Advisory Committee on Infant and Maternal Mortality

Meeting Minutes of June 13-14, 2023

Hybrid Virtual and In-Person Meeting

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DAY ONE: Tuesday, June 13, 2023

Welcome and Introductions

***Vanessa Lee, M.P.H.,* Designated Federal Official (DFO), ACIMM**
***Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair**

The DFO called the Advisory Committee on Infant and Maternal Mortality (ACIMM) to order and welcomed Committee members to HRSA headquarters. She then turned the meeting over to the Chair who welcomed both in-person and virtual attendees. The Chair announced the resignation of Committee member, Dr. Charlene Collier, and introduced two new ex-officio members: Ms. Alicka Ampry-Samuel of the U.S. Department of Housing and Urban Development (HUD) and Dr. Caroline Dunn of the U.S. Department of Agriculture (USDA).

Review and Approve Minutes

***Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair**

The Committee unanimously passed a motion to approve the minutes of the March 2023 meeting.

Federal Updates

Maternal and Child Health Bureau (MCHB)
***Michael Warren, M.D., M.P.H., FAAP,* ACIMM Executive Secretary and Associate Administrator, MCHB, Health Resources & Services Administration (HRSA)**

Dr. Michael Warren provided an update on the National Maternal Mental Health Hotline which has had approximately 13,000 calls or texts since its launch in 2022. Of those who reported their perinatal period, a little more than one-third were in the postpartum period and nearly one-fifth were pregnant. Additional funding from Congress supported the development of new promotional materials for the hotline, which have been requested by more than 400 entities across the U.S. Dr. Warren also announced an enhanced funding opportunity for the Healthy Start Initiative that may provide up to ten awards in new communities, including at least one tribal community and one rural community. Additional funding from the Fiscal Year 2023 budget was allocated for a Maternal Health Research Collaborative for Minority Serving Institutions (MSIs). MCHB was also supporting grantees to work with families who were at risk of losing Medicaid or CHIP coverage as a result of the recent end of waivers implemented during the COVID-19 pandemic.

Food and Nutrition Service (FNS), U.S. Department of Agriculture (USDA)
***Caroline Dunn, Ph.D., R.D.N.,* ACIMM Ex-Officio Member**

Dr. Caroline Dunn provided an overview of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), emphasizing its critical role in ensuring that families have nutrition security. WIC currently reaches only half of all eligible families. The American Rescue Plan of 2021 provided additional funds to WIC to help enroll all eligible families, simplify the WIC experience, and close the equity gap. To better understand the impact of WIC on maternal morbidity and mortality, FNS held a stakeholder engagement session with key federal partners

and researchers in the maternal health field and coordinated with the Agency for Healthcare Research and Quality (AHRQ) to conduct a review by the Johns Hopkins University Evidence-Based Practice Center. Additionally, the USDA intends to initiate two cooperative agreements focused on maternal health and health equity in the coming year—the first to support rigorous academic research on the impact of WIC on maternal health, and the second to understand how to implement innovative approaches to maternal morbidity and mortality in a WIC setting.

Discussion

- The Chair asked if there was any information on why only half of eligible families participated in WIC.
    - Dr. Dunn answered that there were multiple reasons for non-participation, ranging from limited access to the program to not wanting to be considered a burden. Part of their national outreach effort was to ensure that people were aware of WIC and its eligibility. FNS will work closely with Medicaid and the Supplemental Nutrition Assistance Program (SNAP) to identify and conduct outreach with eligible families. Research has shown that a one-size-fits-all approach will not be effective across the different reasons for non-participation and that increasing participation will require a comprehensive effort. The Chair added that immigration status was another reason for non-participation in North Carolina.

- A Committee member asked if there had been collaborations to help families that live in HUD-assisted properties.
    - Dr. Dunn answered that she was not familiar with the comprehensive history of WIC collaborations, but that it would be a good partnership to pursue.

Follow-Up: Recommendations to Improve American Indian/Alaska Native (AI/AN) Birth Outcomes

Moderator: ***Belinda D. Pettiford, M.P.H., B.S., B.A.,*** **ACIMM Chair**
ACIMM Members
Ex-Officio Members

The Chair invited Committee and ex-officio members to provide updates on activities related to dissemination, promotion, or implementation of the Committee's December 2022 recommendations to improve AI/AN birth outcomes.

Centers for Disease Control and Prevention (CDC): Dr. Karen Remley talked about the CDC Public Health Associate Program (PHAP) and the two PHAP associates who were working with tribes to better understand follow-up after newborn screening and hearing loss detection. Their experience being embedded within the tribe rather than working at the state level had provided a lot of insight into the early identification of emerging maternal and infant health issues in tribal populations.

National Institutes of Health (NIH): Dr. Alison Cernich provided an overview of the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) efforts

with federal partners to better understand and prevent stillbirth. The NICHD Stillbirth Working Group of Council developed recommendations in this area and will be working on the implementation of those recommendations going forward.

MCHB: Dr. Michael Warren echoed two recommendations from the September 2022 Committee meeting that were being pursued by MCHB: they were exploring ways to make more funding available to tribal communities and planning to hold one Committee meeting each year in the community. Towards that end, the December 2023 Committee meeting was being planned for St. Louis, Missouri. The Chair added that ACIMM's consumer member, Ms. ShaRhonda Thompson was located there.

Indian Health Service (IHS): Dr. Tina Pattara-Lau provided an overview of recent IHS activities. IHS established a Maternal Care Workgroup focused on safe, quality maternal care and drafted a manual for obstetric readiness in the emergency department. IHS was piloting a Maternity Care Coordinator Program to provide telehealth and home visiting support to increase screening and education intervention opportunities during pregnancy and postpartum. IHS would also be launching a new maternal and child health (MCH) website later this month.

