

# **Advisory Committee on Infant and Maternal Mortality**

**Meeting Minutes of June 14-15, 2022**

**Virtual Meeting via Zoom**

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## **DAY ONE: Tuesday, June 14, 2022**

### **Welcome and Call to Order**

**Lee Wilson, Acting Designated Federal Official, ACIMM**

**Edward Ehlinger, M.D., M.S.P.H., ACIMM Acting Chair**

Mr. Lee Wilson called the Advisory Committee on Infant and Maternal Mortality (ACIMM) to order and welcomed participants. He announced that Ms. Vanessa Lee has returned from maternity leave and will resume her role as Designated Federal Official following this meeting. Committee members whose terms were set to expire in June 2022 have had term extensions approved to participate in the September 2022 Committee meeting and finalization of recommendations to HHS. Mr. Wilson thanked Dr. Jeanne Conry and Dr. Paul Wise, whose terms will be ending before the September meeting, for their guidance and service to the Committee.

Dr. Edward Ehlinger thanked Ms. Anne Leitch and the Maternal and Child Health Bureau (MCHB) team for their support.

### **Introduction of ACIMM Members**

**Edward Ehlinger, M.D., M.S.P.H., ACIMM Acting Chair**

Dr. Ehlinger talked about *backcasting*, a planning method that starts with defining a desired future and working backwards to identify the policies and programs needed to connect the present to that desired future state. Dr. Ehlinger asked Committee members to consider the goals they hoped to attain, and the actions needed to get there. He asked members to introduce themselves by filling in the blank after the phrase, “what will it take to…” with their public health goal.

**Dr. Ehlinger** is the former Director of Maternal and Child Health at the Minneapolis Health Department and former Commissioner of Health in Minnesota. He asked: what will it take for ACIMM to develop a set of powerful, strategic, and impactful recommendations related to the health of First Nations and Indigenous mothers and infants? His answer was that it would take the involvement, commitment, and prioritization of time from every Committee member.

**Dr. Sherri Alderman** is a developmental and behavioral pediatrician in Portland, Oregon. She asked: what will it take to address the unacceptable disparities in the health and wellbeing of children? Her answer was that it would take our society realizing the rights of all children in our country and around the world.

**Dr. Steve Calvin** is a maternal-fetal medicine specialist in Minneapolis, Minnesota. He asked: what will it take for a more coherent and responsive maternity and newborn care system? His answer was that ACIMM needs to continue its work to develop team-based care models that include physicians, midwives, doulas, community health workers, nurses, and all concerned to provide care in a way that meets the needs of both urban and rural populations.

**Dr. Kathryn Menard** is a Distinguished Professor of Obstetrics and Gynecology at the University of North Carolina at Chapel Hill. She asked: what will it take to ensure that every pregnant and postpartum person can access high-quality, holistic, and well-coordinated care that

is appropriate and tailored to her medical and cultural needs and preferences? Her answer was that those with an uncomplicated pregnancy should receive comprehensive quality care delivered in and by their community and those at high-risk of pregnancy complications should receive well-coordinated multidisciplinary care that they deserve in a location or facility that is prepared to meet the mother's and infant's needs. This will require the collaboration of clinical and public health colleagues, policymakers, and payers.

**Dr. Joy Neyhart** is a primary care pediatrician with the Southeast Alaska Regional Health Consortium, a tribal health organization. She asked: what will it take to reduce poor outcomes for all families? Her answer was that for outcomes such as mortality, school failure, substance use, poverty, incarceration, domestic violence, and suicide, there is already evidence that can be used to appropriate funds for services for pregnant people and in early childhood. It is known that every dollar spent on these services results in \$6-10 saved. Using the evidence to support these services would improve lives for all children and all families.

**Dr. Janelle Palacios** is a nurse midwife, researcher, and consultant in ancestral Pomo and Miwok lands in Northern California. She asked: what will it take to improve the health and wellbeing of all people in the Nation? Her answer was that it would take seeing one another, not as "other," but as neighbors, families, friends, and humans. A step toward this goal is for the Nation to address its history, to promote healing and understanding that will serve to change policies and foster general kindness to all fellow humans.

**Dr. Magda Peck** is Founder and Principal of MP3 Health Group and Adjunct Professor of Pediatrics at the University of Nebraska Medical Center. She asked: what will it take for research and local, state, national, and tribal data to be more visible, valued, timely, trusted, available, and used to prevent mothers and babies from death and disability and to eliminate persistent inequities? Her answer was that this will require three approaches. First increased investments are needed for more robust data, research methods, and innovative technologies that will augment shared knowledge and understanding and serve to assure that everyone counts and is counted. Second, strategic storytelling is needed to shape and drive more powerful narratives based on sound science and lived experience that will change hearts and minds to compel social change. Third, collaborative, courageous leadership is needed to provide the wisdom to make difficult decisions based on incomplete, and sometimes imperfect, information.

**Ms. Belinda Pettiford** is Head of the Women's Health Branch at the North Carolina Division of Public Health. She asked: what will it take to prioritize and listen to communities with lived experience in moving this work forward? Her answer was that it requires involvement from specific communities, such as members of the Legislative Black Caucus. These efforts will highlight the specific needs of these communities and what efforts are needed.

**Dr. Marie Ramas** is a family physician and current President of the New Hampshire Academy of Family Physicians. She asked: what will it take to make the health care delivery system better? She answered that it will require system-level recognition of the humanity in each person within the community.

**Ms. ShaRhonda Thompson** is a community advocate. She asked: what will it take to eliminate all racial disparities? She answered that the first step would be training during medical school to teach medical students to view people as a whole person instead of as a race. Training is needed to eliminate mistaken beliefs, such as higher pain tolerance in African Americans. Medical students should also be listening to real life stories and members of the community.

**Dr. Jacob Warren** is a health equity epidemiologist and will soon be the Dean of the College of Health Sciences at the University of Wyoming. He asked: what will it take to make sure that all people can receive quality, accessible prenatal care? His answer was to work across all ideologies and perspectives to find a common thread of humanity and recognize that access to prenatal care is a human right.

**Dr. Michael Warren** is Executive Secretary of ACIMM and the Associate Administrator for MCHB at the Health Resources and Services Administration (HRSA). He asked: what will it take to get to infant health equity by 2030? The Healthy People goals have never been achieved for Black and Brown babies in the United States. Disparities persist and the number of deaths needed to be prevented to achieve equity is 3,700 each year. His answer was that a focused effort is needed in communities where excess deaths are highest, which will require a commitment to do things differently because what has been done has not closed the gap. There is also a need for an aligned effort to address underlying social and structural determinates of health by requiring this focus in funding programs and through partnerships.

**Dr. Paul Wise** is a professor of child health at Stanford University. He asked: what will it take to prioritize communities? His answer was that more discretionary funding is needed to allow community groups to take more risks and to focus more on their own priorities rather than their funder's priorities.

Dr. Ehlinger invited other members of the Committee staff and ex-officio members to introduce themselves.

## **Approval of Minutes**

The Committee unanimously passed a motion to approve the Minutes of the March 2022 meeting.

## **Setting the Meeting Context**

### ***Edward Ehlinger, M.D., M.S.P.H., ACIMM Acting Chair***

Dr. Ehlinger talked about two recent sets of recommendations that the Committee submitted to the Secretary. In June 2020, the Committee submitted final recommendations to address the [effects of the COVID-19 pandemic on mothers and infants](#). In August 2021, the Committee submitted recommendations that outlined [five strategic areas](#) to guide policy, investment, and support for equitable maternal and infant health. Of these five strategic areas, two were ardently led by the advocacy of two Committee members. Dr. Ehlinger emphasized the ability of Committee members to move an agenda forward.

Among these recommendations was guidance to increase the overall funding to the Indian Health Service (IHS) to improve Indigenous maternal and infant health outcomes. Further Committee discussion led to the realization that the topic was too broad and complicated to address in one meeting. The Committee therefore initiated a year-long examination of the issues that Indigenous mothers and infants face.

While American Indians and Alaska Natives (AI/AN) have experienced some of the worst birth outcomes in the United States, there has been some question about the wisdom of focusing so much attention on one small population. To address this hesitation, Dr. Ehlinger referred to Julia Lathrop, the first Chief of the Children's Bureau, which was established in 1912 and was the forerunner of today's MCHB. On page six of Julia Lathrop's [first annual report](#) of the Children's Bureau, she indicated that "[...] the greatest service to the health and education of [all] children has been gained through efforts to aid those who are [handicapped]. Thus, all services to the handicapped children of the community [...] also serves to aid in laying the foundations for the best service to all the children of the commonwealth."

Dr. Ehlinger explained the context of the term "handicap," which, today, often refers to a person who is restricted by some condition or characteristic. However, from the population perspective, "handicap" does not describe the characteristics of an individual, rather the impact of a society's actions on a population. In the dictionary, the word "handicap" can be an adjective to describe a disadvantage by external forces, a noun to describe circumstances that make progress or success more difficult, or a transitive verb to describe the implementation of a policy or procedure that puts an individual or group at a disadvantage.

For too long, challenges faced by Indigenous populations have used the disease or deficit focus, which places responsibility on the individual and considers only the actions of the individual as solutions. Dr. Ehlinger proposed that the focus should be on the policies, structures, systems, and stereotypes fostered and sustained by the broader society and have systematically held back the population of First Nations and Indigenous communities. It is from the population perspective that the Committee has focused its attention over the last year.

The Committee has begun drafting recommendations in consultation with First Nation communities and with guidance from reports and articles written by native authors and researchers. Dr. Ehlinger stated the current plan is for the September 2022 Committee meeting to be held on tribal lands in Minnesota. First Nations and Indigenous populations and organizations will be in attendance to provide feedback on the draft recommendations towards development of a final report of recommendations for the Secretary. Dr. Ehlinger asked: What will it take to achieve equity and social justice for all people? He argued that it would take the involvement, commitment, and prioritization of time from every Committee member to achieve this vision.

To introduce the Committee's next discussion on sudden infant death syndrome (SIDS) and sudden unexpected infant death (SUID), Dr. Ehlinger referenced the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development's [Healthy Native Babies Project](#). He read an excerpt from the report, stating "American Indians and Alaskan Native people experienced SIDS and sudden unexpected infant deaths or SUID more than any other racial or ethnic group nationwide. Consistently high rates of SIDS/SUID among the American

Indian/Alaska Native population show that risk reduction efforts are not addressing the most critical factors, are not reaching AI/AN communities, and are not presented effectively for American Indian/Alaska Native people.”

