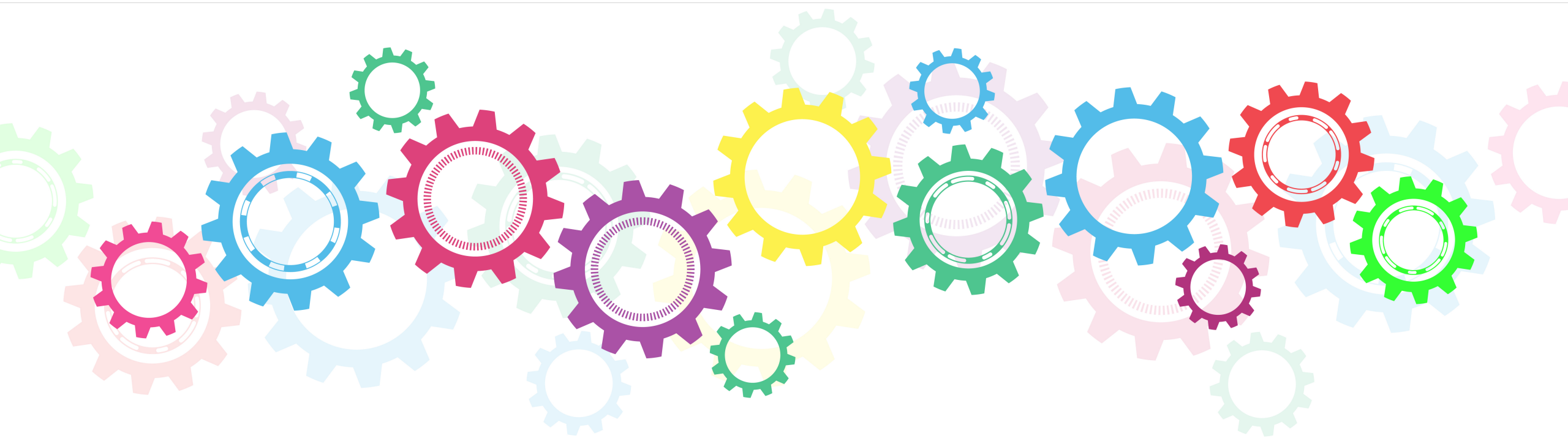


Getting to the Why

Using Root Cause Analysis to Move Towards
Equitable Healing, Growth & Rebirth



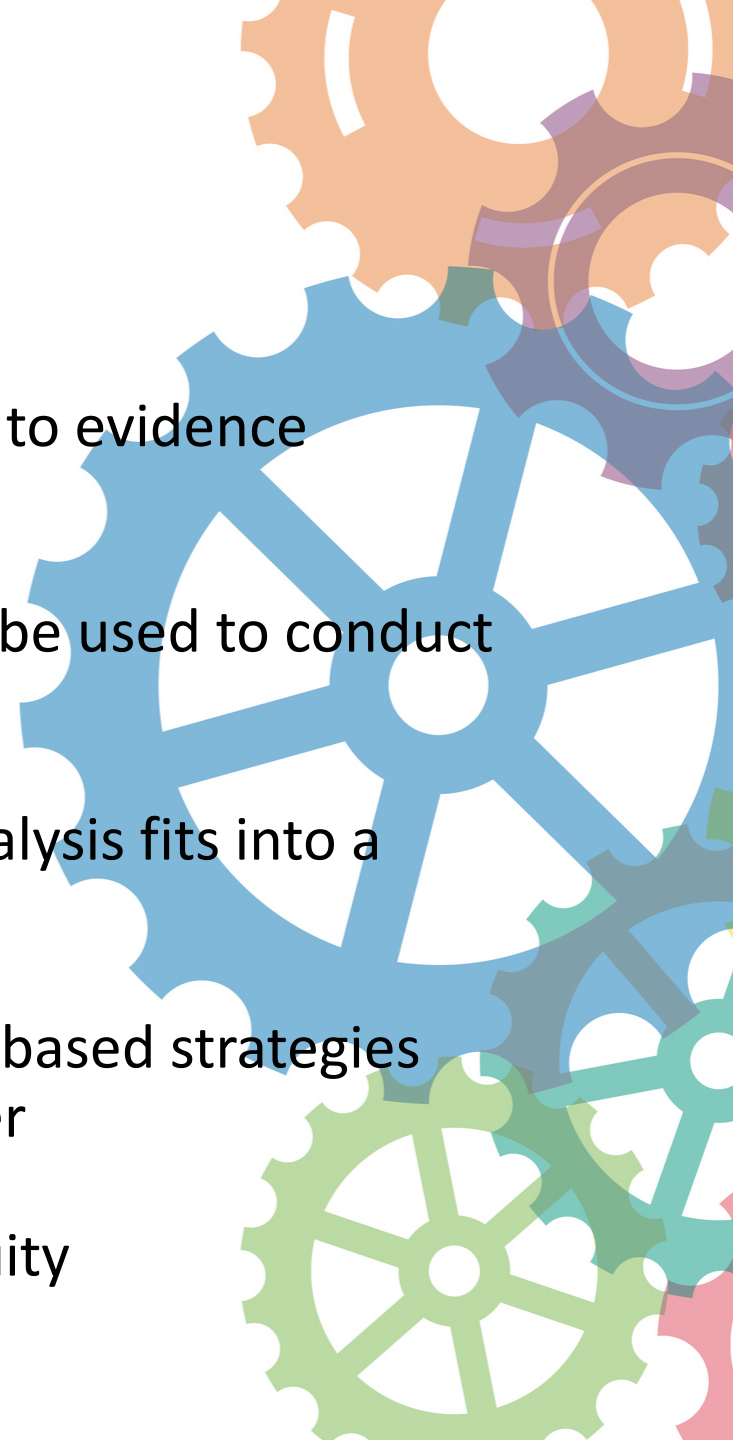
MCH Evidence Center | MCH Navigator | National MCH Workforce Development Center

John Richards, Georgetown University

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U02MC31613, MCH Advanced Education Policy, \$3.5 M. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Learning Objectives

- Increase knowledge of root cause analysis and how it applies to evidence identification and selection
- Increase experience-based understanding of which tools can be used to conduct root cause analysis
- Develop skills to implement a roadmap of how root cause analysis fits into a science-based process for program planning
- Increase skills to identify maternal and child health evidence-based strategies using resources developed and housed at the Evidence Center
- Expand sense of efficacy on using root causes to advance equity



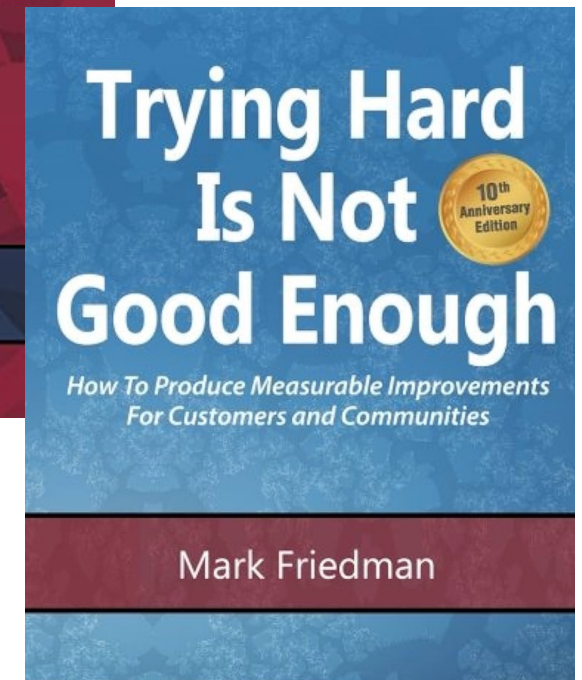
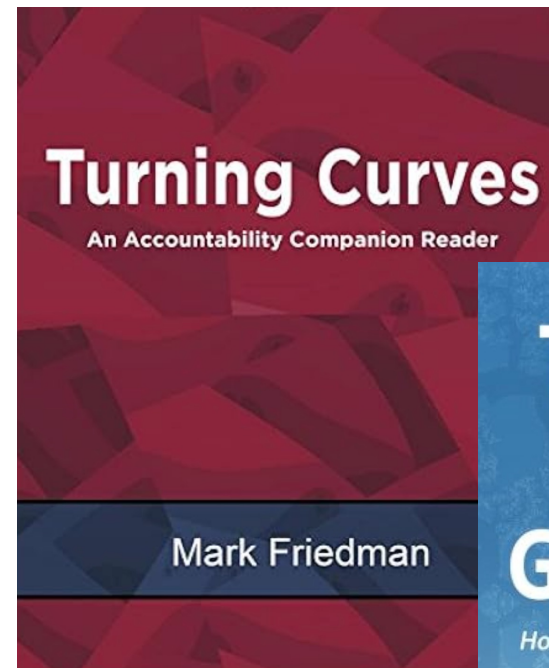
Agenda

- The Four “Hows” of Integrating Root Cause Analysis Tools into your work
 - Overview of Results-based Accountability (RBA[®])
 - Overview of Root Cause Analysis (RCA)
 - How RBA and RCA can lead to more equitable program planning
- Small Group Work & Report Out
 - Review, assess, and discuss RCA Tools
- Aligning RCA with other MCH Evidence Center tools and resources
 - Review the MCH Navigator & Evidence Center Websites
- Q&A



Results-Based Accountability (RBA®) in 5 Minutes

- A systematic approach from counting “widgets” to prioritizing real outcomes
- Addresses 2 fundamental questions:
 - How much did we do? → actions, resources, and initiatives we invest in.
 - How well did we do it? → evaluates the effectiveness of implementation, measured by actual the actual outcomes attained
- 3 Essential Steps
 - Population Accountability
 - Performance Accountability
 - Accountability for Action



Results-Based Accountability

RBA works because it is

- Data-driven decision making
- Transparent and accountable
- Fosters adaptive learning

Population Accountability: We SHARE responsibility

Result	Children to live to their first birthday
Indicators	NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births NPM 5: Percent of infants placed to sleep on their backs

Performance Accountability: We OWN responsibility

Measures	1 – How much did we do?	2 – How well did we do it?
	# of hospitals that report having a safe sleep policy	% of hospital systems partnered with Title V safe sleep initiatives
	3 – Is anyone better off? (Quantity)	4 – Is anyone better off? (Quality)
	# of WIC and MIECHV clients who report an enhanced understanding of safe sleep practices following a structured counseling session	% of staff in state Medical examiner's office who report an increased understanding in SIDS/SUIDS coding % of infants placed to sleep on their back in Baby Friendly hospitals

