California Medical Leadership Forum for Public Health/Preventive Medicine
44th Meeting (17th using Video)
September, 10th 2024, 8:00-9:30 am PST
MINUTES

This meeting used a Zoom account from CAPM with phone access provided. "Handouts" (i.e., the agenda, last meeting's minutes) were attached to the email notice. All attendees except those participating by phone could enter information in "Chat." Web references for some agenda topics were embedded in the agenda.

Dr. Hattis officially began the meeting at 8:00, noting this is the 44th meeting and the 10th year anniversary of the California Medical Leadership Forum for Public Health and Preventive Medicine. He began with a welcome and overview of the agenda including the topic of maternal morbidity and mortality, and how it is reviewed in California. He noted that in between two parts of the presentation, we will include our usual roundtable for participants to provide news of what's happening and introductions and then discuss which pregnancies are likely to be highest risk and how to improve outcomes. There will also be a brief presentation from Cynthia Mahoney on the issue of voting as a social determinant of health (SDOH). Ron noted that the AMA has recognized voting as a SDOH but added that he questions if it is a determinant of health or more of determinative democracy.

I. Approval of Minutes:

Dr Hattis asked if there were any additions, corrections, or comments regarding the minutes, and there were none. Dr. Mankar made a motion to approve the minutes and Traci seconded the motion. Participants were invited to unmute and say 'aye' or show of hands which indicated approval of the June minutes. There was no opposition.

II. Special Topic I: <u>MATERNAL MORTALITY AND SEVERE MORBIDITY: RISKS, MONITORING, PREVENTION</u>

Dr. Hattis introduced this topic by noting that pregnancy-associated mortality is not a cause of a great number of deaths, but is important with respect to rates rather than numbers, in two respects. The rate in the US is higher than that of most other developed countries. We also have inequities in that Black women have the highest mortality, Native American women also have a high rate, and Latino women have higher mortality than whites or Asians. Also, years of preventable life loss are significant when women of pregnancy age die. Pregnancy-associated mortality is also associated with neonatal mortality, which causes even more years of preventable4 life lost. Ron went on to ask, what is the goal of public health, reducing raw numbers of mortality and morbidity, or seeking equity and improvement in rates? Dr. Michael Samuel of CDPH, who is present today and has presented to us in the past, has provided statistics showing that among women in the 15 to 45 age range when pregnancies occur, the top causes of death include opioid overdose, suicide, homicide and motor vehicle accidents. But if we are looking at rates, then maternal mortality is an issue. Dr. Hattis asked Paula if there was anything else to add and to tell us about

the pregnancy-associated review system, risks that have been found through this system, and ideas for prevention.

PART A: Guest Speaker, Paula Krakowiak: She is Chief of Maternal Mortality Investigations Unit at the California Department of Public Health (CDPH). Paula shared a slide presentation titled **"Maternal Mortality in California: Trends, Risk Factors and Prevention Opportunities".** This included:

