Advisory Committee

on Infant and Maternal Mortality

Virtual Meeting

9:30 a.m. until 2:00 p.m.

Wednesday, June 14, 2023

Health Resources & Services

Administration (HRSA) Headquarters

5600 Fishers Lane, Pavilion B Rockville, MD 20857

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P R O C E E D I N G S

Call to Order and Review of Day One

MS. BELINDA PETTIFORD: I'm going to call this meeting to order. I hope everyone had a wonderful evening last night. I know we had a little homework assignment to do, but hopefully you still had a moment to enjoy dinner and to get out a little bit. The weather was beautiful last night. So hopefully everybody had a chance to do some of that.

Just as a quick update we have spoken with Michelle as of this morning. So, the paper that's on your desk. Envelope for the Members, she's going to email this to us with a deadline when it's due and then we will email this document and our receipts back to her. So, you don't have to worry about trying to fill them out at the break, because that's when she was going to come and get them.

So, I think yesterday went well, we had a lot going on. It was really good discussion and great presentations. It was really nice to get the federal updates from both Caroline and from Michael, so that we can get more information. It was good to hear from the Department of Agriculture. We feel like we get to hear from Dr. Michael Warren frequently, but it's always nice to get those updates as we all wait to receive them.

We also spent some time going back to our most recent recommendations to the Secretary. You know, those fifty-nine

recommendations, and several were able to share some of what they were going to continue to elevate them, continue to move those things forward. And we want to keep that on our agenda as a way of just following our recommendations. So, once we make the recommendations, it's a good way for us to kind of keep up with what is happening with them.

And then we spent a good part of the morning really diving into social determinants of health in general, but then we specifically focused on housing. And I felt like we had good conversation there lots of good information around other ways to, you know, make some priorities around pregnant individuals and their children. Are there ways to make sure people are clear of their rights? Are there ways you can support the landlords themselves? So, I felt like it was a really good conversation, good discussion, and hopefully you all felt the same way.

And then we kicked off right after lunch with our Community Voices discussion, so it was good to have both Taylor and Drena join us to share their personal experience but also their experience working with the two infant Catalyst Programs, and their focus on housing.

And then we were fortunate enough to have Lashelle Stewart come in with us who was able to share specifically around the Baltimore Healthy Start program and the work that is going on there.

And then we had Ada, as well as Mia to share with us

about the Federal Healthy Start program, and we had really good information on the data. So hopefully, as members, you all now have a better vision for what Healthy Start is, and you know exactly what it does and has the potential to do in communities around the state, I mean around the country.

ACIMM Priority Focus Areas

MS. BELINDA PETTIFORD: And then we move into our discussion on priorities. And as I shared yesterday we had, I had good individual conversations with all of the appointed members, not the ex-officios yet although there's still time, although with the appointed members I'm able to just talk to you one-on-one around where do you think we should go next as Committee?

We know we're expecting some new members to come on later at the end of the year and so we right now, we have ten or so members, and that's important for us to keep that as realizing what our capacity is to move work for, but yesterday I shared with you all of those twelve priority areas. There's a lot going on with those twelve.

And so last night one of our requests of everyone was to just take a moment, review a couple of things. One, review the guidelines that have come out around the Maternal Health Blueprint and what is already in motion, or at least the potential to be in motion. There was a good article around some of the data related to stillbirths.

And then there was also the recommendations from the last couple of ACIMM groups, and so it was good to see where we are aligned with them but also where we're trying to move forward and what some of that potential was.

I did take some time last night based on reviewing those areas and I narrowed it down--and I say I because it was just me in the room doing it--I narrowed down the focus from the twelve and dropped it down to less than twelve.

And I would like to start the conversation this morning with sharing how I narrowed it down. Because I really want to get your feedback into it. I don't think we by any means want to keep twelve priority areas. So, we've got to bring this down.

But I think part of the conversation will have to be around for those areas where work it's already in progress, I think in part what would be helpful to the Committee so you will correct me if I'm wrong, what would be helpful to the Committee will be really understanding what's the status of those other recommendations and keeping that as an agenda item for us moving forward.

So right now, in our agenda we really look at those recommendations that were made, the fifty-nine around Alaska Native and American Indians, those recommendations. But if we go back a little bit further and look at even recommendations that were made in 2021, there was some very clear recommendations there around the workforce and diversifying the workforce that were

recommendations there around community health workers and doulas. And do we need to make it as a recommendation again or do we just need a status report on those? So, I wanted to share some of that.

So, I don't know if you can pull up the slides that I mentioned earlier today. And this is a starting point okay, just to get us back focused this morning. So, I started narrowing them down last night. The priority areas that I narrowed it down to was those impactful opportunities, because I did feel like from the conversations we did yesterday that there were many.

There was much discussion around so what actually is working. Are there areas of the country, are the communities around our country where they're seeing really good improvements in their maternal and infant outcomes as well as their associated disparities?

So do we need an opportunity to make sure that we're looking at the best promising practices or those evidence-based and what isn't going on. What further opportunities will spread? So, this is one of the areas that I looked at last night on prioritizing it.

Another area where it didn't appear as if we've done enough work more recently is systems of care support, especially for rural communities, so there's been a lot of conversations as we are thinking about what is happening in our country.

But there is some special areas around rural communities. We're seeing labor and delivery hospital closures.

We're seeing challenges with levels of care depending on where you are. We're seeing desert issues; you know access to care issues. And there are different care models that are being implemented around the country.

The third area that's listed here is more around the social determinants of health, the social drivers. And Andre did a great job yesterday kind of laying out for us what the priorities are that are coming out of his team and his programs, but is there an opportunity for us to really narrow our focus on some of those?

Because again he shared the April 2022 report from HHS but are there opportunities there looking at Medicaid waivers and some other areas to really dig down deeper into social determinants or social drivers.

And then one more slide please. And then the other area, the fourth area was around the impact of pregnancy intentions. You know what is the systems going to be? How are we going to measure it? How would it impact individuals? Again, how are we going to know the impact of the changes that are being made?

So those are kind of the four areas that I went from twelve down to four. But I know that's a big jump, so I want to open it up now for, we're kind of going to get your thoughts, your feedback. What did I leave out that you thought, "oh no it has to be on the table for consideration?" So, I'm going to be quiet a

moment and let you all think about that.

DR. MARIE RAMAS: May I make a suggestion that we go point by point and just discuss strengths, weaknesses, opportunities?

MS. BELINDA PETTIFORD: Sure.

DR. MARIE RAMAS: Thank you.

MS. BELINDA PETTIFORD: Can you take the slide and go back one slide. and again, keep in mind I did not include all the twelve so this is narrowed it down so they were part of the twelve or beyond that you feel like you're being included, and we can always revisit those as well.

And this one is called impactful opportunities and we can call it that was just a name so we can call it whatever. But basically, what is working. What is working that we have an opportunity to look at? To invite those individuals to share with us what is working? What is the data saying? What is the community saying? And are there opportunities for spread?

DR. MARIE RAMAS: Thank you, Belinda. I see some positives here, because there's so many good pockets of work being done all throughout the country, and it would be helpful to see what kind of innovations are working for particular community types.

I could envision that if we were to use this as an umbrella, then we can break down further to include concepts of social determinants of health of the specific populations that

respond best to these interventions and what would the likelihood be of expanding and scaling that.

I could also envision that with getting examples from different communities from across the country, potentially identifying if there are already works in progress that might create some synergy to amplify what's happening.

So those are some of the positive aspects that I see with that first point. I'd like to see what the other Committee members may think.

DR. PHYLLIS SHARPS: Yeah, I briefly scanned the recommendations, and there was one, this was around 2013-14, redeploying best strategies. So, I think that would be a good starting point. I think that might be a starting point as the background for this bullet. I think also, as Marie was saying, we could even break it down to look at you know, do some interventions work better in urban settings as opposed to rural settings and that kind of thing. Interestingly, of the four that you mentioned, two were on my list. So, I don't know, like minds but I think that--that's a good one too.

We've invested Healthy Start in a number of agencies that were invested in a lot of interventions, and I think it's been ten years from that recommendation to look at and redeploy, so I think that this would be an appropriate time to see where we are, and you know, where are we getting the best return on investment in terms of outcomes that we're looking for.

While I'm at it, I would ask a fourth one to consider, which I think is something that Marie mentioned, is this whole fourth trimester care because we have a lot of bad outcomes in that fourth trimester when we think about depression, maternal depression, maternal suicide, some of the complications that particularly Black women are dying of. They often happen in the fourth trimester.

So, we could return to that whole notion of the childbearing year. Which would allow us to look at both preconception care and that fourth trimester.

MS. BELINDA PETTIFORD: So, to clarify Phyllis, because I want to make sure we're clear, are you saying that being a fourth priority area or you saying make it part of understanding what is working around the country? Make it another priority area? Okay thanks. Yes, Kate.

DR. KATHRYN MENARD: I'll add something, Belinda. Thanks. Actually, I think we should focus this, not on all impactful opportunities, not on all disparities or equities, but I think we should focus these on Black individuals.

And I say that because of the data we have and the stark disparities that we see, and if you kind of go to rural groups, you go to -- all over the map a bit you know that there's disparities that exist for Blacks everywhere. So that's kind of where I would go. But looking at what has worked and what's going well in certain places, I think that we can't-- we can't not

include that right now where we are in things, so that's my thought.

MS. BELINDA PETTIFORD: Thank you, Kate. Yes, Steve.

DR. STEVEN CALVIN: I agree I like impactful opportunities, just ideas. Because there are things, and we've mentioned it before the Strong Start Study. I mean there's a lot of money spent on it. It was part of the Affordable Care Act. It showed demonstrable benefits, in particular based on race.

So, it's kind of like if we can just say to the Secretary, "Please prioritize that. Please prioritize the implementation." We're making it available to as many communities as possible. So, I like your consolidation.

It is overwhelming at times when we have that fifty plus recommendations, they're all important, but it's just then it becomes stuff kind of thrown up into the air and doesn't really make an impact. I mean it does, a lot of them work, but yeah-- sorry didn't mean to say that.

MS. BELINDA PETTIFORD: It's all right, we understood.

DR. KATHRYN MENARD: Our workgroup would be either together where those are right, together where those interventions are, in the pockets that demonstrated improvement and kind of put that together in a consolidated way? Right in between now and--

MS. BELINDA PETTIFORD: There could be a focus of a workgroup, you know in partnership with the staff here and trying to understand what is working to address and are the others okay

with the focus being on Black maternal and infant disparities? Because I don't want to make an assumption. I want to give a moment to those that are on Zoom in the virtual area, because if you've got anything you want to say, just chime in or raise your hand.

DR. KATHRYN MENARD: Just to clarify, Belinda, I don't think these other groups are unimportant, but I think we can get those in our other priorities, and so the rural issue is listed. That's why I saw--

MS. BELINDA PETTIFORD: Okay. So, if you are an appointed or ex-officio member, you can just unmute yourself and speak. You actually don't have to wait for someone to unmute you. Yes.

DR. MICHAEL WARREN: I think along this line of impactful opportunities an important line of questioning to add, there would be to the extent that these are federally funded.

Where are the opportunities for alignment for things like braiding -- of funds? We've seen this in the early childhood space where often states are getting funding for multiple streams for like projects, but different agencies may have slightly different asks, different deadlines, different definitions and it creates inefficiencies.

And in that space, across the federal government, folks have come together to say how can we use common definitions, share needs assessments, make precious limited resources go farther?

So, I think any time there's an opportunity to go look for those efficiencies on the federal end that will be welcome. And I think on the same thinking there any barriers that are within the scope of the federal agencies on the policy or programmatic side, could be as these come up, once we're -- I love the thought of bright spots, like what's working well and how do we replicate that?

And then what are those lessons learned there that if this was tweaked a little, what would we do more or do better? And that's a really great role for this Committee to be able to take back to the Secretary for things that are under the HHS umbrella.

MS. BELINDA PETTIFORD: Thank you, and I agree with that. I also think that it's not an opportunity as we're looking at what is working. That we don't have to limit as to what is working in the federal government, because there are foundations and communities that have started efforts and using other funds that may be looking really well, and we just don't know about it, and they may not have had an opportunity to share with a broader group.

So, starting with the federal programs, of course, that makes sense, but I think we have to go beyond that as well. So, it sounds like we may have agreed on one part of the area. Thank you all. And following what Marie is asking.

Let's go to the second bullet then. So, if we think about impact for opportunities potentially being almost as an

umbrella, as Marie suggested, then the other areas may fall underneath it, and so then the question is as we think of these other priorities, are these some of the other priorities that we would like to consider?

Should we consider a priority around, was the word I guess, they went away, rural communities, any of these areas around the second bullet? So, I would love to hear your thoughts on it, or how you would want it reworded or changed or say no we don't want to do that. Yes, Steve.

DR. STEVEN CALVIN: Yes, coming from a state to where the North Shore of Lake Superior there's no hospital between Thunder Bay Ontario and Duluth that provides birth care. Two Harbors close to Grand Marais and it's like three hours. And so, the most common out-of-hospital birth is having the mother give birth in an ambulance on her way on to Duluth.

So, I think it is something we have to, because we're a big country. We have certainly the larger population in urban areas. From a political standpoint too, it's helpful, not helpful, it's important for everybody to be looked at. And I really agree too with making the focus that number one on the racial disparities. But this is one that really is important.

It's getting a lot more attention due to people like Harold Miller, from the Center for Quality and Payment Reform in Pittsburgh. He's done a real detailed analysis of the financials of these hospitals.

And we just maybe need to tap into some of the rural health programs that are around the country. I think there are eight of them at universities. There's really a very good one in Minnesota with Katie Cusumano leads it and to just look at the very possibilities.

We don't maybe need to have, except for extreme emergencies, cesarean section capability in places where there's sort of risk assessment. A multi-birth mom who just says I don't want to drive down to Duluth or wait around until my birth happens.

So anyway, I'm just putting in my pitch for yes, we have the rural and that ties in to the maternity deserts as well, which some of those are not exactly rural either.

MS. BELINDA PETTIFORD: Thank you, Steve. Others want to chime in on the rural-- how the rural community focus, looking at the hospital closures, the deserts. Anyone else want to chime in?

DR. KATHRYN MENARD: I can't help it. [Laughs]

MS. BELINDA PETTIFORD: You don't have to help it, you're a Member.

DR. KATHRYN MENARD: I agree with Steve. This is a really important focus. I think where we were a number of years ago and thinking about you know building systems for care and that kind of thing is really different, because this trend that we're seeing with closures is newer, right? And it's something that I very much think we need to address that hospitals are aligning and

the financial decisions that administrators are making an impact on, on individuals that live in these areas.

It's very important. And it's addressable. There are, I've had the opportunity to visit, you know I've always worked all my life in quaternary care, tertiary care settings.

But I've had an opportunity to visit a hospital in Wyoming that was many, many miles away from quaternary care and the system they put in place to provide sick care was amazing, right? But that's one of those bright spots, right? That's not one, as a hospital closes, the systems aren't in place.

So how can we rev up to make sure that when there are closures be sure safeguards are in place to have systems that work? Marie, I'm hoping you're going to comment too on what's happening in New Hampshire. We just chatted on our way in here this morning. There's opportunity to address these things faster than what if we just let administrators do it, you know.

MS. BELINDA PETTIFORD: Thank you. Yes, Marie.

DR. MARIE RAMAS: Since I was put on the spot, Kate. [laughs]. So yeah, I think if we use the umbrella of impactful opportunities, I think that will help frame a solutions focused recommendation document for the Secretary.

One area as far as supporting rural communities that I think we should add is the importance of having residency and loan repayment options for individuals who want to serve in that setting. And so, I would want to explore what is already

available, and what is the capacity we have to expand that. I think loan repayment, National Health Service Corps in particular, has had the tremendous effect in supporting our rural American communities.

The other thing I think that would be interested in and we touched upon it yesterday, was how the demographics within rural communities has shifted. So, with the economic changes that are happening, with the influx of new Americans and refugees, rural communities are becoming much more diverse than I think, I believe just on the onset.

And how has that impacted our potential delivery systems and the effectiveness of those delivery systems? So, I think that would also be interesting.

So, the last thing as far as rural communities and identifying the bright spots is in the levels of care. I am certain that from a state-to-state standpoint and maybe in a federal standpoint, there are different definitions for levels of care.

And so level setting, and what does that mean for us in the federal space? and how does that translate into a state setting? I think that would be interesting, and then as we were talking yesterday, what are some unique and creative models to help create extensions and extenders of that tertiary care that people need?

So, I think again in the spirit of highlighting bright

spots that that will be a nice way to incorporate that topic.

DR. MICHAEL WARREN: So appreciate you bringing up National Health Service Corps and the residency issue. So HRSA has a whole Federal Office of Rural Health Policy and the Bureau of Health Workforce that are both amazing, and so we can easily tee that up for a future meeting.

And I think that there's been a lot of interest in how that work expands, so I appreciate that. I also want to piggyback on this levels of care notion, and I go back to thinking how we let data tell the story and inform as the story.

I remember when I was in state government and we had a regionalized per need system, and you know hospitals pay attention to those numbers, because on the neonatal side, because payment, there are payment implications.

And so purely because of that there is this--well we think we're a three, but really, we're two so we'll create a separate system of 2A and 2b. So, we create all these structures to kind of make everybody happy.

But colleagues in another state started doing analyses where the hospital self-assessment, and the objective assessment were discordant. And like, you know, there's good data I think that shows outcomes are better when those births happen at the right place.

But when there's a discordance in the, the self-attestation versus the objective application those

differences aren't just pronounced. And so, I wonder if there's an opportunity to lean into those data and look at that with all the maternal levels of care work that's going on to think about both the maternal---I mean it's a package deal right. The dyad and think about how that might drive some of this work.

DR. MARIE RAMAS: I'm glad you mentioned that, Dr. Warren. The other impact because of that consolidation of hospital systems, and so when we talk about residency programs, for instance, there needs to be a hospital that sponsors the program typically, and so for trying to get access and create a pathway into rural communities, and we're consolidating those options even further, it makes it much more difficult to expose potential clinicians who would not otherwise think of working in those areas.

And so, I think making sure that the data is in alignment and is saying the same thing, helps us to make a stronger case of keeping hospitals open and creating a trending right. We can create trendings to help explain from a fiscal standpoint why it makes sense to keep those health institutions open so thank you for bringing that up.