Decision Making

Ends to Means

Accountability


Partnerships

Population & Performance

Impact

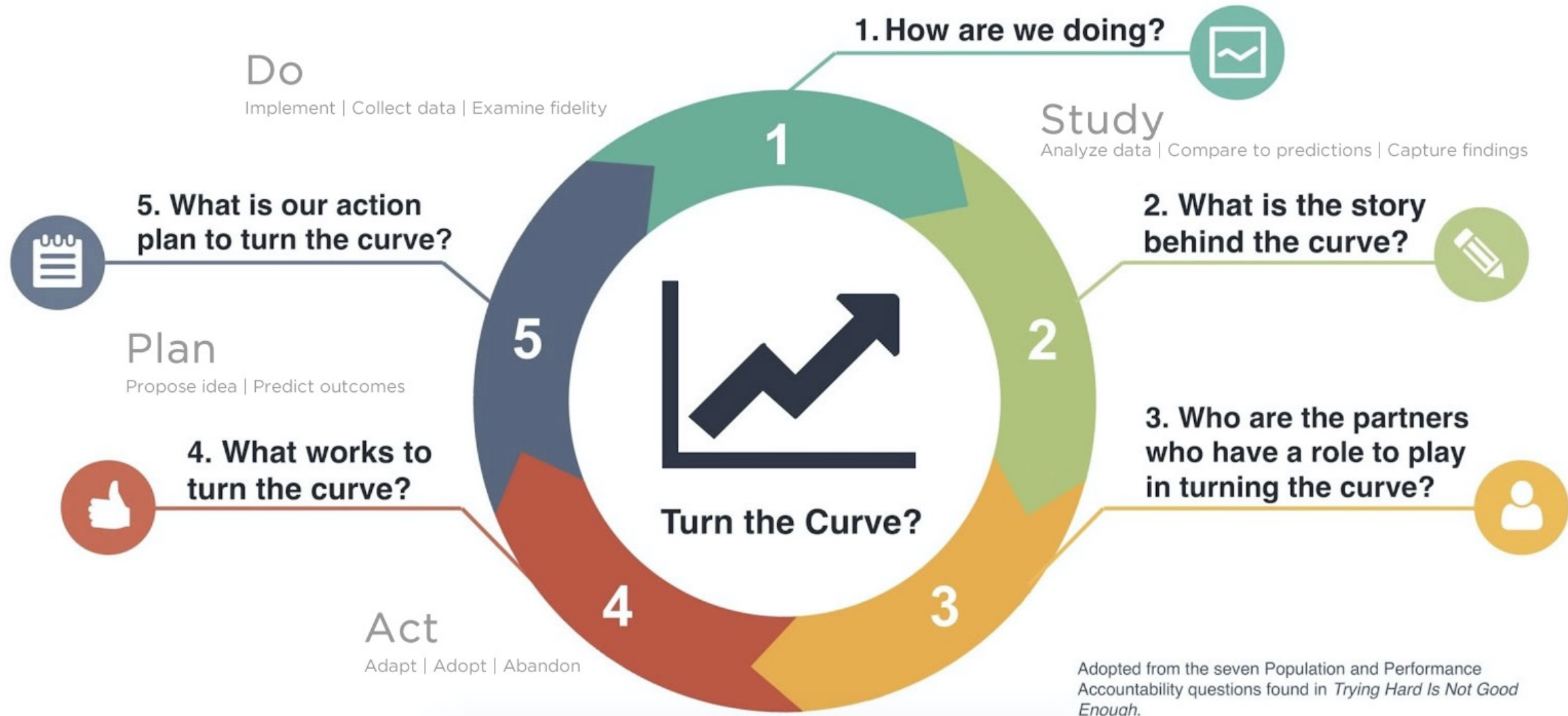
Common Language

Steps of Antiracist RBA



7 Questions of Population Accountability	7 Questions of Performance Accountability
<ol style="list-style-type: none"> 1 What condition of well-being do we want for our community (population results)? 2 What would these conditions look like, feel like, taste like if we achieved them? (NOMs) 3 What measures can we use as a proxy to quantify these conditions (population indicators; NPMs)? What are the data sources? 4 How are we doing on the indicators (broken down by race) and what are the root causes? What are the “hot” roots? (baselines + causes) 5 What could we do to address the “hot” roots selected (brainstorm, internal and external)? (low-cost and no-cost) 6 Who are the partners with a role to play? (typical and new) 7 What strategies do we propose to implement? 	<ol style="list-style-type: none"> 1 Who/what does the strategy aim to impact directly (client/customer) - may be multiple? 2 How can we measure the impact/“better off” of the strategy? (Is anyone better off?) 3 How can we measure the quality and quantity for the strategy? (How well did we do?) <p>Implementation Begins: Steps, Tactics, Timeline, Budget</p> <hr/> <ol style="list-style-type: none"> 4 How are you doing on your better off measures? What are the roots of your performance? 5 What could address the root cause(s) of the problem or strengthen the performance? 6 Who are the partners you need and what is their role? 7 What do you propose to do differently? And What will be needed? <p>Source: Equity & Results, Anti-Racist RBA Training, Spring 2023</p>

Indicators, Performance Measures, and Turn the Curve Thinking



real relationships that can tolerate conflict for impact

relationships built for antiracist impact rooted in trust, rather than naming, blaming, and shaming when things go wrong

understanding and designing for root causes

design strategies to address root causes to powerfully interrupt and build new foundations

data informs practice to prevent harm

data is used consistently to inform practice - **not knowing is harm**

sharing data/data ownership

data is owned by and shared with impacted BIPOC for trust, transparency and effective design

participatory practice

ensuring that power is accounted for and all parts of the process are designed and implemented with **BIPOC** decision-making at the center - “not about us without us”

paying attention to data culture

transforming the usual **punitive data culture** to a learning and use culture

organization self-reflection

a reflective process that doesn’t “prove” or blame BIPOC communities/staff for our **institutional** failures and structural designs



7 Principles: Aligning Anti-Racism with RBA

Population
Level

Result(s): Condition(s) of well-being for people

Indicators

Root Causes

Programs

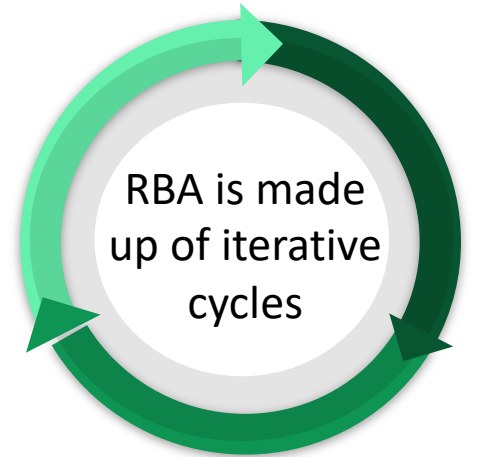
Policies

Functions

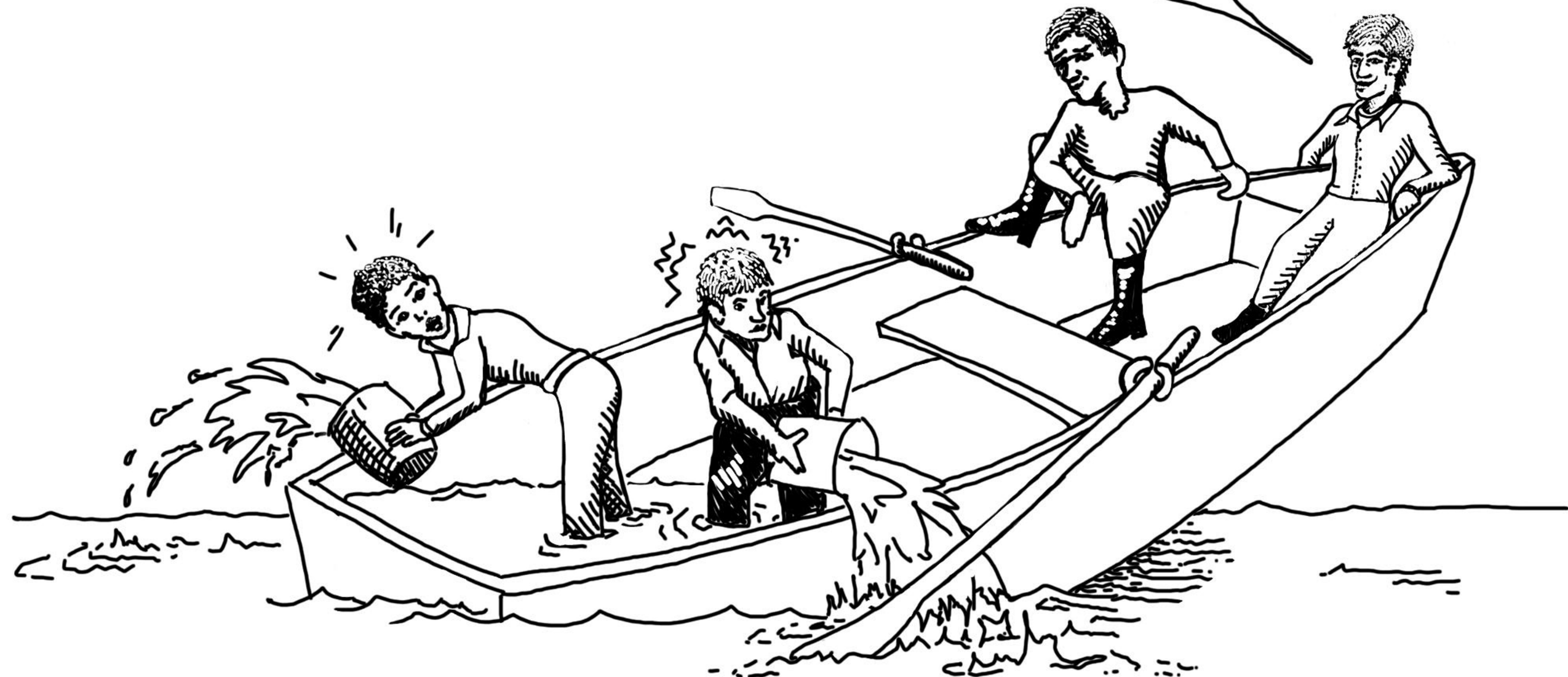
Performance
Level

Better-Off Measures

RBA is made
up of iterative
cycles

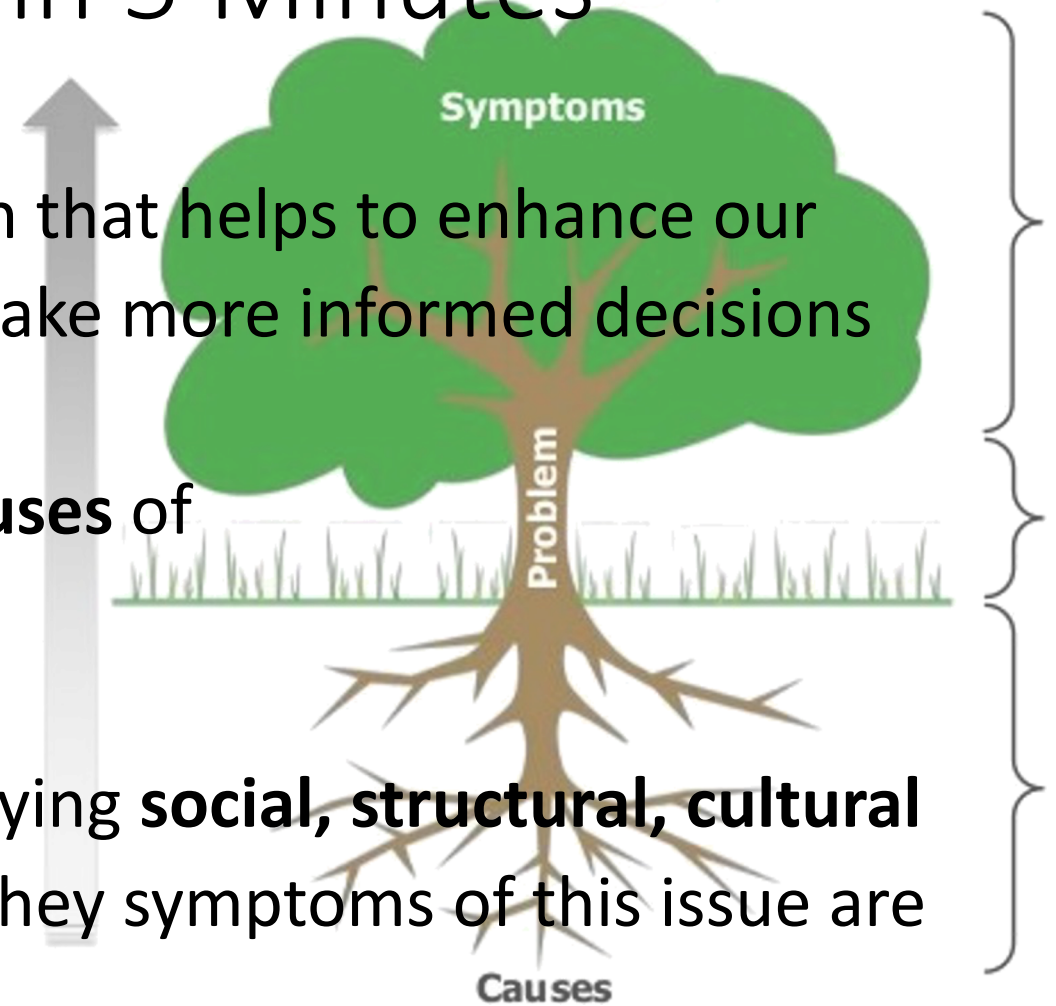


Sure glad the hole isn't at our end.



