices vary 100-900 babies delivered each year. Below are a few points he described about their network. Slides are available at www.mombaby.org in the yellow section.

- 6 months of baseline data is now required for organizations interested in joining IMPLICIT
- All data entry is online – you can query your own data. The Family Medicine Education Center has supported the website for the project. Members can get access to all their articles, activities, updates and guidelines, as well as their data.
- Faculty have to review charts of their residents already – they now double this task by also using it as a chance to abstract data from paper charts and put it into the online data entry form.
- Faculty / resident synergism has really kept it moving forward
- Residencies – systems-based thinking is needed and this fits the bill
- Americorp / Masters students are also used to assist with data abstraction and collection / processing

Dr. Ratcliffe went on to describe the “Nuts and Bolts” of their work. His comments are described below:

- The Hawthorne Effect is certainly at play – giving each other constant feedback on performance does make a difference
- Engaged partners are important
- Since this is a CQI / Research Infrastructure the ability to get data for benchmarking purposes is essential.
- Structure – The IMPLICIT members came to an agreement that they would all do work. They have monthly audioconferences at 7am – rare that people miss and they get together twice a year in person meeting. No sticks – carrots – this is fun stuff and doesn’t take a whole lot of time.
- No free rides – emphasis on local fund raising and in-kind support to help local projects make this happen.
- The Co-Director Model works well particularly when the Co-Directors have complimentary skills
- Importance of strong program director / chair support
- Intellectual leadership – strong knowledge of the data and scientific evidence

- Nursing leadership is essential
- Site leaders are needed to keep things on task.
- Ability of faculty and residents to collaborate on project is a “gold mine”
- Master IRB document – various sites just have to tweak it
- Educating people to not do workarounds on electronic data
- You need to have a team on data – need real time data to really make this work – just old retrospective isn’t as good.

While IMPLICIT continues to focus on their current initiatives (depression screening, 17P, interpregnancy interval, smoking cessation, bacterial vaginosis, and asymptomatic bacteriuria) they are moving into preconception and interconception modules now.

NC Early Childhood Comprehensive System Plan

A grant from the MCH to the Division of Public Health provided support for pulling together shared indicators for school readiness. Their framework focuses on ready children, families, schools, communities, and state. This framework pulled different players together who were not as aligned as they could be to develop a way to glue disparate pieces together. As they were refining their set of indicators they asked questions such as a) is there an existing data source or one under development, b) is there strong evidence that the indicator is linked to the outcome, and c) is there general agreement among partners to keep the indicator? Their final master list is enormous and can be overwhelming so they often pull out subsets of the data for different presentations. The speaker challenged the group to think about the groups of indicators that would be useful for a family medicine perinatal care group. The conversation about indicators, evidence and data sources can be used as a communication tool to foster dialogue and engagement about what the group hopes to ultimately achieve. For more information go to www.state-eccs.org or contact Deborah Nelson.

Round Table Discussion:

Other Resources and Initiatives

Adam Zolotar mentioned the statewide PURPLE period of crying project aimed at reducing the incidence of shaken baby syndrome. He is the Co-PI on this project. Currently, DVDs are distributed to new parents by all hospitals / birthing centers in the state. The project is now moving into pediatric offices. The goal is to normalize crying and educate parents about how to deal with crying safely. Pediatricians have a card they hand out at every well and sick baby visit in the first 5 months postpartum. Posters are available to hang in your offices and they offer online training and nursing CEUs. The national website can be accessed by clicking here <http://www.dontshake.org/sbs.php?topNavID=4&subNavID=32>

Merry-K asked that people consider framing comments from prenatal care to preconceptional care to move the framework in family medicine. She suggested a number of resources including the CME and resources on the www.beforeandbeyond.org website which houses the National Preconception Curriculum for Health Care Providers. This site also contains links to all the Clinical Guidelines for Preconception Care which were printed in AJOG in December 2008 <http://www.beforeandbeyond.org/?page=key-articles-and-studies>. The Women’s Health Report Card is another good resource and can be accessed at http://cwhr.unc.edu/files/report-card-pdfs/rc-2009/2009_RC_Eng.pdf. The new www.EveryWomanNC.org site is now available as a centralized source of information about preconception health and women’s wellness in North

Carolina. Additionally, the March of Dimes has a growing body of resources available about preconception care click here http://www.marchofdimes.com/professionals/14332_1156.asp.

