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Prevention of Maternal Mortality in New York State:

**Proceedings of the New York State Public Health and Health Planning Council's
Public Health Committee Meeting Series
and Recommendations for Action**

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of the New York State Public Health and Health Planning Council**

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I. Background and Introduction:

The *Prevention Agenda 2013-18* is New York State's health improvement plan developed by the New York State Public Health and Health Planning Council (PHHPC) at the request of the New York State Department of Health (NYSDOH), in partnership with more than 140 organizations across the state. The *Prevention Agenda* is the blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability, socioeconomic and other groups.

In addition to its oversight role for the *Prevention Agenda*, the Public Health Committee, under the leadership of chairperson Dr. Jo Ivey Boufford, identified Maternal Mortality as a specific health issue from the *Prevention Agenda* for special attention in an effort to “move the needle” on that condition in the State.

II. The Problem:

In 2012 and 2013, the Committee requested a series of presentations from Dr. Marilyn Kacica, Medical Director of the Department’s Division of Family Health, to provide an overview of maternal mortality data in New York State including a comparison to global and national rates, trends over time and disparities, and to learn more about current work to assess and address maternal mortality in the state. Key data highlights presented included:

- The United States ranks behind 40 nations in maternal death, and within the U.S. New York ranks 47 out of 50 states.
- NYS Maternal mortality rates peaked at 29.2 per 100,000 live births in 2008 and have decreased to 17.9 per 100,000 live births in 2013.
- There are significant racial and geographical disparities in NYS:
 - The Black to White mortality ratio peaked in 2006 at 6.3 to 1, decreased to 4.9 in 2009 and continued to decrease to 3.3 to 1 in 2013. However, in 2013, the rate in New York City alone was 5.7, much higher compared to the rest of the State (1.9).
- There were 132 maternal deaths for the three year period, 2011-2013.
 - 47 were non-Hispanic White women,
 - 57 were non-Hispanic Black women, and
 - 28 were Hispanic women.

III. Opportunities for Change:

Based on the information and discussions at these initial meetings, described in detail in the appendices to this report, and the ongoing work of several key organizations (including NYSDOH, the New York City Department of Health and Mental Hygiene, the Healthcare Association of New York State, the Greater New York Hospital Association, and the NYS chapter of the American Congress of Obstetricians and Gynecologists (ACOG) on inpatient hospital management, the Committee initially decided to focus on the “pre-hospital” antecedents of maternal mortality with special attention to prevention. In subsequent meetings, the group examined opportunities in New York State’s health care reform initiatives and better alignment for existing efforts across stakeholders. These are discussed in the following pages.

A. Pre-Hospital Opportunities in Clinical Practice

The Committee identified three specific cross-systems strategies from the *Prevention Agenda* for its attention:

- Integrate preconception and interconception care into routine outpatient care for all women of reproductive age.
- Assess and address pregnancy planning and prevention of unintended pregnancy among women in general and especially those with serious chronic conditions and risk factors
- Institute systems and protocols for early identification and management of high-risk pregnancies.

The committee convened a series of special meetings with invited discussants to further explore these strategies and identify recommended action steps and use its convening authority to bring attention to this important issue.

In March 2014, the Public Health Committee convened a special meeting focused on the strategy of **integrating preconception and interconception care into routine outpatient care for all women of reproductive age** as a universal/ population-based prevention approach. Staff from the NYSDOH Division of Family Health gave a brief presentation on national and state work on preconception health and health care, including recommendations from the CDC-led Select Panel on Preconception Care and the subsequent action plan of the National Initiative on Preconception Health and Health Care to guide the implementation of the CDC panel’s recommendations.

The Committee then welcomed three clinician panelists, invited to reflect on this approach from a “real world” practice perspective. Each panelist addressed a set of three questions:

- 1) How do providers who care for women of reproductive age currently incorporate preconception health care in routine outpatient practice?
- 2) What challenges or barriers exist to making this approach part of routine care?
- 3) What would support further integration of these practices in routine care?