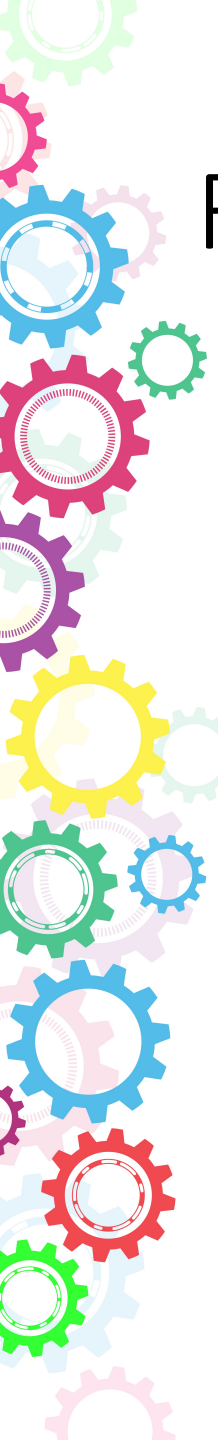
Root Cause Analysis (RCA) in 5 Minutes

- A systematic, problem-solving approach that helps to enhance our understanding of issues and helps us make more informed decisions
- Helps to understand the **underlying causes** of **problems**/events/actions/ policies
- Asks the question: What are the underlying **social, structural, cultural** or **habitual** factors that influence why they symptoms of this issue are being seen?

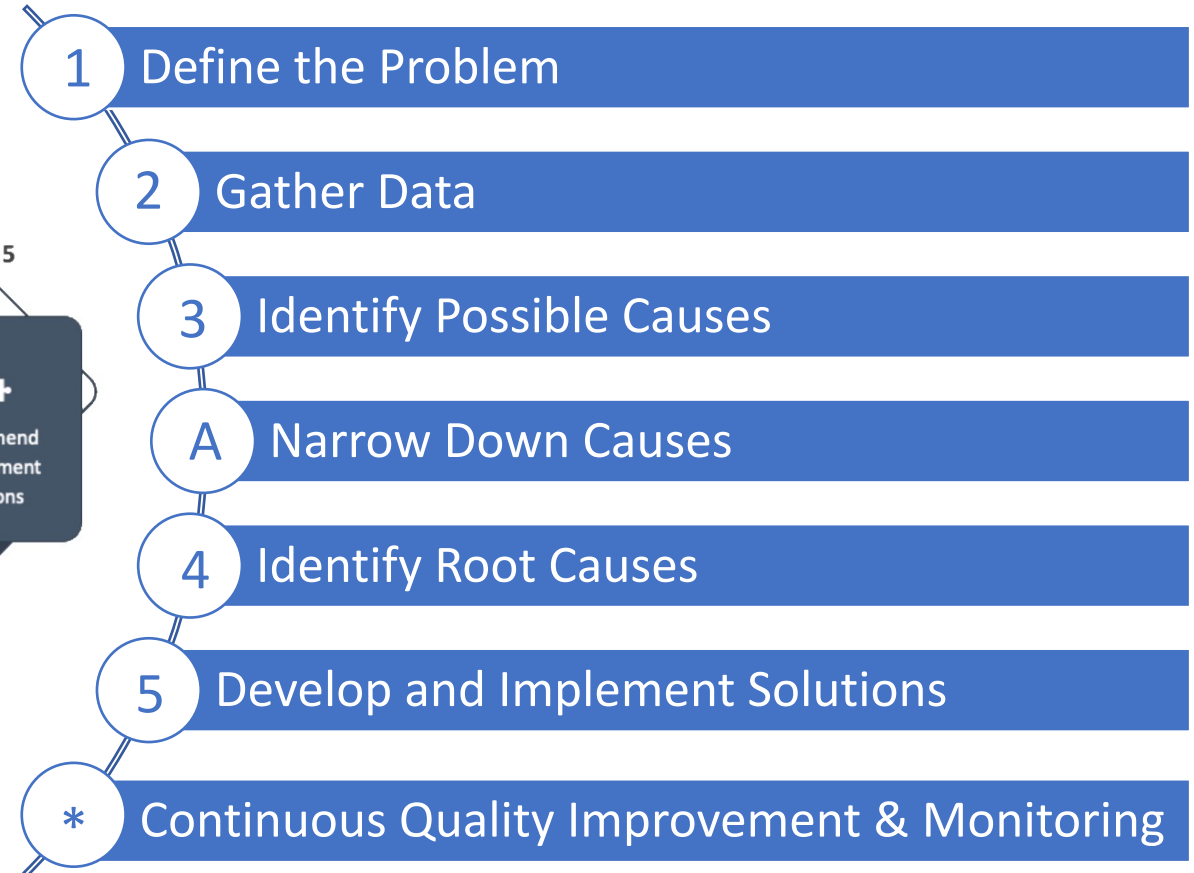


A vertical decorative graphic on the right side of the page, featuring a series of interlocking gears in various colors including blue, red, green, yellow, and purple. The gears are of different sizes and are arranged in a way that they appear to be meshing together.

-
- A vertical decorative graphic on the right side of the page, featuring a series of interlocking gears in various colors including blue, red, green, yellow, and purple. The gears are of different sizes and are arranged in a way that they appear to be meshing together.

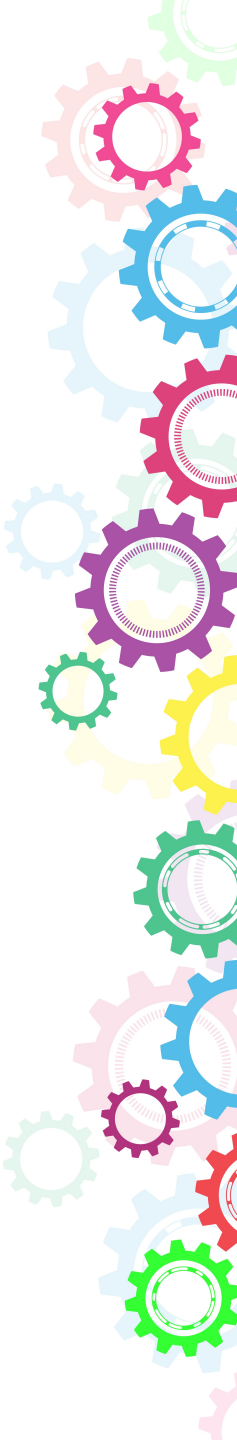


RCA Steps



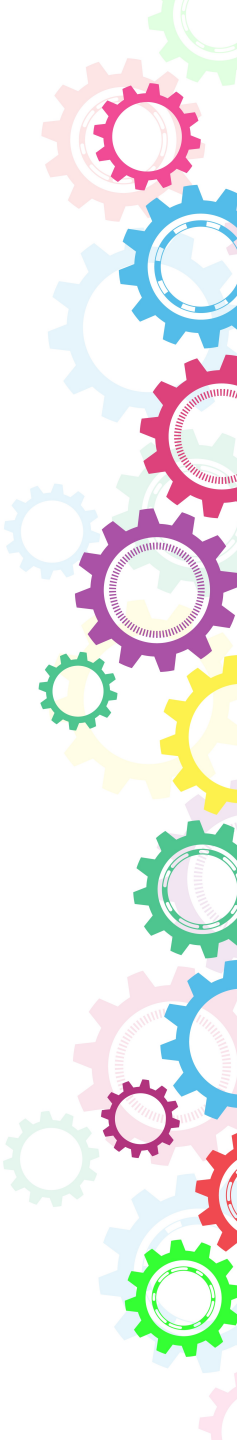
RCA and RBA: Two Aligned Approaches

1. Identify Disparities.
2. Seek to Understand Systems.
3. Develop Targeted Interventions.
4. Rely on Accountability and Monitoring.
5. Focus on Policy Change.
6. Integrate Community Engagement.
7. Shift to Continuous Improvement.
8. Facilitate Data-Informed Decision-Making.



8 RCA Tools in 15 Minutes

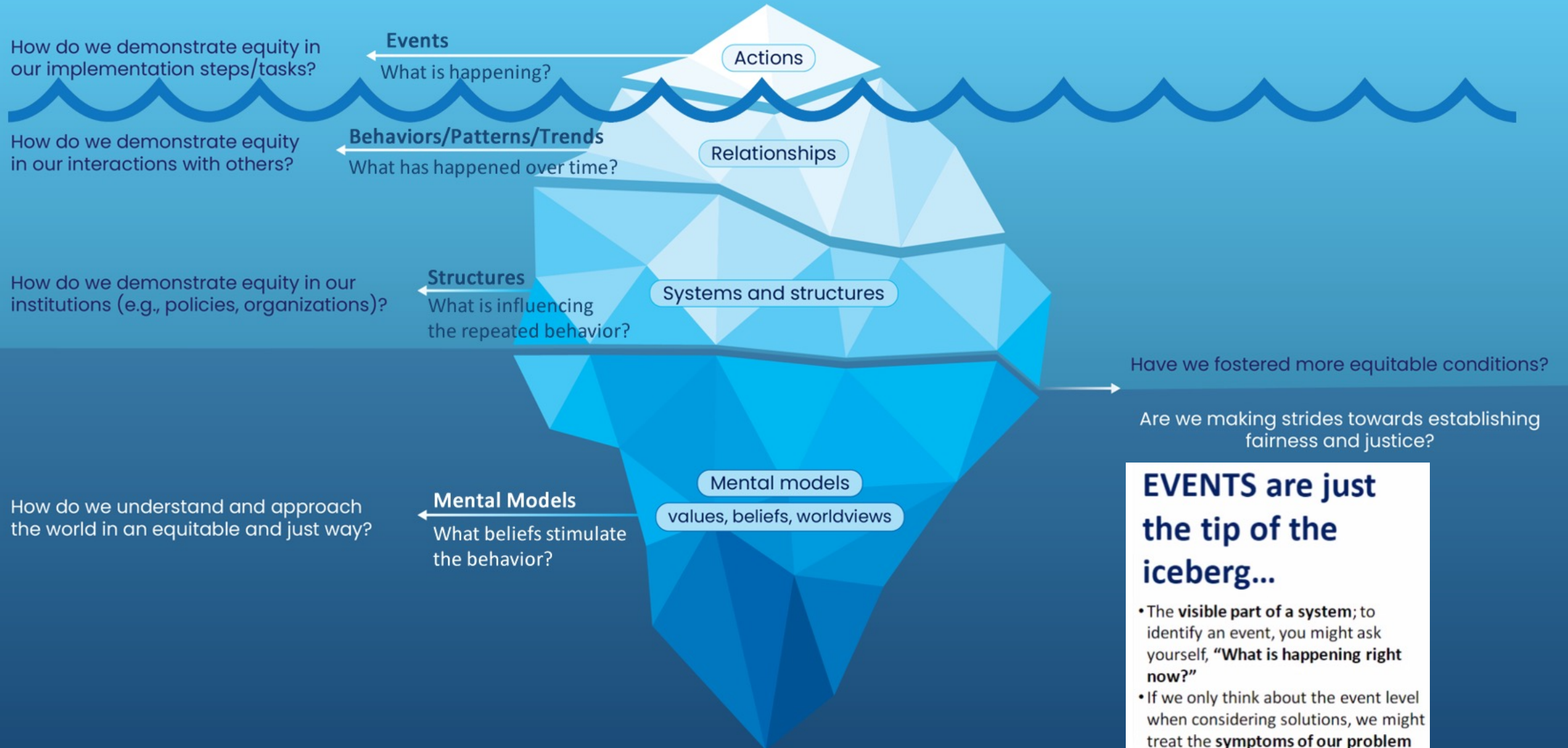
- Top Contenders
 - Equity Iceberg.
 - Fishbone (Ishikawa Diagrams).
 - 5 Whys.
- Other Tools
 - Fault Tree Analysis.
 - Pareto Principle and 80/20.
 - RCA2.
 - Failure Model.
 - Scatter Plot.



Process

Equity Iceberg & Questions to Ask

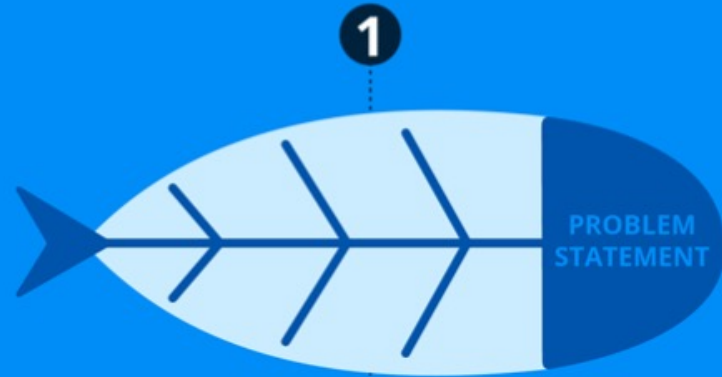
Outcome



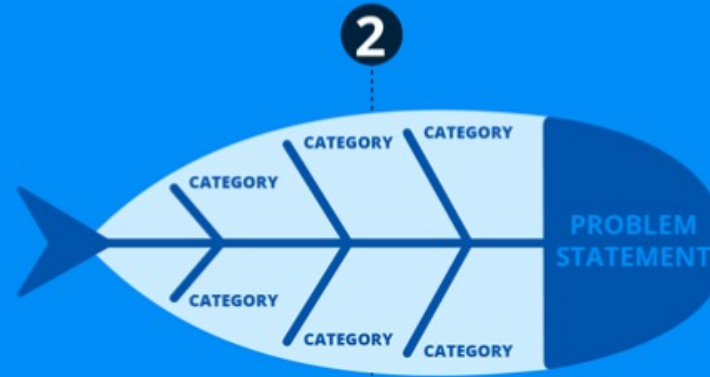
EVENTS are just the tip of the iceberg...