## **SIDS/SUID in Indigenous Communities**

*Charlene Collier, M.D., M.P.H., M.H.S., FACOG, (Moderator), ACIMM Member*

### **Sudden Unexpected Infant Death (SUID) Prevention Investments**

*Diane Pilkey, RN, M.P.H., Senior Nurse Consultant, MCHB*

*Maureen Perkins, M.P.H., Public Health Analyst, MCHB*

Ms. Diane Pilkey provided detailed information about SUID. Approximately 3,400 infants die unexpectedly each year from SUID, which can include SIDS, accidental strangulation or suffocation in bed, or unknown causes. Between 1990 and 1999, public health messages to encourage placing infants on their back to sleep have resulted in a significant decline in SUID. However, for the past 20 years, the rates of SUID have remained essentially unchanged.

Ms. Pilkey described SUID programs within MCHB. The Title V Block Grant programs in 36 states and jurisdictions have included a measure for safe sleep environments. These programs report on data from the Pregnancy Risk Assessment Monitoring System ([PRAMS](#)) that includes safe sleep indicators such as the percent of infants placed to sleep on their backs, on a separate approved sleep surface, and/or without soft objects or loose bedding.

The [National Center for Fatality Review and Prevention](#) has a cooperative agreement to increase the capacity of [Child Death Review](#) and [Fetal Infant Mortality Review](#) teams in their collection of high-quality, standardized data in order to make recommendations to prevent future deaths. The [National Center for Fatality Review and Prevention Case Reporting System](#) provides standardized forms for 47 participant states to enter case data and summarize findings. A subset of these data that includes 104,823 infant deaths (28,110 of which were SUID) are available for researchers. The CDC funds the National Center for Fatality Review and Prevention to provide data collection to [CDC SUID Registry](#) grantees. Beginning in July 2022, new expansion funds will be available to enhance support to states, communities, and tribes.

Through a cooperative agreement with the Education Development Center, MCHB also funds the [Children’s Safety Network](#) to support the work of MCHB Title V and state injury prevention programs to reduce fatal and serious injuries through the adoption of evidence-based policies, programs, and practices within MCHB priority areas and performance indicators. Their [Child Safety Learning Collaborative](#) has implemented SUID collaboratives with 10 states to advance evidence-based policies, programs, and practices through training and technical assistance. Among their accomplishments are 241 hospitals or birthing facilities that provided safe sleep training to health care providers, 48 home visiting programs that distribute safe sleep educational materials, and 52 organizations that have implemented evidence-based safe sleep campaigns.

Ms. Maureen Perkins said that most of MCHB’s work on SUID prevention is informed by the report [SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment](#) from the American Academy of Pediatrics Task Force. The [Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep](#)

[Environment](#) was published in June 2022 and will continue to inform MCHB’s work. Even with these national recommendations, there is variation in SUID rates across states. These disparities may be attributed to poor pre-pregnancy health, high rates of tobacco use, differential access to quality care, socioeconomic inequities, structural racism, and a lack of programs and policies to support new parents.

Ms. Perkins reviewed some of MCHB’s previous efforts to prevent SUID. In 2014, the Bureau funded the Safe Infant Sleep Systems Integration Program that established a national coalition called National Action Partnership to Promote Safe Sleep. In 2017, MCHB funded the [National Action Partnership to Promote Safe Sleep Improvement and Innovation Network](#) that expanded the 2014 coalition and added a quality improvement component. The coalition is also responsible for the [National Action Plan to Increase Safe Infant Sleep](#).

Ms. Perkins reviewed a [study](#) from a researcher at MCHB that showed that caregivers generally receive information from their pediatric provider about safe sleep practices, such as back sleeping. They are less likely to receive other information, such as placing an infant to sleep in a crib, reducing clutter in sleep spaces, or room sharing without bed sharing. Different approaches are therefore needed to help providers educate infant caregivers more fully.

On July 1, 2022, MCHB will launch its new SUID Prevention Program to reduce racial/ethnic disparities in SUID. The program will provide support for pediatric practitioner education on culturally responsive care and system improvements; the use of data, findings and recommendations from the Child Death Reviews and Fetal Infant Mortality Reviews; and implementation of Community Action Teams.

### **Unexpected Death: Alaska Native and American Indian Infants**

#### ***Abby Collier, M.S., Director, The National Center for Fatality Review and Prevention***

Ms. Abby Collier provided more information on the [National Center for Fatality Review and Prevention Case Reporting System](#), which is used in 47 states for Child Death Review and in 18 states for Fetal Infant Mortality Review. Each state uses the case reporting system a little differently, with some states entering only some data and others entering all available data. Despite this reporting variability, the dataset is unique and can be a valuable resource. Data from the case reporting system is available for research and has been used in several published journal articles and reports.

Ms. Collier reviewed their research data file, which comprises case reporting system data from states that have granted data sharing permission. These data include 28,110 infant deaths entered between 2005 and 2018, of which 866 represented AI/AN infants. In their initial analyses, they found that AI/AN infants were overrepresented in the multiracial group. To better reflect the risk in AI/AN infants, they included AI/AN infants regardless of whether another race was also listed. Missing and unknown variables were not included in their analyses and were most often missing for postpartum visits, infants born drug-exposed, and infants experiencing neonatal abstinence syndrome.

Ms. Collier reviewed findings from their analysis of the research data file. Of infants with a history of maltreatment, 21.9 percent were AI/AN as compared to 12.2 percent of all other races.



Of infants with overheating indication, 8.4 percent were AI/AN as compared to 4.2 percent of all other races. Of infants who were breastfed, 70.9 percent were AI/AN as compared to 57.1 percent of all other races. Of infants who were born weighing less than 2,500 grams, 16.3 percent were AI/AN as compared to 21.9 percent of all other races.

Their data analysis also showed little difference in smoke exposure *during* pregnancy between AI/AN infants (49.3 percent) and all other infants (48.8 percent). However, smoke exposure *after* delivery was higher among AI/AN infants (60.3 percent) as compared to all other infants (49.8 percent). There was little difference in infants placed in a new sleep environment between AI/AN infants (23 percent) and all other infants (21 percent). In terms of the American Academy of Pediatrics recommendation for room sharing but not surface sharing, there was little difference between AI/AN infants (14.9 percent) and all other infants (16.4 percent). There was also general consistency across races in terms of the sleep surface. However, the percentage of infants placed to sleep in an adult bed was higher among AI/AN infants (60 percent) than all other infants (54 percent).

Ms. Collier talked about the challenges of data quality in fatality review reporting. She said that there were two ways in which these data can be improved. First, there needs to be consistent access to records across the United States. Second, there need to be resources to support data collection and data entry. Jurisdictions that are funded for fatality review reporting have drastically improved data quality and completeness.

### **Insights on Safe Infant Sleep in Native Communities**

#### ***Shira Rutman, M.P.H., Miami Environmental & Energy Solutions***

Ms. Shira Rutman reviewed the [Healthy Native Babies Project](#), which gathered insight on safe infant sleep from 16 key informant interviews conducted between July 2020 and May 2021. The interviews took place in tribal organizations, hospitals, IHS sites, urban Indian programs, and university- and state-based agencies that serve AI/AN individuals. She reviewed some of the insights from these interviews, including emphasizing the systemic risk factors for SIDS in AI/AN communities and the recommendations for future action.

Ms. Rutman shared more detail about the common challenges identified from their informant interviews. The built environment presents several challenges. Native families typically live in multigenerational homes, which may not provide a place for infants to safely sleep. There may be challenges when living with elder family members who do not want to comply with a smoke-free environment. Native families may lack the resources and space needed to create a safe sleep environment. Young parents may experience housing insecurity, temporarily moving from one home to another among their extended family, and potentially limiting access to a crib. The COVID-19 pandemic exacerbated these housing issues.

Barriers to health care was another common challenge. There may be limited access to prenatal and obstetric care in tribal areas, necessitating travelling long distances for care. When care is received, it is often with different clinicians, who are limited in the time they provide, and who may offer inconsistent messages. Cultural insensitivity and racial incongruence are other barriers to health care that can lead to a lack of uptake in safe sleep practices. For instance,

recommendations from a non-AI/AN provider may be interpreted as a suggestion that traditional cultural practices are inadequate.

Ms. Rutman shared recommended approaches the informants identified for addressing these challenges. Risk-reduction approaches can help focus on reducing potential harm and meet families where they are without resulting in feelings of shame. Patient-centered approaches are those that are driven from the individual's needs and desired health outcomes and can encompass not only clinical considerations, but also emotional, mental, spiritual, social, and financial perspectives. This is a holistic approach that may be aligned with Native traditions.

Informants also recommended early and consistent timing of education, starting from the prenatal period and continuing until the family leaves the hospital. Birth workers, such as midwives and doulas, can also be utilized to continue conversations about harm reduction and support. Extending education to fathers and extended family can help create a supportive environment. Educators and care providers often need support as well, for example, collaboration between providers and organizations through support forums, ongoing professional development, and referral systems to promote continuity of care.

Ms. Rutman reviewed the strengths of traditional and cultural factors that can support safe infant sleep. Tribal families are supported through the strength of their extended family and community members, who often take an active role in raising children. Social support through community events and support groups can promote connection with other families in the same phase of life and a platform for safe sleep and harm reduction messaging. Safe sleep practices can incorporate traditional and cultural practices. For instance, cradleboards are a traditional practice that helps keep the infant safe, secure, and comfortable. There are more than 500 tribes in the United States, each with unique cultures and traditions. It can be challenging to understand all of the unique aspects of the tribes. Seeking to provide culturally-specific care by tailoring care to communities and individuals can help build connection and overcome barriers. Ms. Rutman emphasized the need to listen to and build on the strengths of the communities.

## **Discussion**

Dr. Peck asked about the disconnect between contextual data that come from the fatality review systems and qualitative data that come from experts and people with lived experience. For instance, there was a lot of insight about issues of housing from the expert interviews that was not collected in MCHB Title V performance indicators or in fatality review data collection. Dr. Peck reflected on previous presentations from the Department of Housing and Urban Development (HUD) and the challenges in linking housing and health data. Ms. Pilkey responded that the National Center for Fatality Review and Prevention has been making efforts to add questions to the case reporting system about life stressors. Dr. Warren added that MCHB has a relationship with HUD to address maternal and infant health. MCHB also has a workgroup of federal partners, including HUD, addressing infant mortality and the goal to reach infant health equity by 2030. He said that housing data indicate that the time in people's lives in which they are most likely to be unhoused is the first year of life—an insight to consider going forward.

Dr. Neyhart appreciated the inclusion of community members in this effort and asked if a similar effort could be used to engage community members in Alaska. Ms. Rutman said that, as an ally

of Native communities, she can only do this work in partnership with the communities and through the sharing of their voices. There is an Alaskan Native on their team and Ms. Rutman will connect with her about the opportunity to extend their effort to Alaska.