The Chair then reviewed activities that had been conducted by former Committee members including participation in a webinar about the crisis of inequities in MCH based on a US News & World Report, presentations for the Association of Maternal & Child Health Programs (AMCHP) and the National Healthy Start Association conferences, and a webinar on reconnecting to indigenous life. Future efforts included podcasts, partnership with the Kellogg Foundation, and an article from ProPublica.

Social Determinants of Health (SDOH)

***Moderator: Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair**

Federal Efforts to Address SDOH and Health-Related Social Needs

***Andre Chappel, Ph.D.,* Director, Division of Public Health Services, Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (HHS)**

Dr. Andre Chappel provided an overview of ASPE, an advisory agency that serves as the principal advisor to the HHS Secretary and conducts research using data from all HHS agencies to inform policy development. He talked about the social determinants of health (SDOH) and health-related social needs (HRSN), both of which affected health disparities and played a vital role in the context of maternal health. To address SDOH, HHS developed an Action Plan 1) to enhance data infrastructure and utilization to improve research capability and information interoperability, 2) to improve the affordability of health care services and foster partnerships between health care providers and human services organizations, and 3) to support a whole-of-governmental approach to addressing SDOH while leveraging public-private partnerships and community engagement. ASPE also created four priority groups: 1) health and social care coordination, 2) measurement and data collection, 3) social care referral and SDOH data interoperability, and 4) community and peer health workers. Dr. Chappel asked the Committee

for advice on how best to prioritize and address SDOH and HRSNs to improve maternal and infant health outcomes.

Discussion

- A Committee member talked about how health care financing is one underlying driver of structural problems and asked whether paying for care in a different way would make a difference. They also asked whether the idea of health bonds and incentives to address social determinants might be problematic or not.
    - Dr. Chappel answered that the Centers for Medicare and Medicaid Services (CMS) were testing several payment models. Recently, CMS completed a project to test a community care coordination model and found challenges in both financing and capacity for supporting social care needs. It was therefore important to consider how to bolster this sector, but the challenge was deciding which to address first—financing or capacity.

Social Determinants of Health Focus: The Impact of Housing on Birth Outcomes

Healthy Starts at Home: Cross-Sector Opportunities to Advance Maternal and Child Health through Housing

***Veronica Helms, M.P.H.,* Social Science Analyst, Office of Policy Development and Research, U.S. Department of Housing & Urban Development (HUD)**

Ms. Veronica Helms outlined HUD's mission and recent 2022 to 2026 Strategic Plan. Goal 4 of the Strategic Plan aims to advance sustainable communities, which includes a specific objective to improve MCH—the first time in HUD's history that a strategic approach was developed specifically for mothers and children. HUD takes a broad and inclusive approach to housing insecurity, which is a particular burden on mothers and children. HUD's research on the timing of HUD assistance found that pregnant women were likely to be placed on a waitlist and not be admitted to housing until after the birth of their child. Research also showed that those with a housing voucher had better MCH outcomes than those without. Ms. Helms also noted that infancy is the period of life in which an individual is most likely to be homeless, and that there is a strong link between prenatal homelessness and low birth weight and preterm delivery. HUD aims to continue collecting evidence on the positive impact of housing on MCH, facilitating cross-agency research, and developing partnerships with MCH stakeholders.

Housing Equity for Infant Health Initiative: Health Justice Intervention

***Adam Mueller, J.D.,* Executive Director, Indiana Justice Project**

Mr. Adam Mueller introduced the Indiana Justice Project and its work at the intersection of health, housing, and economic justice. They were a subrecipient of the HRSA-funded Catalyst for Infant Health Equity Program, which supported the implementation of data-driven policy and innovative strategies to reduce infant mortality inequities by addressing the SDOH. Central to the project's efforts was the strong correlation between housing instability and adverse pregnancy outcomes. He talked about their Health Justice Intervention, which aimed to use all available tools to enhance housing, health, and security for pregnant women and their infants at a systems level. The intervention was divided into three primary categories: 1) education on legal rights, 2)

strategic court advocacy, and 3) legal analysis of existing laws that impact housing insecurity and health outcomes. The Health Justice Intervention had several successes within its first year and continues to advocate for policy changes aimed at reducing evictions and eviction-associated trauma. They also planned to hold their first annual Housing Justice Conference in June 2023.

Catalyst for Infant Health Equity Grant
***Lashelle Stewart, M.B.A.,* Executive Director, Baltimore Healthy Start, Inc.**

Ms. Lashelle Stewart talked about the HRSA-funded Baltimore Healthy Start Catalyst initiative that was addressing housing for pregnant women and families by working with Housing Navigators to help secure affordable, healthy housing and by engaging with tenants and landlords. It also provided education to program participants on financial literacy. Going forward, the grant will help facilitate the development of green spaces, implementation of landlord and developer symposiums, and media campaigns to raise awareness about the connection between safe housing and infant health equity. These strategies were developed in collaboration with members of the community to ensure that mothers could speak about their needs. A planning committee had been established for the Housing Provider Symposium in September 2023.

Discussion

- An ex-officio member stressed SDOH begins at conception, but that the focus of services is too often on the adult. They suggested that the Committee move their discussion toward the best opportunities to impact SDOH and improve outcomes for pregnant women.

- A Committee member asked whether HUD had any programs to help landlords provide affordable housing more easily and sustainably.

    - Ms. Ampry-Samuel answered that HUD does connect with landlords to ensure they have the resources and programs needed to keep their units affordable. For instance, it was important to provide a lot of incentives, such as direct funding and support for security deposits, to make participation more attractive. Ms. Helms added that there was a study at HUD on why landlord participation had been so low in previous years. In the study, only 30% of landlords who were surveyed accepted Section 8 and housing vouchers. However, 94% said that they would be willing to set aside units for pregnant women if the women participated in a program that helped with education and support.