1. Overview of maternal mortality and trends in disparities in California
    a. Paula confirmed that the US has the highest rate of maternal mortality among developed countries, and that black women have by far the highest rate within the US.
    b. She also confirmed that actual numbers are not high. There are about 700 deaths per year in the US and 60,000 morbidities not resulting in death. About 70% of pregnancies are uncomplicated. Among the complicated ones, there is a 1% mortality.
    c. 3 commonly used terms to measure mortality: *pregnancy- associated mortality* includes death due to any cause during pregnancy or with-in one year of pregnancy; A sub-set of pregnancy-associated mortality includes *pregnancy-related mortality (CDC)* with-in one year of delivery that are considered to be related to the pregnancy; *Maternal Mortality* as defined by the World Health Organization (WHO) is more restricted by time, including deaths during and up to 42 days after pregnancy that are related to pregnancy or its management.
    d. Two common measures include the Maternal Mortality Ratio (MMR) and Pregnancy-Related Mortality Ratio (PRMR). The MMR data is found only from death certificates and ICD-10 codes for obstetric deaths up to 42 days after pregnancy. The PRMR information is up to 365 days after pregnancy and death is identified thru medical records, hospital data, ER reports, coroner reports and expert committee reviews.
        - Dr. Hattis pointed out that violence including homicide, opioid overdose. and other public health issues in the US can confound this data if you weren't looking specifically at the cause of maternal morbidity and mortality. The US has relatively high mortality in the 15-45 age group unrelated to pregnancy, compared to other developed countries, and including an entire year after delivery creates the risk that data on true pregnancy-related deaths could be contaminated by this background mortality. He asked how that information is removed from these data. Paula stated that this is a factor in pregnancy-associated but not pregnancy-related mortality. The numerator is *pregnancy-related* deaths excludes incidental and accidental deaths. Paula noted that the MMR only focuses on obstetric deaths and medical causes, thus, by definition all injury-related deaths are excluded. The PRMR is also supposed to exclude injury-related deaths but notes that depending on how some states review the reports, it may include some pregnancy-related injury deaths. Usually, however, comparisons are talking specifically

about obstetric-related deaths and not injury, homicide or drug overdose. The denominator for the measures is per 100,000 live births.

2. Examples of prevention opportunities: CDPH has two programs dedicated to tracking and investigating maternal mortality.
    a. California Pregnancy Mortality Surveillance System (CA-PMSS) provides timely and accurate statewide counts and rates of death related to pregnancy.
    b. California Pregnancy Review Committee (CA-PARC): conduct in-depth reviews of deaths to identify prevention opportunities.
        - They also have DATA dashboards where they publish information
        - Paula showed an example of data from 2013-2021 showing pregnancy-associated deaths, 55% were medical/obstetric-related. with 16% being other injury, 14% unintentional drug overdose, 8% homicide, 7% suicide. About one half of the medical deaths were pregnancy-related.
        - California has been consistently lower with pregnancy-related mortality across the country; However, this increased during the Covid pandemic.
        - Maps demonstrate mortality and morbidity by county in California, with higher rates in Southern California and the North Bay region.
        - Paula showed a slide with the leading causes of pregnancy mortality in California. CVD had been the leading cause of mortality until the pandemic. Most deaths occur around the time of birth, except about 1/3 of CV death occur late post-partum. It should be noted, that by definition, the MMR data does not capture this later death.
        - Racial-ethnic disparities continue to be greatest for black women with 3-4x higher rates. The trends did come down a bit, however most recently rates for Latina women have increased to 17.7. Rates of death for Native Alaskan/Native American were not shown due to need for at least 10 years of aggregate data. Native Hawaiian and Pacific Islander is also not included on the graph.
        - Characteristics associated with higher rates of pregnancy-related death include age older than 40, BMI great than 40, Medi-Cal insurance and living in less healthy communities. Sumedh asked what other factors may put users of Medi-Cal at higher risk. Paula thought complex mental-behavioral health factors, access to care and specialists may be a reason. Sumedh also inquired if CV risk is broken down by age. Paula did not have age stratified data but pointed out that although the rates are highest for those 40 years or older those who were in the death cohort were in the 30-34 age range and there may be more who are in this age range. Roughly half of the CV conditions are cardiomyopathy and some of that may be due to substance use, and that may be why it is showing up in

younger age groups. Brian Yadegari provided the following information via chat: on the question of cardiovascular outcomes by age: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9238523/ .