Panelists described several innovative approaches they are using in their respective practices, especially emphasizing how to take advantage of “every” contact that women of reproductive age make with the health care system:

- At the Mid-Hudson Family Medicine clinic in Kingston, Residency Director Dr. Ephraim Back estimates that more than 70% of women patients have made some contact with his practice in the past year, for themselves or their family members. He is leading a project, as part of a collaborative network of 16 Family Medicine residency programs, which incorporates evidence-based interconception care (focusing on four specific elements of care) for women during their baby’s well child visits for the first two years of life.
- At the Institute for Family Health Harlem Family Medicine site, Dr. Lucia McLendon’s practice incorporates assessment of desire for pregnancy, with tailored same-day contraceptive services, into all visits with women of reproductive age.
- At Montefiore Medical Center/ Albert Einstein College of Medicine Department of Maternal Fetal Medicine, Dr. Ashlesha Dayal, a high-risk Obstetrician and Director of Labor & Delivery, developed a comprehensive program to target enhanced preconception/ interconception care to women at high risk for preterm delivery or other poor pregnancy outcomes. This program includes training for both primary care and specialty providers on screening and referral for high risk patients, as well as training for community health workers to expand preconception health education and outreach to the community.

Panelists also identified a number of challenges and barriers to routine integration of preconception and interconception care. Common themes included:

- women not seeking routine well care for themselves;
- inadequate time within a visit;
- provider knowledge/ comfort level, especially for pediatricians during children’s health care visits;
- lack of additional reimbursement for counseling;
- lack of health insurance (including waiting periods for benefits to begin after enrollment; post-partum gaps in coverage); and,
- increasing prevalence and complexity of chronic disease among women of reproductive age.

Panelists and committee members discussed a number of opportunities for advancing attention to risk factors for maternal mortality in this area, including:

- capitalizing on “missed opportunities”, including well child visits and all acute care visits, to ask women basic questions to assess their desire for pregnancy, and, if appropriate, initiate contraception in real time as part of routine care;
- enhanced reimbursement for clinicians;
- expanded use of available guidelines and toolkits for clinicians to support integration of key preconception screening within routine visits;
- incorporating protocols and referral linkages to facilitate more in-depth reproductive health counseling for women for whom medical risks are identified;
- developing more population oriented approaches to educating young people through linkages with schools, community based organizations and trained community health workers, reaching into communities; and,
- policy changes to address gaps in health insurance coverage and reduce or eliminate co-pays for preventive care.

B. Pre-hospital Opportunities to Prevent Maternal Mortality in NYS Health Care Reform

The Committee identified the opportunity to leverage larger health systems reform efforts to ensure that preconception and interconception care are addressed for women of reproductive age. Key opportunities include: Medicaid Health Home; Affordable Care Act (ACA) and New York State of Health (state’s health insurance exchange); Delivery System Reform Incentive Payment (DSRIP); and, Advanced Primary Care (APC) /State Health Innovation Plan (SHIP).

For the September 2014 meeting, NYS Department of Health staff leading three key health care reform initiatives were invited to share information about their work and to participate in a discussion of potential opportunities to incorporate one or more of the three selected key Maternal Mortality prevention strategies within those initiatives.

1. Dr. Foster Gesten, Medical Director for the NYSDOH Office of Quality & Patient Safety, presented an overview of the state’s work to support **risk-based prenatal & postpartum care for women enrolled in the state’s Medicaid program.**

- In collaboration with NYSDOH Division of Family Health and the Island Peer Review Organization (IPRO), Medicaid Prenatal Care standards were updated and unified in 2009-10. Since then, a series of analyses have been conducted including a 2011 baseline evaluation, and a statewide practice self-evaluation/reporting tool was launched in 2013.

Current work is focused on key opportunities for improvement activities, which were identified based on evaluation findings. While data indicate many potential areas for improvement efforts, several key elements of care have been identified for focused improvement including: assessment, treatment, and referral for depression and domestic violence; influenza vaccination, ; obesity and gestational weight gain, ; tobacco use screening and counseling, and prevention of recurrent preterm births focusing on use of 17-OH progesterone. Highlights of the follow-up discussion on potential areas of action included:

- The potential for adding assessment of future pregnancy plans and pregnancy prevention to the quality improvement plan. It was noted that this is currently embedded within the self-assessment reviews as an element of prenatal care standards.
- The extent to which reimbursement for counseling by non-clinicians might help improve preventive practices.
- A recommendation to add family planning providers as key partners for improvement activities.
- The value of Electronic Health Records (EHRs) that include algorithms and prompts to improve documentation of guideline-concordant care without the burden of additional documentation.
- The need to better assess the impact of loss of insurance coverage for women who lose their Medicaid eligibility postpartum.
- Potential strategies for promoting the use of 17-OH progesterone for women with prior preterm births.
- The potential for use of incentives to increase adherence to postpartum visits.