- Mr. Mueller asked HUD whether any of their vouchers were directed for pregnant people.
    - Ms. Ampry-Samuel said that that funding went to public housing authorities for distribution to help support certain populations. Ms. Helms said that HUD would like to provide vouchers specifically for pregnant women, but that it would challenge Fair Housing laws because it would discriminate on the basis of family

status and gender, which are both protected groups. HUD was currently considering how to work around this unforeseen barrier.

- A Committee member asked if there were ramifications to property owners and landlords who did not provide affordable housing or appropriately maintain a property.
    - Ms. Ampry-Samuel said that HUD did have enforcement departments and provided a way for individuals to file a complaint. Their Multifamily and Asset Management Divisions connected with contractors who worked directly with landlords if there was a problem. Additionally, Regional Administrators often talked to families and property managers to ensure residents were supported.
    - Mr. Mueller said that tenants also had rights at the state and federal levels to ensure that codes were enforced, but that it could be very difficult to enforce these rights. For instance, tenants had to be current on rent and able to take time off work to attend court. The Indiana Justice Project aimed to reduce those barriers as much as possible. Ms. Stewart added that parents in their program in Baltimore helped influence the passage of a law that required all landlords to obtain an inspection on their property before they could rent it. After the law passed, there was a large campaign conducted in partnership with other Baltimore agencies to ensure that people were aware of the new law and their right to recourse.

Public Comment

***Vanessa Lee, M.P.H.,* DFO, ACIMM**

The DFO introduced five individuals who provided public comment.

Candi Cornelius, a prenatal care coordinator from the Oneida and Menominee nations in Wisconsin, described the challenges in MCH in tribal communities. She gave examples such as a lack of obstetricians, fragmented services, inadequate funding of IHS facilities, and the need for in-person home visits and increased preventive care and education. Ms. Cornelius also highlighted challenges in qualifying for funding from programs such as Healthy Start.

Joia Crear-Perry, an OB/GYN and founder and president of the National Birth Equity Collaborative (NBEC), spoke about institutionalized racism, classism, and gender oppression. She highlighted discrimination in housing and clinical practices, and the importance of unlearning harmful ideas. She suggested that HRSA increase its visibility and role in influencing MCH policies.

Christin Farmer, founder of the Ohio nonprofit organization Birth in Beautiful Communities, expressed concern about birth outcomes in Black communities and the systemic issues that contribute to these outcomes. She suggested solutions such as increasing education about birth in schools, promoting midwifery, and increasing financial support and birthing choices for families.

Socia Love-Thurman, a citizen of the Cherokee Nation of Oklahoma and Chief Health Officer for the Seattle Indian Health Board, called for greater attention and funding for the healthcare of urban Indians, noting that 76% of AI/AN people resided in urban areas and often lacked access

to culturally-appropriate, community-based services such as midwifery services and alternatives to traditional hospital delivery.

John Mueller, a retired public works engineer and former water treatment professional, advocated for ending artificial water fluoridation, arguing that it posed significant risks to infant and maternal mental health. He believed the increase in public awareness, increased understanding of the risk of fluoridation on prenatal and early brain development, and increased attention from the White House was indicating that the time for change was now.

Community Voices

Moderator: *Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair
***Taylor Thompson,* Indiana Healthy Beginnings at Home**
***Drena Plummer,* Baltimore Healthy Start**

Ms. Taylor Thompson spoke about her experience with homelessness while pregnant and parenting three children, as well as her participation in the Indiana Healthy Beginnings at Home program, which received HRSA Catalyst Program funding. She described both her initial skepticism of the program, as well as the relief that followed as she realized that her family no longer had to worry about where they would sleep. The program helped reduce her stress, which positively impacted both her health and the well-being of her children.

Ms. Drena Plummer talked about her experience with the Baltimore Healthy Start program during her high-risk pregnancy. Specifically, the program helped her manage blood pressure, obtain clothing, receive housing resources, and seek employment. She highlighted their Belly Buddies project, which provided social connections to other pregnant individuals, breathing exercises and other skills to reduce stress during pregnancy.

Discussion

- A Committee member asked what was needed to overcome the barrier of distrust.
    - Ms. T. Thompson said that health care providers were trusted individuals. If a health care provider took the time to learn about the program and call their patients about it, then information would be more trustworthy than if it came from an unknown person. Ms. Plummer agreed and said that her OB/GYN told her about the Baltimore Healthy Start program.

- A committee member asked Ms. T. Thompson to share what helped build trust in the Healthy Beginnings at Home program after her initial skepticism.
    - Ms. T. Thompson said that her case manager was approachable, receptive to questions, and not aggressive about participating in the program.

- An ex-officio member asked if there was anything they would change about the program.
    - Ms. Plummer answered that every aspect of the program was handled perfectly for her needs. Ms. T. Thompson concurred and added that the program worked quickly to help her move into housing.

- A Committee member asked if the panelists had knowledge about the programs prior to being contacted.
    - Neither Ms. Plummer nor Ms. T. Thompson had previous knowledge of the program. Ms. T. Thompson said that she would have participated sooner and had more trust in the program if she had seen an advertisement about it. Ms. Plummer added that it might be more difficult for non-pregnant people to know about the Healthy Start program, since she only learned about it after becoming pregnant/being a first-time mother.

Ms. Stewart commented that many people across the nation have no knowledge about Healthy Start, and yet many families have either lost a child or know someone who has. She added that there was a need for a national platform to raise awareness in communities about infant mortality.