3. Paula shared a slide outlining how the CA-PARC maternal mortality review process works. Currently the focus is on medical causes rather than injury-related deaths and doesn't include deaths not related to pregnancy. Once reviews are completed data is shared with the public.
4. Contributing factors to maternal death are related to multiple levels of factors including factors related to patient, provider, facility. There are also, system-level and community-level factors. She provided an example related to cardiovascular (CV) deaths and the multiple related factors.
5. California Maternal Quality Care Collaborative (CMQCC) toolkits derived from maternal mortality review data are available and include a QS code.
    a. Hypertensive Disorders of Pregnancy, Obstetric Hemorrhage, Venous Thromboembolism, CVD in pregnancy and maternal sepsis. These were informed by the mortality reviewed done in California
    b. Quality Metric Toolkits include Support Vaginal Birth and Reduce Primary Cesareans, Early Elective Deliveries, and Mother and Baby Substance Exposure.
5. Questions, Answers and Chat discussions:
    a. Susan Bradshaw asked via chat what are the mortality and morbidity rates for African Americans and Native Americans? Christine Morton provided the following information links: CDPH Data Dashboards https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Pregnancy-Related-Mortality.aspx
    b. Sumedh Mankar asked who makes up the expert committees reviewing the maternal mortality data. Christine Morton replied via chat that she works with Dr. Krakowiak and answered that there are diverse committee members that include nurses, midwives, ob-gyns, maternal-fetal medicine specialists (MFMs), ED and family medicine MDs, community health reps, doulas, and more. The project is based at the State California Department of Public Health, in the Maternal Child Adolescent Health Division. Christine also provided the following link and information in chat: https://www.cmqcc.org/research/ca-pamr-maternal-mortality-review. She works with CMQCC, which has been the "action arm" of this project, developing maternal quality toolkits for hospitals and healthcare teams to better respond to obstetric complications, hemorrhage, hypertension, sepsis, CVD, etc.
    c. Priyanka Fernandes asked how discharge data are captured and if this information is voluntary or mandated. Christine stated that all hospitals are required to send their discharge data to https://hcai.ca.gov/ which makes the datasets available for analysis. Priyanka wondered how births are captured, and Christine said this is via the birth certificates. They may not distinguish between attended/planned and unattended/unplanned births at home. Christy McCain also replied that they identify home births if there is a birth certificate issued. In CA birth certificates are issued for deliveries at 20 weeks' gestation or more.

d. Susan Bradshaw asked via chat if closing of hospital maternity wings increased risk. Dr. Krakowiak stated there are not a lot of data, but her opinion would be that it would affect mortality, citing examples of rural areas and lack of standardized process to take pregnant patients to an appropriate hospital. Cynthia McCain commented that we have not seen the effect of this yet but may in the future noting that at this time California does not have special hospital units for high-risk maternal levels of care similar to neonaltal intensive care units (NICU's) for high-risk infants.
e. Dr. Hattis inquired if cardiomyopathy is caused by pregnancy or is usually pre-existing. There have been discussions about this in the review committee, recognizing pregnancy can exacerbate CV conditions and either way it would be pregnancy-related. Dr. Tsai commented that it is likely a combination of both.
f. Christine noted in chat that their team looked at CV deaths in our first review - none of the women who died from CV causes had pre-existing disease. Hameed A, Lawton E, McCain C, Morton CH, Mitchell C, Main EK and Foster E. and provided link Pregnancy-related cardiovascular deaths in California: Beyond peripartum cardiomyopathy. From *American Journal of Obstetrics and Gynecology.* 2015
g. Dr. Rutherford asked how the data looks if you divided women into those with pre-existing disease (diagnosed or not) vs substantial disaster such as postpartum hemorrhage adding that it is his impression that about 80% pre-existing conditions and about 20% obstetrical disasters. Dr. Krakowiak replied that she would need to look at the data but added that hemorrhage is the second leading cause of death and is an obstetric emergency yet conditions like CV disease and hypertensive conditions can be pre-existing conditions that impact the emergencies. Christine Morton added in chat: Many hemorrhages are occurring now due to placenta accreta syndrome in which there is difficulty getting the placenta out. This can be the downstream consequence of multiple cesarean sections (CS).. CMQCC is working to reduce the first CS among low risk first time pregnant women.

6. Dr. Krakowiak concluded with a slide demonstrating 'from data to action" outcomes from their work and thanked her team providing names and emails on the slide that will be shared.