Dr. Menard asked how to reconcile the need to meet the broad diversity of more than 500 tribes with recommendations, policies, and best practices for cultural sensitivity training. Ms. Rutman answered that the diversity across tribes is no more unique than the diversity across any other cultural community. Some families or communities maintain traditional practices, and others less so. Some families seek connection to those practices even if they had not grown up with them. There are opportunities to engage partners in the design and implementation of interventions and policies for diverse tribal people. For instance, the [Urban Indian Health Institute](#) is one of several tribal epidemiology centers funded by IHS that can act as a regional partner. It is important that policies and interventions are addressed not only at the national level, but also at the regional level. There are some recommendations that may be relevant across Native people and others that are more specific to a community. Therefore, a combination of national and regional partnerships can be effective. It is important to not use the wide diversity of tribes as a reason not to take the steps needed to develop culturally sensitive approaches. Ms. Rutman also referenced the 2018 [Broken Promises](#) report from the United States Commission on Civil Rights that includes a section of recommendations on housing issues among Native Americans.

Dr. Palacios wondered what other variables are needed in the fatality review data collection that will address the social determinants of health that contextualize infant safety. While it was informative to see data about maltreatment or violence in the home, that does not represent a full picture of the many other relevant variables. Sometimes data, such as co-sleeping practices or smoke exposure, can seem to place the blame on the family. The blame is sometimes placed on race, when it is the racism that creates the risk factors. There is structural context to these variables that needs to be understood and addressed. Ms. Collier answered that there is a section called “Life Stressors” in their form that addresses contextual factors such as housing instability, neighborhood violence, welfare, or juvenile justice. The most recent version of their form includes a new section on medical life stressors. They would welcome feedback on expanding these sections, especially from people with lived experience.

Dr. Ehlinger pointed out the discordance in the narrative that focuses on the social factors that impact SUID and SIDS but then recommends patient-centered care as a solution. There should be a focus on community-centered care. Guidance and recommendations tend to present SIDS/SUID as an individual problem when it is actually a community problem that encompasses housing, environmental contaminants, economic insecurity, and racism. There should be consideration for changing this narrative to address quality care within the context of the community.

Dr. Peck asked about the demographics of the Child Death Review and Fetal Infant Mortality Review teams and if they include tribal members and Indigenous people who could bring lived experience and perspective. She also asked if any data were being captured on family and community strengths, given how important that perspective was in Ms. Rutman’s presentation. Ms. Collier answered that participation on the mortality review teams is variable and she will ask Dr. Peck’s question at their next national meeting. Two years ago, they modified their form to

address risk factors as well as protective factors. Dr. Peck recommended that the questions on protective factors aim to capture the specific strengths of AI/AN communities, and that HRSA seek expert input on the development of such questions. This may also inform MCHB Title V performance measures toward an alignment of these data.

## **Federal Updates**

### ***Lee Wilson, Acting Designated Federal Official, ACIMM***

Mr. Lee Wilson provided an update on MCHB activities. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Innovation Awards have been [announced](#). These awards represent approximately \$16 million to strengthen seven MIECHV programs in eight different states by advancing data and technology innovations with a focus on addressing health disparities. A [funding announcement](#) for the State Maternal Health Innovation & Data Capacity Program had been released to provide \$9 million to expand the program into additional states. This program supports state-level development and implementation of strategies to improve maternal health and health disparities. The application deadline has closed, and awards will be made at the end of fiscal year 2022.

On May 8, 2022, HRSA launched the [1-833-9-HELP4MOMS National Maternal Mental Health Hotline](#). The confidential hotline provides 24/7 culturally sensitive support, referrals, and information. Counselors speak both English and Spanish and there are interpretation services for many other languages. The launch of the hotline has been phased to ensure that security measures and systems are in place as awareness and use of the system grow. The launch has been going well, with much lower wait times than compared to industry standards. Mr. Wilson said that HRSA is developing outreach materials to raise awareness of the hotline and will continue to ramp up.

HRSA and other federal agencies issued a [joint letter](#) on May 25, 2022 to encourage states, tribes, and jurisdictions to prioritize and maximize their efforts to strengthen children's mental health and wellbeing, as well as to outline federal agency plans to support and facilitate state-level coordination. A [funding announcement](#) was released for Healthy Start supplemental funding to increase the availability of community-based doulas through training and the promotion of doula services as a profession. Another [funding announcement](#) was released for the Catalyst for Infant Health Equity program to support the implementation of existing action plans that apply data-driven policy and innovative systems strategies to reduce infant mortality disparities. The Women's Preventive Services Guidelines committee has launched its 2022 review to update guidelines on diabetes during pregnancy and postpartum. There is a [rolling open period](#) for individuals to submit recommendations for other guideline reviews.

Mr. Wilson invited Dr. Michael Warren and other ex-officio members to provide updates.

Dr. Warren provided an update on the current shortage of infant formula. There has been a cross-government group that includes representation from the White House and the Department of Health and Human Services (HHS) agencies. Some of the actions that have been taken to address the shortage include launching [Operation Fly Formula](#) to bring formula from other countries into the United States, invoking the [Defense Production Act](#) to ensure there are no barriers to supplies needed for formula manufacturers, and establishing an [HHS website](#) to provide information to

families and providers. MCHB has also been sharing input that it has received from Title V state grantees and for participants in listening sessions at the [Association of Maternal & Child Health Programs \(AMCHP\)](#). These insights help HRSA understand the different challenges related to infant formula across states and territories. MCHB has also provided information to grantees to share with families and providers. HHS has participated in several public webinars on the formula shortage. For example, HHS Assistant Secretary Admiral Rachel Levine participated in a Moms Rising [roundtable discussion](#), and MCHB will participate in upcoming webinars with a parent advocacy organization, the National Association of Social Workers, and a tribal child welfare group.

Dr. Charlan Kroelinger provided an update on the Center for Disease Control and Prevention (CDC) Division of Reproductive Health activities. In partnership with the Office of Minority Health, the division is developing a segment of the [Hear Her](#) campaign specifically focused on reaching AI/AN women and their communities. In January 2022, the National Indian Health Board posted a [discussion session](#) on Hear Her campaign messaging, which provided insights critical for the development of Hear Her AI/AN messaging to be released later in 2022. In fiscal year 2021, CDC funded 30 recipients through the [ERASE Maternal Mortality](#) program to support Maternal Mortality Review Committees (MMRCs). With the fiscal year 2022 Omnibus Appropriations Bill, CDC anticipates funding eight additional state MMRCs by September 2022 and funding a new effort with tribal nations and regional tribal organizations to support tribal-led MMRCs. As of December 2021, 45 states and three cities have established active MMRCs that are using the [Maternal Mortality Review Information Application](#).

Dr. Kroelinger said that the division supported technical assistance to Navajo Nation for a SUID/SIDS Child Death Review in fiscal year 2021. In November 2021, CDC provided additional support to expand capacity building and technical assistance and enhanced the Child Death Review process through training to 35 Navajo Nation death investigators. CDC plans to use fiscal year 2022 appropriations to expand support for 10 to 15 states not currently funded through the [SUID and Sudden Death in the Young \(SDY\) case registry](#). CDC will also use this funding to enhance the case reporting system and to issue new opportunities to expand the case registry by increasing the number of jurisdictions receiving support for SUID/SDY surveillance programs. Case registry applicants will have an opportunity to apply for funding to develop and implement data-informed SUID prevention strategies that address the drivers of disparities. Five PRAMS sites completed activities in support of tribes through updated data systems, steering committee meetings, development of an AI/AN sampling plan, outreach activities, and efforts to understand driving factors of AI/AN response rates.

## **Discussion**

Dr. Ehlinger commented on the formula shortage and asked how the federal government interacts with formula manufacturers. Dr. Warren said that there are ongoing federal discussions about supply chain issues and dependency on a small number of essential manufacturers. Generally, the Food and Drug Administration (FDA) and other organizations responsible for these issues develop a decision-making framework to address such issues. Mr. Wilson encouraged the Committee to articulate any recommendations on this specific challenge and to forward them to the Secretary.

Dr. Peck asked how the National Indian Health Board activities and responsibilities are different than those at IHS. Mr. Wilson said that the question may be answered in the next segment of the meeting.

## **Indian Health Service**

### ***LCDR Tina Pattara-Lau, M.D., FACOG, Maternal Child Health Consultant, IHS Headquarters***

Dr. Tina Pattara-Lau is the new Maternal Child Health Consultant for IHS. As an obstetrician-gynecologist, she has worked directly with patients in urban IHS and rural clinics. She is familiar with the challenges of underserved communities and has an appreciation for the specific, complex needs of IHS patients including family history; access to food, water, and shelter; health literacy; racism and discrimination; historical trauma; mental health and addiction; intimate partner violence; and other social determinants of health. She understands the need for multidisciplinary approaches, community health outreach, and cultural support informed in collaboration with health care and tribal partners. She, native individuals, and native allies who serve IHS share a common goal of utilizing governmental resources for all native patients, whether in IHS facilities or in the private sector. She will provide what is needed for the Committee to make well-informed recommendations.

Dr. Pattara-Lau presented a brief overview of IHS and its maternity care delivery model and best practices. IHS is an HHS agency responsible for providing federal health services to AI/AN populations, as outlined through treaty obligations and rights established in 1955 and through congressionally-appropriated funding. The IHS [mission](#) is to raise the physical, mental, social, and spiritual health of Native Americans to the highest level. IHS serves approximately 2.5 million of the nation's 5.2 million Native Americans who belong to 574 federally-recognized tribes in 37 states. IHS is divided into [two major categories](#): headquarter offices and regional/area offices. The headquarter offices are responsible for setting policy, ensuring delivery of quality comprehensive health services, and advocating for the needs and concerns of AI/AN. There are 12 area offices, which are responsible for distributing funds to the facilities, monitoring operations, and providing training and technical assistance. Dr. Pattara-Lau briefly described the role of the [National Indian Health Board](#), which is to represent tribal governments and provide advocacy and advice to Congress on IHS and other federal agencies.

There are three health care delivery systems serving AI/AN. The *federal health care system* is funded by congressional appropriations and consists of 26 hospitals. The *tribal health care system* (or "638 contracts") consists of 19 hospitals operated by tribes or tribal organizations that assume full responsibility for health care and operate with full sovereignty. The *urban Indian health centers* serve the approximately 78 percent of Native Americans living in urban areas through competitive contracts and grants with urban nonprofit organizations to provide health care services. These programs define their scope of services based on the needs of their communities. As of 2019, there were approximately 15,000 IHS employees including approximately 2,300 nurses, 770 physicians, 800 pharmacists, and 270 dentists. Approximately 70 percent of the IHS workforce is Native American. There are 12 area offices, in which seven provide planned birth services to varying volumes ranging from 50 to 1,500 birthing patients annually.