MS. BELINDA PETTIFORD: So, thank you all, it does sound like this is a priority area that we do want to try to move forward with. I haven't heard any reason why anyone thinks we should not.

So, let's go to the third one around social

determinants of health with our social drivers of health. Any thoughts on this specific priority area, realizing that there's an HHS report? The highlights were shared with us yesterday for us that got to look at that last night.

There's been some conversations around what are the Medicaid waivers doing. What is actually under the purview of the Secretary versus where this is all somewhere else?

I know one of the conversations I had with Dr Warren at one point was around so when you put funding opportunities announcements out and it includes social determinants of health, you could actually use the funds to address the social determinants of health and sometimes it's a mixture, and so you make a purchase of transportation voucher, but you may not be able to help pay someone's rent for a month or two right at the time that they need it.

So, it's also thinking through all of those pieces as well. So, any thoughts from anyone? Yes, Kate.

DR. KATHRYN MENARD: So, Belinda, I went and reread Andre's, I guess his slides last night, and his presentation is pretty comprehensive and wonderful, even recommendations right within that.

My question is what's our Committee’s role or influence above and beyond what they've already prepared and strategic initiatives? Because do we pull things out say we're behind this or is it just, just there already, and we don't need to do that?

Or we endorse it or something like that? I just don't know the--how we can best use our influence?

MS. BELINDA PETTIFORD: And I think that really is up to us. It's how we want to do that whether we want to elevate one or two areas from the from the report or whether there's something that we feel like is missing from the report, you know. The report was pretty comprehensive, and I agree Andre did a great job with his presentation yesterday, but we have really good conversations and presentations on housing.

So, is there one area out of all of that that we want to elevate and look at what has worked around the country? Again, under that umbrella of impactful opportunities? And we'd love to hear your thoughts on that.

DR. MARIE RAMAS: To that point I'd be interested in hearing from the Federal Housing Association to see if they've considered ways to incentivize preventive care and maintenance with their fundings. HUD typically takes care of low incomes and lower socioeconomic populations, so I wonder if it will be beneficial for us to hear what is currently happening and if there's any cross-pollination already.

I think the evidence and the data is very explicit that housing and transportation are and food insecurity are the top three--had to look at Caroline there [laughter]--are the top three areas of-- as far as social determinants are concerned, that can help just shape and transition to complete outlook of a person's

well-being.

So has there been a coming together and a convening of the Secretary's Office and Housing Authority? So, Boston, I say this because in Boston there have been some unique programs where they have embedded Primary Care within specific housing neighborhoods and have incentivized and provided additional funding for people that are residents there in order to promote healthy living.

That might be a unique approach. And I don't know if that's been something we have talked about. So would that be possible, and I'm looking at Michael for this.

MS. BELINDA PETTIFORD: And I'll also kind of queue up Alicka if there's anything you want to chime in as well.

DR. MICHAEL WARREN: I think one thing I heard that was encouraging like within the authority of the department, and that it's easy enough to pull together those partners and think about where are the share goals and metrics.

And I think about as you were talking; I was thinking about some of the recent infrastructure implementations and some of the funding around certain manufacturing groups being tied to childcare also. And so, are there related metrics that cross domains that folks might not have thought of previously?

So, in that example childcare in manufacturing and in this example, housing, and maternal postpartum visit or well child visit or something are there ways to link those together? That's

certainly within the purview of this group to make a recommendation.

MS. BELINDA PETTIFORD: Thank you so much. Alicka, is there anything you want to chime in and want to say?

MS. ALICKA AMPRY-SAMUEL: So, we have models in the sense that we've, for example, out of COVID there have been some real great, like, relationships and intentional meetings in programs between our public housing authorities and FQHC's to make sure that the residents that live in HUD assisted housing have that connection.

But when you look at the funding that we've just released to deal with the housing crisis, and in particular the unsheltered individuals on the street, we've released different funding to address the social services piece of it to make sure that there's a voucher increase, but also making sure that there's funding coming from HUD to landlords for continuance of care organizations to address the mental health piece of it or the substance piece of it.

So now I'm talking about maternal child health right now, but there are ways that we have, you know, great models of working with other agencies around housing, and another piece that I was mentioning yesterday after our meeting, we have organizations that we've provided funding to, like Breaking Ground, Common Ground, who've developed new construction, affordable housing, supportive housing and there's a medical

office on site that the residents have access to their doctors.

A primary care physician in the building, and there's also models where they're developing just new construction, affordable housing for formerly homeless families that now have urgent cares that are built into the base of the building.

So, we see this happening in many places across the country. It's just really about how do you turn it into a real program, initiative, or structure that can be expanded or utilized across the country? If that makes sense.

MS. BELINDA PETTIFORD: It does. Thank you, Alicka. We appreciate that it sounds like we may want you to present at some point with some or all of these impactful things that you've got going on.

MS. ALICKA AMPRY-SAMUEL: But you know this is the last thing I'm going to say, and then I'm going to shut up.

One last thing right now related to the, the lead-based paint issues that we're having in our properties, we're working directly with HRSA here to make sure that whatever programs or opportunities that they have in place that are directly related to lead paint or lead, we're working with HRSA. But we're also working with the EPA, because they have a certification program.

We're also working with SBA to make sure that if residents in the community want to work with, get certified to work in companies so that they can be the ones that go in and make our units safe, they're the ones that are joining.

So, it's the intentional collaborative effort to our lead issues and units across federal agencies. So that's something, you know, that we're doing on a regular basis, and it kind of puts me in the mind of what we're talking about today. That's it.

MS. BELINDA PETTIFORD: Thank you. We'll come back to you, and I'm going to let you be quiet the rest of the meeting. Anyone else? Any thoughts on this particular priority? It sounds like maybe something we want to get a little bit more information on and see what maybe working in these areas and see where there's an opportunity for overlaps of collaboration with other efforts? Yes, Kate?

DR. KATHRYN MENARD: Don't let me talk too much. But one of the things that resonated with me and his presentation and realistic goals, a lot resonated with me, I'll say.

But goal two is to improve access and affordability of delivered care and support partnerships between healthcare and human services providers, as well as build connections with community partners to address social needs.

I think there's incredible potential there that's untapped, you know, as a provider who talks to a lot of providers. You know the idea of shouldering responsibility for addressing social determinants of health is like ugh, not my job. I can't, I don't have the tools. That sort of thing.

But it's possible to build those tools, right? We heard

from our community representative that she would engage more readily and trust and address the system if that was recommended by her provider. You know I think that's powerful.

You know, I think we try to do a bunch of that in our work in North Carolina, so I think that's worth kind of digging into more. It's more about implementation, and if we're asked to screen as clinicians and primary care, we usually tap CMS to do that but, but it's in primary care, not so much in the OB, at least in my institution but in the -- institution not so much not my job. You know, I do pap smears.

MS. BELINDA PETTIFORD: It shouldn't be.

DR. KATHRYN MENARD: But you know, huge potential. And I think if we make it and we educate and we make it implementable, you know there's great opportunity there.

MS. BELINDA PETTIFORD: Thank you, Kate. And so, let's go to this next priority because I'm also looking at the time. And if you could go to the next slide, please. So, the last one that I put on the list was the impact of pregnancy intentions for the impact on the systems, the individuals. Don't know if anyone has any thoughts on this one.

[Off mic]

MS. BELINDA PETTIFORD: Some more probably around this is the wording that came from the priority around reproductive justice. and reproductive intentions. So maybe pregnancy intentions is not the best word.

Any thoughts, concerns? Want to stay away from it? Want to delve deeper into it?

DR. MARIE RAMAS: So, I'm thinking preconception care when I think about pregnancy intention and accessibility to preconception care. So with that, again in the spirit of looking at particular populations that would benefit from additional insight I think about new Americans, I think about incarcerated people, I think about families who have housing insecurity as well that might be limited to accessing preconception care I think this would also be some blurred lines because state level initiatives and policies affect access to preconception care.

So again, I think that would be interesting to identify some bright spots. What evidence is there available that has shown some positive effects to that regard? I also think the impact of pregnancy intentions that could fall into line with that fourth trimester care as well.

So, concepts like expanded Medicaid and in states with expanded Medicaid for twelve months postpartum have actually demonstrated lower postnatal complications and effects. So that's sort of what, that's what it makes me think about. I'd like to hear what other people have to say.

MS. BELINDA PETTIFORD: Yes, Steven. Phyllis, were you going to say something I don't want to cut you off?

DR. STEVEN CALVIN: So, Belinda, thank you; I think the way you worded it is really helpful, and I wish you were the

Speaker of the House or something. You have a knack for saying, "Okay, certain things are hot buttons that are just going to get a backlash".

So anyway, I just wanted to say I just appreciate how you address that, and I think it would, I think it would get a lot of support with our major divide on a whole variety of issues but particularly that one.

MS. BELINDA PETTIFORD: Thank you, Steve. Yes, Phyllis?

DR. PHYLLIS SHARPS: There is also reproductive coercion, where people don't have access to birth control, and I think you know we may need to think about that as we see what's happening with other access issues to care not only women having access to abortion care.

But also, providers who are not willing to offer services in cases that they should be because they're worried about their own license, you know, that kind of thing.

So, I think we're in a time where there are a lot of threats to mechanisms that women use to control their reproductive health, and maybe there is a way to maybe take a deeper dive on that. So, something else has to be accessible when you take away another part of care that they should be entitled to.

MS. BELINDA PETTIFORD: Thank you, Phyllis, and thank you for specifically calling out coercion. I think that was a piece that we had missed, so thank you. And we'll make sure there's no one online that has anything they want to say. Anyone

online? If not, Marie's in the room, and I'll turn it to you, Marie.

DR. MARIE RAMAS: Thank you, I definitely agree with sentiments that were expressed. I would--I would like for the Committee to consider that if we do discuss social justice around pregnancy intentions that we maintain a very specific gaze so that we have a controlled conversation because what I don't, what I don't want to happen is this is one part of maternal infant health but it is not all of it.

There might be areas of opportunity that are more readily actionable as well. However, I do see that we might have the opportunity particularly, and again as a National Health Service Corps, I think often about our federally-qualified health centers, our rural health centers that are kind of required sort of services for the most historically excluded populations and how does that affect these populations of priority that we've identified.

So again, making sure that we have actionable recommendations to the Secretary and not shy away from this discussion, but where are some bipartisan bright spots that have been demonstrated and could potentially be replicated in a way that is effective to reduce disparate outcomes? And so that's my recommendation.

MS. BELINDA PETTIFORD: No, thank you so much, Marie, because I think that is the focus. We're trying to get to an area

where we can actually have a good conversation without people going into their own corners of the room. We've got to bring this to the center and figure out how we can move some of this work forward, and that's going to be critical in our discussions as a Committee. Yes, Kate?

DR. KATHRYN MENARD: Belinda, I'm not sure and others can educate me on this, but I'm not sure that we really have a good system in place yet to really monitor the impact that these changes in policy and the requirements are going to have on maternal morbidity and mortality.

So that would probably be factored into recommendations that we should include and that would be something I think that, when I think the issue of improving maternal health gets bipartisan support. You know, so that would help.

MS. BELINDA PETTIFORD: No, I think that's a great point, Kate. And I think every community is probably trying to figure this out, and I think it gets to the next point here is what about data, anything on data.

Anything on data research? And specifically what data or research do we feel like we need more of? Do we feel like the data that we get now, realizing that you know we get some really good data, but you know data, we always want more.

And so, is there an area of data or research that we feel like should be factored into any of these priorities as we're moving forward? Yes, Steve.

DR. STEVEN CALVIN: That's why we have Danielle.

MS. BELINDA PETTIFORD: She made a smile when we said data, didn't you?

DR. STEVEN CALVIN: Yeah, but really we had a short discussion about a study that we were doing on outcomes, and I would just be interested, Danielle, if you have any thoughts on if you had every wish you wanted about how it's sometimes a mess that's getting better, but do you have any thoughts?

MS. BELINDA PETTIFORD: You didn't know you can make wishes today, Danielle, did you?

DR. DANIELLE ELY: So, I know one of the things that we've been working on at NCHS in general and with the vital statistics is just getting more timely data. And we've really greatly improved it in some areas, and we're working on improving it for infant mortality and specifically the linked file which is, I don't want to say woefully behind, but it's one of the things I brought up yesterday was just last week we were able to get out our 2021 data. And so, we're trying to find ways to improve timeliness.

One of the issues you're talking about wish lists. You know one of the issues that we've run into is that states need money to collect data. COVID really impacted the vital statistics reporting just all around, but states were also given money related to COVID that could be used towards its final statistics, so it's twofold.

I don't know off the top of my head, I can't necessarily think of anything specific wish list-wise, but I mean there's always the hope that people can get in better data. The move to electronic health systems is helping in some ways, and finding automated ways to code cause of death is helping, but some of it just takes time to get implemented and to test so it's, it's hard to say if I would have a wish list, but my personal wish is that we would be able to find a way to get our data out earlier but a lot of that is internal so--

MS. BELINDA PETTIFORD: And Danielle, you can keep thinking about it, you don't have to just give us your total wish list right now on the spot. [Laughter] We'll come back to you at some point in the future meeting soon. So, we do want you to think about it.

I know some of you have said to me you feel like we don't have enough maternal health data to actually track what some of the outcomes are so much more similar things on the infant front.

We probably have nationally more infant type data than we have maternal health data. So, is there an area there that we want to delve in any further or are we comfortable with the data we have? And that's the reason why I've said that data research piece. Yes, Danielle?

DR. DANIELLE ELY: If you can tell us like what you want, see this is what I always said at the last Committee as well

as some of you were on it, is you just need to tell me if you want something.

MS. BELINDA PETTIFORD: You may have that already and we just don't know.

DR. DANIELLE ELY: And so, I know one of the times it got brought up, like oh we need more AI/AN data of multiple races. Well, we have it but no one's asking me for it, so I just want to put it out there. I can't guarantee we'll have what you want but if you don't ask, I can't tell you.

DR. KATHRYN MENARD: Belinda?

MS. BELINDA PETTIFORD: Yes, Kate?

DR. KATHRYN MENARD: I think one of the struggles we had, and I work enough with the maternal morbidity data and that kind of thing to sort of know what CDC does, know what HRSA is trying to do. It's just kind of a picnic, what different quality trials are trying to do and it's not-- Bill Callahan provided us with a really good starting point. But it's not enough, right?

To look at morbidity with the birth hospitalization, it's pretty well expected that we need to know throughout the postpartum period. We need something broader than what happens in the hospital and administrative data has flaws, and that's kind of what we're working with.

And people are thinking a lot about, you know, how can we expand that standard, but we do need a consistent way to describe maternal morbidity and to have a system for surveillance.

So, Danielle, I don't know what to say to look to ask for, but we do need the right people around to decide.

You know CDC, HRSA, people who are doing this work. Actually, you may know more about this, Christie, than I do, because I think people have gotten together to try to do this, but I don't know that it's been widely accepted.

So wouldn't it be great, I know I don't say that too often, but wouldn't it be great to come up with a consensus from all the stakeholders to say this is the way we're going to do it this is the best we can do with what we have and ask Danielle to push it out?

DR. DANIELLE ELY: And it's not just me, right? [Laughter] No, no what I am saying is you know if you ask say, well we're interested in x, y, and Z, so what can you provide or what can this, very specifically what can your center, institute, office, whatever provide on that specifically?

So, I know for us I can tell you different, you know, national rurality infant mortality. We can talk about, well I'm not sure how much my colleagues from mortality can talk about, you know, maternal mortality in rural places, there are a lot of things we can touch; it's just we have to know what you want us to even look for to start with.

DR. KATHRYN MENARD: I think in previous presentations the recommendations, there's pre-emphasis there that's great. In MMWR, the maternal mortality review committees are expanding,

that's fabulous. There's timeliness, it's mentioned numerous times in the reading that we got last night and previous recommendations, the blueprint, etc. that's all there.

But the topic of a better measure of morbidity I don't see it in that, so that's kind of something different.

DR. MICHAEL WARREN: As we think about with colleagues what those measures might be one of the things keeping our public health hat on, like we're talking a lot about outcome data but then the outcomes already happened, and it's often the outcome that we want to avoid so what are those upstream markers?

Particularly as we think about preconception health, help across the life course, that we might put as flags that are not going to be quick fixes, but I mean this is multi-generations of career work that over time we'll start to bend that curve.

MS. BELINDA PETTIFORD: Thank you. And Charlan, I think you wanted to speak? Please chime in, dear.

DR. CHARLAN KROELINGER: Thanks Belinda I didn't want to interrupt the flow but just wanted to highlight what Kate mentioned that it's really important to examine the maternal morbidity beyond the delivery hospitalization. We think we have a good understanding of that, and we're working with our great partners at HRSA and AHRQ to continue to refine what that might look like.

But in addition, it's really understanding that morbidity events that happen prior to delivery or after that I

think it's important to emphasize.

I also wanted to mention too that respectful care is important. Not just at the delivery hospital where we do have a lot of data, but before and after. So that's another area where I think that this Committee can sense that they're having an impact. Thank you.

MS. BELINDA PETTIFORD: Thank you Charlan, and thanks for chiming in.

I just want to do a quick around the room for those virtually that if we haven't heard from you if you've got anything you want to add to it. Sherri, I know that you're on now. Sherri Alderman, if you want to add anything to this discussion on priorities, and then I'll call on ShaRhonda after you. And then I think Tina is on. Is there anything that you want to add, Sherri?

DR. SHERRI ALDERMAN: No, thank you for asking, not at this point.

MS. BELINDA PETTIFORD: Thanks, Sherri. ShaRhonda, anything you want to chime in with?

MS. SHARHONDA THOMPSON: No, everyone has been hitting good points.

MS. BELINDA PETTIFORD: Thanks, ShaRhonda. Tina? Would you like to add anything?

MS. TINA PATTERA-LAU: I know I think you are all on the right track, certainly in line with a lot of the work that we are putting out moving forward in IHS. So happy to learn more with

the work that you do. Thank you.

MS. BELINDA PETTIFORD: Thanks a lot, Tina, and I think Karen, Karen, I think you're on, Karen Remley, if you want to chime in.

DR. KAREN REMLEY: I don't have anything to add. I fully support this and will be really think it's important to really have our focus here.