Sarah Verbiest mentioned the new You Quit Two Quit Project funded by the NC Health and Wellness Trust Fund. This project focuses on using validated tools to screen and counsel pregnant women and new mothers about smoking cessation. The project is currently doing a quality improvement initiative in four NC counties. Tools and methods for data collection, review and training have been developed. The project is happy to share this information as well as training and technical assistance to any clinic or group interested. To learn more about the project go to www.youquittwoquit.com. This could be one possible QI initiative

Carmen Strickland raised the topic of using the group care model for prenatal (Centering Pregnancy) and well baby (Centering Parenting) care delivery. She is a board member for Centering Health Care Institute (<http://www.centeringhealthcare.org>). The chair of the board is the past president of ACOG. There is a growing evidence base for this model of care. Group care provides an increased amount of time for education and creates a different relationship between the patients and the provider. Several different groups are using it for prenatal care but also for well woman care and well baby care. This model addresses social isolation and can also be cost effective – particularly for groups who are comprised of women who speak Spanish. Carmen’s group is one month away from starting its first class. Hendersonville and MAHEC are also preparing to start their first classes. UNC Family Medicine has made local modifications to the Centering Pregnancy and Parenting models and has been offering both for several years.

There are a number of challenges with getting this starting, particularly in terms of system change issues. It takes a lot of energy and buy in to run group care. It is also a challenge to keep it financially viable – the right numbers of women at the right time per class (the break even point is 4). Family medicine may not always be the best place because family medicine has lower volume. However, this is also one way for them to serve undocumented / uninsured women because while they may not make money on the prenatal care if this brings babies into their practice it can balance out in the end. Carmen is interested in knowing more about what other groups are doing. James Breen is interested in starting a group in Greensboro for Hispanic mothers. Centering Care for Hispanic moms is a way to muster all the forces to provide care to women within clinics where no one speaks Spanish. The Lincoln Community Health Center in Durham holds many groups for this population.

Nurse Family Partnerships were also mentioned – there are 8 partnerships in North Carolina. In this model a nurse provides intensive care to first time pregnant mothers beginning prior to 28 weeks through 2 years postpartum. This group might be a natural ally with family medicine – click here to learn more <http://www.nursefamilypartnership.org/index.cfm?fuseaction=home>.

Data

Several participants raised the issue about data as part of the round table discussion. Having timely data is essential to QI work. CCNC is in the process of building an informatics center to mine Medicaid data and pull different data sets together under one roof and then put it back out into the provider offices on a more regular basis. There was interest in being able to look at family medicine (as a group and by site) data in comparison to national standards and at the regional and state level - these indicators need to align with each other. IMPLICIT retrospective and prospective data sets are available for review online. IMPLICIT has collaborated with natural case managers (Healthy Beginnings) as part of their data collection endeavor. Joe

Holliday mentioned the Baby Love data set, which is collected by maternity care coordinators and includes an intake assessment, a closing assessment and interim services.

Family Medicine Practitioners and Perinatal Care Provision

The first area of discussion focused on impacting the number of family medicine physicians who are providing prenatal care. One way to do this is to increase the number of deliveries their residents are doing. Steve Ratcliffe published a paper that showed the number of deliveries/month performed by family medicine physicians in a community health center was associated with the number of physicians who went on to provide OB care (15 is magic number). As mentioned above, partnering with local health department to address coverage for uninsured – largely for Hispanic women – can be beneficial to family medicine. Provision of low cost prenatal care will eventually bring the children and the payment for the children, which will make up for the low prenatal care over time. This gets at family medicine’s goal of providing family centered care. In the western part of the state this arrangement has brought 120 patients from health department/year and hopefully the retention of 90% of those babies. As these numbers increase so will exposure to deliveries for family medicine residents. Prior to increasing their prenatal patient numbers, one graduate was willing to do prenatal care, with increased numbers 6 this year are willing to do prenatal care. This is a way to reseed their practice from the significant decline. Steve suggested that family medicine look within their community and network of care and find ways to partner to bring that prenatal care back. It requires a mindset within the profession to re establish the levels of prenatal care they were providing in the past.

The second point of discussion focused on creating a clearer identity as a group. In order to move forward on this issue, it is important to know who the ~160 physicians providing this care are in North Carolina. Where are they practicing? The Sheps Center has some data for the family medicine physicians who checked they provide prenatal care when they were renewing their license. Determining who has delivery privileges in the 88 delivering hospitals is another approach. By finding out who is working in family medicine in perinatal medicine, this group can then reach out and engage / support them.

Big Questions

The group raised several very core questions that will continue to require discussion.

- While we clearly want to improve the health outcomes for mothers and infants is that the primary focus OR do we look to improve our practices of our care? There is an important difference between addressing process and outcomes.
- What is the universe of possibilities?
- Family medicine could look at population based data as far as where to begin – we could influence the ~4000 women that family medicine resident programs serve and/or reach all family medicine docs who deliver babies (10%). OR the group could come up with a mechanism or system that plays to larger indicators and goals that can then be moved into policy.
- What do we want to accomplish? Are we trying to impact maternal health or our practices? Timely entry to prenatal care is one issue to consider – currently there just aren’t enough care providers for women.
- Do we want to change the number of family medicine providers who practice OB?
- Is this an advisory group for other family medicine – to support the people who are already out there practicing this care?
- In considering QI should the focus be regional? Community-based? Academic-based? State-based?