Dr. Pattara-Lau reviewed CDC data indicating that AI/AN women are two to four times more likely to suffer pregnancy-related mortality and twice as likely to report late or no prenatal care than their White non-Hispanic counterparts. The infant mortality rate among AI/AN is 26 percent higher than the national rate. Significant trauma within a community can worsen health outcomes over generations extending beyond the actual traumatic events. Native youth today are inheriting this trauma but may not have the same cultural resources for healing that their elders had.

IHS has tracked birth data using a combination of information from annual facility reports, newborn admissions, and National Vital Statistics System (NVSS) reports. NVSS uses a single race identifier, which accounts for an estimated 25 percent of native births. Of these, less than 20 percent occur in IHS and tribal facilities and less than 10 percent of those occur at IHS federal facilities. Native births occur in all 50 states, but only seven of the 50 states have IHS federal or tribal facilities.

Dr. Pattara-Lau provided some recommendations to the Committee. To address health disparities, it will be important to address all of the national health systems providing care to native people. NVSS should address the policy implications of electing a single race versus a multiple race identifier and provide ready access to multiple race-identified data. Tribal epicenters and PRAMS also have pregnancy-related data that should be shared.

Dr. Pattara-Lau reviewed some of the best practices from both IHS and through her experience as a provider. Within his, its Chief Medical Officer has advocated for [Alliance for Innovation on Maternal Health \(AIM\)](#) bundles to be promoted across IHS hospitals that perform planned births. IHS has achieved [baby-friendly hospital designation](#) for all facilities that perform planned births, which helps promote breastfeeding and maternal education. IHS also has a midwifery collaborative practice that includes approximately 84 midwives across five sites and applies a genuinely collaborative model for care in a traditional cultural practice. MMRCs often include IHS and tribal clinicians, and IHS advocates for the continued inclusion of native voices.

Dr. Pattara-Lau also reviewed an IHS pilot project for obstetric readiness in the emergency rooms in rural settings. This pilot included simulation training for precipitous delivery, postpartum hemorrhage, and hypertension, which increased provider confidence levels and familiarity with equipment. IHS has also incorporated COVID-19 telehealth models and initiated trauma-informed care training, including training for culturally sensitive fetal loss.

Dr. Pattara-Lau said that she understands there are many areas of need, which she categorizes as acute or long-term. Acute needs include staffing and facilities. For long-term needs, she would like to expand the maternal and child health program at IHS with the goal of increasing obstetric readiness in rural areas. This can be informed through their partners in the Veterans Administration, which uses a model of maternity care coordinators at each site to help with patient transfer, access to higher levels of care and resources, identification of social determinants of health and the resources needed to address them, and postpartum care through home visits to help with sleep environments and other challenges. There is also a need to leverage academic partnerships toward the recruitment and retention of providers. Finally, there is a need for concrete data to guide initiatives, inform policies, and develop best practice recommendations.

Dr. Pattara-Lau talked about the IHS contract with the American College of Obstetricians and Gynecologists (ACOG), which is a partnership to provide consultation and professional support to women's health care providers for AI/AN populations. It has been a mutually beneficial partnership. ACOG has been able to elevate IHS care through their quality benchmarking and evaluation site visits and reports. ACOG also provides an IHS postgraduate course that focuses on needs specific to native populations on topics such as mental health, substance use disorders, and intimate partner violence. ACOG hosts the [International Indigenous Women's Health Meeting](#) and develops AIM bundles and recommendations. One of ACOG's recommendations was to create the Maternal Child Health Consultant role that Dr. Pattara-Lau now fills.

Dr. Loretta Christensen is the Chief Medical Officer at IHS. She said that IHS is heavily involved in a federal hypertension group and advocacy for the self-monitoring of blood pressure in pregnancy, which is a practice that helps reduce preeclampsia, and have deployed more than 800 blood pressure monitors at pilot sites. They found that maternal morbidity and mortality was often not due to medical failures within the system but from social issues, such as lack of support or childcare, that kept people from accessing care. The challenge was to consider those social issues, especially in rural areas, that keep people from prenatal care. The challenge requires education about the importance of monitoring and early intervention to avoid morbidity, not only during pregnancy but also in health and lifestyles before pregnancy. She added that, although IHS works well with tribal communities and urban sites, each tribe owns its data and are not required to share. IHS continues to collaborate with tribes to create more robust datasets and works at the headquarter level for more robust datasets from [Tribal Epidemiology Centers](#). These efforts will help increase available data to provide clear insights and inform recommendations for maternal health.

## **Discussion**

Dr. Ehlinger asked for clarification on “contract” and “compact” hospital care and the IHS relationship with Medicaid. Dr. Christensen said that there is a contract called [Title I](#) under the tribal self-governance contracts. Title I contracts provide funding and resources for tribes to manage specific programs, such as behavioral health or public health nursing. [Title V compacts](#) provide funding and resources for full tribal management of a service unit, including the building, staff, equipment, and everything needed for success as a self-governing entity. IHS does participate with Medicare and Medicaid for pregnancy and approximately 90-95 percent of pediatric or newborn patients are in the Medicaid program. IHS is self-funded as far as their appropriations and their rates are determined differently by the Centers for Medicare & Medicaid Services (CMS). IHS will cover all pregnancy costs for the few who do not qualify for Medicare or Medicaid. At no point is a pregnant person not supported by health care services, even if they are sent to a facility many miles away. Full care is provided wherever they go and for whatever care is needed.

Dr. Ramas commented on the incorporation of midwives in maternity care and asked how family physicians are integrated into the structure of maternity care, particularly in rural health management. She also asked what level of experience Dr. Pattara-Lau has had with Two-Spirit gender identity and how that has been incorporated into gender-affirming care. Dr. Pattara-Lau answered that she has positive experiences working with family medicine specialists, including



those who are fellowship-trained in performing Cesarean section. With regard to Two-Spirit individuals, the first step is with language (i.e., using the term “pregnant people”) and asking a person for their pronouns. Changing awareness helps change language and promotes education efforts and advocacy. Dr. Christensen added that IHS is strongly in support of LGBTQ+ and Two-Spirit individuals. They are working toward expanding support by formally asking the questions needed to address people appropriately and provide sensitive and responsive support. There are some clinics specific for LGBTQ+ patients and IHS hopes to expand those across the agency.

Dr. Palacios asked if congressional appropriations allocated to IHS, which are made through an obligation to uphold treaties made with sovereign tribal nations, could ever be sequestered. Dr. Christensen answered that sequestration of congressional allocations are possible and IHS is working diligently toward mandatory funding that would not be subject to sequestration. It has been encouraging that they received significantly more funding this year than previous years. They will be using these extra funds toward water access and similar projects in Indian Country. Ms. Elizabeth Carr, Senior Advisor to the IHS Director, added that, for the first time in history, the administration proposed a mandatory budget for IHS. Tribal organizations, such as the [National Council for Urban Indian Health](#) and the National Indian Health Board, conducted a lot of advocacy on expanding the IHS budget. Dr. Palacios reiterated IHS funding can vary from year-to-year and that this year was the first in which the amount funded has come close to the amount needed.

Dr. Palacios talked about the complexity of the AI/AN population and the significant social determinants of health related to maternal morbidity and mortality. The lack of complete data may indicate that the problem is more dire and the needs even greater than the Committee currently understands. She asked what mechanisms could be used to fast-track data sharing or aggregate data to enable the Committee to understand the full gravity of AI/AN maternal morbidity and mortality.

Dr. Christensen answered that IHS has been considering how to identify the level of risk related to social determinants of health. The goal is to include social determinants of health domains into the electronic health record system so that all patients are asked those questions. Once the data are collected, a risk matrix will be applied to create tiers of risk that identify the highest-risk patients. Without these data, it is very difficult to create a mitigation plan. Social determinants may be different in each region—some may have increased transportation challenges and others have increased food insecurity or reduced access to running water. It is important to track these data during pregnancy as well as pre-pregnancy to help ensure a healthier population. Dr. Christensen said that another way to increase data access in specific communities is to work with the Tribal Epidemiology Centers. IHS can make it easier for these centers to request and aggregate data for their communities. The COVID-19 pandemic showed what was possible in terms of data sharing and the ability to mitigate problems through collaboration.

Dr. Ehlinger asked if IHS has evaluated the outcomes and effectiveness of the Title I contracts and Title V compacts. Dr. Christensen reiterated that tribal facilities are sovereign and not required to share data. IHS does collaborate with the centers when they are willing to share data and can evaluate these overall outcomes. There are certain data restrictions with this population,

but they have found alternative pathways to use aggregated data to share best practices and lessons learned with maternal collaboratives. They are now encouraging all tribal and urban partners to participate in these collaboratives, which will be key in moving forward with maternal health. Dr. Ehlinger asked if the ACOG contract with IHS has been evaluated. Dr. Christensen said that she will follow-up with an answer.

Dr. Ehlinger asked for an explanation of the differences in care approaches for Alaska Natives and American Indians in the other 49 states. Dr. Christensen answered that the Alaska Native population is entirely tribally run through their consortiums, and they have adapted care to the population's specific challenges. For instance, during the pandemic, Alaska Native tribes were transporting vaccines using dog sleds. Conversely, IHS was using helicopters to bring vaccines to the Grand Canyon. There is tremendous adaptability in Indian Country. No one knows better than the Alaska Natives on how to run their programs. Alaska Natives provide excellent training through their Community Health Aide Program on issues such as dental and behavioral health. The Community Health Aides are certified to take care of their own communities; they can adapt their health system to their environment and personnel.

Dr. Ramas talked about the World Health Organization's mitigation strategy for maternal care through the utilization of educational services for community members using hyper-local and culturally appropriate approaches. She wondered whether the Committee could consider this strategy as a model for community health workers. She shared a [link](#) to a model for community health worker utilization in high-utilizing Medicare populations, which showed that the return-on-investment was cost savings of \$2.5 for every \$1 invested.

Dr. Peck commented on the Tribal Epidemiology Centers and the CDC-funded maternal and child health epidemiologists and asked if there could potentially be alignment between both to build on the infrastructure of maternal and child health epidemiology. Dr. Christensen said that there have been conversations with CDC, the National Institutes of Health (NIH), and other federal agencies to consider how to work together toward a common data structure and a concerted effort to bring in meaningful data. Increasing IHS relationships with the Tribal Epidemiology Centers is extremely important to better support them and to help them in collecting the data that IHS needs to plan. She will bring the suggestion back to her team to determine what is possible for future coordination. Dr. Christensen referred to Dr. Ramas's comment on community health workers and said that IHS is looking to expand their community health representatives as a priority area. They are also advocating for reimbursement to non-traditional providers including community health workers, behavioral aides, peer-to-peer providers, dental assistants, community navigators, public health workers, and pharmacists.