- The **visible part of a system**; to identify an event, you might ask yourself, "**What is happening right now?**"
- If we only think about the event level when considering solutions, we might treat the **symptoms of our problem** without addressing the root cause.
- Think about **events in the context of outcomes**

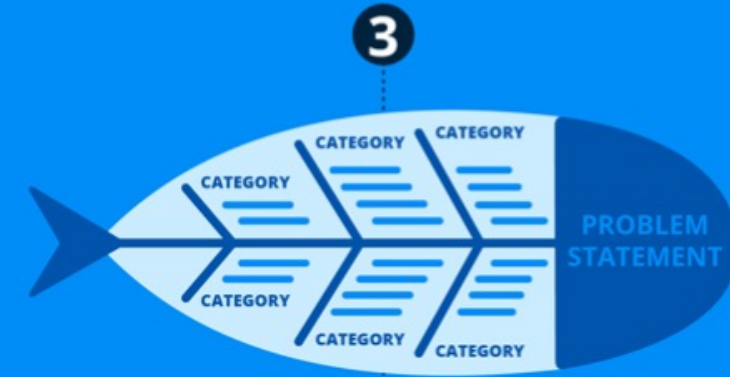
HOW TO CONSTRUCT A FISHBONE DIAGRAM FOR CAUSE AND EFFECT ANALYSIS?



Draft a Clear Problem Statement



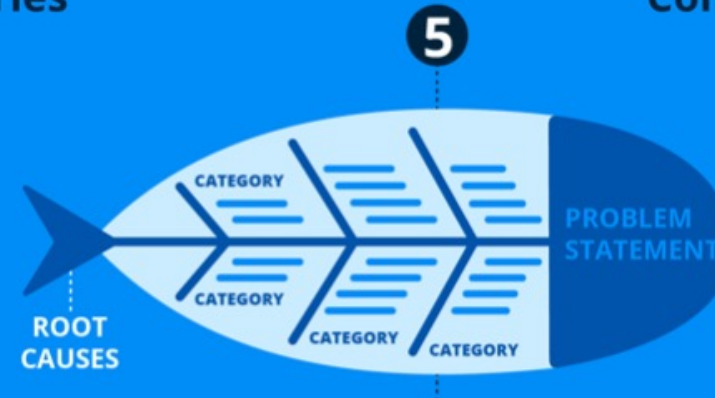
Identify Major Categories



Work Out Possible Contributing Factors

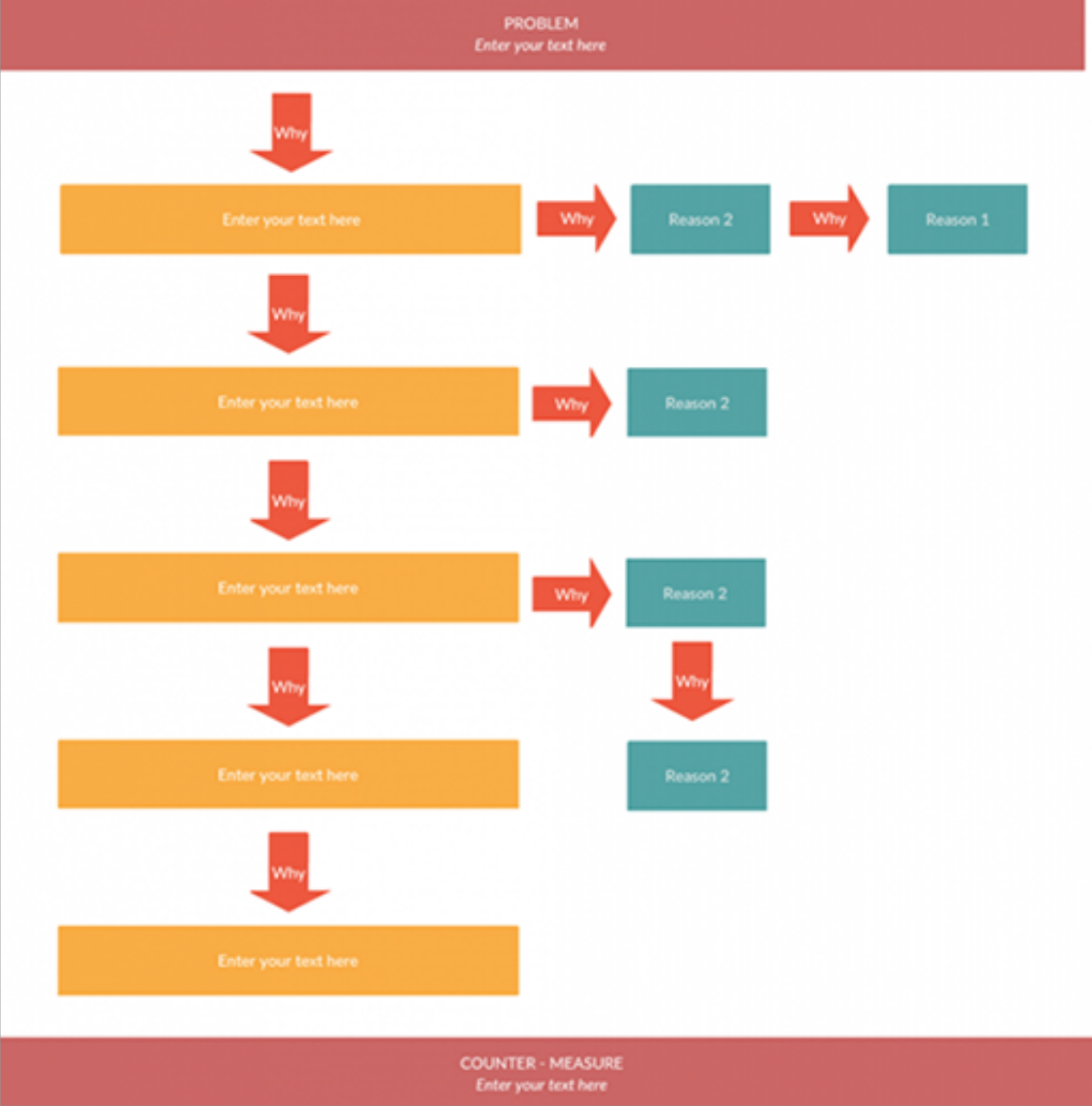
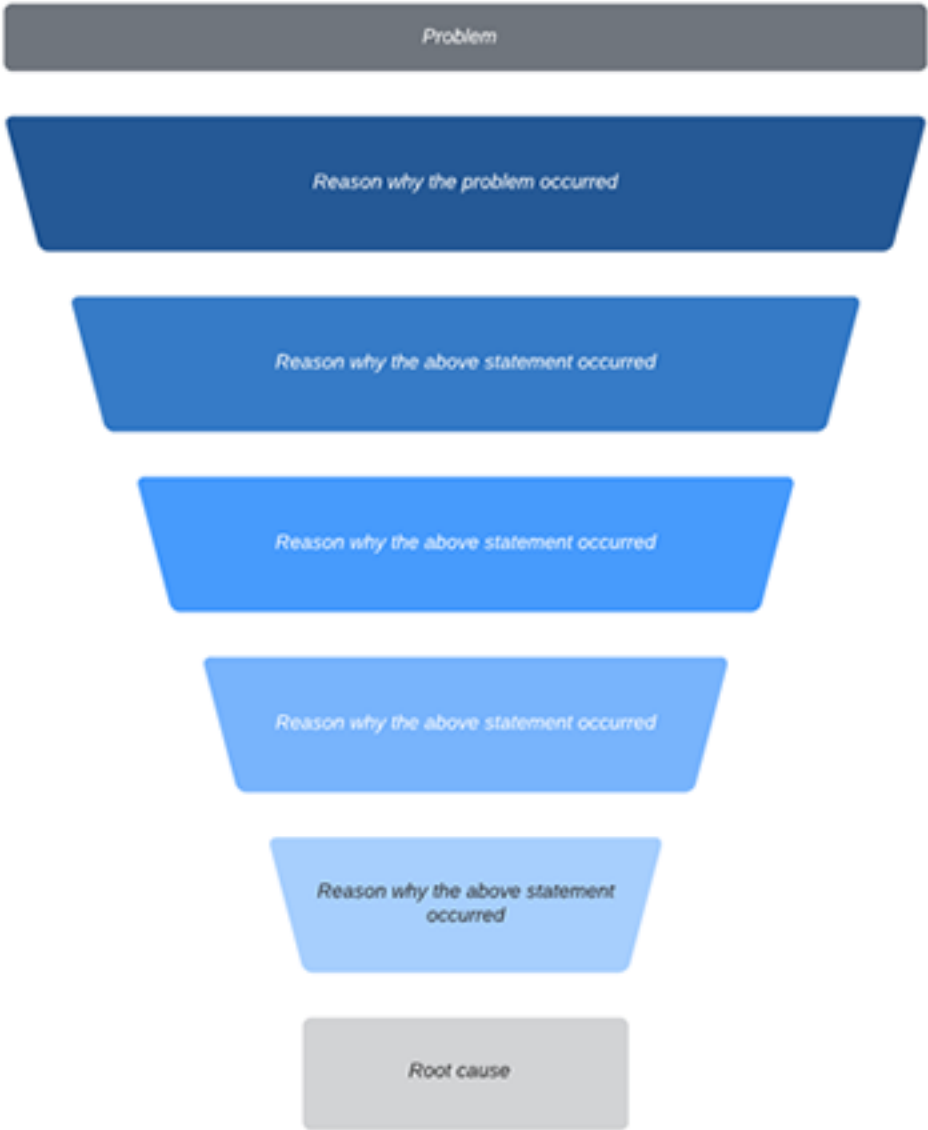


Analyze the Diagram and Investigate



Check for Root Causes That Need to be Addressed

Five Whys Tool



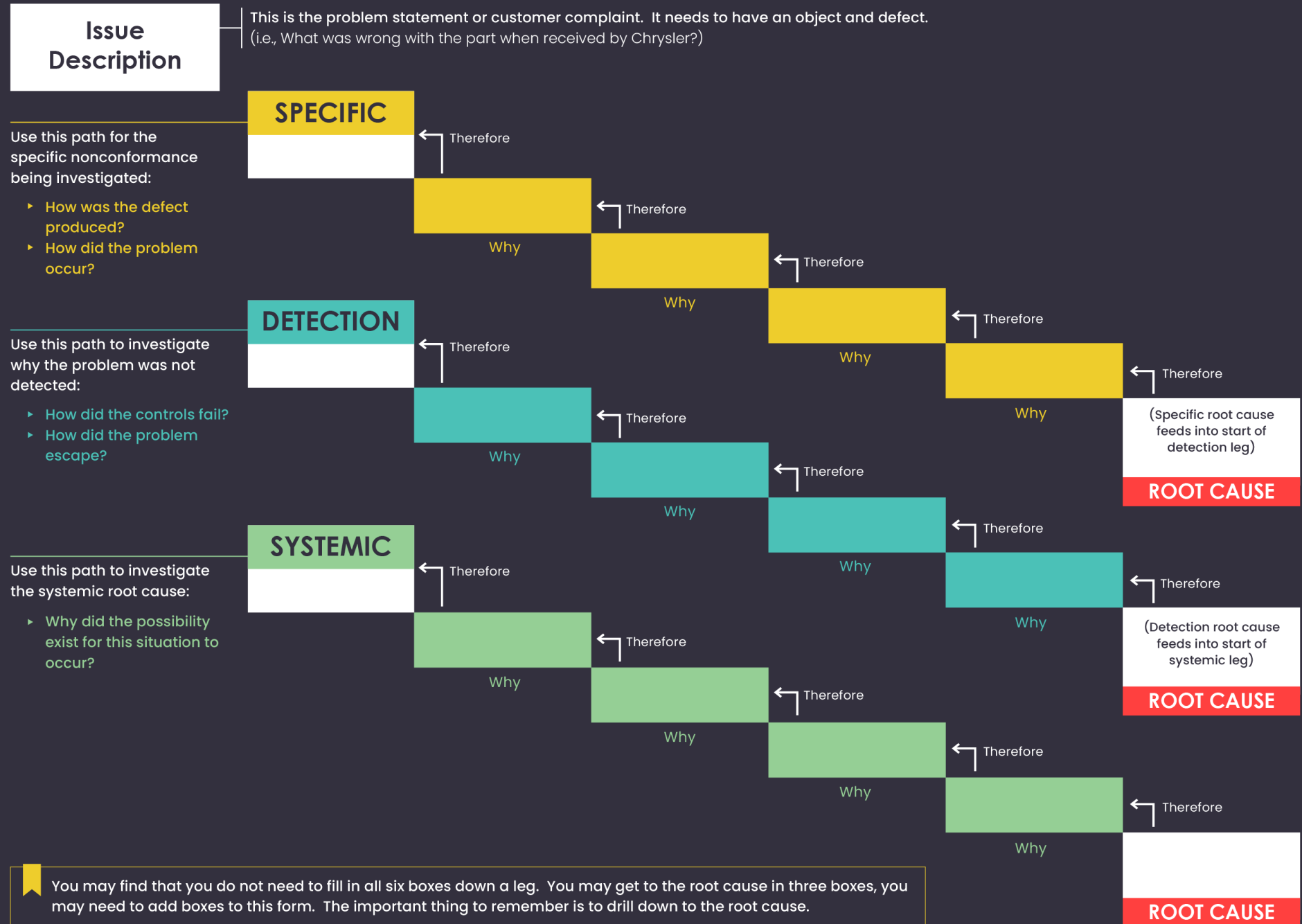
Start by describing the issue and then answer the why's for this leg of the analysis. In this order:

1. Specific
2. Detection
3. Systemic



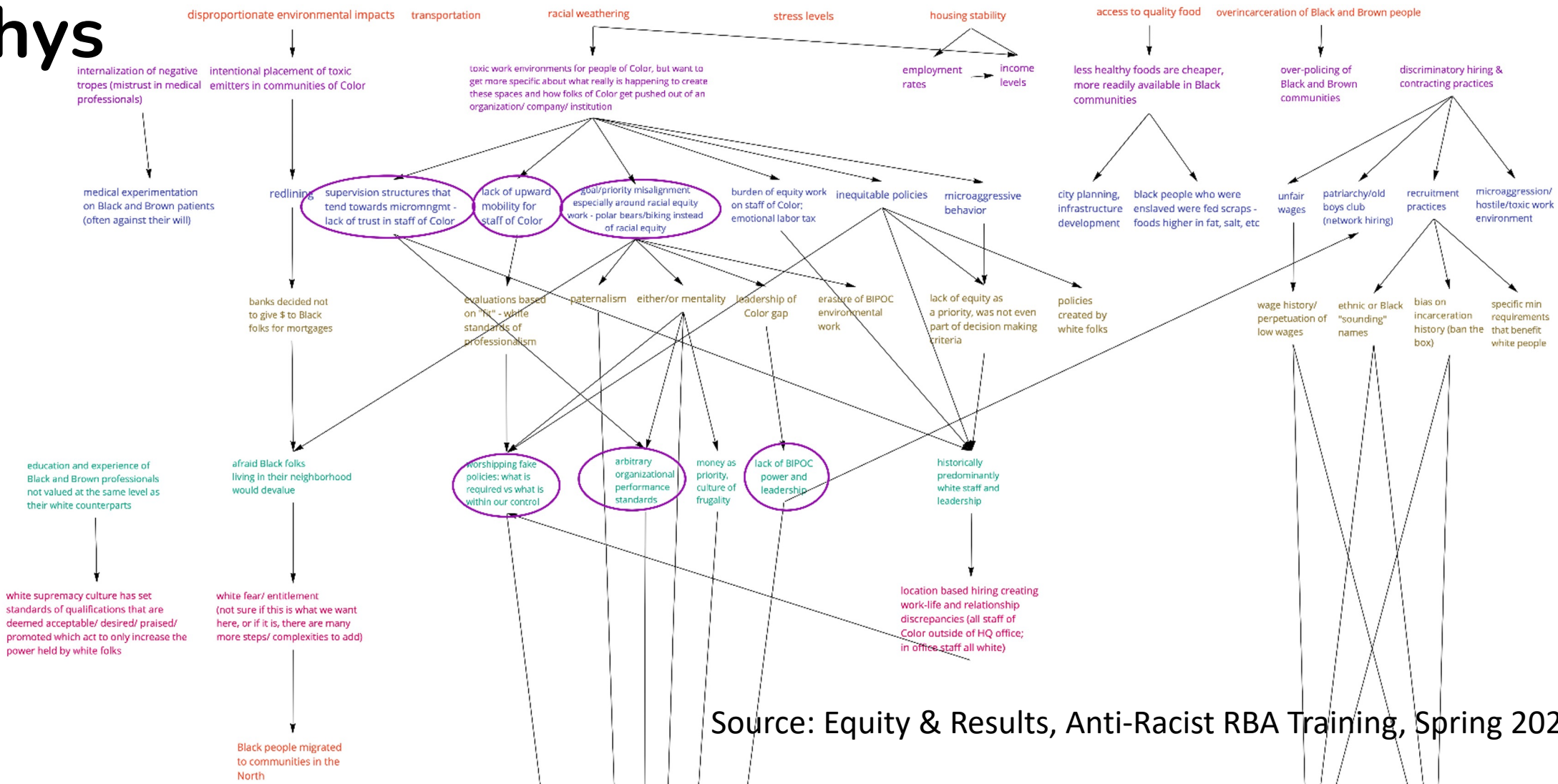
Remember that each box must answer the "why?" to the statement in the previous box.

ROOT CAUSE









Using Anti-Racist Principles with the 5 Whys






Indicator: Life Expectancy (broken down by race)
Avg. Life Expectancy - (source RWJF via wikipedia)
white : 79 years
Black: 75 years

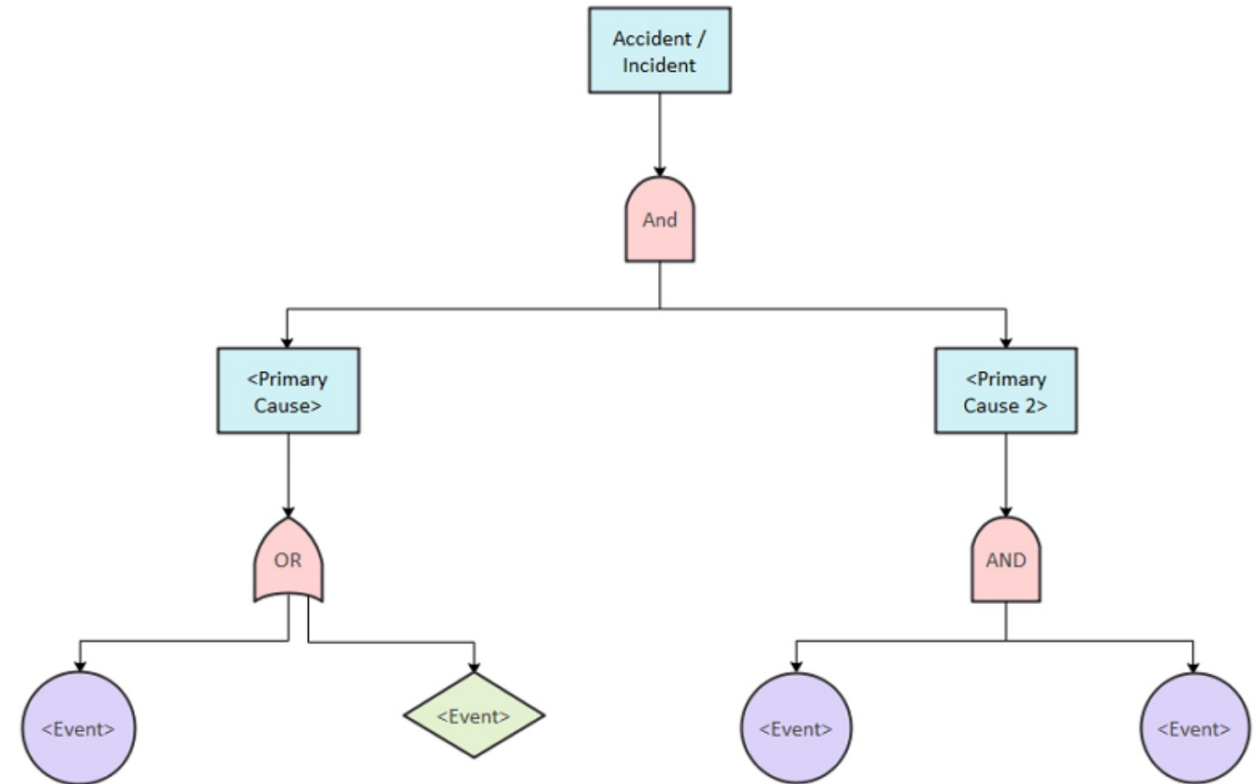


Source: Equity & Results, Anti-Racist RBA Training, Spring 2023

Fault Tree Analysis

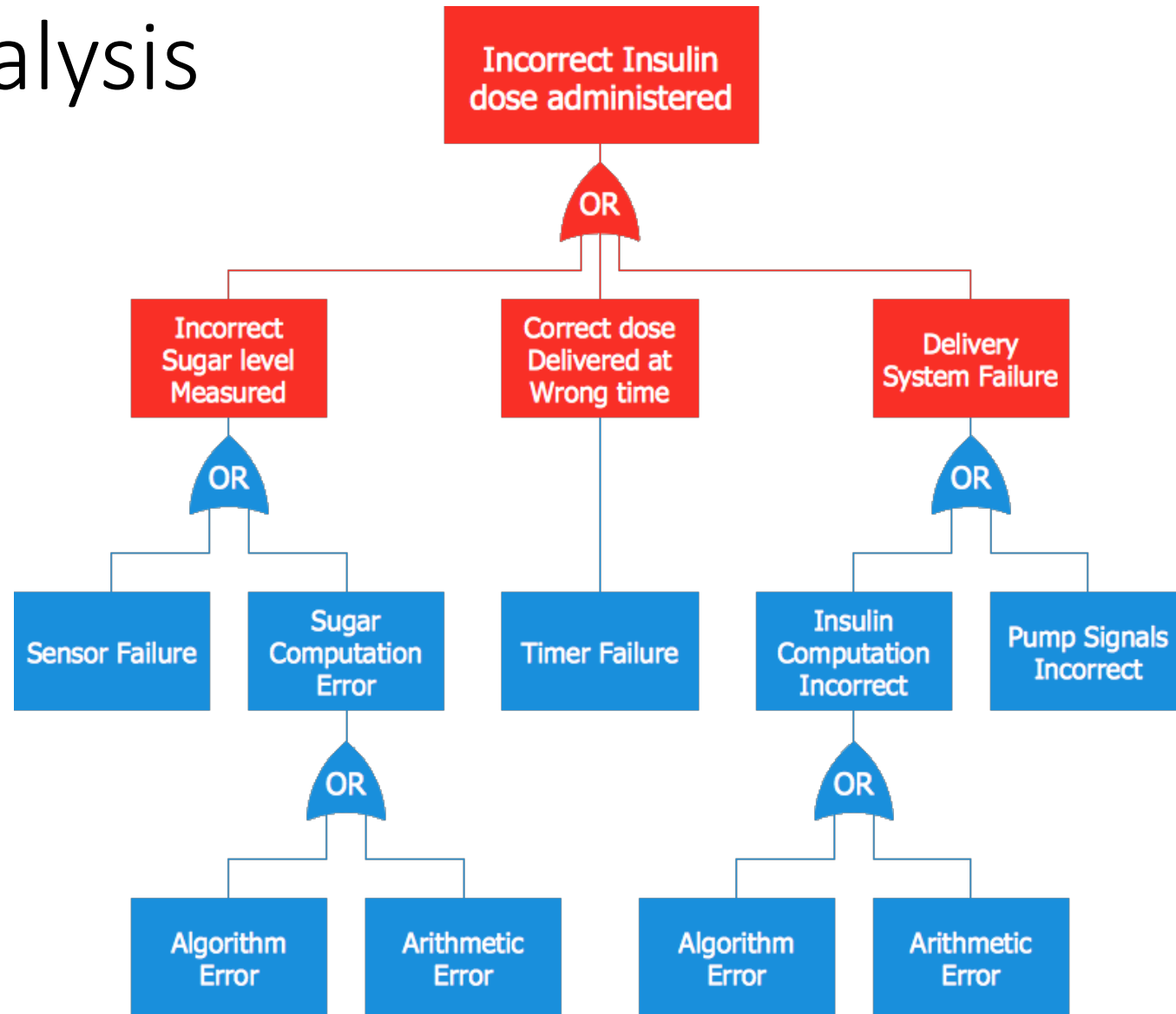
S.No	Event Symbol	Description
1		Primary or basic failure event. It is a random event and sufficient data is available
2		State of system, subsystem or component event
3		Secondary failure or under developed event, can be explored further
4		Conditional event and is associated with the occurrence of some other event
5		House event representing either occurrence or non-occurrence of an event
6		Transfer in and transfer out symbols used to replicate a branch or sub-tree of the FTA