MS. BELINDA PETTIFORD: Wonderful, well thank you all. I just want to make sure if you were trying to say something, we got a chance to hear from you.

So, we only have like four minutes, and we have narrowed this from twelve down to like four or five areas and our next steps we're going to have to kind of figure out how to divide and conquer.

So as we go through today, start thinking about if there is a specific area, and we'll try to get it put on a slide during the lunch time period, that you want to really focus on realizing that we have around ten members now so I don't know if we're going to do five workgroups, so we're going to have to figure out how to manage that.

So, let's think about that the rest of the day if you are one of the members, including the ex-officios, we're going to include you in this discussion. Not leaving you all out by any stretch of the imagination, and then we'll come back to that at the very end of the day.

Okay, anybody else have anything they want to add in? We do have another minute or two as our panel gets ready. Yes, Marie?

DR. MARIE RAMAS: Thanks, Belinda. I do have one data question; I saw your ears perk up. So, something that we know is both helpful for on the maternal side in preventing adverse outcomes and on the infant side is success with breast or chestfeeding.

And I know we have programs to help encourage breastfeeding postpartum, but do we know, or do we have information about the length of continued breastfeeding within that first year postpartum? And then access to, access to supportive services to encourage breast and chestfeeding in the peripartum period?

I say it that way because we do have a certification for hospitals that are breastfeeding or chestfeeding friendly, but I wonder if the populations that are most affected when we're talking about our Black and Brown populations at this time, if they have the same measure of intentionality with supporting breast and chestfeeding in that peripartum period. So, we haven't really talked a lot about our infants, but that seems to be a natural overlap.

MS. BELINDA PETTIFORD: Right, we should make sure that as we're looking at our priorities that we're thinking infant and maternal. So, thanks a lot okay anyone else? You've got a minute.

we're adding breastfeeding to our data research area.

Okay, what a wonderful job! Give yourself a hand, we've narrowed this down much better than we thought we were. I was real nervous about that one. I was like, okay, this one's going to be a long day.

Partnership Panel – Clinician/Provider Focus

MS. BELINDA PETTIFORD: Okay, so now we're going to transition to our panel. I think all of our panelists are here. I guess we're ready to find out.

And I'm going to ask the panelists to come to the front of the room so the mic's there. When you get up to speak, if you want to stand at the podium you're fine to do that, but we would like to get all of you at the front, and then that way when we get to Q&A you'll already be up near microphone. And so, we're going to start with Julia Skapik. Thanks Julia, you knew I was getting ready to pause on your name.

Julia is the chief medical information officer with NACHC, the National Association of Community Health Centers. We're happy to have Julia with us.

We also have Christie Allen with us. She's the senior director of quality improvement and programs for ACOG, known as the American College of Obstetrics, Obstetricians and Gynecologists.

We have Karen Jefferson here with us today, she's the

director of Midwifery Practice for the American College of Nurse-Midwives.

We have Jonathan Webb with us here today. He's the chief executive officer for the Association of Women's Health Obstetrics and Neonatal Nurses.

And we have Debra Waldron with us. She's the senior VP of healthy and resilient children youth and families for the American Academy of Pediatrics. So, welcome; we look forward to hearing from you all. One of the reasons we invited all of them here today was to really kind of share with us what some of the priorities of their organizations, one of the things we've been talking about as an Advisory Group is really thinking through what are the opportunities for alignment with our recommendations with all the work that you all are already doing.

So, I would love to hear your thoughts on that, and we'll just let you go in the order. And I think we'll start with Julia.

DR. JULIA SKAPIK: Thank you so much for inviting NACHC to participate today. I'm Julia. I'm the CMIO at NACHC, I'm a Certified Clinical Informaticist.

And NACHC, it's seen a lot of work in my area of infant and maternal health, and we would like to be partners with some of the folks that have spoken at this meeting and see how we can deepen our relationships and maybe assist HRSA and evaluation across the industry. Next slide, please.

So, this is the NACHC mission. NACHC was founded in 1971. NACHC takes on four sort of major roles doing research-based advocacy, education of the mission and value of health centers, training and technical assistance to healthcare staff and boards and clinical workforce, innovation, and performance. Next slide.

These are NACHC's strategic pillars. I would argue that all of them touch on the topics of interest to the Advisory Committee, obviously equity and social justice first and foremost.

I'll talk a little bit about some projects that seek to build infrastructure or support infrastructure around maternal and child health. We do a lot of workforce programs, and I loved hearing yesterday about the diverse workforce HRSA is working with. NACHC obviously also works with the same doulas and midwives and nurse practitioners and patient navigators, community health workers. I think obviously there's a lot of room for partnership there.

I would say for four and five, many health centers are working on improved care models both on the payer-side and also started from the innovation-care-modeled-side and of course those hopefully will lead to reliable and sustainable funding for the patient-centered dyad family care team support that we need to do better in this area.

And then supported partnerships. Again, I'm here because I'm hoping that we can continue to deepen and broaden our work together. Next slide.

So many of you are probably familiar at the beginning of the community health center movement it started in the beginning of the Civil Rights Movement fifty-seven years ago.

A rural and an urban health center opened together, specifically with the hope of addressing health disparities. And you'll see those two initial health centers on the slide. Next slide.

Today, NACHC supports fourteen hundred plus community health centers which have over fourteen thousand Healthcare delivery sites. In 2021 we treated more than thirty million patients and that included a large number of special populations, as you can see on the slide, many uninsured residents and actually the majority of health center patients are living in poverty or under 200% FPL. Next slide.

So there are five things that make you a health center, and I'm sure the HRSA folks don't need to hear this, but you have to be located in a high need area, provide comprehensive health and related services including enabling services, which I think is within the scope of what many folks now talk about as HRSA or SDOH.

You have to be open to all residents, regardless of the ability to pay. Governed by community boards. One of the cool things about working at NACHC is meeting community board members. And following, of course, reporting and performance accountability requirements. Next slide.

So, housing and patient-centered care. Primary health services at health centers are largely but not entirely and certified domains family medicine, internal medicine, pediatrics, obstetrics, and mental health. I would argue that basically all of those are overlapping with the scope of the Advisory Committee.

But we also do things like dental screenings; actually, a number of health centers have prenatal dental programs where they intentionally enroll their pregnant patients into a dental screening. Many have gone many, many years without dental services.

And, of course, the enabling services. I heard a number of programs doing that yesterday which is fantastic. NACHC has a number of programs also, or health centers also, have a number of programs where they work with dyads or there's housing insecurity or homelessness, and people are in public housing. Of course, those pregnant patients are at high risk. Next slide.

So, when you look at the overall population that's either in maternal or infant time to stage of life, I'll say, that gets close to about under ten million patients a year. I think we can go to the next slide, actually.

So, I want to talk about health centers focused on mothers and children. On the left here you'll see this is from our May 2023 Care Teams's Digest. We featured a program that we have at NACHC where you do self-measured blood pressure with obstetric patients, knowing that hypertension and hypertension related

disorders are a significant cause of morbidity and mortality.

And in 2020, health centers served over 6.8 million women to provide over half million prenatal care, delivered over 170,000 infants. This is 2020 numbers again. And provided contraceptive management to many more patients. Next slide.

So, I want to talk about a couple of programs that individual health centers or networks are working with. The one on the left is one of my favorites. Andrew Hamilton, the CIO at Alliance Chicago, said, "we're using children as lead sensors, and we shouldn't be doing that". I think that's a really valuable statement.

So, this program actually goes into the homes of pregnant women, does the lead screening, and does abatement before the baby is born. It's a program aligned with the city of Chicago. And obviously a very much forward-thinking way of addressing lead exposure.

The maternal health program featured. This is actually from the lay press on the right-hand side, the Detroit Health Center is about sort of doing more patient-centered care, more group support for patients who are at high risk, providing them with more patient navigator and coordination services, much like some of the programs we have already heard about. Next slide.

So, we have some programs funded with the Centers for Disease Control. Thanks, anyone who's on the call from there. This project, the first one I'm going to talk about, we're going to

formally call it we call it Women's Health BP but it's really the Women's Health Quality initiative.

It actually came from several CDC groups, and we sort of merged a project over time to be more focused on comprehensive quality in the postpartum period. And since this project's been going on since 2018, we are focused on using EHR and population health tools to track those primary care quality.

Over time, we've added more quality measures to that flow but our partners have also done workflow reengineering in the electronic health record to create centralized areas or the care team can find information about what services have been provided and which services are needed for specific patients are targeted for all of those measures that are relevant. And also trying to streamline that to make it easier for the care team to provide the services with less burden. Next slide.

These are the partners that we have currently working with. Alliance Chicago have been on board since 2018. Together, they serve about ten million patients in the United States. Redwood is a smaller network we're working with. We're doing some work with Medi-Cal in California.

And then CMQCC probably here someone with the California Maternal Quality Care Collaborative. We've been working with them on sort of the improvement of the specifications of these quality measures. And they've been working in California on that in the state. Next slide.

These are some of the issues and the things that we've tried to address during the project. One of the biggest challenges that we've run into is the poor quality of data around pregnancy.

And NACHC since 2020 has been repeatedly submitting comments to the Office of National Coordinator for Health IT around the need to support all of the continuum of care that supports a pregnancy episode.

We were pleased that the third time we presented pregnancy status that that was accepted in the USCDI, but we know that that's absolutely insufficient to do the work that we need to actually track the state of the pregnancy and then the outcomes before, during, and after the childbirth.

But we've also worked with our partners on improving the completion of that documentation and the record of the actual delivery date. Even with targeted effort outpatient records fifty percent of the time or more will be missing the actual delivery date, we just needed to drive all the quality of care and the decision support that the care team needs.

Obviously, you can't do a three-day follow-up if you don't know the baby has been born. And so, we, considering some projects are wrapping around the care and patient navigator to help fill in those data gaps so that they can also communicate with the patient about the importance of that follow-up and bringing them back into the fold as soon as the baby is born. We can go ahead into the next slide.

I will say that the scope of our quality measures include gestational diabetes and diabetes hypertension, substance use, postpartum depression, and screening. Just part of the postpartum comprehensive visit.

So, this is actual data from our project. We have 104,000 total deliveries as of the last data analysis. This is a breakdown of the number of patients who have different conditions with hypertensive disorder and some of the measures that we were working on. In this area where the use of aspirin in patients with hypertension-related, pregnancy-related hypertension and also an early follow-up visit or early follow-up blood pressure. We also look at preeclampsia screening. Next slide.

This is a newer component of the project as MMRC and PQC collaborative. Also sponsored by the CDC, thanks again. The goal of this work is to convene and establish a model for state and national collaboration with health centers, perinatal quality, and maternal mortality studies.

The idea is a data-driven approach. We're at the state PQC level and the state sort of PQC Health Centers have primary care associations, which are state-based groupings of the health centers. They're looking at the state level data and using it to say in our state what's the biggest threat and how do we address those threats at a state level.

And we're also seeking really to broaden the focus of the perinatal quality collaboratives. Traditionally many of them

have been heavily focused on the birth episode inpatient and done very little if anything to coordinate care before and after the birth episode with the outpatient care providers.

And so, the goal is to actually broaden the scope of the PQC's and address health disparities across the care continuum and improve transitions of care, which we know are a serious problem. Next slide. I'm almost done.

And you'll see perinatal quality collabs coming up. We're excited the CDC has been expanding the program. Next slide.

And then these are two current partnerships. So, we're working with Florida PQC with Health Choice Network which is a health center-controlled network in Florida and in Illinois Perinatal Quality Collaborative, with Alliance Chicago. Those folks have already been meeting in-person to talk about what their strategy is for our next program there which starts in August.

So, I think there's a ton of opportunities for us to collaborate, and I hope that we get the chance to follow-up after this meeting. Please feel free to send me an email.

MS. BELINDA PETTIFORD: Thank you, Julia. We're going to go now, I guess, Christie. If you're good. And we'll hold questions to the very end. [side chatter] I’m sorry Jonathan's up next. [Laughs]

MR. JONATHAN WEBB: Good afternoon and thank you again for the opportunity to come and share with you. I'm Jonathan Webb the CEO of AWHONN, the Association of Women's Health Obstetric and

Neonatal Nurses. Next slide, please.

A few objectives we have for today's meeting, and again, thank you for the invitation to share a little bit about who we are as AWHONN. We're going to talk about highlights and our infant and maternal health portfolio to offer insight from what we're hearing from the field and, last but certainly not least, to explore opportunities for alignment.

So, our mission, our main vision is to make a difference in the lives of women in newborns. Our members are committed to the health of women and newborns, and we want as an organization to empower them and empower our nurse members to care for women and newborns to research, education, and advocacy. Next slide, please.

We are a nursing organization. We have 25,000 plus members and we represent 377,000 nurses who are in the women's health obstetric and neonatal specialties. Our member profile includes bedside nurses, researchers, nurse administrators, educators, academicians, and we actually just recently expanded our membership base to reach out to and include LPNs, doulas, and others who are associated with maternity care. We're engaging with those populations to make sure and invite them into the fold. We have resources that are wholly supportive of their needs.

And we support our members through the provision of education, the development of guidelines standards, research programming, and advocacy, among a number of other things. Next

slide, please.

I'd like to first start with a grounding that we believe all patients deserve equitable and respectful care. We are coming from a place where we have a firm understanding of the growing U.S. maternal morbidity and mortality crisis and the underlying Black maternal mortality crisis, an understanding of the disparities of exist in maternal and infant health in the U.S.

The importance of a systemic approach to addressing these issues, and while we firmly believe and understand that many of the challenges and the solutions to these issues need to be addressed from a systemic and social determinant of health perspective, there is still a large role for the healthcare workforce to provide assistance to this issue. Next slide, please.

So, I wanted to---along these lines I wanted to first start out with the effort that we've been focusing on because we as an organization have realized and acknowledged some of the historical challenges that we've had being fully homogeneous in our membership base. So, we are focused over the last year and a half, been really intent about what it means to be diverse, equitable, and inclusive.

This is important for us because we need to make sure that as we are building the guidelines, as we are looking to build some of the educational resources that we-- I'm going to highlight a little bit later that we're doing so with the support of a diverse group of members and a diverse group of contributors, to

make sure that when we produce these materials and innovation that includes a number of different perspectives.

And that's from a racial role, geographic perspective as well as sexual orientation, so this is an effort that we've gone through. Next slide, please.

And develop these pillars on our roadmap focusing on transparency, focusing on how we share power, operational accountability, how we internally support our members and our staff around people and culture and building equitable systems that ensure our policies and processes are fair and equitable. We've also, in addition to during the process of building this, we were making this available to our members and partners and those who are inside the MCH space, we look for public comment to make sure this was striking the right note.

And then we are in the process of building a dashboard so people can hold us accountable to how we're moving these forward. The reason why I highlight this as I mentioned before is because it will impact where we put our materials.

But we also think it can be an example to our members of how you can be transparent around your efforts towards being more diverse, equitable, and inclusive. Because that's one of the challenges and questions that we heard from our folks.

Now that they've been trained, now that they understand or are in the process of understanding what levels of accountability and transparency have existed, so the people can

see that there's a change and we can track the progress towards it. Next slide, please.

This is a long-standing statement that we've had in our mission statement on racism and bias in maternity care. We continue to train our members and support their understanding around how to be more equitable, inclusive, and really dismantle the systems of structural racism that have gotten us in the position we're in today. Next slide, please.

Here are a few items that I wanted to highlight around our maternal health portfolio, and I have a similar slide for our neonatal portfolio. I won't spend too much time on these because a number of these items were provided to you ahead of time as leave-behinds.

But we have a really extensive offering of products for our nursing members. The perinatal orientation education program is an online module that focuses on some of the essential education components required for prenatal nurses.

These types of education is really important to our members because we've seen a contracting of dollars around training, and so our nurse members are coming to us to help to fill that gap. And also, as I'll touch base on a little bit later, as we're seeing the growing number of nurses who are leaving the profession, there are numbers of individuals who are now filling the shoes of seasoned veterans without the proper training.

So, we're being relied on to help fill some of that

gap. But we have about 3,200 instructors who are out and training in the healthcare system around fetal heart rate monitoring. There is extensive maternal immunization program. Our Maternal Fetal Triage Index educates perinatal nurses about the triage basics and the meaning of obstetrics and nursing and the nurses' role in developing a systemic approach to moving the process of triage.

Many of you are familiar with our post-birth warning signs to help to identify any issues or challenges obviously post-birth. One of the newer items that you may not have been familiar with from AWHONN is a set of staffing standards. We did have a version of this out a few years ago. We were referring to them as guidelines.

We've added some, a more evidence-based to the guidelines and are referring to them as standards. These standards are nurse members and nurse leaders, and hopefully having conversations with the administrators about what the appropriate level of care needs to be in their spaces. Because we have heard reports from our members that the nurse-to-patient ratio is just something that is not optimal. So hopefully having this set of standards helps them have a different conversation with their administration.

The Obstetric Patient Safety Bundle and our OB Triage programs are again tools that we have, curriculums that we have to educate our members on the leading causes of maternal morbidity and mortality and put together some suggestions and resources

around how to address those obstetric emergencies, as well as triaging some of the challenges they're seeing.

The OPS and OB Triage programs also really, we've heard from our members, really are helpful in rural settings because this provides them with some resources that they need to address some of the challenges that they're seeing in resource-light environments.

And last but not least, about a year ago we released our Respectful Maternity Care Toolkit, and I'll talk a little bit more about that in our next slide. But one of the challenges that we were hearing from our members is that they were going through implicit bias training.

There was a great deal of focus and emphasis on that. We're really hearing from them about what the next step was now that they know better how do you do better. So, this was an effort from---a member-driven effort to try to provide them some resources on how to do that. Next slide, please.

This tool is, I just put this in here so you can see what our Maternal Fetal Triage Index looks like in your handouts, so I won't spend too much time here. Next slide, please.

And this is the Post-Birth Warning Signs that have already been made, so I won't spend a ton of time here, but it provides our nurse members with some resource on how to identify those warning signs.

Our respectful maternity guidelines come from a place

where we treat every patient equally. We're using cultural and linguistic competencies to understand the patient's perspective. We center the patient, communicate with respect, and are creating collaborative and inclusive supportive work environments. Next slide, please.