- Should this group become an advocacy group for family medicine?
- How can this group inform other statewide initiatives and work? Some hospitals create barriers to family medicine to prevent them from doing deliveries. This is a regional issue. The northwest of NC has few barriers while the south and north east of the state has many barriers.

Areas to Consider:

- Contact the folic acid campaign to link into the 2009-10 free multivitamin distribution project. Email Amy Mullenix at amullenix@marchofdimes.com or go to www.getfolic.com
- There may be some policy changes around the Medicaid Family Planning Waiver that could benefit populations cared for by family medicine. Right now it is complicated for women to move from Medicaid for Pregnant Women to the Family Planning Waiver. Babies are automatically enrolled in Medicaid. There may be some policy / service synergy that family medicine could effect to improve the continuity of care they can offer to mother/baby dyads.
- Call for a review of regionalization in North Carolina. There is concern that past trends are starting to reverse. Examine this in the context of access to perinatal care for women across the state. Also in light of the fact that referral patterns often have to do with relationships and patient preference.
- Start with the low hanging fruit – preventive education to women who are receiving care. Very few women are getting the info they need. If every woman of reproductive age who is cared for by a family medicine practitioner receives info about vitamins or reproductive life planning this will make a difference. If we look only at the uninsured we're setting up an existing barrier.
- Family medicine has a very unique role it can play in Preconception / Interconception health. The IMPLICIT network is moving clearly in this direction with the introduction of four interconception projects. They are looking at initiatives that can be embedded in a well child / well family format. Areas such as depression screening, birth intervals and smoking encompass prenatal, postpartum and interconception health.
- Family physicians should be engaged at some level on the March of Dimes late preterm birth (39 week initiative).
- Consider a collaborative or partnership around group care / well baby / well family care models. There was also a lot of conversation about the well family assessment.
- Focus on the training of residents and their knowledge base around QI, interconception care, and perinatal medicine. The residency program at Coastal Family medicine focused on one initiative (diabetes). They taught quality assurance techniques around this issue to their residents and then they went out to do it in the community. It's ok to start this with residency. This creates practitioners out there who know what they're doing.
- Pregnancy is a stress test for life. At present only 10% of family medicine practitioners are providing prenatal care – in part driven by malpractice. One key barrier is that only two companies that will cover family medicine to do OB care. With this in mind, how can we make care seamless as women go into ob/midwifery care during pregnancy and then back to family medicine.

Next Steps:

The group agreed that this first meeting was a success in that it established a starting point for collaboration with representatives of family medicine leadership from across the state.

- Develop, review and share the executive summary of this meeting. (Sarah Verbiest)
- Reflect on this meeting and share ideas / insights with group via email.
- Locate and reach out to all the family medicine practitioners in NC who provide perinatal care. (Dan Frayne)
- Reach out to the academic groups who did not attend the meeting.
- Send representation to the next PQCNC meeting in October (Jan Beste and Richard Hudspeth)
- Conduct a brief survey of practitioners (described above) to learn more about their interests / needs / communication preferences (Sarah Verbiest – graduate student help is needed)
- Send a representative to the IMPLICIT meeting at the end of October.
- Move forward with CCNC to engage them in the NC 17P Initiative (Richard Hudspeth and Sarah Verbiest)
- Provide follow up information to the group about possible pilot funding / opportunities related to the interconception waiver initiative as well as other directions CCNC is taking in terms of serving OB populations. (Richard Hudspeth and Sarah Verbiest)
- Consider using the NC Association of Family Physicians conference in Asheville (first weekend in December) as a next meeting point. Jan Beste offered to find a place on the agenda and a meeting site during this meeting for this group.
- Sign up for the IMPLICIT network and begin to access their modules and information online as a way to become more familiar with their work.
- Reflect on the issues raised in the “areas to consider” and determine feasibility of incorporating some of these issues into practice. Consider personal areas of passion and capacity to provide leadership on a specific issue.
- The upcoming Sept/Oct 2009 issue of the NC Medical Journal focuses on preconception health. An article co-authored by Dan Frayne, Jan Beste and Richard Hudspeth will be included. The issue can be access online at <http://www.ncmedicaljournal.org> in early November.
- The Forsyth County Infant Mortality Prevention Coalition is sponsoring a statewide symposium on Preconception Health on October 27-28 in Winston Salem. Information about this symposium may be found on the Northwest AHEC website by clicking here http://northwestahec.wfubmc.edu/courseware_v3/3_0_0/index.cfm?method=doTransition&_webFlowTransitionId=SET_EVENT_SEARCH_TERM&searchTerm=preconception

Meeting Sponsors: The North Carolina Chapter of the March of Dimes, the UNC Center for Maternal and Infant Health, and the UNC Department of Family Medicine

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