2. Hope Plavin, from the NYSDOH Office of Quality & Patient Safety, presented an overview of the **State Health Innovation Plan (SHIP)/ State Innovation Model (SIM)**; the state's application for federal funding was pending at the time of this meeting. The overarching goals of SHIP/SIM are to improve health, improve care and utilize health care resources more effectively. Funding requested in the state's recent SHIP grant application would support regionally-based primary care practice transformation, a transition to value-based primary care payment models, and performance improvement and capacity expansion in primary care including community-clinical linkages and an enhanced focus on prevention. Next steps include the establishment of workgroups and creation of a health policy agenda for 2015 and beyond, pending feedback on the state's submitted application.

3. Lana Earle, Deputy Director for the Division of Program Development and Management in the NYSDOH Office of Health Insurance Programs, presented an overview of the Medicaid (MA) **Health Home** care management program and led a discussion on its potential for improving health outcomes among women of reproductive age.

- Health Home (HH) is an optional Medicaid State Plan benefit authorized under ACA to provide comprehensive, integrated care management and coordination for Medicaid enrollees with chronic conditions which was implemented in NYS beginning January 2012. It is targeted to the highest-need/highest-cost MA members who have two or more chronic conditions or one single qualifying condition of HIV/AIDS or Serious Mental Illness and who meet "appropriateness" criteria for an intensive level of care management. HH is closely aligned with the state's Delivery System Reform Incentive Program (DSRIP).
- Over the January 2012 – August 2104 period, 55% of the HH members enrolled in NYS were women, and 35% were women aged 11-50 years. Approximately 9.5% of women enrolled in HH had a live birth during that period. Informal discussions with HH lead organizations suggest that they are incorporating a variety of approaches to address the needs of women of reproductive age within their comprehensive care plans, including the use of preventive and

specialty health care, assessment of pregnancy plans and linkage to family planning services, and linkage to prenatal services for women who become pregnant.

Highlights of follow-up discussion on potential areas of action included:

- The value of providing training for HH care managers on maternal risk factors and family planning, including simple assessment questions and interventions that could be readily incorporated with care management interactions. It was noted that there is an established system in place for providing such training and this can be pursued in collaboration with NYSDOH public health and external subject matter experts.
- The extent to which a previous adverse pregnancy outcome could be considered a “chronic condition” for purposes of establishing HH eligibility. This would not be consistent with CMS defined criteria.
- Interest in learning more about the ~10% of women who gave birth while enrolled in Health Home.
- How to better connect clinical providers with the resources that are available for their high risk patients, including HH as well as managed care plan high risk OB case managers and community home visiting services.
- The role of HH in supporting women identified with serious mental illness, including depression, during pregnancy or after delivery.

At the conclusion of the meeting, Committee members identified several follow-up requests (*follow up information noted*), including:

- Obtaining information on gaps in eligibility and enrollment in health insurance that may be impeding coverage for family planning and/or adequate perinatal care

Based on further inquiry with the New York State of Health and Medicaid, the specific scenario described could not be validated, as coverage for Medicaid begins immediately as of the date of application, while coverage for commercial plans begins between 2-6 weeks from the date of application. With the launching of the New York State of Health, many previous gaps in coverage are improving. Furthermore, effective January 1, 2016 in New York State, pregnancy is classified as a qualifying event triggering a special enrollment period for women using New York State of Health to access coverage. This allows pregnant women, who are not Medicaid eligible, to enroll in commercial health plans outside of the open enrollment period.

- Looking more closely at the subset of Health Home enrollees who have given birth to assess maternal risk factors and connection to services. Data on outcomes for women using health homes, including data on women with disabilities, and the costs of providing these services could be useful in the development of training for managers of health homes on women’s health.

An updated analysis of Health Home data demonstrated that among women ages 11-50 years enrolled in Health Homes from the launch of the initiative in January, 2012 through May, 2015,

about 4,900 gave birth. Staff in Division of Family Health are requesting additional data to get more information on these women and their diagnoses and the cost of their care.