Federal Healthy Start Program

Baltimore Healthy Start, Inc.
***Lashelle Stewart, M.B.A.,* Executive Director, Baltimore Healthy Start, Inc.**

Ms. Stewart said that the Baltimore Healthy Start program was the only federally-funded program of its kind in Maryland. The program partners with B'More for Healthy Babies to reduce infant mortality by providing nurturing environments for children and comprehensive services for families. The program uses a holistic approach to maternal health, focusing not only on clinical, but also community and societal factors. The Baltimore Healthy Start program provides comprehensive care including home visits, health education, maternal depression screening, infant developmental screening, and a program that schedules postpartum visits at the same time as infant well visits. The program also supports community improvement projects and provides services such as a food pantry, GED classes, parenting classes, prenatal stress reduction classes, fatherhood engagement, teen groups, and transportation services.

Healthy Start Data Overview (2019-2021)
***Ada Determan, Ph.D., M.P.H.,* Health Scientist, Division of Healthy Start and Perinatal Services, MCHB, HRSA**

Dr. Ada Determan provided an overview of 2019 to 2021 performance data for the MCHB-funded Healthy Start program. Healthy Start participation increased from nearly 60,000 in 2019 to 77,000 in 2021. Approximately 60%of participants were Black and 20% were White. Participation from Hispanic individuals increased from 20 to 25% between 2019 and 2021. Healthy Start consistently met or surpassed several performance targets such as health care access, early prenatal care, well-woman visits, reproductive life planning, interconception spacing, tobacco use in the third trimester, personal well-being, parenting practices, home life, and children's care. Notably, 99% of Healthy Start participants were screened for depression as compared to the national average of 9%. The program fell short of its targets for postpartum visits, depression referrals, intimate partner violence screening, and breastfeeding at six months. Infant mortality among Healthy Start participants decreased from 8.05 in 2019 to 6.67 in 2021, while the national infant mortality rate remained steady (between 5.42 and 5.58). The Healthy

Start Monitoring and Evaluation Data System launched at the end of 2020 and will become the primary source of data by 2024.

Healthy Start Engagement Activities and Future Priorities
***Mia Morrison, M.P.H.,* Supervisory Public Health Analyst, Division of Healthy Start and Perinatal Services, MCHB, HRSA**

Ms. Mia Morrison reviewed results from engagement activities that MCHB conducted with Healthy Start stakeholders. There were three key activities: 1) four meetings with partners, experts, and people with lived experience; 2) two listening sessions with Healthy Start grantees; and 3) a Federal Register Request for Information. These engagement activities resulted in four key takeaways outlining the need to: 1) increase emphasis on addressing upstream factors and the social and structural determinants of health (SSDOH); 2) strengthen family and community engagement from program design to implementation and evaluation; 3) implement flexible strategies to address key drivers of infant mortality; and 4) reduce grantee burden. Ms. Morrison said that MCHB had begun implementing some of these recommendations in their 2023 initiatives and gave several examples. MCHB was also exploring strategies to retain Healthy Start program staff, reduce data reporting requirements, and reassessing monitoring protocols.

Discussion

- An ex-officio member said that there had been an increase in infant mortality at the national level and asked Dr. Determan if any provisional 2023 Healthy Start data had been released that might show a similar uptick.
    - Dr. Determan answered that they were currently working on 2022 program data.

- A Committee member talked about "the fourth trimester" and timing of care during the postpartum period and asked whether the new guidelines had been incorporated into Healthy Start.
    - Dr. Determan answered that MCHB had been aware of this recommendation from the American College of Obstetricians and Gynecologists (ACOG) and was working on measures to capture services up to 12 weeks postpartum. They were also mindful that Medicaid was moving toward coverage for the year postpartum and was tracking this to ensure that their program was aligned.
    - Dr. Warren added that there was recently published guidance for reporting postpartum visits under the MCHB Title V Block Grant Program.
    - Ms. Morrison said the inclusion of funding for doulas in Fiscal Year 2023 was important because doulas could identify early maternal warning signs.
    - A Committee member shared a project at the American Academy of Family Physicians (AAFP) to identify best practices for primary care physicians during the one-year postpartum period.

- A Committee member asked for the number of Healthy Start applications that were not funded.
    - Dr. Warren said that MCHB received far more applications than they were able to fund and that he would obtain the exact number that were not funded.

- A Committee member asked for the definition of a Healthy Start "community".
    - Ms. Morrison answered that the selected community must meet the program's infant mortality rate requirement, which was 1.5 times the national average in a three-year period. If the community did not meet that requirement, it could still qualify using other data such as low birth weight or preterm birth data.

- A Committee member said that the rate of stillbirths was a topic of growing interest across Healthy Start sites and asked whether MCHB tracked stillbirth rates as one of their outcomes.
    - Ms. Morrison said that MCHB did not currently track data on stillbirth but might consider it in the future. Dr. Remley added that CDC had begun tracking stillbirth disparities data using the MATernaL and Infant NetworK to Understand Outcomes Associated with Medication for Opioid Use Disorder During Pregnancy (MAT-LINK).

- The Chair asked whether there had been discussion on how a rural or frontier area could qualify for Healthy Start, given the size of their populations.
    - Ms. Morrison said that their Fiscal Year 2023 grant cycle included flexibility in the numbers served requirement by slightly lowering the requirements for those receiving case management care coordination. The telehealth tools that emerged during the pandemic also increased flexibility in terms of how applicants could propose to serve their community. The Chair added that rural areas could still be challenged by a lack of broadband internet.

- Ms. Stewart talked about how prices increase each year, but that funding levels remain the same across the five-year grant cycle—making it difficult to attract and retain staff. Additionally, hospitals were beginning to hire community health workers and offer them competitive salaries and benefits, making it even more difficult for a Healthy Start program to compete for staff.
    - Dr. Warren responded that they had implemented a tiered funding approach in the past and the feedback they received was mixed. Funding from Congress was generally flat, providing no ability for Healthy Start to increase funds over time. It had been an ongoing challenge at MCHB because increasing funding over the grant lifecycle would decrease the overall number of communities it is able to serve.