This is a snapshot of our guidelines around RMC guidelines or framework. You have a copy of these in your handouts. One of the things that we do again is provide them with resources on how to have meaningful conversations with the patient that centers them. You'll see that in the next slide. Next slide, please.

That outlines some of the suggested ways on how to frame a conversation with a patient, understanding the situation, identifying, and working with them to understand their background, making appropriate assessment and recommendations.

Again, so this is a way to help center the patient and meet that need around what we heard from the members now that we have training, now that we understand what needs to be done. What can we do to actually move this forward? Some of the conversations that we've been having around these RMCs, and I'm going to talk a little bit more about this in terms of ways that we can partner, is how to embed tools like this.

AWHONN has a tool--there are other organizations that have developed really meaningful respect maternity care guidelines. How do we embed this in the frameworks within the

health systems that allows this to be accountable?

Things like the CMS birthing family hospital initiative. If those, if there was some sort of measure that requires these types of guidelines to be adhered to in a similar JCAHO kind of inspection process, we think that we can see more traction with how care is delivered. Next slide, please.

Our Infant Health Portfolio, we have the NOEP Program that we talked about-- excuse me for the typo here-- the POEP Program that we talked about earlier. We have a similar version of that. The NOEP web tool kit. Again, that's an online module to meet the same need because we're hearing about the gap in the outflow of nurses in needing to be able to provide some level training to bring people up to speed in a really quick and timely fashion.

We spoke about the staffing center, so I won't spend too much more time on that. Next slide, please.

So, we were offered the question of what does it take to have a healthy pregnancy and birth outcome, how can more babies reach their first birthday? So, there were a number of components that were obviously discussed within AWHONN and I'm sure within the MCH community that are now part of the AIM safety bundles.

And in our opinion those components are still relevant today, and they permeate a number of our programs and resources that we develop. And then the things that those components would address would be readiness so processes structure to manage that

in a timely response.

A standardized process to respond to issues when they're recognized. Reporting and, I think I heard some discussions around that even this morning, creating a culture of data gathering and monitoring, debriefing, and a continuing focus on process improvement and then respectful care obviously centered on the patient and partnering within a provision of care. Next slide, please.

A few elements that were beyond some of the discussions around what was included in the AIM bundles from our perspective is the provision of unbiased equitable care through a trained perinatal workforce, a diverse perinatal workforce, and a valued perinatal workforce. And I'll talk a little bit about why that's important on a couple slides later.

We also believe in order to have a healthy pregnancy and birth outcome, there needs to be support provided for the workforce outside of the maternity unit. The partnerships that we're entering into now with the American Red Cross to provide some of this work out for around neonatal resuscitation, to support births that are happening outside of the traditional care setting.

But we've heard from a number of our members, especially those in rural and underserved areas, that there aren't a ton of resources to support them in their work. And then support as I've mentioned here for the communities receiving care in those

areas, the rural areas, but also the spaces which are becoming care deserts because of the closings of OBGYNs. Next slide, please.

So, here's the challenges that we are hearing from our nursing workforce. As I mentioned before there is, depending on what space you're in, growing nursing workforce shortage.

There are some data and research that we've seen that predicts within the next five years or so we expect to have anywhere from 800,000 to 900,000 nurses leave the workforce. A number of those individuals, I think they just burn out because of the sacrifices and the cull related to COVID.

There was a nursing workforce shortage prior, I think, to COVID, they were just called upon to do a humongous task without the proper resources and support. So, there was a significant amount of burnout.

As I mentioned before, since we're seeing and anticipating great number of nurses leave the workforce, we're hearing from them that the training to backfill is inadequate and insufficient.

So, we're trying to fill that gap and support them in that effort. Most of them are feeling undervalued and overworked. This is, I'm not making this statement to cast any judgments or dispersions on our healthcare system. They have to do what they need to do to fill the need but there's a huge -- there was a huge disparity created between though what I refer to as "the rank and

file" nurses who are in the space in the hospital setting already and those travel nurses that had to come in to fill gaps.

The travel nurses had disparity and pay, and support was huge, and you're hearing from a number of individuals who just feel like they're you know being undervalued and underappreciated in that respect. Alluding to the fact that those are severely under-resourced.

And last but certainly not least we have an advocacy agenda around all of these elements, but one of particular interest to us is the workplace violence that nurses are experiencing. So, in addition to those individuals who are burnt out, overworked, and underpaid, many indicate they feel unsafe when they come in to do their jobs. Next slide, please.

Opportunities for alignment. I would not be doing my job if I didn't say that we would love to get support to increase utilization access of the resources that I mentioned more provided, but I also acknowledge that there are other organizations, many organizations that have really credible and important tools, and if we can do our collective best to amplify and scale up those training tools, I think that will be a huge win for the MCH Workforce and community.

If we could have a collective effort towards diversifying the nursing workforce, and I would expand that to include the perinatal workforce support the adoption of staffing standards to make sure that not just equitable care, but we want

quality care but equitable care because the patient and nursing we show is adequate.

Of accountability, as I mentioned earlier in the Guidelines linking this to some sort of measure that requires health systems to put things like this in place, and then last but not least, one of the things that has -- that we've been working on with the American Nursing Association is how do you utilize this NPI, the National Provider Identifier.

Many individuals use this for a tool for reimbursement, but a secondary benefit would be ways to track the nurse's contribution to the birthing experience. Right now, nurses aren't even factored into that equation so it's very difficult then to determine if the standards that we're producing are valid.

You know, how are nurses actually being utilized in this space. So, if you start to track the nurse's contribution to the birthing process in this way, I think that level of data will give us an insight that would tell a very interesting story. Next slide, please.

With that, thank you for the opportunity, and I look forward to answering any questions with the others if we have time.

MS. BELINDA PETTIFORD: Thank you, Jonathan. I'm almost afraid to say who is next so we'll just see what slide comes up. [laughs] That might be the easiest way.

[Off mic]

MS. BELINDA PETTIFORD: So, we're going to start with you, Christie, then.

Next slide, please.

MS. CHRISTIE ALLEN: Thank you so much I want to start by thanking the Committee for the opportunity to speak about ACOG's work to support pregnancy and outcomes. If you are not familiar with ACOG, we are the professional association for OBGYNs--Obstetricians and Gynecologists--which was founded in 1951.

As you can imagine, we've evolved just a little bit since then. We currently have over 60,000 members. ACOG's stated mission is support our members to improve the lives of all people seeking OBGYN care, their families, and the communities.

Work at ACOG is focused on the sense of supporting patient care throughout the lifespan continuum. We do this through publication of clinical guidelines and other publications, provider education, patient education, and population health projects and support.

And I'm going to talk a little bit about each of those collections of work and offer some examples on how the various programming fits together to address clinical conditions that impact pregnancy in birth outcomes, such as perinatal mental health conditions.

ACOG is maybe best known for publishing clinical guidance to direct OBGYN care, which is developed by expert

committees. ACOG guidance is often used to establish policies and standards for care nationally.

As an example, ACOG released two clinical practice guidelines this month in response to providers' desire and need to integrate perinatal mental health into the care that they provide. And one of the guidelines is related to treatment and management of mental health conditions in the perinatal period, and the other is focused on screening and diagnosis.

Provider education at ACOG encompasses a full spectrum of professional development from new physician training to resident physicians to ongoing professional development for more experienced providers.

Building on the example of the mental health conditions I just mentioned, ACOG recently provided sessions on supporting perinatal mental health at our annual meeting, which provided education for over 4,000 attendees.

The sessions that were included around perinatal mental health, included building clinician capacity to address perinatal mental health, as well as screening diagnosis, initiation, and management of psychopharmacological treatment.

Patient education resources are also developed by ACOG and are maintained on a patient-facing website. ACOG's engagement in developing resources for patients helps assure that clinicians and patients have accurate, aligned, and timely information for shared decision making.

The site provides things like answers to frequently asked questions for patients on a variety of topics, including perinatal anxiety and depression, as well as articles by experts and patient education information graphics.

Finally, ACOG is fortunate to be engaged in a variety of partners and funders. Focused on population health work--we work--we have the Centers for Disease Control and Prevention, with HRSA, with health services, private donors, and a variety of other partners to address--and I have to say this list is in no way comprehensive--fetal alcohol spectrum disorder, immunization, and pregnancy obstetric emergency readiness, contraception access, early pregnancy loss management, and programming to address maternal mortality and severe maternal morbidity.

Through one of these programs, we had developed a perinatal mental health toolkit specifically for clinicians available on the ACOG website.

And another program I think that most of you are familiar with and also support, is the HRSA-funded cooperative agreement, the Alliance for Innovation on Maternal Health, which folks have heard mention today as the AIM program. The AIM program provides technical assistance and capacity building for forty-nine states and the District of Columbia. And the States are working to use patient safety bundles to make for safer and improved maternal health outcomes and save lives.

All AIM resources seek to create specifically

respectful equitable and supportive care for all of the patients that are served and are seeking to address health inequities that can contribute to the known disparities in maternal health outcomes.

The AIM program recently released a perinatal mental health conditions bundle, staying with our theme. A patient safety bundle is a collection of best practices and is accompanied by both a data collection plan and resources for implementation.

All of these are developed with input and support from multidisciplinary some of which I'm joined here today and also include patients with lived experience as subject matter experts. And the AIM program is incredibly fortunate to be able to leverage internal and external expertise to be responsive to what we hear about from professionals around the nation, such as hospital obstetric care and closures, staffing turnover, and shortages, as we've heard mentioned.

In recently released Obstetric and Emergency Readiness Resource Kit, which compares non-obstetric or lower-resource settings to manage and prepare for emergencies in the perinatal period, including for folks experiencing mental health conditions are crises.

When state nurse leaders let us know that the use of contract travel nurses during the height of the COVID-19 pandemic was disrupting safety bundle implementation and quality improvement bundles, implementation of quality improvement

bundles, the AIM program also developed a brief video module entitled, "AIM at the Bedside," which is available on our website.

The video serves as a quick resource for training new and temporary staff to better understand how facilities and staff members engage with the AIM program to improve care and outcomes. It's not possible for me to cover the work that ACOG does, all of it anyway today, participating in around a few of the other pieces that I'm not going to go all the way into are quality metric development, health policy advocacy, Indigenous health program, quality, and safety training and on-site review of the quality of care provided at specific facilities for obstetric care.

While less of the focus of this Committee, ACOG also engages in resources and guidance that support gynecologic care, including oncology. Through this variety of work and partnership, ACOG is very proud to support care that contributes to healthy birth outcomes to families. Short and sweet.

MS. BELINDA PETTIFORD: Thank you, Christie. I'm sure we'll have a few questions afterwards. So, we can go to Karen.

MS. KAREN JEFFERSON: So, thank you, Committee, for inviting the American College of Nurses and Midwives to participate in this panel. Thank you and let me just say that my description of the work at ACNM is going to be a little bit more upstream than some of the other organizations, and I think when I go through it, you'll understand why we're focusing on what we're focusing.

So, the American College of Nurse Midwives is the professional association that represents certified nurse midwives and certified midwives in the United States. I remember our primary care clinicians who provide evidence-based midwifery care throughout the lifespan, with an emphasis on pregnancy, childbirth, gynecologic, and reproductive healthcare.

ACNM works to promote equity, diversity, and inclusion throughout the midwifery profession and across the care continuum to ensure better healthcare outcomes for the people that we serve.

So, I'm sure you are so aware of that the United States is continuing to face maternity care provider shortage in rural and underserved areas, and the shortage of OBGYNs, coupled with the steady decline in primary care physicians, reinforces the need to increase the number of full-scope maternity care providers.

Access to care provided by certified nurse midwives and certified midwives has been shown to produce high quality outcomes, including spontaneous labor, vaginal birth, and increased rates of breastfeeding and people who received midwifery care reported high rates of satisfaction with the care.

Midwifery is underutilized in the United States. We attend 10.3% of births and we could be doing so much more if there were more midwives, and here's the focus of our organization right now. There are almost 14,000 CNMs and CMs in the U.S., which is an increase in only 2,800 since 2015. To meet the demand for reproductive and sexual health care services, ACNM has been

investing in a workforce study and increasing access and funding for midwifery education.

The Bureau of Labor Statistics doesn't single out midwifery as a profession. So, it's hard to accurately count how many CNMs and CMs are providing care, as well as where they are. ACNM has been doing a workforce study based on publicly available data, as well as information collected by the American Midwifery Certification Board. We have also been surveying and interviewing student midwives and people who have left the profession.

The workforce study has three prongs to describe the workforce and create state specific models for increasing the number of midwives: to describe barriers and facilitators to entry a practice to midwifery, and to describe reasons for attrition, and create recommendations for addressing what thirty percent of CNMs and CMS leave clinical practice within the first five-year certification cycle. So, like other professionals we have a fairly high attrition rate.

We can figure out how many midwives we need where, but that doesn't tell us how we can educate more. We also must address the fact that the majority of CNMS and CMs are white, and we don't match the population that we serve.

We started the Access to Equity Midwifery Education and Care Project to try to increase recruitment, retention, and graduation of midwives of color.

We have a dual approach, working to improve existing

programs as well as reaching out to Historically Black Colleges and Universities to facilitate discussions about the benefit of midwifery and to generate interest and starting education programs.

We identified some next steps for this project. We're developing an Equity in Midwifery Education Report Card which will be part of the required annual reporting for program accreditation. We realize they're an unmet need for cross-institutional programs with peer support groups, mentoring, and community building.

If we would like to see more Black and Brown faculty, we have to support them to become directors of education programs. There's a need for professional development to increase the skill set and accreditation, budgeting, grants, curricular development, and management.

And we're going to continue to do our outreach to HBCUs because they have created an education model that supports their students and fosters success.

ACNM has also been working to increase access to midwifery care through pursuing government funding for midwifery education. So, in every department we're really trying to scale up our workforce. ACNM has worked with Congress to secure over twenty-five million dollars in federal funding for midwifery education through the annual appropriations process.

This is setting the precedent with the larger goal of

establishing a permanent funding stream to increase the number of National Certified Midwives in the U.S., via passage of The Midwives for Maximizing Optimal Maternity Services Act. And this bipartisan Midwives for Moms was reintroduced in the House and the Senate in June, this June.

This bill would establish new funding streams for midwifery education. It creates a midwifery expansion program for accredited midwifery education, programs that educate CNMs, CMs, CPM students. The bill will help mainstream midwifery in the United States in a way it is not yet mainstreamed.

And HRSA, once this bill passes, may provide grants to midwifery education programs for direct support of students, establishment, or expansion of accredited midwifery programs, providing support for increasing the number of preceptors at clinical training sites, which is the greatest limitation for expanding midwifery workforce, lack of access to clinical sites.

And prioritization will be given to programs that seek to increase racial and ethnic representation and those who agreed to serve in health provider shortage areas.

So, midwifery is also now a part of the Black Maternal Omnibus Act of 2023. We worked with Representative Underwood's office to draft and review the new Perinatal Workforce Act language where there is now funding for midwifery education as part of the Black Omnibus as well.

And finally, I want to mention ACNM's participation as

a partner with ACOG and other organizations on the AIM project, which is an important piece of what we do. Midwives participate in bundle development and revision. We hold space for physiologic birth. We represent core midwifery values and other professional values, listen to people.

We are glad to be in the room where things are happening. We co-create guidelines. We add midwifery voice to the national conversation. We are part of systems level change and finally we participate in implementation, revision, and provider education as part of the AIM Project.

So in conclusion, midwifery in the U.S. is small but we're mighty, and we're really working to scale up so that there could be more access to midwifery care and midwifery-led care so in terms of aligning with this Committee, we have very similar interests and would be happy to align on anything we can be of assistance with. Thanks.

MS. BELINDA PETTIFORD: Thank you so much, Karen. And now we'll go to Debra.

DR. DEBRA WALDRON: Good morning. Thank you so much to this Committee for inviting the American Academy of Pediatrics to present our perspective on how we can work together on infant morbidity as well as infant mortality as well as the more maternal morbidity and mortality component.

MS. BELINDA PETTIFORD: Now, Debra, can I ask you to get a little bit closer to the microphone. It'll just pull it up just

as close to you as you can. Thank you.

DR. DEBRA WALDRON: Thank you, Belinda, and thank you again for inviting the American Academy of Pediatrics to present to the Committee. Next slide, please.

So, the American Academy of Pediatrics, I know everyone else started with an overview of what their organization is. The American Academy of Pediatrics was founded in 1930, so we've been around for a while, and we really have been established to address the unique needs of infants and children and including their mothers.

The mission of the American Academy of Pediatrics is to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults.

We have over 67,000 members both in the United States and globally. We have chapters in every state, and in some of the larger states we have more than one chapter. We also have chapters within Canada. We have a component of committees, councils, and sessions that address a wide variety of child health topics, clinical practice, specialty care, community pediatrics, and others.

The American Academy of Pediatrics' approach is grounded in public health. We have primary, secondary, and tertiary intervention, and I'd like to highlight through this presentation what the AAP is doing in these areas not only to support clinical practice, community activities, but more

importantly state and national advocacy.

In terms of tertiary prevention, for instance, it's about the care of the preterm infants once they have been born. We have many things on secondary prevention, screening for diseases and problems and importantly the primary prevention, what interventions do we have to prevent disease such as vaccinations and injury prevention?

How does the AAP effect change? Through our policy, our education programs, research, and advocacy. As we've heard others say, the utmost importance for the Academy is the strategic priority on equity: how to best address the social and structural determinants of health.

And AAP has an essential policy on the impact of racism on child and adolescent health and that was published in 2019 and that has been embedded in all of the work that we do in terms of revising our clinical practice guidelines, making sure that race-based medicine is eliminated from clinical practice guidelines as well as in our programmatic and advocacy work.

I think that the most important thing that the Academy does do is its partnerships with families and communities. We encourage and support pediatric providers to work with our communities and listen to them to see what they need. Next slide, please.

So, I put this up here not to educate all of us on infant mortality data, but to recognize that congenital

malformations, preterm birth and low birth weight, sudden infant death syndrome, unintentional injuries, and maternal complications are the five leading causes of infant mortality in 2020. The asterisk is there, not because it's in the top five, but about half of the child abuse fatalities were in children under the age of one. And this is the data from 2021.

And the Academy has efforts in all of these areas that work has been generated by AAP subject matter experts, developed with support from federal agencies, strengthen through partnerships with national state and community entities, such as the ones that sit here with me today.