III. FOLLOW-UP ON "FUTURE OF PUBLIC HEALTH" FUNDING

Ron Hattis reminded the group that at the last meeting we passed a resolution to urge the Assembly and Senate budget committees to save the Future of Public Health $300 million per year program that the governor had removed in his deficit budget. Ron states the budget ended up with about an 8% cut rather than total elimination, and probably will not require layoffs. Don Lyman confirmed that this was correct as the legislative action was to reduce the budget for line items across the board by 8%. The budget has been signed into law. The Legislature is now adjourned, waiting for the election and will reconvene on December 1st for the new legislative year.

IV. Roll Call: There were 25 Identified Attendees

California Academy of Preventive Medicine (CAPM)

1. Ronald Hattis, President, led the meeting.
2. Sumedh Mankar Forum Vice Chair, conducted the roll call.
4. Donald Lyman, present, chairs legislative affairs for CAPM.
5. Susan Bradshaw, former president of California Academy Preventive Medicine, helps with legislative issues

Dept. Health Care Services

1. Karen Mark, present, Dr. Mark stated CalAIM is still funded although she does not have all of the details at this time. She also noted they have launched a birthing care pathway and are doing a lot of work to improve maternal mortality.
2. Anastasia Coutinho, present. She works with Karen Mark in quality and population division focusing on birthing care. She is a family doc and does labor and delivery.

California Department of Public Health

1. Michael Samuel, Office of Policy and Planning. Michael encouraged participants to look at his office's website for a huge array of data on maternal mortality, perinatal data, child related issues, nothing there is a huge amount incredibly valuable data on an excellent dashboard.

Public Health Institute

Christy McCain was present. She works in collaboration with CDPH and CMQCC along with colleague Christine who had to leave the meeting earlier. They have been working over 15 years on pregnancy-associated mortality review and she is excited that they are able to present the data back and hope that it continues. She notes they collect a lot of data. She has a medical abstractor, and they put together case summaries that are reviewed by committees that were discussed in the chat. They currently have a southern California and committee and are forming a Central Valley Committee. There was a committee reviewing COVID deaths and a committee on hemorrhagic deaths noting they go in depth in certain areas.

Ron noted that this Forum would like a closer relationship with the Public Health Institute, and that we have accepted Michael Rogdiguez who is running the alliance of the schools that give public health degrees that are not medical schools. Christy noted they have a new CEO, Stafford Jones, and they will see what direction she takes the organization noting it is an amazing organization

California Medical Association

1. Alecia Sanchez, present. She noted that this meeting is relevant to work they are doing and working with house of delegates in October on the issue of maternal health drivers, including the identification of maternal care "deserts." Major issues will be posted to the website on September 24th and CMA members can view, comment, and provide feedback as it relates to policy. She also noted that CMA established policy is in alignment with the AMA

regarding voting as a Social Determinant of Health. Alecia also noted that CMA is actively engaged in effort to pass proposition 35 related to funding for Medi-Cal raised thru the managed care organization tax. This would make the funding permanent and establish criteria that would stay in place over time, noting this could be an entire conversation in itself. The CMA has a website for further information and materials. Alecia also provided the following links in chat:

a. Protect Our Health care (cmados.org)
b. The Medical Board of California worked to amend the licensure application in a way that will reduce stigma for seeking mental health care. CMA praised medical board for reducing stigma around physician mental health (cmadocs.org)
c. CME Next Virtual Grand Rounds to feature the Surgeon General on new program to reduce maternal mortality (cmadocs.org)

Medical Schools

Touro University California, College of Osteopathic Medicine

Traci Stevenson, Forum Secretary and professor at TUCOM shared that because of the discussions held at this Forum she has been able to integrate information into the undergraduate medical curriculum. This includes gun safety from Stanford with Drs. Parsonette and Winslow and the excellent resources from Bulletpoints all of which was learned through this Forum. She states that students are now actually requesting further gun safety training including attendance at the upcoming SAFE conference. Likewise, Dr. Mahoney (who will provide a brief talk today on voting as a social determinant of health, SDOH) will provide a lecture on voting hosted by Touro, further information below and shared in the chat. Dr. Stevenson also provided a link in the chat to the upcoming SAFE (Scrubs Addressing Firearm Epidemic) Zoom meeting for anyone interested. It is rewarding to be developing these collaborations and look forward to more.