- A Committee member said that providing the right level of services to those with the highest need was an increasing area of concern in the medical community. The approach should be reframed as not losing services but rather improving the identification of those with the highest needs—providing the most impact with limited resources. She asked whether there was a way to identify those high need populations.
    - Dr. Determan said that they had asked an expert panel to develop a risk assessment profile so that interventions could be targeted to those with highest risk for adverse birth outcomes, which was a continuing effort.

    - Dr. Warren also said a recent Notice of Funding Opportunity (NOFO) added an option for a group education intervention, which could be a way to triage people with lower need into a different intervention and focus resources on groups with the highest risk for adverse birth outcomes.

- The Chair and a Committee member talked about North Carolina's effort to develop a maternal and infant impactability score, and the relationship with low birth weight and outcome disparities that it identified. She asked if funding was better used to target certain communities or to serve the population or a mix of both.
    - Dr. Warren suggested that the best approach was likely a mix of both, although it would be difficult to do both with limited funds. It was important to also consider MCHB's authorizing legislation and congressional requirements on its use of funds. MCHB uses a targeted, population-focused service approach across several of its programs.
    - Ms. Stewart said that many of the programs she presented on were not funded by MCHB's Healthy Start program funds, but rather multiple funding sources.

- A Committee member said middle income families often have incomes that are not low enough for eligibility into programs but not high enough to fully meet their needs. She asked whether there was a service for pregnant people who fall in this income area.
    - Ms. Morrison answered that the Fiscal Year 2023 Healthy Start Enhanced Initiative was to serve all families within the selected project area. Over 50% of the families served were required to be from the target population, but anyone living in the selected project area could receive Healthy Start services.

- An ex-officio member talked about the need to fund the Centering Pregnancy model, which has been shown to decrease maternal and infant mortality.
    - Dr. Warren said that Healthy Start NOFOs could not specifically include the Centering Pregnancy model because it was proprietary. Other funding strategies, such as the MCHB Title V Block Grant, could be appropriate. He highlighted Strong Start as a program that leaned toward the Centering Pregnancy model. The Chair added that some states incentivize group prenatal care.
    - An ex-officio member said that CMS was modernizing and extending their benefits for birthing options and may be another funding approach to consider.

- A Committee member reiterated that the U.S. has the highest Black maternal and infant mortality rate in the world. While it was important to ensure equal access to these resources, there were some populations that were dying by the second. It was therefore the Committee's responsibility to create additional urgency to expand the programs that are known to work.

Open Discussion

***Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair**

The Chair asked Committee members to identify priority areas. Committee members shared several potential priority areas to consider, including:

- The allocation of federal resources and equitable access to care.
- Interventions in federally-assisted or subsidized housing settings.
- Racial disparities (irrespective of income).
- The lessons learned from Medicaid-expanded states.
- Novel approaches to expand access to care, such as paraprofessionals.
- The experience of rural families and the complexity of their access to care.
- Health literacy in populations such as rural communities and incarcerated people.

The Chair shared additional priority areas that were discussed outside of the current meeting in individual calls she held with Committee members. These were:

- Wraparound services and models of prenatal care.
- The impact of SDOH.
- Reproductive justice and the impact of reproductive health restrictions.
- Systems changes in adoption and foster care.
- Systems of care to support rural hospitals.
- Expanded data in preterm birth, maternal mortality, severe maternal morbidity, and stillbirth.
- Root cases of disparities and inequities, discrimination, bias and the impact of the political climate.
- Evidence-based and promising practices in communities.
- Money flow with private and public payors.
- Preconception and interconception health care.
- Extreme preterm birth and birth defects.
- Accountability and measures.

Wrap-Up and Considerations

***Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair**

The Chair and Committee members discussed actions and information needed to move forward. These included:

- Narrowing priority areas to topics that resonate with most Committee members.
- Obtaining clarity on the HHS Secretary's priority topics and areas of influence to ensure recommendations are actionable.
- Gaining a better understanding of federal synergy.
- Assessing actions and impact resulting from previous Committee recommendations.

The Chair asked Committee members to review the suggested priority areas, the AI/AN recommendations, and the White House Blueprint for Addressing the Maternal Health Crisis in preparation for their discussion on Day Two.

DAY TWO: Wednesday, June 14, 2023

Call to Order and Review of Day One

***Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair**

The Chair welcomed Committee members and provided an overview of Day One.

ACIMM Priority Focus Areas

***Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair**

The Chair provided a revised list of priority areas that narrowed the previous list into four overarching priorities: 1) the impactful approaches and best practices currently in place to improve maternal and infant health and disparities—both across the nation and within specific communities, 2) systems of care specific to support rural communities, 3) SDOH/social drivers – narrow to a few areas, and 4) the impact of unintended pregnancy at both the individual and systems levels. Committee members suggested adding the fourth trimester as a fifth priority area.

Committee members discussed the first suggested priority area—impactful approaches and practices. It was suggested that both community and federal partners be invited to present on their approaches, data, and outcomes. The Committee could then determine the potential synergy of efforts in place across the country—at both the community and federal levels—to amplify the implementation of those approaches and their outcomes. Other examples of Committee suggestions included:

- Dividing the overarching priority into specific subareas by identifying innovations that worked for specific communities (i.e., rural versus urban) and innovations that would be ready for implementation and scaling.
- Identifying alignment of federal funding approaches (i.e., definitions, deadlines) to reduce grantee burden and extend the value of funds.
- Concentrating the focus on the Black community.
- Considering using this priority area as an umbrella for all of the recommendations to the HHS Secretary.