I want to give specific acknowledgment to our federal partners at HRSA and CDC for their invaluable and long-standing collaborations with the academy.

I apologize that I cannot address all of the important work the Academy is doing in this brief overview but direct you to the Academy's website, both the public-facing one on healthy children.org which contains our parent- and family-facing information, as well as aap.org. I'm happy to address any specific topics in the panel discussion. Next slide, please.

Bright Futures. I'm sure all of you have heard about Bright Futures. It's really our quintessential guidance on health promotion and prevention, and it contains a lot on primary and secondary prevention. It is supported in part by HRSA and the Maternal Child Health Bureau. They provide age-specific,

theory-based, and evidence-driven guidance for all preventive care screenings and health supervision.

And to point out this role of Bright Futures in preventing infant mortality and addressing infant morbidity through the one prenatal visit, I think there should be more with the pediatrician to establish a medical home and then a minimum of nine well-child visits through the time the child is fifteen months of age.

And these provide important touch points to provide screening and parenting education. Next slide, please.

So, we're going to talk about clinical care a little bit, you know, many individuals who are on this panel talked about the initiatives they have in terms of the maternal side of things. This is about the neonatal side of things.

The AAP has a policy statement on levels of neonatal care is a review of data that supports the tier provision of neonatal care and the need for nationally consistent standards of care to improve neonatal outcomes. It supports a well-defined regional system perinatal care and designation levels.

First as a base of comparison of health outcomes, so I heard this Committee talk about data, so there's a wide collection of data that occurs at the different levels of care as well as our resource use, and healthcare costs.

It provides standardized nomenclature for public health, uniform definitions for pediatricians and other healthcare

professionals providing neonatal care, and the Foundation for Consistent Standards of Services for Institutions, state health departments, and state regional and national organizations focused on the improvement of neonatal care.

We have a companion standard for levels of neonatal care for levels II, III, and IV, and it's a complimentary implementation tool. And then lastly, we have an NICU verification program which helps establish and implement risk appropriate neonatal care through standards that improve neonatal outcomes. And we really want to ensure that every infant receives the care and the facility with the personnel and resources appropriate for newborns' needs and conditions.

And as others around the table have spoken about, the needs to make sure that we have a competent or force and the authority, capacity, and capability within that workforce. Next slide, please.

I know we've heard a lot about breastfeeding, and we do know that breastfeeding is associated with a significant reduction in infant mortality. The AAP has policy, education, and Leadership around this important topic.

In 2022 we updated our landmark breastfeeding policy, Breastfeeding and the Use of Human Milk. We have an important policy on paid family medical leave so addressing those Upstream causes to support families and establishing successful breastfeeding and we also have a policy on the pediatrician's role

in decreasing racial disparities in breastfeeding.

So again, a common topic that we heard here: the importance of breastfeeding and chestfeeding especially in our populations of color.

We also had a free online breastfeeding curriculum developed in conjunction with the CDC and we also have educational webinars and most importantly we have in-person breastfeeding education at our national conference, and we have leadership Across the Nation and having a breastfeeding champion in every U.S. state to promote and support local breastfeeding initiatives. Next slide, please.

Immunizations. I won't go a lot into this. We all recognize the importance of immunizations, but I think what we also need to recognize is that the value of the immunizations has been attacked. And the academy is doing everything it possibly can to assure that individuals, parents, and others recognize not only the importance of vaccines, but the safety of vaccines and the role that they played and preventing maternal mortality and infant mortality throughout the ages.

We have the information in our Red Book Online, communication guides and again chapter immunization representatives. How does a National Academy affect change at the local level? Next slide, please.

Sudden infant death syndrome. Again, the leading cause of death, and we do know that there are disparities amongst our

populations in terms of sudden unexpected infant death and SIDS. We have a landmark policy again in 2022 on recommendations for reducing infant mortalities in the sleep environment.

And then we have the programmatic efforts again funded by the Maternal Child Health Bureau that aims to reduce the overall rates of SUID and reduced racial and ethnic disparities.

We have a website where we have developed a number of safe infant sleep resources. We promote fatality review through collaborations through the Child Death Review and the Fetal and Infant Mortality Review. And we have a National Collaborative for Safe Infant Sleep. Next slide, please.

I really want to dig into something that I've heard a bit about here when we talk about screening for perinatal depression. But what's more important is early relational health. So, it's the flip side of perinatal depression. How can we actually build those strong bonds between the mother and the infant in terms of making sure that relational health is the grounding piece, how we better support infants as well as their mothers?

We recognize that family relationships promote resilience and positive health and mental health outcomes for both the caregivers and the children. Relationships should be safe, meaning the relationships are free of physical and psychological harm.

We need to know the children believe that the

caregivers will protect them. They need to be stable. That the adult is dependably there for the child, and children believe that their caregivers will be able to meet their needs and nurturing the child's physical, emotional, and developmental needs are sensitively and consistently met and children believe the caregivers will use warmth and clear expectations to foster their development.

This is really grounded in a family-centered generation approach and is needed to promote the optimum growth and development. The founders of the AAP recognized the interconnection between maternal health and well-being and the health of their children and that thread has been carried through ninety-three years of existence of the American Academy of pediatrics. Next slide, please.

Trauma and infant mortality. I mentioned at the beginning that half of the child fatalities secondary to abuse occur in infants. We recognize that adverse child experience literature has demonstrated the effects of childhood adversity on adult health. We recognize that systemic racism and racial trauma affect the health and well-being of mothers and there is strong evidence that it is linked to infant mortality.

We recognize that caregivers who have experienced trauma may also experience substance use disorders, mental health concerns, and continued adversity. So, this linkage is to trauma early in life if carried through into adult challenges. And we

understand that this may lead to child abuse and neglect and unfortunately even death.

And we also recognize that trauma can impact the ability to meet a child's physical and emotional needs, and this is a term that we refer to as disrupted caregiving. The Academy has many programmatic policies and tools and resources to support not only awareness but also attention and improvement in relational health. And the next slides kind of highlight that.

So, the AAP supports pediatricians and assessing and supporting the mental health of maternal caregivers. These are just some questions that are embedded in Bright Futures under anticipatory guidance. "Has anything scary happened to you or your child? What are you doing to take care of yourself? And I know that we've talked a lot about your child's health, but we want to talk about you as a person?"

Brief interventions. We have tools and resources to help promote the strength of the caregiver child relationship, encourage understanding or responding to child's behavior, encourage reading and talking to the child: simple things-- routines for security, sleep, diet, exercise, stress, and relief.

We want to encourage mothers as well as families to promote realistic expectations. All of us live within the barrage of social media and perfect pictures. That's not what reality really is, and we have a whole campaign on social media and the effect on the adolescent brain.

And I would have to say that the work that we're doing is to make sure that people are realistic about what pregnancy is all about, what the delivery is all about, and what caring for an infant and a child and adolescent is all about. And we also encourage social connections and connection to community resources. Next slide, please.

So maternal and relational health at the AAP. It aligns with strategic priorities. We're building capacity not only maternal health and well-being, perinatal mental health, someone mentioned fetal alcohol spectrum disorders. We do recognize when we talk about birth defects that exposure to alcohol is preventable, and we do know that exposure to alcohol is a preventable cause of a birth defect.

Maternal infant health and opioid use. Some of the individuals here talked about substance use and the effect on the ability for a mother to care for her infant as well as other work as we do in terms of supporting our chapters through our early childhood chapter champions.

I think the next slide is just a list of additional resources. Next slide. And I won't go into further detail, and I think-- next slide. Again, a number of different programs we put that out there for you all to look at and their links on aap.org. And I think that's the end of my presentation. Thank you. Be more than happy to answer questions.

MS. BELINDA PETTIFORD: Thank you all so very much. We

appreciate those informative presentations. Now, we will open it up for questions because I know we have a few. Yes, Marie.

DR. MARIE RAMAS: Thank you all for the great work that you're doing all around nationally. I appreciate a lot of the overlap that was discussed in your presentations with your national organizations are working in partnership. Like you said, many organizations are sister organizations when it comes to supporting maternal health.

One organization I haven't seen, and I'd love to hear what you're doing, is with the Academy of Family Physicians. Family doctors see over 50% of all ambulatory visits in the rural settings, have the highest presence in rural settings compared to a specialist colleague in the health center setting or an integral role, as well when it comes to general primary care, but certainly with maternal primary care as well.

I had the great pleasure of working together with ACOG to develop advanced life support for obstetrics, and now we're working with the fourth trimester care work that you're doing. I had the pleasure of working with your colleague at AAP with some great projects that we worked in alignment.

So, I would love to hear you know what are some advocacy areas that you're cross-pollinating with your specialty colleagues as we're trying to touch on maternity and infant mortality.

And the second question I had is slightly related to

that in innovative ways. And I think this is more related for NACH. In community health and particularly federally qualified health centers, we get -- there's a specific amount of reimbursement for all visits.

The only exception that I know of is with annual wellness visits with Medicare patients. You get a little bit more reimbursement for annual wellness visits in the health center setting. Has there been any advocacy on the maternal side to have a parallel type of reimbursement for maternity care? Like an annual wellness visit equivalent that would get a higher reimbursement rate in a federally qualified health care center setting?

And similarly with the problem of finding that date of delivery, what could be a possibility of considering something like a transition of care management type visit postpartum that requires access to delivery information within that first three days of delivery? Has there been anything to that level of advocacy to try to encourage and incentivize this kind of work?

So maybe the latter would be an easier question to start with and again I'd love to hear about other partnerships.

DR. JULIA SKAPIK: Sure, so I'll jump on the latter as the informaticist here. Yeah, so you know the federal government already requires that inpatient facilities provide a discharge or ADT Notification within seventy-two hours, but we know that that's really not remotely close to 100% in terms of transmission.

Another challenge though is that many organizations can only take ADT messages in and that's sort of in semi unstructured format. So, for example you might get basically the equivalent of an electronic fax. That information can't be taken in into the EHR.

You know that's part of the reason that I mentioned the U.S. CDI right, the federal standards for what concepts electronic health records have to support. So given that there's no standardized code or approach to structuring the data and the birth encounter there's no way of easily mapping that back into an EHR and there's no actual guarantee that there's even a target place for that information to go in an electronic health record.

Many organizations will create sort of a customized field, or you know place to put that stuff, but that doesn't mean that two systems even from the same vendor could talk to each other and recognize that. So, it's a bit of a technical challenge, I think you know more accountability from CMS on you know--an actual follow-up action that occurs in a transition between the inpatient and outpatient facility is really important.

And I think also a notification that goes to the outpatient organization when the person hits the hospital door also has the potential to allow better coordination during the birth episode.

To speak to the reimbursement piece, I'm obviously not the policy side of NACHC here. One of the things I can say is

traditionally I know that health centers have struggled because in most federal regulatory policies, health centers have to be opted into any new programming.

So frequently it's totally unintentional that congressional leaders and their aides will not include that language because they're not sort of aware of it or tracking it, and so then NACHC spends a great deal of advocacy effort just trying to correct those omissions.

I think that idea of doing a sort of proactive program is really smart and important, and when we talk about transitions of care. I know some health centers are also really looking into the post postpartum transition of care.

As a primary care provider, I can't think of any time I've ever actually gotten a transfer from a primary obstetric person to like, “hey, your patient is back. This is what happened.” I don't get any of that hand-off either, and I think in terms of thinking about the long-term health of the patient, if they have gestational diabetes, if they had hypertension during pregnancy. Those things are important because they changed the way I approached the patient in their post-postpartum life right.

But certainly, the risk in the peripartum setting is really important. And you know the MMRC data shows that more than 50% of deaths happen in the postpartum period, right? The seven to forty-two days and then almost a quarter so in the forty-two days to a year.

So, I think the amount of attention that we're paying to the birth encounter is probably doing us a disservice because we're not focused on that period where actually now most of the, of the bad outcomes are happening. So, I think that if HRSA or anyone else would like to go in on that proposal to sort of raise the bar on both the reimbursement and on sort of the accountability of that transition, I think we would be really interested in that.

And I'll just say our CMO is a family physician who became---he did primarily obstetric care for migrant health workers in California, became the CEO of their health center, and he can probably speak much better to our AFP collaboration, but I think from a health center perspective we think of sort of the same relationship that we have with our midwives and with our family docs and our obstetricians.

DR. DEBRA WALDRON: So, from the Academy's perspective, we work very closely with our colleagues at AFP. We have representatives from your Academy sitting on many of our committee's councils and sections and most importantly they are well embedded within the work that we do around Bright Futures. We really, truly appreciate that partnership, so thank you for bringing that up.

MS. CHRISTIE ALLEN: I was going to say ditto on what you just said. [laughs] We're also incredibly fortunate to have engagement with AFP, as you know at ACOG, I can speak specifically

to the engagement in the departments that I support, which is the AIM program as well as the broader quality and safety work. In AIM, AFP is a contracted partner as are other folks at the table.

They are engaged in development of all of our resources, and they were integral in the development of OB Readiness Emergency Readiness Resource Kit left and actually led the way in some of that. We recognize that OBGYNs weren't the ones to talk about how to provide care in the areas where there are not obstetrics care.

So that is a wonderful collaboration, and I have some folks at AFP at on speed dial so our collaboration in rural space I think it's just going to grow that more and more including the Also--program.

We also collaborate in that way when we work with Indian Health Services and provide Indigenous health training, because we also recognize those providers are actively engaged in obstetric care. Just a word about the pair, I am not in that department, but I will tell you my background is in policy.

And it's a priority area for ACOG working in the health economics department to specifically address reimbursement around prenatal and postpartum care across the continuum and to recognize that a bundled reimbursement does not meet the diverse needs of patients, and as we add in very rightfully the expectation that providers address and screen for social and structural drivers of health, we have to make sure that they're being reimbursed in a

way that allows them to do it effectively and to build partnerships effectively that are going to augment that work.

MS. BELINDA PETTIFORD: Well, thank you all. Any other questions in the room and then virtually? Yes, Steve.

DR. STEVEN CALVIN: Sure. For Karen at ACNM. I really appreciate what you're doing for Historic Black Colleges and Universities.

One thing we found in the work, I work with midwives and doulas and whatnots in Minnesota, and if we can also get to high schools in our neighborhood--you know, we live in inner city Minneapolis--it's a great way, sort of the pathway of interested students who say, "hey, I think doula services or maybe just working at a birth center working at a maternity care setting." And then they go from that and then they think about oh, I can be a nurse. And after that they say I really would love to be a midwife. So, I would also recommend just considering doing some outreach into schools and communities that way.

Another thing too, all of your presentations were great. And Julia, I'm a person who I did my National Health Service Corps Service back before while we were still using paper charts. [Laughter] And so a long, long time ago.

But I really appreciate the fourth trimester work that you're doing with CDC, and as we were talking before we're trying to figure out, I mean, we could come up with a whole bunch of recommendations, but a recommendation that has an impact is that

fourth trimester work and I--I truly believe that what you're doing could be transferred into Medicaid programs in every state and also commercial insurers.

They should know about that, and I do know that the data transfer, and OCHIN is -- remind me, the Epic-Based EHR?

[off mic]

DR. STEVEN CALVIN: Right. And I know just being you know being able to put the pressure on us at the office of the National Coordinator to just say you need to insist that data flow is---because that's what it takes.

Anyway, the work that you're doing with the CDC on the fourth trimester is very impressive.

MR. JONATHAN WEBB: I just wanted to make a quick comment, to just build on that. So, with respect to the diversification of the workforce, I appreciate the work with HBCs. AWHONN It's also doing some work with HBCs also and comments about going upstream from a pathway perspective.

One of the areas I think we should also continue to focus on for non-traditional students is work with community colleges as well. So just putting it out there for consideration.

DR. PHYLLIS SHARPS: I just wanted to, I'm a long-time member of AWHONN and I wanted to compliment Mr. Webb on his presentation about trying to map out the contribution of nursing care. I don't know that many people don't know that most of Nursing Care Services is a part of the hospital room cost.

And many years ago, when I was an active duty Army Nurse, we did a very in-depth study on workload management where we were looking at nursing staffing and patient acuity. So, I think it's another part of the puzzle in terms of maternity care and health severity issues, so important work.

MS. VANESSA LEE: This is really excellent. Thank you to our panelists and I'll just say, Marie, that was our aim in not including AFP and trying to think of every possible I think association, and I'm not sure how we missed that. We will--Belinda and I were saying we'd love to obviously get them at the next meeting.

The one group we had also invited but couldn't make it was the National Association of Community Health Workers. So just wanted everyone to know that we did try there, and they unfortunately couldn't join. But we are going to try again at another meeting.

I know Karen you mentioned, I think it was you, the Bureau of Labor. And I just wanted to share that we have an ex-officio member coming from the U.S. Department of Labor, their Women's Bureau so for a lot of these workforce issues we are excited to have a new member that will be able to join, and I hope we can introduce her the next Committee meeting.

MS. BELINDA PETTIFORD: Yes, Kate.

DR. KATHRYN MENARD: So, my question is who can we recruit from all of you to work on the work that we're talking

about? And I'm not---I mean, Julia, man you would be great for the day to workforce, but you know, Mr. Webb you would be fantastic for our kind of commitment to looking at racial disparities and what will work.

I could say for something for you to do, of course, Christie, I know well. But anyway, wouldn't it be great you know to include this--

MS. BELINDA PETTIFORD: Please know we will be reaching out to them. [Laughter] They didn't just get an invite to come and share. We can plan to stay engaged but thanks for the reminder, Kate. And I think we have one hand up, Sherri. One of our members is participating virtually and Sherri will be our last question.

DR. SHERRI ALDERMAN: Yes, thank you very much. And thank you so much to the panelists. I agree with Marie this was beautifully put together and you all presented so effectively, and it was very easy to see overlaps.

I would like to spotlight something that Dr. Waldron mentioned and that was the establishment of the infants' medical home through a process of pre [cut off] -- unfortunately our healthcare system is very siloed.

It's very challenging to figure out how we can achieve this Bright Futures recommendation, that expectant parents will engage with the pediatric practice to establish their baby's healthcare before the delivery of the baby.

Families often are thinking more about where they're

going to get their childcare than where their newborn baby is going to be getting their medical care. I would like to propose that the connection between obstetrics and pediatrics, when that new family comes to their pediatrician, that is also a return on health care as well.