Loma Linda University

Brian Yadegari, present, noted he is a recent residency graduate Loma Linda. He will be giving a brief presentation following this roll call on maternal mortality in Part B of Special Topic I.

Kaiser Permanente,

1. Bernard J. Tyson, School of Medicine
2. Rose Rodriguez, present, shared that they graduated their first class in May of 2024 with successful matches noting all students matched. Their inaugural Dean, Dr. Mark Schuster, stepped down and the new Dean, Johnathon Ripple, started on July 1st. He is from Harvard and was senior associate dean of medical education. He is a gynecological oncologist and is "off and running," learning about the KP system and the school.

UCLA

1. Priyanka Fernandes, Program Director for the UCLA fellowship program.

2. Candace Michelle Grag, shared in chat that she is the ADP of the UCLA Preventive Medicine Fellowship.

UCSF

1. Roz Plotzker, Program Director at UCSF. She notes she is taking over the role from George Rutherford who is still in the faculty and joins these calls. They are in process of expanding their program to a satellite in Fresno and have their first resident starting in January. She provided a link to their updated website below:
   https://epibiostat.ucsf.edu/public-heaalth-and-general-preventive-meidcine-residency-program
2. George Rutherford, recently retired, was present and contributed to discussion.

V. Special Topic I, Continued: MATERNAL MORTALITY AND SEVERE MORBIDITY– RISKS, MONITORING, PREVENTION, CONTD.

PART B: Ronald P. Hattis and Brian Yadegari

a. Dr. Hattis introduced preventive medicine physician Brian Yadegari, noting that Dr. Yadegari worked with him as a resident 2 years ago at San Bernardino County to develop a proposal on prevention of maternal mortality. At that time, the Public Health Department in cooperation with the Loma Linda University Preventive Medicine residency were thinking of starting their own county pregnancy-associated mortality review committee. However, the department determined the State (California) had a good system under today's first presenter, Paula Krakowiak, so San Bernardino County will cooperate with-in that established system to focus on ways to identify high risk pregnancies and to mitigate the risks. Ron showed a handout (also included in the email announcement) built by Brian that addresses SDOH related to mortality and morbidity risks related to pregnancy. This is a self-scoring risk detection tool with a number of points indicating high risk pregnancy. He noted that being Black or Native American or having an elevated BMI > 40 add almost enough points to automatically categorize the pregnancy as high risk. Exposure to substances, including alcohol, methamphetamine, etc. is also captured and correlated pretty well to statistics. He noted this was the SDOH portion and the other outline includes work Brian wrote. It includes the OB risks to add to the point scores. It also includes mitigating activities that can help reduce scores.
b. Brian quickly highlighted the work, adding that the presentation provided by Dr. Krakowiak pointed to different family, community, and system factors among the 5 risks identified. The write up focused on those risks, noting many are associated with patient-related factors. It provides an overview of what might be contributing to each of the risk factors. There are multiple categories (such as age or BMI) and they did their best to risk stratify by scoring based on actual mortality rations and number. This is referenced in the handout that was sent to the meeting invite. He noted this was written 2 years ago, so some data may have changed. There is a list of resources to mitigate the risks that they made for San Bernardino County and the Inland Empire. The paper also includes a section where they focused on summary of guidelines and public health and community resources.

c. Ron added, because there is no budget for extra services for high-risk services, they wanted to make sure women at least got existing services such as WIC, housing services, etc. He also noted that the 'worried well' tend to get the most attention from physicians, and also tend to be the more affluent and lower risk. They need to identify and provide more prenatal attention to the higher-risk women, perhaps by tele-health and home visits to overcome time and transportation difficulties impairing clinic visits. To reduce stigma and to emphasize the importance of their pregnancies and of achieving optimum outcomes,, high-risk pregnancies should be called "deserving extra-care' noting that they deserve extra care, that their pregnancies is important. This is focusing on patients who deserve extra care rather than labeling high risk by race. He added this system has not been field tested but they are interested in anyone who would like to try it.