Dr. Palacios shared her experience with the community where there was a recent closure of the labor and delivery center at the Phoenix Indian Medical Center. The community felt that there was no communication about the closure from IHS. Dr. Palacios asked if there has been a formal evaluation with tribal community leaders, health directors, and other community members to determine if IHS is meeting community needs. Dr. Christensen responded that communication is key but that even when there are efforts to communicate, there are invariably people who are missed. The pandemic disrupted normal communication during this closure. She would appreciate more community feedback on this topic and in general. The ability to send surveys

into the community is very limited within IHS, which is working to modernize. She would also like to survey IHS staff, implement community town halls in all of their service units, and conduct a patient experience survey to obtain more feedback. She added that their new trauma-informed care training program, which is mandatory for all staff, volunteers, and contractors, helps create a connection between systems and people to make sure that everything is done with respect and sensitivity.

Dr. Ehlinger asked if there was a direction for the Committee to consider in their deliberations for recommendations to the Secretary that would best help IHS. Dr. Christensen said one important focus would be at true equity--equal footing to provide services in the best possible manner at every site. There should also be prioritization of support for the diversity of the workforce and the ability to reimburse non-traditional staff. A much bigger project would be the expansion of their graduate medical education into all tribal communities through a pathway of education in areas where there are few providers. There is also a need to train emergency medical service providers to address needs in rural areas and communicate with the hospitals so that rural patients do not have to wait for care.

Mr. Wilson acknowledged that Dr. Christensen, Dr. Pattara-Lau, and Ms. Carr have not been long in their positions and expressed appreciation for the time they have spent with the Committee to share their thoughtful insights. He said that the conversation should be ongoing between this and the September 2022 meeting, during which time the Committee will be developing recommendations for reducing AI/AN maternal and infant mortality. He suggested that IHS share agency-level priorities that the Committee could highlight during their deliberations in September and amplify in their messages to the Secretary.

Dr. Ehlinger said that there will be smaller working groups that will continue conversations with Dr. Pattara-Lau during the summer.

## **Open Discussion**

### ***Edward Ehlinger, M.D., M.S.P.H., ACIMM Acting Chair***

Dr. Ehlinger opened the discussion to ex-officio members and federal partners.

Dr. Danielle Ely said that NVSS multiple race data for AI/AN are available on [CDC Wonder](#) and offered to provide multiple race data for any statistics related to birth files or infant death files.

Dr. Kroelinger added that CDC is examining the definition of race and ethnicity to disentangle data and increase the number of AI/AN members in their analyses.

Mr. Wilson provided updates from HRSA's working group on tribal affairs, which meets with tribal entities to provide updates on related HRSA activities. He reviewed some of the activities that were most recently shared with tribes. Healthy Start has engaged in efforts to eliminate ethnic/racial disparities before, during, and after pregnancy and in infant deaths. For instance, Healthy Start awarded \$2.3 million in grants and a one-time supplement of \$80,000 for infant health equity to tribally-designated organizations. The MIECHV program has a tribal home visiting program that provides grants to AI/AN tribes and 23 five-year competitive awards for tribal entities, totaling \$12 million annually. In fiscal year 2020, MIECHV served 3,315 parents

and children and 1,606 families through 17,129 home visits. MCHB awarded \$10.7 million in American Rescue Plan funding to 24 new pediatric mental health care access program award recipients, which included two tribal entities. Recipients were awarded up to \$445,000 per year for five years to promote behavioral health integration into primary care. The Healthy Start Technical Assistance & Support Center offers educational webinars that include strategies to strengthen programs on health equity, fatherhood, and quality improvement. From March to June 2022, the center will offer educational webinars for tribal entities on various topics.

Dr. Peck asked if there is a strategy for budget investments for tribal activities within HRSA, given the lack of a mandated budget. Mr. Wilson answered that some of their activities have evolved over time with clear measures to track spending toward different populations. There are also funding streams targeted toward specific interventions rather than by population. There are deliberate efforts to coordinate across tribal activities and there was a recent reorganization of tribal activities at the HRSA-level. There are no set-aside funds at HRSA for tribal activities. IHS is the primary recipient of set aside funds for AI/AN populations. HRSA has set aside funds for programs, such as Healthy Start, which provides services to rural, border, urban, and tribal areas across the Nation. HRSA's tribal consultation program is relatively new, and a structure is being put into place to align funds with strategies. He suggested including HRSA tribal affairs representatives in future Committee meetings. Dr. Kroelinger said that the HRSA structure is similar to CDC's with strategic funding lines to target some AI/AN activities.

Dr. Peck commented on the need to coordinate tribal health outcomes across federal agencies. One of the recommendations of the Broken Promises report was for Congress to provide funding to establish an interagency workgroup to share systems data methodology for accurate, aggregated population-level data. There is currently no nexus of data coordination and there is an opportunity for the Committee to recommend a specific direction.

Ms. Kristen Zycherman said that the CMS Office of Minority Health has released a report on [Advancing Rural Maternal Health Equity](#). They also partnered with the Office on Women's Health on a [Racial Equity in Postpartum Care Challenge](#) and a [Hypertension Competitive Innovator Award](#). The competitions are closed, and phase two will focus on scaling evidence-based programs. CMS approved an [extension of postpartum coverage](#) that states may continue to apply for. They also have a newly launched [postpartum care affinity group](#) and [low-risk Cesarean delivery learning collaborative](#). Within these groups are states that are focused on AI/AN populations.

Ms. Rutman said that funding for the limited competition cooperative agreements through IHS maternal and child health programs came through CDC, which is an example of coordinated funding and a comprehensive effort to address data and surveillance and intervention efforts. This may be a model for future coordinating efforts.

## **Report Out from Breakout Sessions**

### ***Edward Ehlinger, M.D., M.S.P.H., ACIMM Acting Chair***

Dr. Ehlinger asked breakout session members to consider the draft recommendations through the lens of the three workgroups. He also asked them to specifically consider whether the

recommendations addressed pertinent issues, should be revised or removed, or should be reframed as expectations rather than assumptions.

### **Health Equity Workgroup**

***Janelle Palacios, Ph.D., C.N.M., R.N., ACIMM Member, Healthy Equity Workgroup Co-Lead***

***Belinda Pettiford, M.P.H., ACIMM Member, Health Equity Workgroup Co-Lead***

Ms. Pettiford reported on the Health Equity Workgroup breakout session discussion. The group thought the recommendations were comprehensive. They suggested an emphasis on listening to people with lived experience and an integration of their voices throughout all of the maternal and infant mortality activities. This emphasis could be accomplished through including hyperlinks for the Secretary to listen to some of the voices, such as through the Hear Her campaign. The group also suggested adding a recommendation for accountability, using some language from the Broken Promises report, and a recommendation to engage with policymakers so they understand the potential impact of their efforts. The group felt there was a need for a historical perspective on SUID/SIDS as context for why the rates are so high. The group suggested using “substance use” rather than “substance abuse.” They also discussed the importance of valuing traditional native knowledge systems and the need to highlight this in the recommendations.

### **Quality and Access Workgroup**

***Steve Calvin, M.D., ACIMM Member, Quality and Access Workgroup Lead***

Dr. Steve Calvin reported on the Quality and Access Workgroup breakout discussion. He said that the group particularly benefitted from Ms. ShaRhonda Thompson’s important consumer perspective. There was a focus on personal relationships because of the importance of direct, one-on-one assistance in navigating systems in a culturally appropriate manner. The group also highlighted mental health, not just for mothers but also for infants and in early childhood, in light of the Uvalde school shooting and the need to identify troubled situations. Ms. Thompson brought up the need to involve husbands, partners, and fathers in the assessment of mental health needs. They discussed the “disconnect” in making recommendations to support telehealth while many people experience a lack of access to reliable internet, technology, and services. The group also suggested changing the word “interventions” in one of the recommendations to intervene in a cultural situation to another appropriate term. The group also had a presentation from Ms. Kendra Wyatt on issues related to health information technology and the need to improve interoperability.

### **Data and Research to Action Workgroup**

***Magda Peck, Sc.D., ACIMM Member, Data, and Research to Action Workgroup Lead***

Dr. Peck reported on the Data and Research to Action Workgroup breakout discussion. The group first gathered insights from the presentations to ensure that this information was included in their discussions about data and research to action recommendations. They talked about how nuances in language matter and the need to be intentional about the language used in recommendations. For example, the recommendation about First Nation involvement should include the word “lead” to give First Nations a leadership role and to not perpetuate a structural hierarchy from the history of oppression. They talked about the need for cultural humility and the desire to not offend through language. There was a suggestion to include a glossary of terms within the preamble of the recommendations to educate other audiences that may read the

recommendations. The group analyzed what should be elevated, where there were gaps, and what should be clarified and sharpened. Dr. Peck emphasized the power of qualitative data, storytelling, and first-person voices and the need to bring those voices forward across different recommendations. She reiterated the need to harmonize and standardize the fragmented data to strengthen the capacity to inform programs, policies, and practices.

Ms. Thompson added her thoughts about the importance of language. For instance, she has always framed the focus around infant “vitality” rather than infant “mortality”.

## **Wrap-up, Overnight Considerations, Adjournment**

### ***Edward Ehlinger, M.D., M.S.P.H., ACIMM Acting Chair***

Dr. Ehlinger acknowledged Dr. Wise’s arrival at the meeting and thanked him, as his term on the Committee was ending, for his valuable contributions and leadership in maternal and child health.

Dr. Ehlinger talked about different ways to potentially transmit the Committee’s recommendations to the Secretary. After this meeting, he will form four workgroups that focus on IHS: data collection; violence, incarceration, and substance use; and care delivery and workforce. These workgroups will meet over the summer to clarify and finalize the recommendations. The workgroups should include one newly appointed Committee member, one departing Committee member, and an ex-officio member. He would like the workgroups to finalize their recommendations by August so that there is time for external review of the recommendations before presenting them at the September Committee meeting.

## **DAY TWO: Wednesday, June 15, 2022**

### **Call to Order and Review of Day One**

#### ***Edward Ehlinger, M.D., M.S.P.H., ACIMM Acting Chair***

Dr. Ehlinger said that the Committee’s work to address the needs of First Nations and Indigenous people will benefit everyone. He provided three quotes to start the second day of the Committee meeting.

From Michael Harrington:

“One cannot raise the bottom of society without benefitting everyone above.”

From Paul Wellstone:

“We all do better when we all do better.”

From Martin Luther King, Jr.:

“Injustice anywhere is a threat to justice everywhere. Whatever affects one directly, affects all indirectly.”

Dr. Ehlinger invited Committee members who were not present on Day One to introduce themselves.