- Pursuing training of Health Home care managers on maternal health and family planning topics/tools

Staff from the Division of Family Health and the Office of Health Insurance Programs will work together to develop a training for care managers on reproductive life planning and care management of high risk pregnant women in Health Homes in 2016.

C. Recent Updates and Next Steps

At the July 2015 Public Health Committee meeting, Dr. Rachel de Long, Director of the Division of Family Health, updated the Committee on work that is underway to use health care reform opportunities to support improvements in women's health. The discussion focused on ways to integrate pregnancy planning and, if pregnancy is not desired, tailored contraceptive counseling into routine care for women of reproductive age.

Dr. de Long explained that the goals for the emerging APC model within the state's SHIP provide an opportunity to talk about advancing higher quality, better integrated and coordinated primary care for women, including the concepts of pregnancy intention and planning and prevention. There are several aspects of the SHIP/APC work that could support the goal for improved health for women.

- Ensuring that women's health is included in the development of standards for primary care transformation, including standards for patient-centered care, population health and care management.
- Making sure that the practice transformation infrastructure that will be supported with the grant includes technical support to strengthen the quality of primary care services delivered to women.
- Including women's health in the quality measures being selected to define and drive areas of care that need attention. *Dr. deLong noted that the current draft set of measures does not include measures specifically linked to women's health, with the exception of one measure on chlamydia screening. There is no quality measure that assesses the percent of women of reproductive age for whom pregnancy intention has been assessed and tailored contraceptive counseling provided. However, the current set of proposed measures does include several measures addressing areas of chronic disease such as controlling high blood pressure, weight management and counseling, and management of diabetes that are relevant to the goal of reducing maternal mortality.*

Dr. de Long noted that staff from the Division of Family Health are engaging in discussion with NYSDOH colleagues, including participation in the DSRIP, SHIP/SIM workgroups, to promote

continued attention to the importance of addressing women's health through these elements. A key challenge identified in the process is that while there is general agreement about the fundamental importance of reproductive health as part of comprehensive patient-centered care, including recommendations from ACOG and the American Academy of Family Physicians, the US Preventive Services Task Force (USPSTF), which is charged to assess the evidence for approval of reimbursement decisions under the ACA, has not reviewed or issued recommendations specific to assessment of pregnancy intention or contraceptive counseling. As a consequence, there is no rigorous nationally established evidence-based standard or nationally endorsed quality measure comparable to standards and measures for other specific practices, such as tobacco assessment and counseling.

Discussion focused on the fact that New York State should not miss the opportunity to use initiatives to advance primary care to strengthen care for women to be a leader in this area by adding to the research base to demonstrate that these practices can be effective and addressing this gap with the USPSTF.

Next Steps

Office of Public Health staff will continue to engage in planning and implementation groups to support the integration of women's health needs and practices within DSRIP, SHIP/APC and Health Home, while also continuing to lead public health surveillance activities to review cases of maternal death and mobilize prevention activities to address relevant factors identified as well as address the disparities noted.

As a further outgrowth of the Committee's role in drawing attention to this issue, the NYSDOH has convened a group of partner organizations that include the Healthcare Association of New York State (HANYS), the Greater New York Hospital Association (GNYHA), American Congress of Obstetricians and Gynecologists (ACOG) District II, the New York Academy of Medicine (NYAM), the New York City Department of Health and Mental Hygiene (NYCDOHMH) and clinician experts to improve information-sharing and coordination of strategies to address maternal mortality. These partners met in November 2015 to review shared goals and current initiatives, identify gaps and initiate steps to launch a more strategic and coordinated approach to this important problem. At the November meeting and a follow-up conference call in December 2015, participants voiced a shared commitment to formalizing a working partnership and pursuing joint initiatives to raise awareness and improve both community prevention and clinical strategies to support maternal health. A second in-person meeting, held January 13, 2016, began the formalization of the partnership and focused on an initial collaborative project on preconception/interconception health which will be further developed. The Public Health Committee will be kept informed about progress of this promising new partnership.

Appendix

Defining the Problem of Maternal Mortality: September 2012 – January 2013

In September 2012 the Committee invited Dr. Marilyn Kacica, Medical Director for the Department of Health Division of Family Health, to present on the issue of maternal mortality in New York.