S.No	Gate Symbol	Description
1	 AND Gate	The output event occurs when all the input events occur
2	 OR Gate	The output event occurs when at least one of the input events occur
3	 Priority AND Gate	The output event occurs when all the input events occur in the order from left to right
4	 Exclusive OR gate	The output event occurs if either of the two input events occur but not both
5	 Inhibit gate	The output event occurs when the input event occurs and the attached condition is satisfied



Source:EdrawMax Online

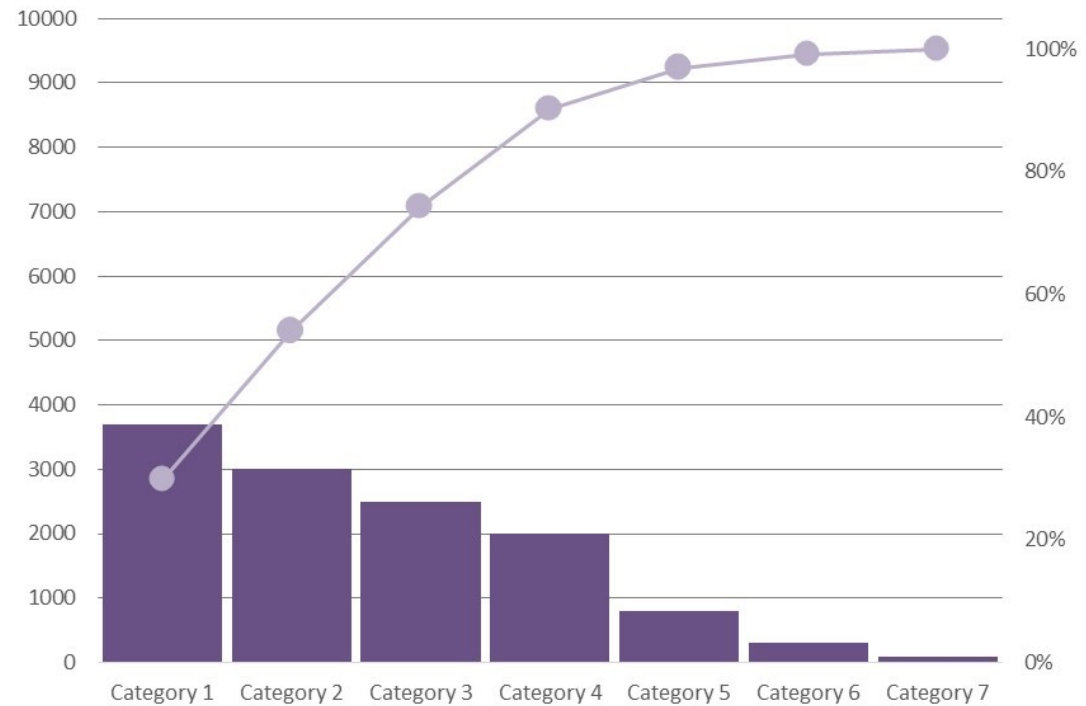
Fault Tree Analysis



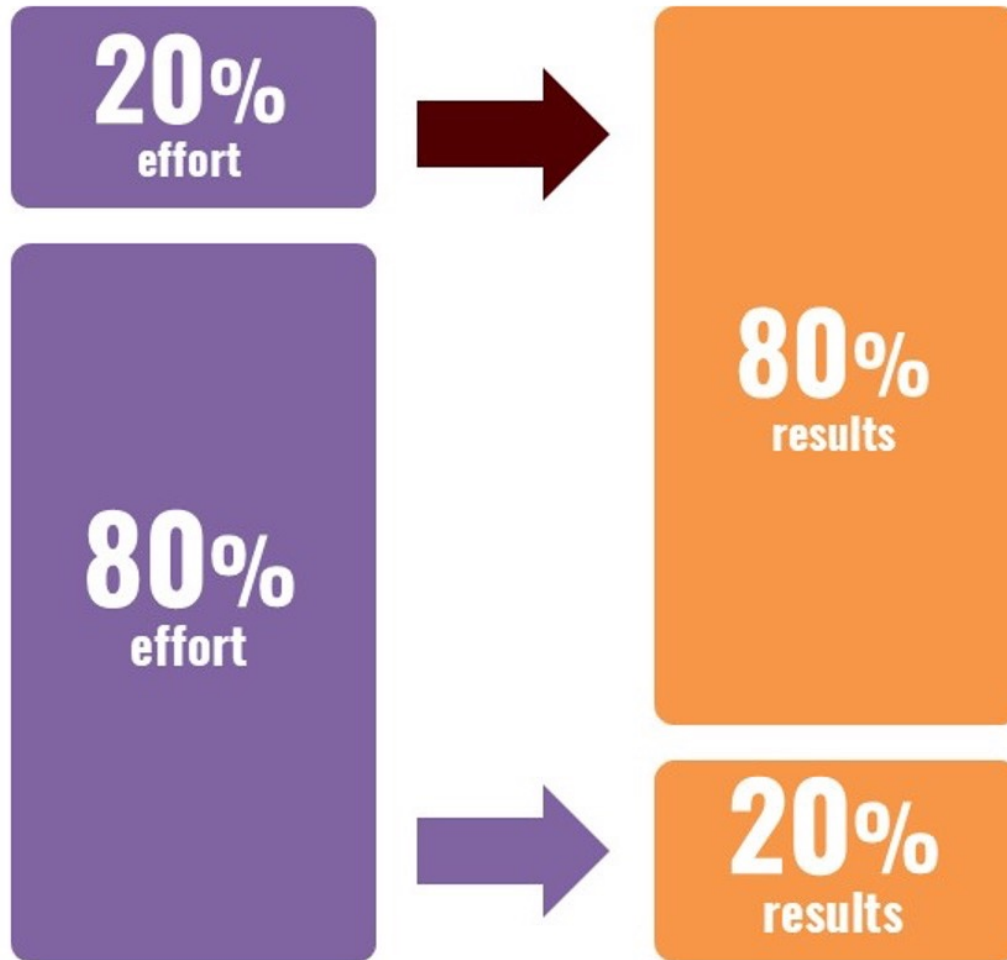
Pareto Principle

- Developed by Vilfredo Pareto , an Italian Sociologist, engineer, economist & philosopher
- Discovered that 80% of Italy's wealth was in the hands of only 20% of the population
- Joseph M. Juran, a management consultant, converted these findings into the 80/20 Rule.
- Currently this 80/20 Principle is used for planning decisions, six sigma, & performance management

Pareto Chart Example



Pareto Principle



The 80/20 Rule in Practice

Vital Tasks

20% Attention

80% Outcome

These are the few vital tasks you've determined are the most important to your success.

You choose to focus 20% of your time and attention to getting these done the right way.

Because of their importance, these few vital tasks produce 80% of your success.

G2.com

<https://slidemodel.com/pareto-principle-80-20/>

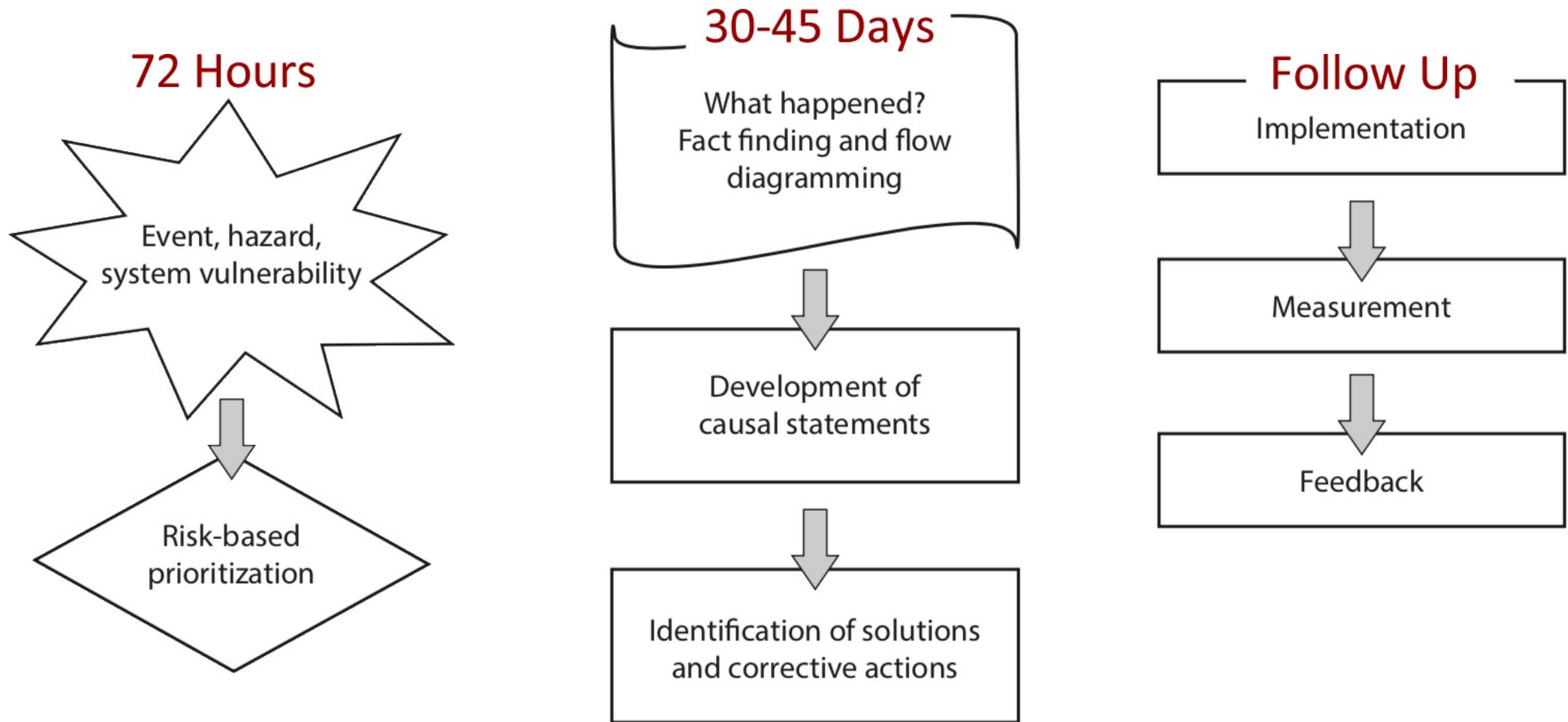


IHI Root Cause Analysis² Tool

- “The purpose is to systematically review vulnerabilities so that they can be eliminated or mitigated.”
- Focuses on systematic issues and system level challenges. It does not focus on the individual.
- Developed for patient safety and improving medical errors, close calls, near misses, and other potential issues in healthcare.