The Committee then discussed the second proposed priority area—systems of care in rural communities. It was suggested that the Committee focus this priority area on racial disparities, and explore the changing demographics of rural communities, their needs, and the impact on health systems. A Committee member said to leverage knowledge about best practices from rural health programs across the nation. Other Committee suggestions included:

- Seeking to understand the financial and administrative decisions behind hospital closures, and determining the safeguards that bridge systems gaps when a hospital does close.
- Examining the impact of residency and loan repayment options for providers who decided to serve in a rural setting.
- Identifying innovative models to extend tertiary care.

Committee members discussed the third proposed priority area—SDOH and social drivers of health. It was suggested that the Committee leverage the HHS Action Plan to identify gaps or opportunities for elevation, as well as examine how NOFOs (i.e., federal funds) could be used to support addressing SDOH. In addition to a previous suggestion to better understand the impact of Medicaid waivers, other Committee suggestions included:

- Exploring existing, intentional federal collaborations that shared goals and metrics for SDOH and identifying opportunities for other collaborations.
- Looking at clinical-community partnerships to improve access to and delivery of equitable care.
- Understanding the role of trust in the implementation of SDOH approaches.

Committee members discussed the fourth proposed priority area: the impact of unintended pregnancy. It was suggested that the Committee highlight the mechanisms that threatened the ability of women to control their reproductive health in a way that was actionable at the HHS level. The Committee could identify areas with bipartisan support that could be leveraged. A Committee member suggested incorporating the fourth trimester topic under this priority area and identifying approaches with positive outcomes (e.g., expanded Medicaid). Other Committee suggestions included:

- Shifting the wording of this priority to emphasize reproductive justice, intentions, and coercion.
- Focusing on specific populations, such as new Americans, incarcerated people, and people with housing insecurity, who may have barriers to preconception care.
- Understanding the blurred lines between state-level initiatives and policies that affect access to preconception care.
- Identifying the data needed to better understand maternal and infant health disparities (e.g., breast- and chestfeeding outcomes). The Committee could consider convening a group of federal representatives and other stakeholders to obtain consensus on data definitions and gaps.
- Extending maternal morbidity data beyond the hospital to better understand the post-morbid events leading to delivery.

The Chair asked Committee and ex-officio members to consider how these priority areas might be directed into future workgroups.

Partnership Panel: Clinician and Provider Focus

Moderator: *Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair

NACHC and Infant & Maternal Health

***Julia Skapik, M.D., M.P.H.,* Chief Medical Information Officer, National Association of Community Health Centers (NACHC)**

Dr. Julia Skapik provided an overview of NACHC, which aims to promote research-based advocacy, education about the value of health centers, training and technical assistance for health

center staff and boards, and clinical workforce innovation and performance. NACHC had served more than 16.8 million women in 2020, providing prenatal care, delivery services, and contraceptive management. Some of the special programs for mothers included a lead screening program for pregnant women's homes, a patient-centered care program for high-risk individuals, and a collaboration with CDC to track care quality over the postpartum period. One ongoing challenge in these efforts was the lack of high-quality data for pregnancy. Even with targeted efforts to improve these data, at least 50% of records were missing the delivery date that was needed to drive quality of care and decision support.

AWHONN—Infant and Maternal Health Insights
***Jonathan Webb, M.P.H., M.B.A.,* Chief Executive Officer, Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)**

Mr. Jonathan Webb said that AWHONN's mission is to empower their more than 25,000 nurse members to provide care for women, newborns, and their families through research, education, and advocacy. AWHONN strived to reduce racism and bias in maternity care settings, as well as increase diversity, equity, and inclusivity within its organization. The organization developed a dashboard to track progress and increase accountability and transparency. They also offered a perinatal training module, fetal heart rate monitoring training, a maternal-fetal triage index, and a post-birth warning signs guide. Their Respectful Maternity Care Implementation Toolkit provided their nurse members with resources to help them understand their patients' perspectives and create a collaborative, respectful, and inclusive work environment. AWHONN had efforts to diversify the workforce, adopt staffing standards, increase accountability, and track progress of nursing contributions to the birthing process.

American College of Obstetricians and Gynecologists
***Christie Allen, M.S.N., RNC-NIC, CPHQ, C-ONQS,* Senior Director, Quality Improvement and Programs, American College of Obstetricians and Gynecologists (ACOG)**

Ms. Christie Allen reviewed ACOG's work in enhancing the lives of people seeking OB-GYN care, as well as their families and communities. ACOG promotes patient care across the lifespan through the publication of clinical guidelines, provider education, patient education, and population health projects. ACOG had recently released two clinical practice guidelines on the integration of perinatal mental health into patient care, including screening, diagnosis, treatment, and management. ACOG collaborates with partners such as CDC, IHS, and private donors to address public health issues, including fetal alcohol spectrum disorder, immunization and pregnancy, contraception access, and maternal mortality. They had also published a perinatal mental health toolkit for clinicians. Another program described was their HRSA-funded Alliance for Innovation on Maternal Health (AIM), which provided assistance and capacity building for states to implement patient safety bundles to improve maternal health outcomes, such as their recent perinatal mental health conditions bundle and their AIM obstetric emergency readiness resource kit.

American College of Nurse-Midwives
***Karen Jefferson, D.M., C.M., FACNM,* Director of Midwifery Practice, American College of Nurse-Midwives (ACNM)**

Ms. Karen Jefferson talked about ACNM's focus on promoting equity, diversity, and inclusion throughout the midwifery profession. She reviewed the role of certified nurse midwives (CNMs) and certified midwives (CMs) and stated that the midwifery workforce was underutilized in the U.S. ACNM invested in a workforce study to create state-specific models to increase the number of midwives, identify barriers to entry, and investigate reasons for the high attrition rate. ACNM was also working to increase racial diversity in the midwifery workforce through its Access to Equity and Midwifery Education and Care Program that fostered diversity by promoting midwifery in Historically Black Colleges and Universities (HBCUs). The organization also supported the passage of the Midwives for Maximizing Optimal Maternity Services (MOMS) Act and helped draft the Black Maternal Momnibus Act of 2023 to include funding for midwifery education. ACNM also partners with ACOG and other AIM organizations to create guidelines—adding the voice of midwives to the conversation and contributing to systems-level changes.