VI. Special Topic II: VOTING AS A SOCIAL DETERMINANT OF HEALTH

Presenter: Cynthia Mahoney

Cynthia provided a brief presentation on Voting as a Social Determinant of Health. She noted that she came to this topic in 2019 when she helped found Climate Health Now but didn't expect to be talking about it regarding voting in 2024. She said that the individual care, we provide in our office is no match for the health impacts of climate change.

a. She provided a graphic demonstrating social and environmental determinants on effect on care. This was followed by a slide recognizing the role of upstream *structural* determinants (often 'lumped' together as SDOH) such as voting.
b. Daniel Dawes at Morehouse School of Medicine notes that for every SDOH there is a decision or a structuring of resources that has enabled conditions to exist. It is argued that voting is the most important aspect of political determinants of health.
c. The healthy democracy index demonstrates the strength of this relationship as noted on a graphic that demonstrates states with more inclusive voting policies and greater civic engagement score much higher on a group of 12 public health outcomes.
d. Health professionals can advocate for policies that affect health and empower our patients to be informed voters for health creating a virtuous cycle.
e. Voting as a social determinant has been recognized by the AMA and CMA, it is included as a key metric in healthy 2023 and increasingly taught in medical schools.
f. As trusted messengers with connection to patients most likely harmed and with least civic engagement, we have opportunity to connect the dots for patients between their health and their vote. This is a form of anticipatory guidance.
g. Although some would argue this is too political, Cynthia referenced Virchow's statement that medicine is inherently political. She highlighted that what we must do is remain non-partisan while advocating for our patient's health.
h. Health professionals have historically voted 12-23% less than their peers which translates to millions that do not vote, with estimates as high as 7 to 8 million in the last general election.

i. Cynthia encouraged participants to help get out the vote by providing information on how to sign the "We Will Vote" Call to action organizational pledge and information on how to share with others.
j. Cynthia concluded that civic engagement does belong in healthcare because health is always on the ballot.
k. Questions, Answers and Comments:
    1. Ron Hattis provided two caveats, one that it is assumed people vote for their own interest, noting, however, they don't always do so, and that health is not usually a determining political issue and is currently outweighed by the economy and immigration. He also stated voting is less directly related to health outcomes than substance use habits, living in healthy communities, etc. He suggested that voting is more of a social determinant of democracy than of health.
    2. Michael Samuel added that his team has been doing some analysis, and it is intriguing that as additional evidence regarding the association of SDOH and voting at the community level suggests that perhaps in communities that have higher level of voting may also have some other advantages. For example, maybe voting leads to other community organizing that supports other benefits in their lives or it is a measure of other aspects of social cohesion.
    3. Cynthia agreed, adding that effects of voting are both direct by improving self-efficacy and also indirect. We tend to just focus on the top of the ticket. However, local elections matter to things such as 'do you have a cooling center in your neighborhood', 'how much pollution do you have' etc., so there are a lot of things that can be done. The county roadmap work information does show this at the level of small communities. She did not have time to go into detail today but would be happy to talk more about this at a time.
    4. Traci. Stevenson provided information regarding the talk Dr. Mahoney will be providing via Zoom hosted by Touro University College of Osteopathic Medicine and OPSC (Osteopathic Physicians and Surgeons of California), thanks to Holly Macriss at OPSC (also a representative on this forum) as part of OPSC commitment to awareness to inequities of SDOH. The program will be free for all and to share with fellow colleagues and students.

VII. Topics For Next Meeting and Conclusion

a. Participants can email Ron at preventivemed@aol.com if they have suggestions for future topics.
b. The meeting concluded at 9:33 am.

These minutes were submitted by Traci Stevenson, and were approved on January 14, 2025.