<https://www.performancehealthus.com/blog/rca2-tools-to-prevent-harm>; <https://www.med.unc.edu/ihqi/wp-content/uploads/sites/463/2018/07/RCA2-National-Patient-Safety-Foundation.pdf>

Root Cause Analysis²



Root Cause Analysis²

Template: Action Hierarchy Tool

	Action Category	Example	Action
Stronger Actions (these tasks require less reliance on humans to remember to perform the task correctly)	Architectural/physical plant changes	Replace revolving doors at the main patient entrance into the building with powered sliding or swinging doors to reduce patient falls.	
	New devices with usability testing	Perform heuristic tests of outpatient blood glucose meters and test strips and select the most appropriate for the patient population being served.	
	Engineering control (forcing function)	Eliminate the use of universal adaptors and peripheral devices for medical equipment and use tubing/fittings that can only be connected the correct way (e.g., IV tubing and connectors that cannot physically be connected to sequential compression devices or SCDs).	
	Simplify process	Remove unnecessary steps in a process.	
	Standardize on equipment or process	Standardize on the make and model of medication pumps used throughout the institution. Use bar coding for medication administration.	
	Tangible involvement by leadership	Participate in unit patient safety evaluations and interact with staff; support the RCA ^a process; purchase needed equipment; ensure staffing and workload are balanced.	
Intermediate Actions	Redundancy	Use two RNs to independently calculate high-risk medication dosages.	
	Increase in staffing/ decrease in workload	Make float staff available to assist when workloads peak during the day.	
	Software enhancements, modifications	Use computer alerts for drug-drug interactions.	
	Eliminate/reduce distractions	Provide quiet rooms for programming PCA pumps; remove distractions for nurses when programming medication pumps.	
	Education using simulation-based training, with periodic refresher sessions and observations	Conduct patient handoffs in a simulation lab/environment, with after action critiques and debriefing.	
	Checklist/cognitive aids	Use pre-induction and pre-incision checklists in operating rooms. Use a checklist when reprocessing flexible fiber optic endoscopes.	
	Eliminate look- and sound-alikes	Do not store look-alikes next to one another in the unit medication room.	
	Standardized communication tools	Use read-back for all critical lab values. Use read-back or repeat-back for all verbal medication orders. Use a standardized patient handoff format.	
	Enhanced documentation, communication	Highlight medication name and dose on IV bags.	
Weaker Actions (these tasks require more reliance on humans to remember to perform the task correctly)	Double checks	One person calculates dosage, another person reviews their calculation.	
	Warnings	Add audible alarms or caution labels.	
	New procedure/ memorandum/policy	Remember to check IV sites every 2 hours.	
	Training	Demonstrate correct usage of hard-to-use medical equipment.	

<https://www.performancehealthus.com/blog/rca2-tools-to-prevent-harm>; <https://www.med.unc.edu/ihqi/wp-content/uploads/sites/463/2018/07/RCA2-National-Patient-Safety-Foundation.pdf>



Failure Mode Effectiveness Analysis (FMEA)

- A bottom-up analysis
- Identifies potential ways (modes) in which each part of the system can fail
- Assesses the priority of that failure in the terms of likelihood and impact
- Used proactively or retroactively
- Comes from engineering and science → modified for health care

How likely is failure to happen?

What is the severity of the failure (or this failure)?

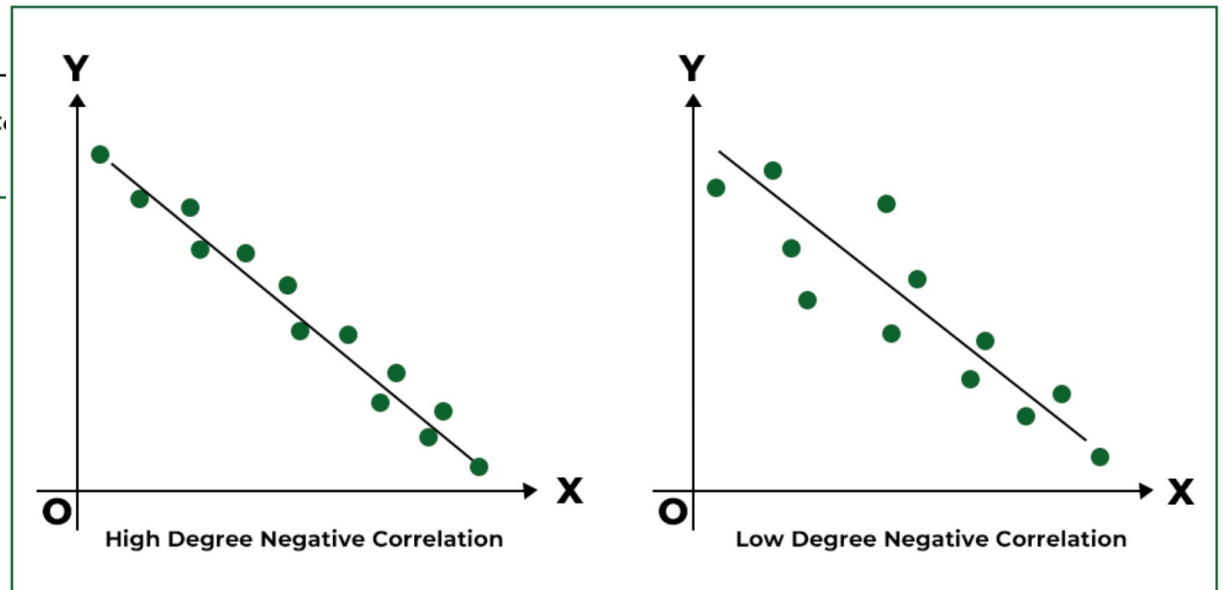
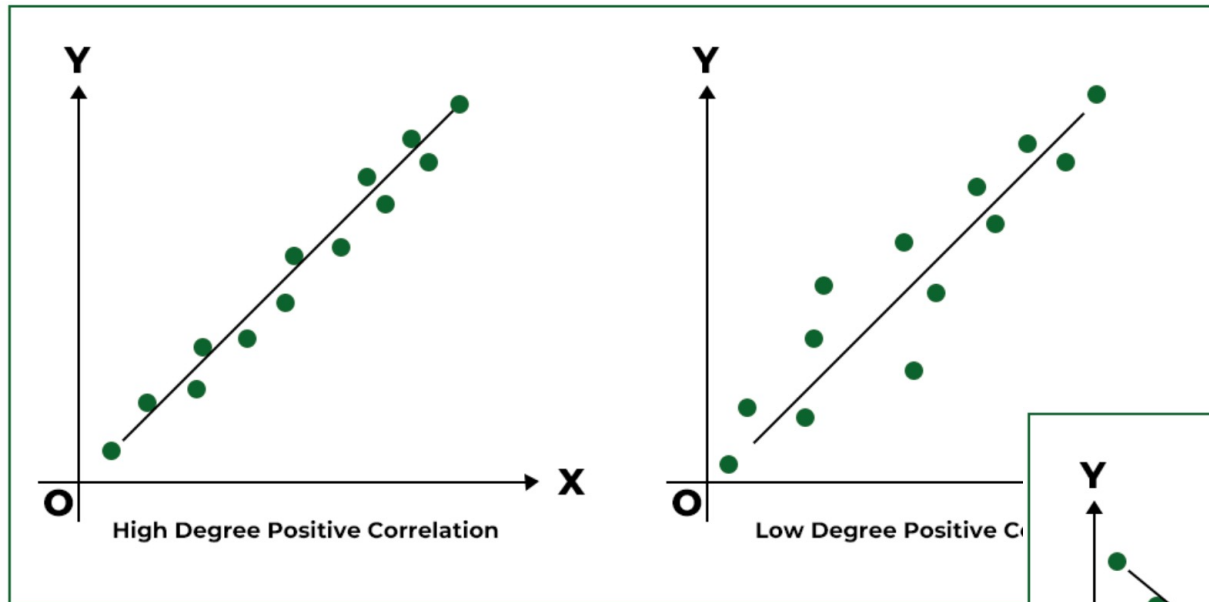
What are the short-term and long-term impacts if it fails?

How difficult will it be to fail?

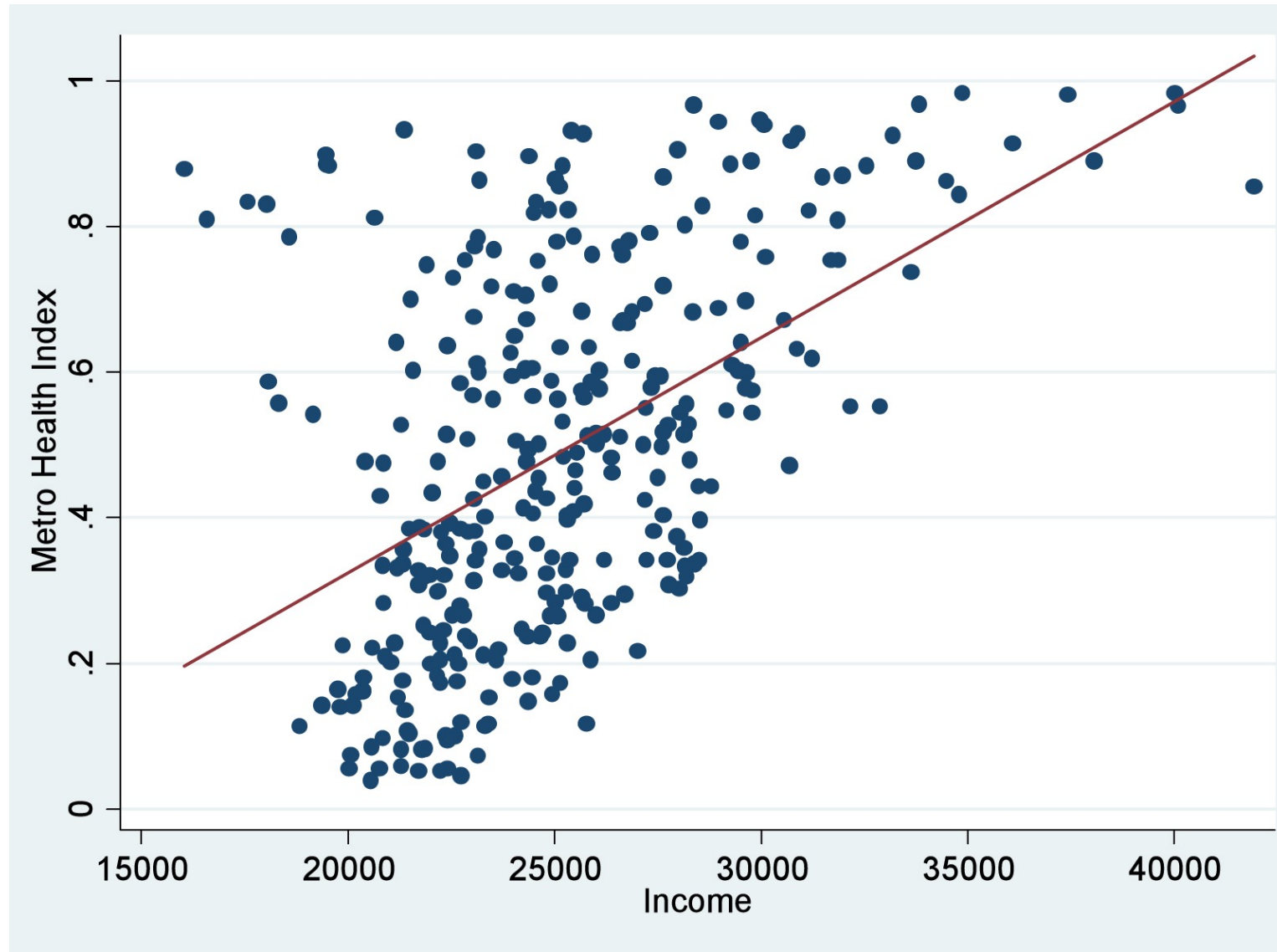
FMEA for Hypertension Informational Packet

Process and Sub Processes	Failure Modes	Causes	Effects	Severity	Probability	Hazard Score	Actions to Reduce Failure Mode
Educational Materials	Difficult terms used in the educational materials	Not enough feedback received from PDSA cycles	People will not read the entire packet	2	3	6	Utilize more infographics and pictures; ensure right people are providing feedback in safe environments
Physician Access	Physicians are still far away	Lack of transportation	People will not seek treatment	3	3	9	Research and include transportation resources
Medication Cost	Medication is still unaffordable	Medication not listed in cost-reduction programs	People will not seek treatment or purchase medication	3	2	6	Research ahead of time to understand scope; work with providers to learn about substitutes of any medications and provide resources

Scatter Diagrams (Plots)

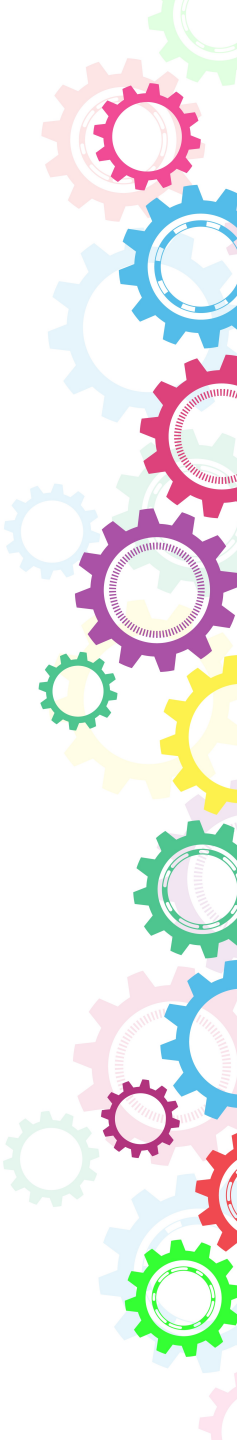


Scatter Examples



RCA Tools: A Summary

- Top Contenders
 - Equity Iceberg: Simple way to look under the surface.
 - Fishbone (Ishikawa Diagrams): Visualize potential causes and their relationships to identify root causes.
 - 5 Whys: Repeatedly ask "Why?" to drill down and identify the underlying cause of a problem.
- Other Tools
 - Fault Tree Analysis (challenge is that shapes each mean something)
 - Pareto Principle and 80/20 (more complicated, because you need to be intimately familiar with what the data says).
 - RCA2 (really good for health care and clinical work).
 - Failure Model (process-based, but complicated).
 - Scatter Plot (advanced epi tool; need to really analyze data).