Promotion of Maternal and Child Health in Pediatric Care Settings to Prevent Infant Mortality
***Debra B. Waldron, M.D., M.P.H., FAAP,* Senior Vice President, Healthy and Resilient Children Youth and Families, American Academy of Pediatrics (AAP)**

Dr. Debra Waldron reviewed AAP's initiatives to combat infant and maternal morbidity and mortality through clinical practices, community activities, and state and national advocacy. AAP sought to address the impacts of racism and eliminate race-based medicine in clinical practice guidelines. AAP's HRSA-funded Bright Futures program provided guidelines for all pediatric preventive care screenings and well-child visits towards preventing infant mortality and morbidity. Some of AAP's other initiatives included policies and standards to improve neonatal outcomes, an emphasis on the benefits of breast- and chest-feeding toward reducing infant mortality, education for parents and caregivers on the importance and safety of immunizations, and recognizing the significant role of early relationship health in promoting strong bonds between mothers and infants.

Discussion

- A Committee member asked about other national organizations that AAP works with, such as AAFP. They also asked about innovative ways to increase reimbursement for maternity care visits, similar to the pay structure for annual wellness visits, and whether there could be a transition of care management visit that required access to delivery data.
    - Dr. Skapik stated that there was a requirement to provide a discharge notification, but that the requirement was often not adhered to. There was currently no standardization for the birth encounter data and there was often no entry area for it in electronic health records. NACHC had advocated for policies that supported transitions of care in health centers. The transition period was an important time because data showed that more than 50% of maternal deaths occurred in the postpartum period. In terms of reimbursement, Dr. Skapik suggested that HRSA could advocate for increased funding and accountability for the transition period. She highlighted some of NACHC's partnerships with family doctors, midwives,

and obstetricians. Dr. Waldron added that AAP worked closely with AAFP and collaborated with them on Bright Futures.
    - Ms. Allen said that ACOG also maintained a partnership with AAFP during the development of all ACOG resources. ACOG also collaborated with IHS and provided indigenous health training. She emphasized that ACOG prioritizes reimbursement for prenatal and postpartum care across the continuum. Since the organization expected providers to address SSDOH, it also worked to ensure reimbursement for that work.

- A Committee member suggested that high schools could be a pathway for reaching students who might be interested in becoming doulas and midwives. They also expressed the importance of advocating for the inclusion of the fourth trimester into Medicaid and commercial insurance.
    - Mr. Webb added that community colleges were another good direction to diversify the workforce.

- A Committee member commented on the importance of nurse workload in terms of providing quality maternity care and addressing health disparities.

- A Committee member suggested that the panelists would be very insightful as members of the Committee's future workgroups.

- A Committee member asked how to break health system siloes and bridge obstetrics and pediatrics to ensure that an infant had a medical home.
    - Dr. Skapik answered that community health centers have that bridge built in, although there has been a recent trend of hospital-based systems pushing pediatric patients into their own hospital-based pediatric practice rather than community-based care where those records can be linked. It was critical to have a model of care that combined those records so that risk patterns could be detected, especially among high-risk patients from vulnerable social situations.
    - Ms. Jefferson encouraged working with health centers and suggested that there could be different kinds of group prenatal care. For instance, a pediatric provider could attend prenatal group care or the midwife team could shift to the family practice or pediatric team.

Partnership Panel: Policy Focus

Moderator: *Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair

Improving Infant and Maternal Health
***Jennifer Moore, Ph.D., RN, FAAN,* Founding Executive Director, Institute for Medicaid Innovation (IMI)**

Dr. Jennifer Moore talked about IMI's research and policy efforts to improve the lives of Medicaid enrollees. The organization conducted a wide range of activities including research and educational initiatives, and recently published an Issue Brief on Community Priorities in Women, Gender, & Maternal Health. IMI conducted focus groups and surveys with various

Medicaid stakeholders, which found that maternal mental health ranked as the number one priority topic across policymakers and maternal health leadership. They also found that individuals with lived experience and community-based organizations prioritized chronic conditions, sexual and reproductive justice, violence, caregiver roles, housing, unmet mental health needs in the criminal justice system, delayed care, and community-based maternal health. Individuals with lived experience and community-based workers did not like the terms *social determinants of health* and *equity*, preferring instead to use *social needs* and *justice.* IMI recently conducted a national environmental scan on Innovations in Perinatal and Child Health in Medicaid that covered several themes including perinatal community health, home visiting, maternal opioid use, and the integration of community in perinatal and child health design.

State Legislatures Efforts to Reduce Infant and Maternal Mortality
***Tahra Johnson, M.P.H.,* Director, Health Program, National Conference of State Legislatures (NCSL)**

Ms. Tahra Johnson provided an overview of MCH activities at NCSL, a bipartisan membership organization that represents state legislators to promote policy innovation and cross-communication. One of NCSL's activities was the Maternal and Child Health Fellows program. Participating legislators learned from peers and health experts about the different MCH priorities and policies being considered in their state. Ms. Johnson reviewed the state legislators' five key priority areas, which were 1) the maternal care workforce, 2) maternal mortality, 3) maternal mental health, 4) infant mortality, and 5) newborn screening. Specifically, legislators were interested in expanding doula services, midwifery licensing and practice scope, provider bias training, improved services and access to care, and maternal mortality data. They also prioritized maternal mental health and substance use, infant mortality, increased access to care in rural communities, and newborn screening. NCSL tracked nearly 100 enacted bills over the last two sessions to identify common MCH trends. Notable 2023 legislation included Texas recognizing September 23, 2023 as the Fourth Trimester Care Day and Mississippi extending Medicaid coverage to 12 months postpartum.