And I can base that on a personal story. As a general pediatrician, I saw a mom and a newborn in clinic three days after delivery. And she, fortunately the baby was healthy. She was doing well however the mother was febrile, looked very ill, and through that clinic visit she was transported to the hospital and admitted and treated for sepsis.

Every encounter in pediatrics is an opportunity to see the family and see, as Dr. Waldron also mentioned, the importance of the caregivers' health and well-being very much impacts the infant and the young child. So, we really in pediatrics only strongly believed in the dyadic work that we do.

And we mentioned also that half of deaths due to child abuse are in infancy. And that violence does not begin at the moment of birth of a child. It usually preexists the birth of that child. So, most reports of suspected child abuse and neglect comes from professionals including pediatricians, and that is also an opportunity for assuring the health and well-being of the mother when they're coming to their pediatric visit.

So, I really would like to ask the panelists how can we break down the silo, build a bridge between the obstetrics and

pediatrics and promote a standard that assures that a baby has a medical home through a prenatal visit with a pediatrician prior to birth? Thank you.

MS. BELINDA PETTIFORD: Thank you, Sherri. And we'll see who wants to respond.

DR. JULIA SKAPIK: So, the community's health centers have that a little bit built in. I will throw out a word of caution. We've been hearing reports that hospital-based systems are trying to push pediatric patients out of the health center to their own hospital-based pediatric practices, and that's probably a threat to that sort of community-based care as well as those coordination activities where mom and babies' records are being linked.

That's another important area. How do we connect those two things so that we can look for those patterns, the history of domestic violence, a history of--screening for depression not getting back to mom even if it's happening in the pediatrics office?

So building on that comment from earlier about having these models of care that actually combine those two pieces at the same time I think especially for the patients at high risk and the patients who come from vulnerable social situations that's going to lead to much better outcomes than mothers who chose to work with health centers.

MS. KAREN JEFFERSON: I just want to add a few thoughts.

With a pretty broad use of group prenatal care, different kinds, it would be a great opportunity to have a pediatric provider attend prenatal group care. And also, to have a family dyadic care in the group setting continue postpartum, shifting from the OB/midwife team to the family practice/pediatric team afterwards where the community stays intact, and the new providers can follow the dyad through time. It does exist, and it should be more widely done.

DR. DEBRA WALDRON: Thank you for that. So, the American Academy of Pediatrics does have a policy statement on the importance of prenatal visit and outlines many of the things that were just discussed here. We do know when the umbilical cord is cut it does not sever the tie between the mother and the infant, and that does need to continue. it happens preconception, it happens during the pregnancy, and most importantly after delivery.

So, we would encourage any type of ability for the prenatal visit to a care, as well as that establishment of care. One of the things that the academy works on is transition of care from adolescence to adult providers, but we need to work a little bit better on assuring that transition.

And continuation of the care continuum after an infant is born. So, we'd love to work on that. Because again that relational health and dyadic that Dr. Alderman pointed out is extremely important.

MS. BELINDA PETTIFORD: Well, thank you all so very

much. Please join me in thanking this awesome panel today. And thank you all again.

Lunch

MS. BELINDA PETTIFORD: So, we will take a lunch break now, so we do need to get back by 12:30 now. I know it's a little short, but we should be used to that by now okay.

Partnership Panel – Policy Focus

MS. BELINDA PETTIFORD: So hopefully everyone has had a good lunch. If you are still eating, please continue to do so. We know we didn't give a whole lot of time for that for this meeting. We'll try to do better next time.

We're now going to move into our next session. And our next session is again we're bringing together partners. These partners are specifically partners in the field that are going to focus on some policy areas that they're working on. And keep in mind that we continue to think about ways for alignment.

So, I think all of our panelists this time are virtual. So, we're just going to do a quick check in. So, we are happy to have with us this afternoon Jennifer Moore. Jennifer is the founding executive director for The Institute of Medicaid Innovation. Jennifer, do we have you? We have your slides so I'm thinking you're there.

After Jennifer will have Tahra Johnson. Tahra is the director for the health program for the National Conference of state legislators. So, I'm thinking Tahra is on as well and after Tara will have Brittney Roy. And Brittney is the program director on public health for the National Governors Association. So, we will go in that order, and we will start with Jennifer. So, thank you, Jennifer.

DR. JENNIFER MOORE: Thank you, I'm so happy to be here. Thank you for the invitation to share more of the work that we're being aligned with the work of the Committee. As a former Committee Member, I can appreciate how important these presentations can be. We've been given five minutes per presentation so I'm going to go quickly as possible.

You'll see as I go through the slides that they are jam-packed with information so that you can refer to them after. Next slide, please. And next slide.

So, the Institute for Medicaid Innovation is a 501c3 national non-profit nonpartisan research policy and community power building organization. We're located here in Washington, DC.

We center our work around improving the lives of Medicaid enrollees, focusing specifically on individuals, families, and communities. We're known for our partnering with all types of Medicaid stakeholders and partners. Including state Medicaid agencies, Medicaid Health Plans, provider health groups, including those who are on the last panel, and individuals with

lived experience and those in the community. Next slide.

We have a large portfolio of work. Our four topics are represented in the circles around the large circle, ranging from behavioral health disparities and equity, child health and women and gender health and in the center represents the center circle, the middle circle represents the type of deliverables everything from quantitative and qualitative research studies that are published in JAMA and health affairs to our national learning series and learning cooperatives. Next slide.

And I just have to ground us all that while we get excited about the statistics and the data, but it's truly---when you love someone that's when it becomes very real. As a former Medicaid enrollee myself for eight years as a child and five years as an adult, I know how important this program is to the lives of individuals, families and communities in this country. Next slide.

So, I'm going to share with you some perinatal and maternal health findings through our work, and I touch very high level. Go to our website to get more information. And then I'm going to dig into the recent survey and focus group that we conducted that will be helpful in informing your work. Next slide.

So, this is a very small snapshot of a comprehensive portfolio of work that we need in maternal, perinatal, and reproductive health including resources in maternal mortality and morbidity, maternal mental health, high value evidence-based maternal models of care including doulas and midwifery where I'm

also the chair. Other maternal health priorities.

All of these resources are available on our website, and we have even more categories of information. We are known as the national hub for maternal child health and Medicaid and probably have a resource on every topic that you could be looking for. Next slide.

So, the one that I really wanted to dive into in more depth to which you received in advance of today's meeting, is an issue brief that we released on identifying priority topics in Medicaid specific to women, gender, and maternal health.

We surveyed federal policy makers, state policy makers, Medicaid Health Plans, national subject matter experts, and also individuals with lived experience and those working in the community. Next slide.

So, as you can see from this table, across the board, regardless of the stakeholder type, whether it's federal policy maker, state policy maker, Medicare health plan or subject matter expert, you'll see that maternal mental health ranked number one amongst all these groups.

From there there's some close alignments but some differences that exist between doulas and perinatal community health workers, sexual and reproductive health, and prenatal to three rose to the top. I will also add that although midwifery models of care was ranked at number eight for the other stakeholders, the federal policy makers identified midwifery-lead

models as number two.

I think in the grand scheme of things since we had conversations around these topics, all of them were forefront in their mind and of great interest to their work however in the process of ranking someone has to be eight and someone gets to be one. So, all of these were very important, and I don't want anyone to walk away from these findings thinking that only maternal mental health was number one. Next slide.

So, as I shared, we also surveyed individuals with lived experience and those represent individuals with current or past Medicaid Health Insurance coverage and also members of the community, community-based workers such as doulas, community health workers.

And they shared with us unranked their priority topics, including chronic conditions, sexual reproductive justice, violence, caregiver roles, housing, substance use disorder, criminal justice system, addressing developmental health needs, delayed care and community-based maternal health which include midwifery led models of care and doulas.

It's also worth noting that inside this table we provided some conceptual information. This was gleaned from a focus group. Given the incredible information that they'd provided during the survey, we scheduled an ad hoc focus group just with individuals of lived experience and community-based workers. You'll see on the slide quotes in addition to contextual

information.

The next slide, it makes a little bit bigger so it's easier for you to see some of the quotes, there were so many quotes it was hard to--for the release but these really did capture the high-level sentiments of the group.

I also want to note that there were two other different ways that are outlined in this issue brief. One being that they didn't like the term "social determinants of health." They felt that it was jargon that was created by individuals who did not have experience with challenges with social needs and asked that we start using a--naming the social needs such as housing, personal violence, instead of the term social determinants of health.

They also did not like the term "equity," recognizing that it centers whiteness and white supremacy, using white outcomes as the benchmark or the standard and instead prefer the word justice.

So, as you can see from the previous slide, they identified sexual reproductive justice. They talked about birth justice, mental health justice. And I just want to leave that with you as you consider ways of moving forward as a Committee. Next slide.

We also recently released a National Environmental Scan, identifying information in perinatal and child health, specifically in Medicaid. This work was funded through the Kisco

Foundation and provided us an opportunity to get a sense of the landscape in the U.S. and where that innovation and best practices are landing and also gave us insight into what states are prioritizing.

No surprise most states were either in the initial stage or pilot stages of a doula and perinatal community health worker program. Home visiting programs also are very prevalent along with dyadic care, thinking about a pregnant postpartum individual with along with child or children in the home.

And then of course mental health and substance abuse disorder arose to the top. This is a resource that you can also access. It's a comprehensive report outlining many, many best practices and innovative initiatives. It serves as a roadmap in many ways and what's next in what our people are leading.

So, I hope I didn't go over my five minutes. I tried to talk as fast as I could, and I don't want to take away from my other colleagues who are presenting today, but you can certainly find more information on our website, including the references and resources I mentioned today.

If you have any problems accessing them let me know. I'm happy to make sure that you get them. With that, I will defer to the moderator and transition to the next speaker.

MS. BELINDA PETTIFORD: Thank you, Jennifer, can you stay around in case there are questions at the end?

DR. JENNIFER MOORE: Absolutely.

MS. BELINDA PETTIFORD: Thank you, so now we'll go over to Tahra Johnson or Tahra I may have mispronounced your name, so please forgive me.

MS. TAHRA JOHNSON: No problem at all. Thank you very much, Chair and for the Committee for inviting me to speak with you today. My name is Tahra Johnson and I direct the health program at the National Conference of State Legislatures.

Today I will share with you how state legislators including NCSL's maternal and child health fellows have focused on maternal and infant health improvement in the last few years and what the legislative charges are. Next slide, please.

First off, it's important that you know that NCSL, it's a bipartisan membership organization serving the 7,386 state legislators on several—well, tens of thousands of legislative staff in the fifty states, Washington, DC, and the U.S. territories.

Our organization promotes policy innovations and communication between state legislatures, among many other things. Next slide, please. So NCSL's maternal and child health fellows program is designed to support legislators who are experienced or emerging leaders on maternal and child health issues.

These fellows learn from peers and from health experts while discussing maternal and child health priorities and policies that are being considered in state legislatures across the country.

So far, we've had four cohorts, consisting in total of ninety-six state legislators and eight legislative staff from forty-one states and the U.S. Virgin Islands. These fellows come to us with a variety of different backgrounds and professions.

So former fellows include pediatricians, lawyers, educators, farmers, and business owners. They hold leadership positions in their legislatures, such as assistant majority leaders, senate president, and chairs or vice chairs of health committees.

So, they're policy makers, and many of them have lived experience, and they hear regularly about the experiences of their constituents. We were able to hear about efforts that fellows were making in their states following their programs, during an alumni meeting in December of 2022. We brought together former cohorts, and then we also had a 2023 cohort twice this year, both in January and in April.

They did deeper dives into specific topics, and one topic that continues to rise to the top is maternal mortality and maternal health. We also covered priority issues around telehealth insurance coverage for doulas and postpartum Medicaid extension. Next slide, please.

So as a part of this program, fellows are asked to create action plans and so many of them did that for 2023. So, these action plans are intended to provide a framework and support for legislators to help them accomplish whatever their legislative

goals are.

So major theme from these action plans as well as the requests that we were receiving at NCSL relate to what several issues that were just mentioned by the previous speaker, the maternal health workforce, maternal mortality specifically, maternal mental health, infant mortality, and newborn screening.

We're seeing the maternal workforce as one of the top priorities among our members. Workforce across the board is a top priority for state legislators and our fellows expressed specific interest in workforce solutions, such as expanding the use and coverage of doula services, review of scope or practice for licensing midwives and providing bias training for providers, in many cases specifically mentioning the intention to improve birth outcomes and reduced maternal morbidity and mortality.

Legislators are focusing on improving services and access to care related to reducing maternal mortality and there's a specific focus for many of our members on rural communities. Fellows, in particular, were interested in reviewing the Maternal Mortality Review Committee in reports in their states and meeting with their Title V directors who are holding committee meetings on maternal mortality to receive more information about the specific data information in their states.

And as the previous speaker mentioned, state legislators are focused on maternal mental health and substance use disorder supports, including coverage for these services, and

that is a priority for state legislators that we're continuing to hear.

Now while the focus primarily has been on maternal health in this last legislative session, we have seen reversed continued focus on infant mortality by way of educating parents and providers on sudden unexpected infant death and exploring ways to increase access to maternal and infant care in rural communities.

And then lastly one of the trends that we've seen with our members is a focus on newborn screening panels and other screening processes, such as aligning with the R.U.S.P., and exploring future funding opportunities for screening programs. Next slide, please.

So NCSL has tracked nearly a hundred enacted bills in the last two sessions, specifically on infant and maternal mortality. There were a lot more that were introduced but a few of the trends that we saw in terms of enacted bills really focused around access to care, maternal care workforce, awareness and education and studies and committees.

And again, there's also a priority within here and in other bills that we saw around maternal substance use disorder. As the largest single payer of pregnancy-related services, Medicaid plays a significant role in the coverage, and we've seen a lot of states' interest in passing legislation around extending postpartum coverage for Medicaid to twelve months.

Our members are becoming increasingly aware that a third of maternal deaths occur between two weeks and one year postpartum, and for example, this year we saw Mississippi and Nevada pass postpartum Medicaid extensions for twelve months this legislative session.

We've also seen an uptick in legislation around telehealth and providing telehealth options to increase care for our maternal population. Arkansas, for example, operates a telehealth program for high-risk pregnant women and the programs consist of video conferencing with maternal and fetal medicine specialists.

We've also seen New York now cover remote patient monitoring for prenatal and postpartum care, if it's recommended by a physician. Again, to increase access in areas with limited access to care.

And as I mentioned earlier, the maternal health workforce is really a big focus area for our members and our fellows. For example, Louisiana requires to insure state-licensed midwifery care, including certified nurse midwives and certified professional midwives.

Currently ten states require Medicaid coverage, at least ten states require Medicaid coverage for doula services, and at least twenty states are setting or piloting doula benefits in Medicaid. This has been an interesting measure to watch. State legislators aren't always aware of what doulas are, but as they

are getting more educated on the different types of workforces around maternal care, there's definitely been an uptick in legislation and an interest in learning more about doulas.

A maternal and child health fellow this year sponsored legislation in Utah, for example, to increase insurance coverage for doulas services in the Public Employees Benefit and Insurance Program.

Another interesting bill you might be interested in is the Delaware Omnibus bill that had several bills within it, around workforce which one requires implicit bias training and competency training for healthcare workers. They also enacted a law to provide access to doula and midwifery services for woman in the Department of Corrections custody.

States also are looking to reduce maternal and infant mortality by again raising awareness and educating constituents on the common causes of maternal and infant mortality. And this again can be informed by their review committees in the state.

Oklahoma, for example, required perinatal providers to provide certain information to pregnant individuals including educational resources, basic first aid, and information on cord blood banking and donation.

Texas recognizes a specific day as fourth trimester care day, and Louisiana requires all hospitals and birthing centers to provide labor and delivery--that provide labor and delivery--to provide pregnant women and their families with

information about perinatal mood and anxiety disorders, including symptoms and treatment available information on that so the individuals and their families have information prior to discharge.

We've also seen state legislatures be interested in learning more, again, about their maternal mortality review committees, and some have been very engaged in their review committees, specifically we've seen some states serve participation membership and duties of the committee.

So, for example, North Carolina now requires the committee to include community representation, and other states have modified their committees to require recommendations around racial disparities, specifically. Next slide, please.

So, the three big takeaways I will leave with you. Number one, state legislators are doing a lot of work to promote maternal and infant health in a variety of ways.

Two, maternal mortality and maternal health in particular is a priority area in state legislatures, and there are discussions happening in just about all fifty states, D.C., and the territories on maternal health.

And lastly, the number of bills and policies related to maternal workforce access to care in mental health have increased in the last year. So, I'm going to thank you for your time today, and I'm happy to answer any questions right now or through follow-up.

MS. BELINDA PETTIFORD: Thank you so much, Tahra. If you will hold on, we're going to quickly go over to Brittney Roy. But thank you. We will come back to you with questions.

MS. BRITTNEY ROY: Thank you. Can everyone hear me okay?

MS. BELINDA PETTIFORD: We can. Thanks Brittney.

MS. BRITTNEY ROY: Perfect. Okay. Thank you all for this opportunity to speak with everyone online today. So, my name is Brittney Roy, and I'm the director for public health of the National Governors Association. NGA, as we call it, is the only bipartisan organization that serves fifty-five governors, so that's states and territories, and support looks like a variety of things, including of course to send an "extra set of hands" if you will, policy creation, recommendations, convening power, etc.

The maternal and child health portfolio at NGA has had this work since 1990, primarily through federal partnerships and here more recently through what we like to call public/private partnerships. So, this includes community-based organizations, think tanks, local and state government entities as well as industry partners.

Over the last year for about eleven months, we have been working diligently on a chair's initiative, so NGA every year alternates between a Republican governor or a Democratic governor, and they get to choose what their initiative will be for the year. We staff them and essentially host roundtables to collect policy recommendations.

So, this year, Governor Phil Murphy of New Jersey and the First Lady, Mrs. Tammy Murphy, their initiative is focusing on youth mental health and maternal and infant health. The public health team at NGA are building backwards on the Maternal and Infant Health Initiative, and essentially what we have done over the past year is convene with the support of governors regionally, roundtable discussions, like I mentioned before, through that convening power.

Governor Murphy and Mrs. Murphy recognize that we have an issue and also recognized that we did not have a solution, and so we have gone all throughout the country and tapped many folks to help us think through where do we go next, and someone expressed that they were engaged enough at this time to marry.