Key highlights of data presented include:

- The United States ranks behind 40 nations in maternal death rates, despite spending more on care per birth than any other nation.
- New York ranks 47th out of the 50 states for maternal mortality rates. In 2005-07, New York's maternal mortality rate was 14.7 per 100,000 live births, compared to 11.1 deaths per 100,000 live births (2005-2007 national data) nationally.
- There are notable geographic differences in maternal mortality rates within the state: 30 deaths per 100,000 live births for New York City, compared to 18.9 deaths per 100,000 live births for rest of state (2010 data).
- There are striking racial disparities in maternal mortality rates within the state: 15 deaths per 100,000 live births for White women, 58.2 deaths per 100,000 live births for Black women and 15.3 per 100,000 live births for women of other races.

Dr. Kacica also discussed steps the Department is taking to address the issue of maternal mortality, using the three priority action steps defined by the New York Academy of Medicine in its report on maternal mortality:

1) ***Improve reporting, case review and data system*** – the state's case ascertainment and review process has transitioned to a comprehensive statewide reporting process that identifies cases through multiple data systems including New York Patient Occurrence Reporting and Tracking System (NYPORTS), birth certificates, death certificates and hospital discharge data. Once cases are identified, charts are requested and reviewed using a comprehensive review tool and abstraction form. Aggregate results are presented to a state-convened Maternal Mortality Expert Review committee for discussion.

2) ***Prevention and risk reduction before and during pregnancy*** – several key prevention and clinical quality improvement initiatives to reduce preterm deliveries and Cesarean section rates and increase the quality of prenatal care services, including: New York State Perinatal Quality Collaborative (NYSPQC), Medicaid policy changes including adoption of statewide prenatal care standards and reimbursement for non-medically indicated elective deliveries, and a pilot project (pursuant to Medicaid Redesign Team recommendations) to utilize health information technology to assess risks and coordinate service delivery for pregnant women.

3) ***Hospital based screening and intervention*** – the role of the state's Regional Perinatal Centers was highlighted, along with several initiatives to develop and disseminate clinical practice guidelines in partnership with other professional organizations.

In January 2013, Dr. Kacica was again invited to join the committee for a follow-up presentation and discussion. Additional data were presented to highlight demographic and medical risk factors for maternal mortality identified through New York's data analysis to date. She also highlighted strategies to address maternal mortality from the state's Prevention Agenda for different Health Impact Pyramid levels and sectors.

Refining a Prevention Focus: November 2013 – January 2014

In November 2013, the Committee was joined by staff from the Department of Health Division of Family Health, who presented information on related issues of maternal mortality, preconception health and unintended pregnancy. The purpose of the discussion was for Committee members to gain a better understanding of these issues and to link past discussions of maternal mortality to the Prevention Agenda as a framework for helping the committee identify specific issues on which it might take action.

Dr. Rachel de Long, Director of the Division of Family Health, and Kristine Mesler, Director of the Bureau of Maternal and Child Health within the Division, gave a presentation to help frame these discussions. Dr. de Long recapped key data from previous meetings that highlight the significant burden and dramatic racial and ethnic disparities in maternal mortality nationally and in New York State, based upon which maternal mortality was selected as one of the goals for the Prevention Agenda. She noted that data from the ongoing review of maternal deaths in NYS illustrate the significant contribution of pre-existing chronic health problems and risk factors, both medical and psycho-social, while also noting that national studies suggest that racial disparities in maternal death rates are not fully explained by differences in these underlying conditions. This highlights the need to focus on multiple and interrelated factors including preconception and interconception health status of women, as well as improving the quality and equity of health care provided to women during pregnancy and delivery and across the life course. Within the framework of the Prevention Agenda, she related the goal of reducing maternal mortality to other intersecting goals and priorities including prevention of unintended pregnancy, prevention and management of chronic disease, promoting preconception and interconception health and health care, and addressing mental health and substance abuse.