**Dr. Tara Lee** is a scientist, former director of a clinical research laboratory focused on pediatric disease, and Senior Fellow and Director of Life Sciences at the Charlotte Lozier Institute.

**Dr. Jeanne Conry** is an obstetrician-gynecologist, former President of ACOG, President of the Environmental Health Leadership Foundation, and Chair of the Women's Preventive Services Initiative. Dr. Ehlinger thanked Dr. Conry, whose term on the Committee is ending, for her outstanding contributions and advocacy for the impact of environmental contaminants on birth outcomes. He elevated Dr. Conry as a model for advocacy and reminded the newly-appointed Committee members that their interests and expertise could result in a similar impact.

## **Incarceration of Pregnant and Post-Partum Indigenous Women**

*Edward Ehlinger, M.D., M.S.P.H. (Moderator), ACIMM Acting Chair*

### **Pregnant and Postpartum People in Prisons**

**Rebecca Shlafer, Ph.D., M.P.H. Research Director, Prison Doula Project, Associate Professor, Department of Pediatrics, University of Minnesota Medical School**

Dr. Rebecca Shlafer provided an overview of women in United States prisons. There has been a nearly 700 percent increase in the number of incarcerated women since 1980. Of these women, most are of childbearing age, are disproportionately women of color, and have high rates of chronic health and mental health conditions. Approximately four percent of females entering state prisons and three percent of females entering jails were pregnant at admission and would give birth in custody. In Minneapolis, Minnesota, the arrest rates of Indigenous women are higher than of Black men. For example, in Minnesota Correctional Facility in Shakopee, 25 percent of individuals identified as AI/AN and 18 percent as Black. Among pregnant people sentenced to the same facility, 35 percent identified as AI/AN and 12 percent identified as Black.

Dr. Shlafer talked about the care and treatment of pregnant and postpartum people in prison. There is a lack of supportive policies and practices for pregnancy in prisons and jails. While prisons do routinely screen for pregnancy, jails do not. Many people will sit in a jail for long periods of time before being processed, and Corrections staff may not realize they are pregnant and need care. There is no mandatory standard in prisons for pregnancy-related care, resulting in significant variability. Care has consistently been described as poor, with no assurance of access to prenatal nutrition or limits to environmental toxin exposure. Despite clinical best practices and guidelines, detoxification for opioid use disorder is common among pregnant people in prison. Despite well-documented risk associated with restraint use during pregnancy, labor, and childbirth, more than a dozen states do not have laws prohibiting the use of restraints and those that do have laws may not comply. During labor, an incarcerated pregnant person is transported to a local hospital. However, policies do not permit the pregnant person to know when the transfer will occur, causing uncertainty and anxiety. Policies also prohibit contact with family members and two guards are typically placed in the room during the entire labor and delivery.

Dr. Shlafer reviewed pregnancy outcomes in United States prisons. According to the [Pregnancy in Prison Statistics](#) project, data collected from 2016-2017 showed that 46 of the 753 live births in prisons and 41 of the 144 live births in jails were miscarriages. There is a need to better understand the timing of these miscarriages and identify miscarriages that are not reported. After birth, nearly all newborns will be separated from their biological mothers. Postpartum people are

generally discharged within 48 to 72 hours and often undergo unclothed body and cavity searches at discharge and upon return to the prison facility—a practice that is particularly inhumane for a population with very high rates of previous sexual trauma. Postpartum screenings are inconsistent or nonexistent and few facilities have policies for breastfeeding or lactation.

Infants born to imprisoned mothers are most often placed with their grandparents (33 percent) or child protection services (17 percent). Infants are less often placed among other family members, biological fathers, host or adoptive parents, or maternal friends. These care environments are often unstable, resulting in children being moved around across multiple caregivers. This creates bonding and attachment challenges during early childhood and for the biological mother upon release from prison.

Dr. Shlafer reviewed the [Ostara Initiative](#), a nonprofit organization that houses the Minnesota Prison Doula Project and the Alabama Prison Birth Project. It aims to end prison birth in the United States. The Ostara Initiative provides highly specialized prison doulas, in-person labor and postpartum support, parenting education, supportive visitation with children, re-entry support for parents, legislative advocacy within Minnesota and Alabama, training for prison doulas in other states, and research on the effects of incarceration during pregnancy. Prison doulas typically meet with pregnant people twice in the prenatal period, will be present during labor and delivery, and provide support both in the postpartum period and during the mother's return to the community. Last year, Ramsey County, Minnesota passed the [Healthy Start Act](#) to permit the release of pregnant and postpartum people into community-based alternatives to incarceration for up to one year. The new policy allows re-entry navigation and support, whether there is a need for culturally-specific programs or substance use treatment, and the ability for the person to safely parent their children or have pregnancy needs met.

Dr. Shlafer talked about the Ostara Initiative's work with Indigenous people, which is focused on respect, compassion, and cultural understanding to address barriers to prenatal care and support cultural birthing practices. There is also consideration for disparities among Indigenous people. It emphasizes the importance of personal control over an individual's care, reflective of generational trauma, a history of separation from children, and mistrust of traditional health care systems. Dr. Shlafer stressed that incarceration causes harm, perpetuates health inequities, and threatens maternal and infant health

***Juliet Swedlund, LCCE, CD(DONA) Program Manager, Community Health Worker Section, Kansas Department of Health and Environment***

Ms. Juliet Swedlund is a doula who works in the prison system. She trained at the [Simkin Center for Allied Birth](#) in Seattle, Washington and provided doula services with the [Open Arms Perinatal Services](#), a nonprofit that provides doula support to underserved populations throughout Seattle. She moved to Kansas and provided doula services on a sliding scale before developing a nonprofit called the [Topeka Doula Project](#) to provide doula services for low-income families, adolescents, and incarcerated people. She also took a position as a program manager for the Kansas Department of Health and Environment in their Community Health Worker Section.



Ms. Swedlund encouraged the Committee to connect with Ms. Camie Jae Goldhammer, who launched [Hummingbird Indigenous Doulas](#) and is President-elect of the [National Association for the Professional and Peer Lactation Supporters of Color](#).

Ms. Swedlund shared her experience working as a prison doula. When she partnered with the Topeka Correctional Facility, they already had a program for women and child in place, including a mother-infant bonding program that provided six weeks of daily visitation (as compared to the standard weekly visitation) and a navigation program to connect pregnant people with doulas. Typically, a family navigator would contact Ms. Swedlund to connect with a family. She would then meet one-on-one to share what a doula does and to provide the prenatal planning process. Their contract with the facility also provides midwifery visits, although pregnant people may not have access to that midwife when they are transferred to a hospital.

Hospital visits are permitted with up to two people who have already been cleared at the correctional facility. Ms. Swedlund emphasized that Topeka was just one facility within the entire state. The practicality of this visiting program did not always work for everyone. Nearly all of the pregnancies are scheduled for induction at 39 weeks, which helps reduce uncertainty and provides a sense of control. There may be up to two guards present during birth, and Ms. Swedlund aims to have female guards when possible. Topeka Correctional Facility also has a breastfeeding program and a pumping station. During the pandemic, the facilities shipped breastmilk. Prenatal consultations were shifted to a virtual format, although doulas were permitted in the hospital.

Ms. Swedlund described her experiences with births for individuals who had experienced rape, domestic violence, childhood adversity, homelessness, and other trauma. Importantly, this program ensures that incarcerated pregnant people who have already experienced significant trauma and anxiety will not be alone during labor and delivery. It is important to provide community health and doula services, as well as to ensure that their training includes education on trauma-informed care. It is also important that doulas reflect the communities that they serve.

### **Trauma, Incarceration, and Maternal Morbidity: Connecting the Dots**

***Diane Bohn, R.N., C.N.M., Ph.D., FACNM Retired Nurse-Midwife, formerly School of Nursing, University of Minnesota***

Dr. Diane Bohn reviewed research findings from the [National Intimate Partner and Sexual Violence Survey](#), which indicate that 1 in 4 women experience intimate partner violence (resulting in three murdered women each day), 1 in 5 experience rape, and between 30-50 percent of women experience some form of abuse in their lifetime. Rates of abuse are much higher among AI/AN women and Dr. Bohn's studies of this population found that 87 percent of AI/AN pregnant women experience intimate partner violence, child abuse, and/or child sexual assault. In her routine clinical assessments, approximately two-thirds of AI/AN women have experienced some, and often multiple, forms of violence.

Dr. Bohn talked about the intersection between incarceration and abuse. According to the American Civil Liberties Union (ACLU), women are the fastest growing segment of the prison population. More than one-third of these are women of color, the majority are mothers, and most are incarcerated for nonviolent crimes and have been a victim of violence. Women are frequently

arrested for acts coerced by intimate male partners or in response to violence, such as trafficking; drug use, sales, or transportation; or fraud. Some were arrested for being present during violent crimes committed by their partner or arrested for responding to the abuse. Women who kill male partners receive harsher sentences than men who kill female partners. Many women continue to experience abuse in prison.

Women of childbearing age are the most likely to experience intimate partner violence, which may escalate during pregnancy or postpartum and is associated with poor infant and maternal health outcomes such as poor weight gain, substance use, injuries, and late or inadequate care. The most common causes of pregnancy-associated maternal mortality are homicide, suicide, and drug overdose—each of which are known to intersect with intimate partner violence and are more common among AI/AN women. Approximately one-third to two-thirds of femicides are associated with intimate partner violence. Pregnant women are at higher risk of femicide. In Minnesota and Washington, 10 percent of maternal deaths are attributed to injury.

AI/AN have a higher overall maternal mortality rate than any other racial/ethnic group and Dr. Bohn said that it is important to recognize racism as a major cause of this inequity. Violence (particularly sexual assault) against AI/AN people is often committed by non-Indian people. Indigenous people experience daily micro and macro aggressions that create chronic trauma. Exposure to chronic stress and trauma can lead to physiological changes that may ultimately increase the risk of conditions such as diabetes and heart disease. This exposure can also lead to alterations in epigenetics, which may further increase risk of disease, affect embryonic development, and change stress responses. Epigenetic alterations can also be transmitted intergenerationally. Therefore, racism as a cause of inequity can be theoretically explained by both historic generational trauma and the “weathering” hypothesis (i.e., exposure to historic and current chronic trauma resulting in premature aging and increased risk of health conditions).

Dr. Bohn said that, because of the increased exposure to chronic stress and trauma, AI/AN people can enter pregnancy with pre-existing conditions such as increased risk of disease; higher rates of risk behaviors, stress, and abuse; decreased access to quality health care and care from a member of their race/ethnicity; increased risk of poverty; and increased exposure to food insecurity and violence. To address maternal mortality in this population, it is important to pay attention to the presence and effects of lifetime abuse and racism. Specifically, support for midwives can drastically decrease maternal mortality.