[laughter]

So, we are thinking about that next stage of engagement, right? So, our playbook will come out in a month with all of these recommendations, and we call them practical recommendations and considerations because they have been essentially driven by governors. And then NGA will step in and help states think through implementation, practices, and policies. Just how do we move the landscape?

Some of the things that we have heard over this past year from governors and their advisors are questions around public health infrastructure, modernization. What does that look like for the maternal and child population? What does data modernization

look like and what are the things as well as being what does accountability look like?

So, we ask a lot of people and so now we are trying to figure out how do we hold systems accountable? Which is one of the reasons the public health team also carries the Medicaid portfolio. So how do we use the traditional payers and systems to bolster public health and improve the lives of the MCH populations?

A little bit more about the MCH work at NGA, we work very closely with community-based organizations. We heard this loud and clear in--in our initial brainstorming sessions. Nothing for us without us. And so, we sat down with various experts in this to say "how do we think through this?"

A lot of it we did not know, some we had heard. But this is more engagement with communities of color, so Black, Hispanic. And the part that we are getting better at, and have put a lot of attention to are American Indian and Alaskan Native populations, the Indigenous populations, and where do we go and how do we move the needle forward in terms of accountability piece?

Reaching out across multiple sectors to help us think through what does system reform look like? Hearing things from states in terms of you know, the public health emergency has now ended, but where do we go from here? Where are the lessons learned from the COVID-19 pandemic that we can carry forward? How do we

get that support?

It also looks like working with our partners at NCSL to hear what's happened at the legislative branch, as well as our partners at HHS to see what is happening at the federal level and to determine how we support the governors as they work to improve lives and improve health outcomes.

And so, I know we only have five minutes, so I wanted to stop there and happy to take questions.

MS. BELINDA PETTIFORD: Thank you so much, Brittney. We're going to open it up for questions now to see if anyone has any questions. Either virtually or here in the room. Any questions? This may be the effect of right after lunch. So, we're going to go with any questions.

I know Brittney, this is Belinda. You mentioned something about that the leadership rotates between the National Governors Association, and then you said something about they select a priority? Each year? I just wanted to make sure I understood you correctly.

So how do they actually utilize that priority once it is selected? Do the other Governors join in and say we are supportive of it as well or do they still have options?

MS. BRITTNEY ROY: Well, they--they have options, which is why this roadmap is so important because we are vetting it with all fifty-five, of the actually out with the advisors and the policy directors right now, to make sure that we're tracking. But

the governors do work to gain support.

So, we've been hosted by Governor Cox in Utah, Governor Whitmer in Michigan, Governor Shapiro in Pennsylvania, and we'll wrap up in New Jersey next month where we'll have about forty-six Governors in attendance, and we will essentially lay out this playbook that has been vetted.

And the other thing I'll emphasize is that being bipartisan, contrary to what we see on TV sometimes, they all play well together in the sandbox, if you will, and so we lean on that for them to tell us what will work, what will not work, what is operational and really working to trickle information up, if you will, to the federal government on what's just practical for states.

MS. BELINDA PETTIFORD: Thank you so much and thank you for reiterating the fact that they do play nice in the sand. We'll probably do better if we don't watch as much news, as much TV. [Laughs] Thank you.

Any others with questions? Or comments?

DR. KATHRYN MENARD: I just have this one, Belinda. Thank you all for your presentations. Jennifer, your ears might have been burning because all yesterday, and today we've been talking about innovations, particularly to Medicaid, and I'm thinking what kind of we're going to be canvassing for these priority areas that we're thinking about.

You know, what's out there that's working, and I think

your group has a lot of that cataloged for us, and five minutes was not nearly enough to, you know, to hear that but thanks for all the resources that you're going to share with us to go on.

And for Brittney and Tahra, you kind of really kind of understanding what's on the radar for our legislators and the governors and the legislature is usually important as we put together thinking for recommendations so thank you.

MS. BELINDA PETTIFORD: Thanks, Kate.

DR. MICHAEL WARREN: Good afternoon. This is Michael Warren with the Maternal and Child Health Bureau. Thank you all for your presentations, and I think it really resonated again with me.

We talk a lot in the Bureau about the federal government can't solve all these challenges, and the solutions look different depending on what state you're in and what the environment is there, and I appreciate those themes coming up around framing, the frames particularly around social determinants of health and equity. So, thank you for that.

Tahra, I had one question in particular, you mentioned newborn screening. Could you just say a little bit more about what, what the themes are that are coming up around that?

MS. TAHRA JOHNSON: Absolutely and thank you for the question. We have seen several bills, and I can provide a follow-up with the specific states, but we've seen several states that have moved to cover the recommended panel, so the R.U.S.P. for

example.

There are--you all probably know this very well. Every state covers their newborn screening differently, and there are some states that do not cover all of the recommended screenings, but we've seen several States move in that direction to cover more. SMA for example now is on the R.U.S.P. and we saw several states move to cover that.

It is more challenging in states to just say "yes, we'll cover it" because the way that the screening is done is different and more complex, and as you all know who's worked on this table in this area, getting the labs with the capabilities to do the screening and that process is, can be complex, so it does take states a different amount of time to be able to actually implement that.

So, we have some states, last session and this session moved towards that, I would say SMAs, but there's one in particular that we've seen somewhat movement on, and I'm happy to follow-up with some more details.

The other thing I will add, just screening generally, we talked about children with special healthcare needs at our meeting in January with maternal and child health fellows. So, there were about again thirty, about thirty state legislators were there from different states and for special healthcare needs came up as one of their top priorities related to children's health and screenings, newborn screening as well as developmental screenings

are areas that our members were very interested in.

And we've seen several states enact legislation to or introduce legislation to increase access to certain screening. And again, I can follow-up with some specifics following this call.

DR. MICHAEL WARREN: Thank you.

MS. BELINDA PETTIFORD: Yes, thank you.

DR. STEVEN CALVIN: Hi, Steve Calvin. Jennifer, thanks, well--thanks for all of the presentations. I think we've interacted a few times. Steve Calvin from Minnesota.

I was going to ask what kind of collaboration is happening between the Institute for Medicaid Innovation and CMMI? Are they informal and you know specifically related to system care delivery model innovation and then possibly even payment innovation? Do you have any updates on that?

DR. JENNIFER MOORE: You know, that's a great question and great to see you in here. Although you are very small on my screen at least I know you are human-sized in-person. [Laughs]

So, we maintain really strong relationships with our federal colleagues including those at CMS and CMMI. We meet regularly monthly or quarterly with folks at CMMI and CMCS.

There are representatives who serve on our advisory committees for all of our projects including Midwifery-led Models of Care and Doula and Community Health Worker and the most recent one that I shared, Perinatal and Child Health Best Practices and Innovative Initiatives.

So, there's this symbiotic relationship to the comment made earlier that no--no individual, stakeholder or group in the Medicaid space can do this alone. It truly takes everyone, all working collectively and rowing in the same direction.

We're going to be hosting a Medicaid Maternal Health Policy Summit in September in partnership with the Aspen Institute, and we're going to be bringing together federal colleagues, state Medicaid colleagues, Medicaid health plans, provider groups, advocacy organizations, community-based organizations, people with lived experience altogether around four core areas including maternal mental health, doulas and perinatal community health workers, midwifery-led models of care.

With each of those four areas we're going to dive into identifying policy strategies and workforce, payment, data and quality and health systems, so that we're all collectively coming out with big commitments that we are going to lead, co-lead, sponsor, support, fund, whatever our role capacity is so that we are all moving in the same direction in a collective way.

We recognize that there's an upcoming presidential election. A lot can change in terms of politics, and we want to ensure that there's some stability through those potential transitions and are coming together as a group, including with CMMI to make sure that we have a plan going forward to carry this work forward.

MS. BELINDA PETTIFORD: Thank you so much. Any other

questions? I was wondering when you were just talking about that summit, Jennifer. Are you encouraging the state Medicaids to bring in their MCH people to the meeting? Or is it really just focused on Medicaid?

DR. JENNIFER MOORE: Absolutely. All right. wonderful. Yes, we have one more question here in the room.

DR. MARIE RAMAS: Hi. Thank you for the presentations. Tahra, I was just wondering if you see any themes across the states regarding the Momnibus bills?

So, I do know that there were several states that were several states that were pushing for different kinds of Momnibus bills so I'm just curious, have there been any underlying themes? Certainly, I'm sure paid medical leave is probably one of them, but I'd be interested to hear your thoughts and trends?

MS. TAHRA JOHNSON: Yeah, absolutely. Thank you for the question. We know Delaware and New Jersey come to mind as they were really large packages of bills and workforce was certainly one theme. I'll have to follow-up on paid family leave because that is a really interesting area. We've seen some legislation, some in Momnibus bills and then some in just in standalone bills in states, and I'd be happy to follow-up with some examples of that and what that looks like across the country.

We certainly have seen a focus on racial disparities, as well, as I think I mentioned, and implicit bias training, but there's also some other focus on ensuring that we have good data

within those states, and that is what we saw in legislation.

Those are the top things that I can think of off the top of my head, but again I'm happy to follow-up with some others because I know those two states in particular have very robust legislation.

And then those themes I'm calling out, we've seen a lot of states have standalone bills or bills that they're not calling Momnibus, but they have done a lot of the same types of legislation just in separate packages.

MS. BELINDA PETTIFORD: So, thank you all so very much. Please join me in thanking this great panel for coming and spending some time with us today.

[Applause]

We will be in touch as we move forward because we would love to make sure we stay engaged with you all. So, thank you for your time. We know Brittney had to drop off early but thank you so much to Tahra and Jennifer for hanging out to the end. Thanks.

MS. TAHRA JOHNSON: Thank you for the opportunity, appreciate it. Have a great day.

Break

MS. BELINDA PETTIFORD: Thanks. I know you all can't believe it but we're actually going to take another short break so we can get ready for public comments. So, if you didn't finish your lunch earlier, you now have time to do so. So, we will come

back together at 1:30 for our public comment period.

[BREAK 1:15 p.m.-1:30p.m.]

Public Comment

MS. VANESSA LEE: Welcome back, everyone. I hope everyone had a great break. We are heading into the public comment period of day two of our Advisory Committee meeting.

As I mentioned yesterday, we always open up the floor for comments to the Committee from the public as a federal advisory committee.

I did not remind our speakers yesterday that we do try to keep everyone to about two to three minutes because it's so important that we get to everyone who told us that they wanted to speak before the Committee. And we have eight people signed up for today so I'm going to try to really hold us to two minutes per speaker.

And I'm just going to say kind of folks that we-- any order that we received to. So, David Kennedy, I think you're a teed up first. If Mulubrhan Mogos, and I apologize if I mispronounced your name, we have the second. If you're online, we will look out for you in the Zoom.

Emily Price, I see you online, thank you. Andrew Williams will be fourth. Jennifer Kelly, we see you online. Jackie Campbell, Donyale Abe, and Shonita Roach.

And that's who we received requests to hear from and

again two minutes. I'm going to use my timer today. I'm going to not be afraid to interrupt people. So, David can be, why don't we have you speak first?

Good afternoon. Are you able to-- I think you're unmuted. So, you're welcome to begin. David Kennedy, we can see you, and I think we can hear you if you wanted to begin. Sorry, we were muted on our end thank you for being here.

DR. DAVID KENNEDY: Thank you for having me. My turn? I'm Dr. David Kennedy. I'm the past president of the International Academy of Oral Medicine Toxicology, and myself and several other authors published a paper about exactly what you're talking about today. Infant mortality and maternal mortality.

For finding in 2005, using CDC data, pointed out that one in five infants have levels of mercury in their blood as to cause brain damage, neurological damage, IQ loss. That's a terrible figure. But that's adult level, and that's not meant to protect babies, and it clearly does not.

Josh in 1994 measured infants that had died, and found the amount of mercury in the baby was proportionate to the number of silver amalgam fillings in the mother's teeth, brain and kidney and liver, bones, and all showed that the amount of mercury coming out of the baby's hair in their first haircut is proportionate to the number of fillings in the mother's teeth that contain mercury.

They also showed that autistic infants had no mercury in their hair. They're non-excreters. They lack the ability to get

rid of the mercury from their body. The majority of--we identified two substances-- fluoride and mercury both harm the infant. The majority of fluoride exposure is either the direct result of reconstituting the baby's formula with fluoride in the tap water or significant amounts of fluoride residue in the processed foods including soy formula.

The level exceeds the level known to harm that baby. The discovery of fluoride's known toxicity at the lowest levels possible further impugns the widespread exposure of fluoride and drinking water. It's simply not necessary and the government should stop promoting it, now.

Women, Infant and Children (WIC) whose job it is to protect the infant, now steadfastly refuse to warn indigent mothers, low-income mothers of the harm they're doing to their baby by using tap water. They said the reason they won't warn them is because they don't want to impair the program of fluoridation. Their job is to protect the infant, not a flawed program.

In 2005, Bill Haley invented a strongly safe compound, MBMI, that immediately binds and removes mercury from all biological systems, immediately. All expectant mothers therefore should drink purified water and regularly take MBMI to remove heavy metals from their system, so it doesn't accumulate at a four-fold plus in the infant.

Despite the FDA's learning in 2020 about you know mercury fillings during pregnancy and children, there have been

fifty million new mercury fillings placed annually by the Army, Navy, Air force, Welfare, Indian service in indigent mothers. Two steps that would immediately lower the risk to newborns are a simple pill that protects the woman and her fetus from mercury and several other heavy metals and stopping the fluoridation program which will cause nothing because systemic fluoride only harms.

There's no evidence that systemic fluoride does anything but harm the human being. Taking it out of the water turning the switch off. Our obligation is to protect the infants, not a risk-addled policy.

MS. VANESSA LEE: Thank you very much for your comments, and I apologize again to everyone if I have to cut you off. I'm trying to make sure we hit everybody that has signed up today. So again, thank you Mr. Kennedy for being on, and I think we were accidentally still muted when we began the public comment.

I did mention I'm going to be keeping everyone to two minutes, just because we have so many people signed up, and we want to be sure to hear from everyone.

So next, is there a Mulubrhan Mogos who has joined yet? I'm not seeing him online, so we will move to Emily Price, and if we see you later, we will circle back. Emily?

MS. EMILY PRICE: Hello everyone, thank you so much for this opportunity. My name is Emily Price, and I'm the CEO of a nonprofit organization called Healthy Birthday Inc., founded fifteen years ago out of the loss of five baby girls to stillbirth

or infant death.

I'm here representing tens of thousands of families and maternal health professionals who have endured the tragedy of stillbirth in America. We ask that stillbirth, the loss of a baby at twenty weeks or greater during pregnancy is elevated in conversations related to improving birth outcomes for moms.

We often talk about maternal mortality and infant mortality in this country. Two extremely important and devastating issues that must be addressed. But we often leave out stillbirth. This Advisory Committee itself is called the Advisory Committee on Infant and Maternal Mortality but no mention of stillbirth and no committee for stillbirth, which actually claims the lives of more babies each year than infant mortality, and horrible racial disparities persist in stillbirth.

Years ago, we thought stillbirths just happened, and they really couldn't be prevented. Today we know that's not true. Research shows that a minimum of one in four stillbirths can be prevented. And now that we know this, we must do all we can to prevent preventable stillbirths and get more babies here safely.

The crisis of stillbirth is getting more attention in the past year, as the ProPublica series on stillbirth is now a finalist for Pulitzer Prize.

There are two pieces of stillbirth prevention legislation in Congress and new research published in AJOG and BJOG show proven positive results of the "Count the Kicks"

stillbirth prevention program.

Our organization created "Count the Kicks" fifteen years ago to raise awareness about the importance of paying attention to babies' movements in the third trimester of pregnancy and speak up to your doctor if you notice a change.

The results of the program are so compelling we must act now. In Iowa, the state where Count the Kicks began, we saw 1% stillbirth rate reduction every three months for an entire decade while the rest of the country remained relatively stagnant.

Within that we witnessed a 39% stillbirth rate reduction among Black women in just five years. No other state has seen such a change in stillbirth.

Health departments, health systems, AWHONN, ACIMM, the National Center for Fatality Review and Prevention, Healthy Start coalitions, MCFE programs, health insurance companies and many, many more have become our key partners in this work and believe in this work.

Today, free Count the Kicks stillbirth prevention educational materials, just like these, this is what they look like, are available in half the country totally for free. And the other half you can get them at very, very low cost, depending on if you have a funder of them in your state.

These materials sparked the kick counting conversation between patient and provider about how a change in a baby's movements can be a red flag during the third trimester. It's

simple, it's easy to understand with health equity at the center.

You can visit Countthekicks.org to order this prevention education or learn more about our proven evidence-based work that saves lives and does not lead to any unnecessary doctor or hospital visits.

Instead, it sends the right people in at the right time. Together we can get more babies here safely and improve outcomes for moms. We know through a white paper that was issued last year that "Count the Kicks" and noticing a change in your baby's movements can alert moms to things like a placental abruption, a maternal fetal hemorrhage, and other issues that may be causing real issues in pregnancy.

So, today our simple ask is to place an increased focus on stillbirth prevention in this conversation: to name it, to talk about it, to provide funding behind it when we can, and work together to make it a maternal health tragedy of the past. I know so many of you do this already. I want to commend you so much for the work that you're doing for moms and babies across our country, and thank you so much for your service, and thank you so much for your time. We really appreciate it.

MS. VANESSA LEE: Thank you so much, Emily. We still have not seen Mulubrhan Mogos or Andrew Williams. So next in line as we received it is Jennifer Kelly. Jennifer Kelly, if you're still on I believe we gave you the ability to unmute your line on Zoom. Okay we'll circle back.

Jackie Campbell, I believe you're also teed up if you are able to unmute yourself, we gave you the co-host.

DR. JACQUELYN CAMPBELL: I am, and I thank you. I'm Jackie Campbell from Johns Hopkins University School of Nursing. And I also commend the Committee for all of your work. I've been listening these past two days. It's indeed impressive.

I want to circle back to the issue of partner violence because of the increase in the past two years of intimate partner homicide, both during pregnancy and outside of pregnancy. And we know all too well that this is associated with intimate partner violence and that we need to do a better job of helping our providers assess for intimate partner violence, especially in the fourth trimester.