Governor's Maternal and Child Health Initiatives
***Brittney Roy, M.P.A.,* Program Director, Public Health, National Governors Association (NGA)**

Ms. Brittney Roy talked about the NGA's role in improving MCH. NGA serves 55 governors across the nation, offering technical assistance, policy creation recommendations, and stakeholder convenings. NGA recently hosted roundtable discussions and was preparing a set of practical recommendations to assist states in their implementation of policies and practices to improve MCH. These included recommendations on public health infrastructure modernization, data modernization, and accountability practices. Specifically, NGA was considering Medicaid and other payor systems to improve public health. NGA works closely with community-based organizations and engages Black, Hispanic, and AI/AN communities. NGA was also leveraging lessons learned from the COVID-19 pandemic to promote accountability and systems reform.

Discussion

- The Chair asked how NGA gains support from other governors for the priority area they choose each year and whether governors had other options.
    - Ms. Roy said that governors have options. Governors do work to gain support on their priorities and tend to work well together to identify what can be operationalized. It was also important that NGA's recommendations were vetted with advisors and policy directors to ensure that the recommendations were operational.

- Dr. Warren commented on the challenge of identifying solutions at the federal level when solutions often differed across states. He asked for clarification on the newborn screening priority.
    - Ms. Johnson said that there had been several states introducing bills to align their newborn screening program with the RUSP. The newborn screening process could be complex and there were differences across states in their ability to implement screening for all recommended conditions. At the January 2023 NCSL meeting, legislators were interested in children's health screening and several states had introduced legislation to increase access to certain screens.

- A Committee member asked whether IMI and the Center for Medicare and Medicaid Innovation (CMMI) collaborated, specifically in terms of system delivery and payment innovation.
    - Dr. Moore said that IMI met regularly with federal colleagues, including CMMI. IMI will be hosting a Medicaid Maternal Health Policy Summit in partnership with the Aspen Institute in September 2023. The summit would bring together federal and state Medicaid colleagues, provider groups, advocacy groups, community-based organizations, and people with lived experience to discuss core areas, one of which included maternal health. The summit would address policy strategies in workforce, payment, data, and quality health systems. Additionally, IMI and their colleagues were tracking the upcoming presidential election in 2024 to ensure there was stability in these priority areas during a potential transition.

- A Committee member asked if there were any themes across states related to the Momnibus bills.
    - Ms. Johnson said that Delaware and New Jersey supported robust legislation that included workforce. Other priority areas included pay and family leave and the availability of quality data to understand racial disparities.

Public Comment

***Vanessa Lee, M.P.H.,* DFO, ACIMM**

The DFO introduced three individuals to provide additional public comment.

David Kennedy, past president of the International Academy of Oral Medicine Toxicology, highlighted two major health risks for infants and mothers: mercury exposure from maternal dental fillings and fluoride exposure from tap water. He recommended ending the use of fluoride

in tap water and promoted purified water and a compound to remove heavy metals for pregnant women.

Emily Price, CEO of the nonprofit Healthy Birthday, Inc., called for greater attention to stillbirth, noting that stillbirth claims more lives annually than infant mortality. She talked about the organization's successful Count the Kicks program in Iowa, which led to significant reduction in their stillbirth rate. Ms. Price urged the Committee to prioritize stillbirth prevention in their discussions.

Jackie Campbell from the Johns Hopkins University School of Nursing addressed the rise in intimate partner violence (IPV) and homicide, both during and outside of pregnancy. She underscored the need for culturally appropriate IPV assessment, "safe staying" for pregnant women who want to stay with their partner, and gun locks for mothers before they leave the hospital.

Next Steps and Assignments

***Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair**
ACIMM Members

The Chair presented three priority areas based on the Committee's discussion earlier in the day:

1) rural health (i.e., residency and loan repayments, levels of care, deserts, and hospital closures);
2) SDOH/social drivers of health (i.e., housing, Medicaid waivers); and
3) preconception/interconception health and healthcare, including reproductive justice and the fourth trimester.

She invited Committee members to provide feedback on these priority areas. Committee members agreed on the three priority areas, and discussed whether the priority areas should be centered on Black maternal and infant health, similar to the focus on AI/AN birth outcomes in the last set of Committee recommendations. Committee members agreed on this new population of focus, and proposed three overarching themes across each priority area:

- Looking for impactful approaches, "bright spots", and best practices.
- Considering financial aspects of any recommendations made such as cost, value, payor models, and funding.
- Identifying any data challenges such as the availability of quality data and data modernization approaches.

The Chair then asked Committee members to think about which priority topic area they wanted to work on and to volunteer to lead a workgroup for each of the three priority areas. She expressed hope that the Committee could have an additional meeting in September and that the workgroups would meet virtually before that September meeting.

Meeting Evaluation and Closing Observations

***Belinda D. Pettiford, M.P.H,, B.S., B.A.,* ACIMM Chair**

The Chair invited the DFO to provide operational updates. These were:

- The renewal package for the Committee's charter was moving forward and on track for renewal by September 30, 2023.
- HRSA was still working on getting new Committee members approved and appointed.
- An ex-officio member from the Department of Labor was slated to start soon, and HRSA was in process of identifying an ex-officio member from the Substance Abuse and Mental Health Services Administration (SAMHSA).
- At the request of the Chair, HRSA would look into whether a one-day virtual Committee meeting in September 2023 would be possible.
- The tentative dates for the next Committee meeting were December 4 and 5, 2023. The December meeting would be held in St. Louis, Missouri or virtually, depending on the weather.
- Committee meetings for 2024 were tentatively bookmarked for March and June.

Adjourn

***Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair**

Ms. Pettiford adjourned the meeting at 2:00 p.m. ET.