## **Discussion**

Ms. Pettiford asked if there have been efforts to provide incarcerated people with the ability to express breastmilk. Dr. Shlafer said that Minnesota has been challenged with lactation support. Conversations to address these challenges have often included stigmatizing and illogical ideas, such as the potential for the mother to poison the breastmilk or the inability to provide refrigeration. Despite this, there has been some progress. In the last six months, her program has two clients who have successfully pumped, stored, and frozen their breastmilk for volunteers to pick up and deliver to community caregivers. Alabama has a robust lactation program including lactation space, storage, freezing and shipping. Much of these efforts have been supported by volunteers, which can be logistically challenging for long-term sustainability. She foresees considerable advances in the next five years to support onsite breastfeeding when the mother and

infant are within the same community and when opportunities are made available to store and deliver breastmilk. Ms. Swedlund added that the Topeka Correctional Facility has the same challenges and that she has personally delivered breastmilk. However, they have had several instances in which an incarcerated mother successfully pumped and breastfed their infants.

Dr. Conry commented that most health care facilities routinely conduct pregnancy screening for diabetes, which affects 1 in 10 pregnant people, but do not routinely conduct pregnancy screening for intimate partner violence, which affects 1 in 3 pregnant people. She asked how best to encourage local, state, and federal prison systems to understand and cultivate empathy for the needs of incarcerated pregnant people and mothers. Dr. Shlafer said that she published a [study](#) on reactions to the federal [Black Maternal Momnibus Act of 2021](#) that indicated the need for work at the local, state, and federal levels. She has been a part of a grassroots effort to share resources and engage in conversations about practices such as data collection and doula invoicing. She anticipates continued recognition of this underserved population and acknowledgement that mothers and infants cannot be health without access to adequate nutrition and prenatal care. People who wish to advocate within their state should begin with local conversations about adapting programs to the correctional facility and the needs of the community. As understanding of this issue spreads across the country, there will be more sharing of resources and increased state investment for new programs. There must be cross-agency solutions among HHS and other relevant agencies because the issue is complex with inherent intersections.

Dr. Peck asked if the increasing privatization of prisons is considered a risk or an opportunity for helping pregnant people and mothers. She also asked what connection there might be between home visitation in incarcerated pregnant people and mothers. Dr. Shlafer said that most correctional health facilities are privatized and only a handful are administered by local public health services. The local public health nurses understand the importance of upstream prevention and intersections with mental health and substance use. This concept is lost on private companies, which tend to focus on working within limited budgets or reduced spending. There are studies showing that family home visiting prevents maternal engagement in the criminal justice system and improves longitudinal outcomes for their children. She is currently working on a scoping review to better understand the intersection of home visiting and crime prevention. At a micro level, they have found that 1 in 10 men in the prison system has a pregnant partner in the community. There is a need for those families to be referred to early prevention. There are also challenges with privacy. Despite these issues, there may be creative ways to use MCHB Title V funds for home and family visitations.

Dr. Yanique Edmond said that the Office of Minority Health had investigated incarcerated pregnant people and visitation. They found that one of the restrictions was uncertainty in the source of federal funding. Home visiting can include non-traditional spaces to meet people wherever they are, such as shelters or correctional facilities, thus creating funding challenges. Dr. Edmond agreed that creative solutions are needed to lift or modify these funding restrictions so that these services can be implemented.

Dr. Alderman commented that there has been preliminary work in Oregon to bring home visiting into women's prisons. She also stated that there is a need to extend this service to include fathers. The implementation of home visiting often requires the system to accommodate multiple

exceptions. For instance, [Healthy Families Oregon](#) granted an exception in the definition of “home” to include the women’s prison. Healthy Families Oregon is a state-wide organization, which was important because it is looking to expand visiting to mothers, following release into community. They also obtained an exception under the [Oregon Bill of Rights for Incarcerated Parents](#) expanding the number of visitors with an inmate at any one time. This allows the that the home visitor, the accompanying adult, and the infant or young child to visit together.

## **Murdered and Missing Indigenous Women and Girls**

*Janelle F. Palacios, Ph.D., C.N.M., R.N. (Moderator) ACIMM Member*

### **Annie Belcourt, Ph.D., Community and Public Health Sciences, College of Health, University of Montana**

Dr. Annie Belcourt shared the [Missing and Murdered Indigenous Women & Girls report](#) from the Urban Indian Health Institute. She also shared an [article](#) she wrote on the intersection of violence and injustice during the COVID-19 pandemic, which has differentially impacted people of color and LGBTQ+ people. In addition to being a professor of Native American studies and a member of the Native American community, she has experienced the loss of her sister to murder. She said that there was a constellation of factors that led to her sister’s murder and that many families share the same factors, history, and stories. These stories are intertwined with maternal, infant, child, and young adult health in which disparities create a cascade effect developmentally.

Her research has focused on unpacking the layers of violence in their culture and communities, such as lateral violence, direct discrimination, and internal violence. Often the questions she asks in her research are not welcome, but they are important to address. Dr. Belcourt talked about resilience and generosity of spirit in Native communities, and its immersion into their language and culture. This can mitigate some of the harms from the violence and loss they endure.

The cities in the United States with the highest rates of missing and murdered Indigenous women and girls are the cities in which Indigenous people were relocated to when they were forcibly removed from their homes. The violence against Indigenous people in the Nation has been intentional and has led to structural outcomes of inequality. There is a need to create structures and policies that are informed by survivors, families, and communities. Public health efforts in Montana have brought together Native communities to enrich their culture, heritage, and language to promote resiliency in both individuals and communities as a whole.

Dr. Belcourt talked about Maslow’s Hierarchy of Needs, in which needs are described with a triangle with basic needs at the foundation and a cumulative meeting of needs upward toward self-actualization, when self-esteem is high and there is a sense of security. Dr. Abraham Maslow spent time with the Blackfoot tribe and his Hierarchy of Needs was developed through his interviews with elders. However, Dr. Maslow misinterpreted the elder’s teachings. The elders described having emotional needs, meaning, and hope as the foundation for a bountiful life. When thinking about solutions for Native people, it is important to consider their culture and language. For instance, the Blackfeet tribe often do not use words for “goodbye” but “I will see you later.”

Recommendations from initiatives such as Urban Indian Health Institute are based on this culture and language. For example, there should be support for law enforcement and accountability for those who perpetrate crime, a reclassification of race for better data surveillance, investment in tribal sovereignty that would allow for notification of an individuals' death, and increased research. It is also helpful to partner with Native communities, using creative paths such as television and media to bear witness to these stories.

**Administration for Native Americans: Missing and Murdered Indigenous People**  
***Michelle Sauve, M.P.P. Executive Director, Secretary's Intradepartmental Council on Native American Affairs***

Ms. Michelle Sauve talked about the [Administration for Native Americans \(ANA\)](#), which is a program office within the Administration for Children and Families (ACF). It was authorized by Congress in 1974 under the Native American Programs Act and was an extension of the War on Poverty and the Self-Determination Era for Tribes. ANA serves all Native Americans including federally- and non-recognized tribes, AI/AN, and Native Hawaiian and Pacific Indigenous populations. ANA's mission is to promote the goal of self-sufficiency for Native Americans by providing funding for community-based projects, training, and technical assistance. The ANA Commissioner serves as Chair of the Intra-Departmental Council on Native American Affairs (IHS Director is vice-Chair) and the Deputy Assistant Secretary for Native American Affairs.

ANA funds three broad areas: social and economic development strategies, Native language preservation, and environmental regulatory enhancement. One of the ANA Commissioner's [policy initiatives](#) added bonus points to their social and economic development strategies funding to address murdered and missing Indigenous people. Last year, those bonus points funded two projects, including an effort by the Riverside San Bernadino County Indian Health program to provide education and raise awareness of murdered and missing Indigenous people.

ACF has a Tribal Advisory Committee with delegates from across IHS regions that meets regularly with ACF leadership. In February 2020, the Tribal Advisory Committee identified missing and murdered Indigenous people as one of their four priority areas. In November 2019, an [Executive Order](#) to establish a Task Force on Missing and Murdered AI/AN was in effect between November 2019 and November 2021. Task Force members from HHS, the Department of Justice, and the Department of Interior worked closely to achieve the vision of the initiative. The Task Force held a series of [listening session and consultations](#) with organization such as the National Congress of American Indians, the Violence Against Women Task Force, and the ACH Tribal Advisory Committee. These efforts sought input for recommendations for HHS actions. Ms. Sauve reiterated the importance of engaging at all levels, including people with lived experience, to partner toward ending this crisis.

For many years, the crisis of missing and murdered Indigenous women, girls, and gender-diverse people was invisible to the general public. Through years of grassroots activism and advocacy, organizations and communities unified to spotlight the crisis. It was believed that the numbers were being underreported and that several Native women who had been missing did not get the same media attention as other women.

In November 2021, a new [Executive Order](#) was issued, which included specific actions for HHS to evaluate the adequacy of research and data to accurately measure the prevalence and effects of violence, and to develop a comprehensive plan to support prevention efforts that reduce factors for victimization and increase protective factors. In November 2021, CDC published National Violent Death Reporting System (NVDRS) data on the homicides of AI/AN in their [Morbidity and Mortality Weekly Report](#). Of the 2,226 AI/AN homicides in 34 states between 2003 and 2018, the age-adjusted rate of homicide was 8 per 100,000 (not all states were initially required to report into NVDRS). CDC therefore recognized homicide as a leading cause of death among AI/AN people and that intimate partner violence contributes to many of these homicides. The homicide rate of male victims was three times higher than female victims. Additionally, 1 in 2 victims lived in urban areas and 1 in 2 homicides involved a firearm. Of the suspects, 8 in 10 were male, 1 in 3 were AI/AN, and 4 in 10 were current or former intimate partners.

Ms. Sauve said that these data also showed that 343 of the homicide victims were females of reproductive age, 88 of which had a known pregnancy status. Of those, 14.8 percent were pregnant or within six weeks postpartum. She added that the impact of missing and murdered Indigenous mothers and their infants causes great spiritual, mental, and potentially economic trauma on their families. HHS recognizes violence not only as a crime but also a public health challenge that disproportionately affects AI/AN. HHS has been working diligently to develop wraparound strategies from the public health perspective. These strategies include primary prevention to address the underlying factors of vulnerability to different types of violence at the local level and through technical assistance at the local, state, and national levels.