And I've been very pleased with hearing about this attention to the fourth trimester and mental health issues there and want to be sure that intimate partner violence is part of those mental health packages, the packages that address these issues. And those assessments need to be culturally appropriate, especially for Indigenous and Black women and also immigrant and refugee women.

The other thing that I just want to mention is that in the intimate partner violence field we are thinking a lot about the notion of safe staying. Pregnant women want to stay with this partner. They want the partner to learn to do differently. And thus far the interventions have been for abusive people, partners

who are abusive, has been centered in the criminal justice system. You have to be arrested and court mandated to do it. And the pregnant women that I talk to want to stay with this person. They want him to get interventions.

And if we think about interventions and the behavioral health kind of process, interventions for people who use violence, whether it's toward partners or otherwise, that are part of our federally qualified health care services, that are part of the services that Indian Health Service provides so that women can stay in an abusive relationship and the relationship become non-abusive. So, it's not harmful to her nor to the babies.

One of the things that we think about is that now with homicide such a big problem and also gun deaths to children that one of the things that mom should go home from the hospital with is gun locks. You know that this is the kind of prevention the strategy that can help both the moms, and if there's a horrible situation where he goes for a gun to kill her, so that it's at least locked up, so he has to think about how to get it unlocked, and also for the safety of the babies as they grow.

So again, thank you for the time, and let's not forget that this is increasingly a cause of death for women both when they're pregnant and in the postpartum period.

MS. VANESSA LEE: Thank you so much, Jackie. Good to see you again, and thank you for your comments to the Committee. We believe Jennifer Kelly may be trying to be hooked up to Zoom. Her

audio, I apologize Jennifer you were trying to unmute. Try again. Looks like it's trying to connect. Jennifer Kelly, I see you are trying to connect.

Unfortunately, we aren't having success, it looks like, in connecting your audio. We can also offer you the option to submit your comments in writing, Jennifer, to submit. I think we have a way to contact you through your registration, so we will follow-up with you to be able to get your comments to the Committee in writing. Perhaps you could join the next meeting to do oral comments.

Any reactions or questions from the Committee members before we move on from the public comment period? Okay, well thank you again to all of those that were able to speak today, and Jennifer, we'll follow-up with you.

MS. BELINDA PETTIFORD: Thank you, Vanessa, and thank you all for all of your public comments.

Next Steps and Assignments

MS. BELINDA PETTIFORD: We're going to continue on our agenda now and go into next steps and assignments, and I'll ask if you all want to pull up one slide from our earlier conversation. And thinking about priorities and how do we move forward, pull together one slide and hopefully that it will depict what we just talked about.

And so, if we look at it and we look at this slide and

we're thinking overarching, we'll be looking at impactful opportunities related to you know following these areas and beyond, or specifically the three focus areas. One would be around the rural health focus, which would include the things like the residents and loan repayment program, and levels of care, deserts, hospital closures, I think the National Corps--What was the one that you mentioned, thank you--National Health Service Corps. All would be part of that area.

The second area would be more on the social drivers of health including determinants of health. We can narrow down the focus with a specific area. We can look at you know what some of the other states are doing around with their Medicaid waivers and other areas. And then our third focus would be around preconception, reproductive justice, fourth trimester would be part of this area as well.

So as a Committee are you all good with these three specific areas overarching our initial focus as well? There are opportunities where those bright spots that are already in place. And what is missing if you're not good with these three? Yes, Marie?

DR. MARIE RAMAS: I just wanted to clarify this with the focus of Black maternal health--

MS. BELINDA PETTIFORD: That is correct, thank you for bringing that up it is in my notes I just didn't make the slide.

DR. MARIE RAMAS: And yes, I'm okay with the three

overarching points.

MS. BELINDA PETTIFORD: And it would be Black maternal, and infant health?

DR. MARIE RAMAS: Yes.

DR. KATHRYN MENARD: Belinda, would one of these points be the Black maternal health or this would refer to all of them?

MS. BELINDA PETTIFORD: This would be part of the overarching, but feel free to chime in if you are feeling differently.

So, I was thinking that overarching would be impactful opportunities, specifically impacting our opportunities related to Black and infant--Black infant and maternal mortality or health. And then within those overarching areas we would also be looking at rural health, social drivers of health, reproductive justice, preconception, fourth trimester.

DR. KATHRYN MENARD: Okay.

MS. BELINDA PETTIFORD: So, the overarching areas the focus would be on where we see improvements in the country or in communities around Black, infant, and maternal health.

DR. KATHRYN MENARD: Okay, just another question. As I was hearing it, I was thinking that the overarching impactful opportunities applies to Black maternal health, right? And there's, you know, social drivers of Health and SDOH in that, but that would be sort of one.

And, you know, rural health was actually the rural

health issues in the systems of care thing wouldn't necessarily be Black maternal health focused but would be rural for systems of care. But it's still an impactful opportunity, right? For Rural Health Improvement. I just thought of that as a separate thing from the Black--

MS. BELINDA PETTIFORD: I just want to make sure I'm clear. So, you're thinking of it as four priority areas versus three?

DR. KATHRYN MENARD: Yes.

MS. BELINDA PETTIFORD: Okay.

DR. KATHRYN MENARD: Under all, looking, as we approach them looking for the impactful opportunities for things that have worked and then looking to scale those things in those categories.

MS. BELINDA PETTIFORD: So instead of the--you still see overarching would be impactful opportunities but you're saying add a fourth bullet that focuses just on Black maternal and infant health?

MS. BELINDA PETTIFORD: Okay, let me hear from other Committee members, and that includes those that are virtual. Are you all thinking four bullets underneath the overarching or are you thinking that is part of overarching that includes Black infant and maternal health outcomes? Yes, Marie?

DR. MARIE RAMAS: I think that all three of those areas are distinctly related to Black maternal and infant mortality in the United States. There may be programs where the Black

population may not be as significant but could still be amplified to reach that particular priority population, which is suffering in the United States.

So, I haven't looked at all of the recommendations historically, but I suspect that there may have been already some recommendations just in general on Black maternal and infant health like in general. So in the spirit of trying to be generative, I think those three areas we've all agreed are potential drivers of a change that we can help with impacting, and if we can have a focus on what can particularly support the health, well-being of birthing individuals and their children, I think that might be a unique take.

So, I would prefer to keep the three categories highlighting bright spots and overarching programs that we can highlight. But the underlying context is how can these particularly help reduce the morbidity and mortality and disparity for Black birthing parents and children?

MS. BELINDA PETTIFORD: Thank you Marie, others? Yes Phyllis.

DR. PHYLLIS SHARPS: I would agree because in any one of those three categories Black maternal and infant health is going to show up and we know when we look at any of the health disparities data, no matter what the category is, Black folks just do worse.

And you know when I think about some of the rural

settings in our southern states where Black women are just--we know about some of the urban issues but I think it would be, I like the overarching theme of Black maternal health, and we may find that there are certain things that work for certain rural populations, but maybe not for the Black maternal health and that kind of thing. So, I think we have, we've created a structure that's going to allow us to broadly but also specifically add a particular population as we did with our most recent report.

MS. BELINDA PETTIFORD: Thank you so much, Phyllis. Yes, Steve?

DR. STEVEN CALVIN: Yes so, I was just going to ask. Is that-- this is our one slide of focus priorities?

MS. BELINDA PETTIFORD: That is correct.

DR. STEVEN CALVIN: And I would just say too I totally agree and believe we should focus on the racial disparities, particularly for Black mothers and babies but I also think too, and I'm happy to volunteer for it, and you know it's really clear that unless we learn to pay for it differently.

So, I'm happy to keep following the money. The slide I sent earlier today was basically just to say, "well, you know what is value in healthcare?" And value is, you know, the patient's experience and outcomes, either plus or minus divided by the cost. And I think that's something I'm looking forward to maybe in St. Louis or down the road to just maybe focus on that area.

And I know CMS has some--you know it used to be called

the health care financing administration--but CMS, there are experts there too we can just bring in and say, "why is this not working?" And we have some examples of how it's not working, and some examples of how we could fix it.

So, I'm totally on board with this, but we need to look at it still through a lens of find the value. I mean we want to do all these things, but currently we're hoping for grants, we're hoping for focuses of various agencies, but we can say, "look, there's money in the system. It's not being used well."

MS. BELINDA PETTIFORD: Thank you. Others, anyone virtually? And this includes our ex-officios. Don't be shy. ShaRhonda, we see your hands up. Sharonda?

MS. SHARHONDA THOMPSON: Yes, I agree with the focus being on Black parents and birthing parents, based on the recommendation for 2021. In that recommendation letter. It was reading that particular consideration should be given to those who are Black, Indigenous, and People of Color. So, I think that in the spirit of let's do a deeper dive into what we've already recommended. I think that should be part of that focus.

MS. BELINDA PETTIFORD: Thank you, Sharonda. I'm going to go around the group to make sure you hear from everyone. Sherri, you're still on? Kate?

DR. KATHRYN MENARD: I think with this, with what I'm hearing from colleagues, and that kind of thing I think we'll go with this theme. I think with the rural health it will take on,

you know since there are areas of rural health that we'll have to look at that aren't necessarily that population—well, you deal with it. What's not on that list is the issue raised about data and maternal mortality data. Is that kind of not making it to the final list of working to get better measurement and deciding on uniform outcomes for respectful care and maternal morbidity?

MS. BELINDA PETTIFORD: I think data to me kind of falls under that overarching, so it really just depends on which area you're looking at. So, if everyone is reviewing that area that they select to focus on, I think all of us need to think on do we have data to move the work forward to make the decisions? So, we can include data in the overarching, but if you feel like we need to separate data group, just remember this is not the largest group in the world yet, and I'm not trying to spread us so thin that there's like a workgroup of one, so we just-- I just want us to be cautious about that okay.

And let me go to Sherri, and then I'll come back to Marie. Sherri, do you want to chime in on anything? I know that you're virtual, and I want to give you an opportunity to say. Anything that you would like to say about any of these focused priorities?

DR. SHERRI ALDERMAN: Thank you for asking I agree that any of the three, it would not be hard. It would be glaringly obvious that disparities that impact Black women and their babies would rise to the top so overarching consideration, I would agree

on having a focus on Black parents and their babies. I do feel that they will be a focus later.

MS. BELINDA PETTIFORD: Thank you, Sherri. And Marie?

DR. MARIE RAMAS: I just wanted to be sure I heard correctly. So, in these three categories these would be the workgroups essentially. The overarching themes that we would look into and make sure to comment on would be one, what are some programs that are currently working well within that, etc.

Two, the financial and physical component and the relationship of those programs in cost savings and resources that could be allocated from the federal level or from different departments. And then the third one I heard was data. Is the data sufficient and effective and reproducible in a way that we could use and interpret effectively?

So, did I hear that correctly from the group?

MS. BELINDA PETTIFORD: I think you heard it well. I think the piece that I didn't say earlier was the financial fiscal component, the cost savings piece but I do think it's important piece.

DR. MARIE RAMAS: Okay.

MS. BELINDA PETTIFORD: So, thank you for bringing that back to the group. So, thank you. Is everyone good with moving forward with this, realizing that we've got health care financing, the value of that? And Steve will continue to help us think through that and figure out because it really may impact any of

these areas in reality? So, thank you, Steve.

So, our next great opportunity is for us to figure out who wants to lead each of these three groups. Because we can't just have workgroups out operating on their own.

We need at least one person that's willing to convene the group and have a conversation about it to at least begin the discussion. I think we can work with the staff here and others to think through where there are some impactful programs.

So that we can make that connection, but we will need to know. It would be nice today if we could get three people to volunteer to lead the three different workgroups, but if not today, an email will be going out [laughter] really quickly there afterwards. But it's so much easier to do it now. Because we need people to sign up for them.

And as I'm saying that, I know our goal is to meet in-person in December. We're trying to figure that out we plan to meet in St. Louis at that time, but we feel like December's a long time away. So, our hope is that we'll be able to do a virtual meeting sometime, maybe in September.

And so, it would be nice if the workgroups or whatever at least met once before we come together for a truly--and we don't know if we can actually do September. Our team is going to look into it, Vanessa and Sarah, they're going to check in to see if we can add one more meeting to you know to the list.

They have a contract, and I'm sure adding what this one

meeting was a part of the original contract. But it does feel like a very long time between June and December.

So, thoughts, questions, concern? Yes, Kate with the microphone.

DR. KATHRYN MENARD: Unless someone else wants to take the lead, I'd be willing to convene the rural health bullet.

MS. BELINDA PETTIFORD: You'll take the rural health?

DR. KATHRYN MENARD: Rural health systems bullet.

MS. BELINDA PETTIFORD: You see how people just volunteer, everyone?

DR. KATHRYN MENARD: I'll be needing lots of help from people.

MS. BELINDA PETTIFORD: And Steve has agreed to help you. I heard that in the room. [Laughter] I come from strong genes. I told you my mother just turned ninety. She could steer here well too.

Does anyone want to take social drivers of health or fourth, trimester, preconception, reproductive justice? Not everybody at once, and make sure the virtual people know that they can just come off of mute and say, "I'll take it."

Yes, Phyllis. Phyllis wants to work on the number three. So, if you take it, Phyllis is willing to be on the Committee. She just does not want to lead it. So, you have a Committee member, and we will get other Committee members at some point we just don't have them yet.

DR. MARIE RAMAS: I will help in the second, social drivers.

MS. BELINDA PETTIFORD: So, Marie is willing to help on the social drivers of Health.

DR. MARIE RAMAS: Yes.

DR. SHERRI ALDERMAN: And this is Sherri. I'm willing to help on the social drivers of health too.

MS. BELINDA PETTIFORD: Oh, wonderful, Sherri and Marie. So, if you all are meeting, maybe you can think about being co-leads.

DR. MARIE RAMAS: Sherri, I think she got us.

MS. SHARHONDA THOMPSON: I would also like to help with social drivers of health, or social determinants of health.

MS. BELINDA PETTIFORD: Is that you, ShaRhonda? Thank you, ShaRhonda. So ShaRhonda is also going to help on social drivers. So, who missed a meeting? [Laughter]

So, Tara and Jacob, we'll have to get them in. Meanwhile, Phyllis, I will work with you on the preconception, reproductive justice, fourth trimester. I will not chair it, but I will work with you on that until we get it to a next level of agreement.

And we will check in with Tara and Jacob and Joy. Am I missing anyone? And all the ex-officio members? I noticed you all got very quiet, but we will need you all to work on these workgroups. That includes you, Karen, and you, Danielle.

And anyone else that's out in virtual land, we will need you all to join in with us. And this will give us an opportunity to expand to any of our partners, you know those national partners that have come and joined, and people like others that are in the room that want to join. But we will need to get started, okay?

All right. Any thoughts, questions, concerns? I know Vanessa wants to share a few things. Vanessa wants to share a few things before we adjourn.

Meeting Evaluations and Closing Observations

MS. VANESSA LEE: I'm going to keep it really brief because I know we're out of time. Just some quick operational updates.

Thank you all for the feedback and the input on the charter. Just want to let you know that we're moving forward with that renewal package, and I think we're on track we should have no problem renewing your Committees Charter by September 30th.

So as soon as we get more clarity on that final language and things like that, we'll be sure to share, but I did want to acknowledge and thank everyone who submitted feedback for us to consider.

The second thing was membership. As Belinda said, we are still working to get approval of seven new members. That package is in the process still of being reviewed but it does have

seven potential new members there for you.

And we've also been trying to fill the open ex-officio spots. So, we have U.S.D.A. now, HUD. We have someone from the Department of Labor that we'll be able to introduce. We're still looking for someone from SAMSA and a couple other key departments and options that you all have been discussing.

So, we'll be sure to keep working on that, and as Belinda said, we'll try to see if we can have a virtual meeting in September, but we definitely have plans for that December meeting in St. Louis. We're tentatively looking at December 4th and 5th. It's a Monday and Tuesday. If you want to just save the dates in your calendar, we'll be sure to obviously circle back after today to be sure that works for the majority but again, December 4th and 5th in St Louis, if possible, is what we're looking at.

Anything that I missed? Belinda or Sarah, something operational?

MS. BELINDA PETTIFORD: I think you covered it well. I think the only thing we're looking at, and ShaRhonda, we'll be in touch with you for December 4th and 5th.

I know at one point, ShaRhonda, you were a little concerned about what the weather looks like in St. Louis in December. I think we've gotten mixed reports that the sun could be shining, and it could be relatively warm, and then we also heard it could be snow and ice. And so, I don't know.

At some point, we'll have to make a decision and take a

chance, and then if we find out it is snow and ice, we're going to have to quickly turn it into a virtual meeting because safety will definitely come first. So, we will be in touch with you, ShaRhonda, as hosting us in St Louis or virtually that day, depending on what is happening, as we get a little bit closer to it.

MS. VANESSA LEE: Thanks, Belinda, and that reminds me just to think through some of the following meetings that we have on the books in the contract. So, after the December meeting, the thinking was to convene again in March and that would be potentially a virtual and then following that would be a June meeting like this one. Probably here at HRSA. That sort of booking us out for the next year. So, December, March, and then June is what we're sort of tentatively looking at.

DR. MARIE RAMAS: I know June is a busy time of year for those of us that have families and what not, so early June or late June tends to be better, just thinking about graduations and other life needs and goals.

MS. BELINDA PETTIFORD: You have a life outside of the Committee?

MS. VANESSA LEE: Thank you, Marie.

[Off mic]

MS. BELINDA PETTIFORD: Yes, so if you will hold December 4th and 5th for the moment that will be helpful. We will keep our eye on the weather, and we will also keep our eye on the

appointments coming through, because the other thing is for some unusual reason that the appointments don't make it by December, we do not, we will change that in-person meeting to a later time.

Because we would like our new members to meet us in-person with the meeting. And for September, we're looking at one day, not two days, so we'll be sending out some, once we confirm that we can actually hold it, then we'll start looking at a one-day virtual meeting in September.

So, any parting comments for anyone? I know we're a little bit over time. And many of us are trying to get to the airport. I wanted to make sure if anyone virtual wanted to come off mute and say anything. Otherwise, thank you all so very much for your time, your energy, your expertise. It's been a great two days, and I look forward to seeing you again soon and look for some emails next week. We'll send emails next week.

Meeting Adjourn

(Whereupon, the meeting was adjourned, at 2:11 p.m.)