Accelerate with Evidence

Explore the Evidence



bank of
evidence-linked
strategies &
tools



innovation hub
AMCHP | *Explore. Build. Share.*



MCH
DIGITAL LIBRARY

Find evidence-based/informed strategies through the MCHbest database, promising practices through AMCHP's Innovation Hub, and field-generated resources from the MCH Digital Library.



Evidence-Based/Informed Strategies: Consult the MCHbest Database



Promising Practices: Learn from AMCHP's Innovation Hub



MCH Library Databases: Access the Evidence Base Directly



Tips: Review how to strengthen strategies to be meaningful, measurable, and moveable.



Ensuring Effectiveness: Adopting or adapting strategies to meet the needs of your populations



Think Upstream to Plan

Incorporating Equity into Result-Based Ability: Two Evidence Center Tools



Turn-the-Curve Strategy Tool
Developing Population-Level Strategies

Result: _____ (your goal)
Indicator: _____ (what will it look like)
Baseline: What's the curve? Chart the past trend and the forecast. Use new worksheets for each indicator

5 Years Ago

Now

In 5 Years

• Add available comparison data & aspirational goal.
• Is the forecasted future OK or not OK?

Health Equity: Where do you see disparities?
Can you engage groups facing these disparities?

Story Behind the Baseline: Why does the curve look like this?
Dig deep for causes, barriers, and competing factors.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Information and Research Agenda – Causes. What do you need to know more about? How will you get that information?

Partners: Who has a role to play in doing better?

A. _____
B. _____
C. _____
D. _____
E. _____

Instructions: Circle critical partners.
Remember: Causes + Partners = Actions.
New Partners:
F. _____
G. _____
H. _____

Ideas: What Works to do better (Don't forget to look for ideas from the evidence). Look for "Sharp Edges" to implement.

• _____
• _____
• _____
• _____
• _____
• _____
• _____ (no/low cost)
• _____ (off the wall)

Instructions: Combine number from causes and letter from partners (e.g., 1A) after each idea. Circle where you can explore the evidence related to each idea.
Information and Research Agenda – Solutions. What do you need to know more about? How will you get that information?
Health Equity: To help ensure that strategies are effective for groups most effected by health disparities, consider these questions:
• What about the strategy works (what causes behavior change)?
• How does it work (what components make it effective)?
• In what contexts does it work (how can it be adapted for other settings)?
• For whom does it work and for whom does it not work?

Note: This tool is based on the Results-Based Accountability (RBA)™ Framework developed by Mark Friedman, author of *Trying Hard is not Good Enough* and founder/director of the Fiscal Policy Studies Institute.
* These questions were developed as part of the Science-Based Intervention Framework, created by Harvard University's Center on the Developing Child.
www.mchevidence.org

ESM Quadrant Measurement Tool
Developing Performance-Level Evidence-based/informed Strategy Measures

Instructions

	How Much?	How Well?
Effort	<div>Step 1: How much did we do? – Quadrant 1 • Start with "Number of customers served." • Better, more specific ways to count customers? Subcategories of customers? • What activities are performed? (e.g., training providers). Convert each activity into a measure (# of providers trained).</div>	<div>Step 2: How well did we do it? – Quadrant 2 • Start with common measures: o Workload ratio (e.g., # client/provider) o Customer satisfaction (e.g., Did we treat you well? Were you satisfied with services?). • Take each Quadrant 1 activity and ask how well was the activity performed. o What is your reach? (e.g., % of providers trained, % of eligible mothers who have received outreach materials). o Can you measure the activity based on time? (e.g., % of lactation consultations completed within 24 hours). o Can you measure the activity based on accuracy or meeting standards? (e.g., % of providers compliant with training).</div>
Effect	<div>Step 3: Is anyone better off? How are they better off? – Quadrants 3 and 4 • Ask: "If your program works really well, in what ways are your customers better off?" How would you observe/measure this? • These often occur in pairs (6 in Quadrant 3, 6 in Quadrant 4). • To save time, just focus on Quadrant 4 and place # signs in Quadrant 3 to show parallel. • Four categories to consider – improvement in: o Skills/Knowledge (e.g., % of staff who showed improved knowledge after a learning session). o Attitude/Opinion (% of mothers in pre-conception care who report intention to breastfeed). o Behavior (e.g., % of families reporting adhering to safe sleep practices after receiving guidance). o Access to/receipt of care (e.g., % of youth receiving transition plan).</div>	<div>Step 4: Headline your measures – Determine communication, proxy, and data power • Circle each measure that you have good, timely, and reliable data that is available now or with little effort (only circle Quadrant 2 and 4 measures). • Ask: "If you had to talk about this in a public setting, which circled measure would you choose?" (Public Square Test). Rank with #1, #2, #3. These are Headline Measures. Remaining circled measures are Secondary Measures that can be tried medium-term. Step 5: Data Development Agenda • Ask: "If you could invest in one to two measures for which you don't have data, which ones would you choose?" Rank with A, B, etc. These make up your Data Development Agenda (in priority order).</div>

Work Space

Quadrant 1: Measuring Quantity of Effort
(Counts and "Yes/No" Activities)

Primary Customer: _____
Other Customers/Subgroups: _____
(think about vulnerable groups in order to address health disparities)
of Customers Served: _____
(reword this for your customer)
of Activities Performed? _____
Other ideas: _____

Quadrant 2: Measuring Quality of Effort
(% of Reach; Satisfaction)

Common Measures (e.g., ratios, satisfaction): _____
% of Customers Served (Reach): _____
% of Activities Performed: _____
(measured by time or accuracy/standards)
Other ideas: _____

Quadrant 3: Measuring Quantity of Effect
Is Anyone Better Off (#)?

Health Equity Considerations:
1. Are the groups affected by this measure at the table?
2. How will this measure affect vulnerable groups differently?
3. How will this measure be perceived by vulnerable groups?
4. Will this measure ignore or worsen existing disparities?
5. Can we focus on a vulnerable subgroup with this measure to address disparities?

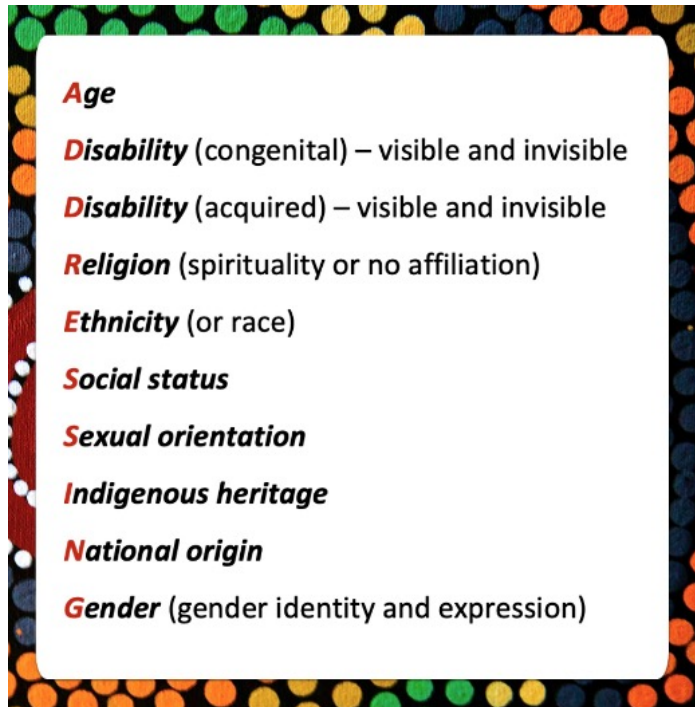
Quadrant 4: Measuring Quality of Effect
How Are They Better Off (%)?

Changes In:
• Skills/Knowledge: % _____
• Attitude/Opinion: % _____
• Behavior: % _____
• Access to/receipt of care: % _____
Other ideas: _____

Note: This tool is based on the Results-Based Accountability (RBA)™ Framework developed by Mark Friedman, author of *Trying Hard is not Good Enough* and founder/director of the Fiscal Policy Studies Institute.
www.mchevidence.org
















Work Together with an Equity Lens

The Hayes ADDRESSING Model



Hays PA. 2008. *Addressing Cultural Complexities in Practice (2nd ed.): Assessment, Diagnosis, and Therapy*. Washington, DC: American Psychological Association.

Tools. The Center has identified and uses the following tools in work with Title V agencies to ensure that new and ongoing strategies reflect the needs of all populations, advance health equity, and address SDOH.

-  **Collaborating for Equity and Justice Toolkit:** Case Studies, Resources, and Tools
-  **Community Commons:** Our Favorite Equity Data Tools
-  **Cultural Competence:** Tools from the National Center for Cultural Competence
-  **Disparities Impact Statement:** A Five-Step Worksheet from CMS
-  **Equity Organizational Self-Assessments:** Tools to Drive Internal Change
-  **Family Engagement:** A Systems Assessment Tool
-  **Health Equity Report Card:** Create Your Local Report
-  **Hexagon Tool:** A Six-Step Process
-  **Is My Implementation Practice Culturally Responsive:** A 38-Question Assessment
-  **People with Lived Experience:** Six Considerations when Making Evidence-Based Decisions
-  **Promoting Health Equity:** A Resource to Help Communities Address SDOH
-  **REIA:** Race Equity Impact Assessment Tool
-  **SDOH Crosswalks:** Linking the Ten Essential Public Health Services to Addressing SDOH
-  **SDOH Screening and Policy Tools:** Multiple Tools with Common Goals
-  **Systems Change:** "The Water of Systems Change" Approach



Request Technical Assistance

 **SMARTIE TA:** An Equity-Centric Approach to Our Work



Specifically, we provide **SMARTIE TA** that leads to:

- › **Sharp, Specific, and Systems-based ESMs.** We help sharpen ESM goals to more fully advance NPM topics and utilize systems to sustain these strategies.
- › **Measurable and Meaningful ESMs.** We ensure that your ESMs are measurable and in line with related projects in other states and jurisdictions.
- › **Actionable, Achievable, and Aligned ESMs.** We ensure that your ESMs inform your actions, are aligned with your needs assessment, and flow from your State Action Plan.
- › **Relevant and Research-based ESMs.** We connect your ESMs with the published evidence, emerging promising practices, and what other states are currently doing.
- › **Translatable, Targeted, and Time-phased ESMs.** We engage your team in developing sustained approaches to address specific needs of your populations, including Children and Youth with Special Health Care Needs (CYSHCN).
- › **Inclusive and Integrated ESMs.** We encourage you to work with all population groups as decision makers in every step of the process to ensure a meaningful partnership draws on the strengths of your communities.
- › **Equitable ESMs.** We continually ask the tough questions to address disparities, gaps, and issues of equity.

[Read about our TA in our brochure](#) | [Read about how our TA promotes implementation science](#)

Questions, Contacts, and Comments (2:50)

Learn More with the MCH Navigator through Competency-Based Trainings:

[Using Quality Improvement Tools to Uncover the Root Causes of Health System Issues](#)

Connect with Us

Leslie deRosset, University of North Carolina,
Chapel Hill

derosset@email.unc.edu

John Richards, National Center for Education
in Maternal and Child Health, Georgetown University

jrichards@ncemch.org