Their populations of focus include Native women, men, children, and elders; children in the child welfare system; runaway and homeless youth; LGBTQ+ and Two-Spirit individuals; individuals with disabilities; individuals with mental or substance use disorders, and victims of violence. ACF published the [Missing and Murdered Native Americans: A Public Health Framework for Action](#), which was a culturally informed approach to strengthening vulnerable and high risk populations. The framework comprised four pillars addressing culture, language, and traditional practices; economic mobility; prevention; and social determinants of health. The American Rescue Plan provided \$237 million to ACF that included grants for tribes to provide temporary housing and support services for victims of family, domestic, and dating violence. ACF intends to implement the framework through communication, collaboration, capacity building, and community engagement. Ms. Sauve said that this public health challenge needs targeted funding, collaboration, and efforts at all levels (i.e., individual, family, community, national)

***Stephen Hayes, M.P.H., Public Health Analyst, HRSA Office on Women’s Health***

Mr. Stephen Hayes talked about the Office on Women’s Health (OWH), which is within the Office of the Administrator at HRSA. Its mission is to advance health and wellness for women across the lifespan by leading and promoting innovative sex- and gender-responsive public health approaches. Importantly, OWH provides subject matter expertise to service providers and patients and has an ongoing commitment to addressing intimate partner violence.

One of the priorities in the [HRSA Strategy to Address Intimate Partner Violence](#) is to leverage health care provider settings. Research has shown that women who talk to their provider about

abuse were four times more likely to use an intervention and nearly three times more likely to exit the abusive relationship. A person may not want to discuss experiences of violence with their providers for several reasons, including shame, fear of retaliation, fear of children being taken away, judicial involvement, and fear for their safety. Similarly, providers have cited many reasons for not wanting to screen for intimate partner violence. As a HRSA priority, the goal of leveraging health care provider settings is not only to implement screening as the start of a conversation, but also pathways for when intimate partner violence is identified.

Mr. Hayes provided a brief overview of HRSA's other three priorities to address intimate partner violence, which were to develop partnerships to raise awareness, increase access to quality health care services, and address gaps in knowledge. HRSA's strategy has been an agency-wide effort that was successfully implemented and can serve as a model for a large federal organization to effectively coordinate efforts. In its next stages, HRSA will continue to build on its efforts by recognizing the far-reaching impact on health, opportunities to prevent additional violence, and intersections with other critical public health priorities such as behavioral health, substance use, and maternal morbidity and mortality. Some examples of their success include the MIECHV program exceeding their goal to conduct intimate partner violence screening in 80 percent of its visits, the health provider [intimate partner violence toolkit](#), and the inclusion of language to account for and address intimate partner violence and other forms of violence in funding opportunities.

Mr. Hayes shared some of the lessons HRSA has learned that may be applied to missing and murdered Indigenous women and girls. For instance, there should be a focus on prevention. Trauma and violence are cyclical, and it is important to address the social needs that create the cycle. Additionally, patient-centered care that respects culture and is responsive to needs should be informed by lived experience. Multisectoral engagement is also needed to address the intersection of multiple risk factors that increase vulnerability and negative outcomes. Siloed services cannot meet these complex needs and collaboration provides a more comprehensive approach to addressing different social needs with supportive services. The pandemic provided an opportunity to find innovative approaches to alleviate the burden on providers by using advocacy models or community health workers.

HRSA is currently developing the next iteration of its strategy to address intimate partner violence, which is expected to be released in early 2023. This iteration will build on lessons learned, reflect HRSA's commitment to equity, and consider the opportunities to leverage existing data to further inform needs and approaches. Mr. Hayes shared a [toolkit](#) for health and advocacy centers, a [report of practices](#) for responding to violence in Indian Country, and a national [training and technical assistance resource](#) from HRSA's Bureau of Primary Health Care.

## **Discussion**

Dr. Palacios commented on how efforts to come together—whether through multiple arms within one large agency or multiple federal agencies—mirrors that of the language and culture in many tribes that represent the idea that “we are one.”

Dr. Ehlinger commented on the tendency to focus on quantitative data and that the stories and qualitative data are those that bring out the humanity in everyone.

Dr. Alderman talked about the importance of recognizing infants and children as humans and their entitlement not only to human rights, but special rights to address their particular vulnerabilities. Once those special rights are operationalized through policies, programs, and practices, then there can be movement in addressing disparities.

Dr. Belcourt added that systems to provide care for children and families do not have adequate coverage, particularly in rural areas. There is a marked lack of access to psychotherapy, counseling, or inpatient psychiatric care. There are children who experience violence who fall through the cracks because they are not in the system. There could be more support for traditional health methods and practitioners that are already in place.

Dr. Peck asked the panelists to address the question of “what will it take” in terms of the data needed to raise awareness, shape strategy, and create accountability.

Ms. Sauve said that IHS asks most often for its budget to be reclassified as Mandatory Funding. Full funding would increase capacity for better data systems and data integration and would be a step toward addressing the inequities in the system.

Mr. Hayes said that lived experience is data that can inform decision-making in the absence of controlled trials. There is an extensive amount of data that can help identify priority areas and tools. There are also challenges in prevention data because it is often unknown what specific factor brought about an outcome. Comprehensive data are available and could help demonstrate what contributes to positive outcomes.

Dr. Belcourt said that many Native people live in urban areas, and it is difficult to deconstruct the barriers they face. Data are needed to capture these experiences and to inform a response that is of equal magnitude to the problem of racism and discrimination.

## **Public Comment**

### ***Lee Wilson, Acting Designated Federal Official, ACIMM***

Mr. Wilson said that there was one request for oral public comments; however, the individual was not available to present.

## **Report Out from Breakout Sessions**

### ***Edward Ehlinger, M.D., M.S.P.H., ACIMM Acting Chair***

Dr. Ehlinger asked breakout session members to consider the same questions about the draft recommendations, but through the lens of their specific breakout room topic.

## **SUID/SIDS**

### ***Charlene Collier, M.D., M.P.H., M.H.S., FACOG, ACIMM Member (Moderator)***

Dr. Collier said that their group discussion centered on the need for approaches that acknowledge the environmental and social contributions to disparities in SUID. In particular, housing insecurity drives many of the disparities, but there is a shortage of solutions. It is important to acknowledge the downstream effect of unsafe sleep environments, including the influence of



historical trauma, colonization, and racism that results in a disproportionate number of particularly unsafe sleep environments and SUID. There is also a need to continue research to better understand the medical conditions that increase risk of SIDS. The group talked about increasing funding and scale for solutions that were already in place, such as the Healthy Native Babies Project. Many of the risk factors occur during the prenatal period, and educational resources are needed for prenatal providers to address factors such as housing insecurity or tobacco use. Indigenous midwifery, doula, and breastfeeding supports are needed after the infant is born, as well as recognizing other traditional Native practices and wisdom, such as cradle boarding, offer fundamental solutions for infant safety. There is also a need for funding to provide Indigenous people who live in urban areas with solutions for accessing their community and the shared wisdom. Support for traditional practices should be aligned with safe sleep practices and made consistent across providers and programs. Funding should be provided to Native populations to identify and provide potential solutions for the problems that they identify as driving disparities. Funding that is provided to the medical community tends to drive solutions from a medical lens. There is also the potential to create Fetal and Infant Mortality Review programs within Indigenous and Native programs so that their wisdom informs data collection. The Broken Promises report can be referenced as a Committee-supported set of recommendations.

### **Violence, Incarceration, and Substance Use**

#### ***Sherri Alderman, M.D., M.P.H., IMH-E, FAAP, ACIMM Member (Moderator)***

Dr. Alderman said that their group identified a gap in knowledge about available data. They recommended a survey to identify these data sources and methods for coordinating those data with other data banks. Having this knowledge would help create recommendations for specific data elements and its integration with other data collection efforts. The group also talked about a glossary of terms and the use of inclusive language to ensure there is no unintentional exclusion of certain segments of the population. They discussed the integration of education for professionals, such as bringing medical providers and law enforcement together. They also recommended a comprehensive array of services in the system of care to include promotion, prevention, harm reduction, assessment, evaluation, treatment, and services.

### **IHS**

#### ***Joy Neyhart, D.O., FAAP, ACIMM Member (Moderator)***

Dr. Neyhart said that the group benefited from insights from Dr. Pattara-Lau and Dr. Palacios. She invited Dr. Palacios to share her perspectives of the group discussion. Dr. Palacios said that much of the discussion centered on funding issues. The group echoed the previous Committee recommendation to fully fund IHS and talked about the priorities that these funds might address, such as comprehensive data collection, workforce development, and integration of community members into IHS services. The group talked about a point person or centralized office within HRSA to integrate their different lines of work for AI/AN. There is a need to fund and support comprehensive data collection across federal agencies, which is especially important for a population with small numbers and different tribal identities. It is also important to involve the community at all levels such as in workforce development, evaluation of IHS effectiveness in meeting community needs, and support and reimbursement for traditional healing practices. The group talked about the need for clarification on the IHS partnership and activities with ACOG, as well as for any other IHS contracts with similar partners.

## **Discussion**

Mr. Wilson asked for clarification on the recommendation for fully funding IHS. Dr. Palacios said that a number of Government Accountability Office (GAO) [reports](#) have found that IHS is not adequately funded. She referenced the [Tribal Budget Consultation](#), which is an annual effort to engage with tribes and federal agencies to obtain input about the IHS budget. Mr. Wilson told the Committee that the IHS funds not only pay for health services but also very large construction and maintenance efforts, some of which have fixed budgets but that are also underfunded. Therefore, the Committee should consider specific areas for funding in their recommendations.

Dr. Ehlinger added that there is a significant disparity between AI/AN people and the rest of the population in comparing the average annual cost per person on medical care. It would be helpful to include such data comparisons in the Committee's recommendation for adequate funding. Dr. Palacios pointed out that IHS received a significant funding increase in 2020 to respond to the COVID-19 pandemic that should be explained.

Dr. Neyhart asked if the Committee could access Medicaid data to compare annual spending per patient to highlight the disparities in base funding for AI/AN people. Dr. Ehlinger suggested that, of the Committee's draft recommendations, the recommendations for IHS will require the most deliberation and asked Committee members to consider joining that workgroup.

Dr. Conry suggested inviting ACOG leadership to address questions about the relationship between ACOG and IHS. Dr. Peck added that ACOG's journal *Obstetrics & Gynecology* published an [article](#) on the 50-year commitment between ACOG and IHS. She also recommended not only defining an adequate level of funding for IHS, but also mechanisms to support mandatory funding, such as treaty obligations.

## **Meeting Evaluation, Closing Observations, and Adjourn**

### ***Edward Ehlinger, M.D., M.S.P.H., ACIMM Acting Chair***

Dr. Ehlinger said that he would compile the workgroup feedback on the draft recommendations and send the Committee a revised draft for comment before sending to external reviewers and presenting a final draft. The next Committee meeting is planned to be in-person on tribal land in Minnesota on September 13-15, 2022.

In closing, Dr. Ehlinger asked Committee members to summarize their takeaways from the meeting and adjourned the meeting at 5:00 p.m.