Ms. Mesler then presented information about unintended pregnancy nationally and in New York State. The most recently available data indicate that over 50% of pregnancies, and over 25% of live births, in NYS are unintended. Like other population health measures, there are notable racial, ethnic and economic disparities in these rates. Published literature demonstrates associations between unintended pregnancy and other risk factors or adverse birth outcomes including delayed or inadequate prenatal care, use of tobacco and alcohol during pregnancy, preterm birth and lower rates of breastfeeding. Focus groups conducted across the state with adolescent and young adult men and women identified several relevant factors including "reactive" (rather than preventive)

approaches to use of health care, the role of media in influencing health behaviors, significant unfavorable misconceptions about the effectiveness and reliability of contraceptive methods and the positive influence of stable relationships and employment on planning pregnancies. Finally, she reviewed major public health initiatives and investments to prevent unintended pregnancy, including:

- clinical family planning services supported through grants and Medicaid reimbursement;
- community-based adolescent pregnancy prevention programs that incorporate evidence-based sexual health education and social/environmental supports to help teens build life skills and transition to adulthood;
- community health collaboratives to support preconception, pregnant and interconception women and infants through community health worker services as well as organizational and community-level systems-building activities.

Finally, Dr. de Long returned to the Prevention Agenda to identify relevant strategies that have the potential to link the actionable issues identified, including maternal mortality, prevention of unintended pregnancy and health promotion across the reproductive life course. Six strategies from the Prevention Agenda were identified as potential approaches the Committee could help advance (listed roughly in order from most comprehensive/universal to more targeted):

1. Address the cross-cutting social determinants of health, including housing, education, racism, poverty and violence.
2. Provide comprehensive, evidence-based health education, including sexual health education for youth in all schools.
3. Promote norms of wellness through effective social marketing across the lifespan,
4. Integrate preconception and interconception care into routine primary and specialty health care for women of reproductive age,
5. Implement strategies to support pregnancy planning and family planning to reduce unintended pregnancy among women with chronic conditions or other specific known risk factors.
6. Focus on women who have experienced an adverse pregnancy outcome—e.g., preterm birth, low birth weight - to ensure that they are engaged in interconception care.

Following these presentations, the Committee considered the issues and identified several opportunities for further discussion or action. Dr. Boufford emphasized the overarching goal of bringing further and more sustained attention to the issue of maternal mortality, and identifying actionable issues to focus that attention. Additional specific suggestions from the Committee included:

- Putting a team around those people who are at highest risks, using models from chronic illness, community care coordination. Work being done under Medicare to reduce utilization and costs and improve outcome, i.e. the Triple Aim, should be pursued with the maternal population.

- As a specific approach to care coordination for high-risk individuals, we should look at how the Medicaid Health Home program addresses preconception and pregnancy-related care. Women on Medicaid with two or more chronic medical conditions should be enrolled in health home, and we need to make sure that good prenatal care, family planning and effective contraception is part of an expected outcome and expected service delivery in the health-home program. The committee could engage the Health Home team in a discussion about this issue.
- Working in the primary care setting with doctors to have them ask the simple question of “do you want to be pregnant in the next year, - which provokes either “are you using contraception to prevent pregnancy” or “how can we get you healthy” - to focus on use of preventive health services and health promotion behaviors, and make sure that women get prenatal care early when they do become pregnant.

At its January 2014 meeting, the Committee revisited and built further upon the November discussion. Previously-defined interests were further articulated within a life-course continuum approach to addressing maternal mortality by addressing: prevention of unintended pregnancy and planning of desired pregnancies; promoting women’s health prior to pregnancy (preconception) and between pregnancies (interconception), include wellness/preventive health as well as management of risk factors and chronic disease; and, ensuring optimal care during pregnancy, with special attention to identification and management of high-risk pregnancies. The set of six Prevention Agenda strategies identified at the previous meeting was further refined to focus on three strategies as focal points for further committee attention:

1. Integrate preconception and interconception care into routine primary and specialty care for women of reproductive age, to include:
 - Screening and follow up for risk factors
 - Management of chronic medical conditions
 - Use of contraception to plan pregnancies
2. Assess and address pregnancy planning, including use of highly effective contraception, among women with severe chronic conditions or who have experienced a previous adverse pregnancy outcome.
3. Implement comprehensive and coordinated systems and protocols for early identification and management of high-risk pregnancies.

The Committee confirmed its interest in convening a series of conversations with key partners and stakeholders to further inform these issues. Specific initiatives and individuals were identified as potential invitees for these discussions. Dr. Boufford and Dr. de Long committed to arranging the first of these conversations and invited Committee members to contribute additional comments in the interim.

Members of the Public Health Committee