Advisory Committee

on Infant and Maternal Mortality

Virtual Meeting

11:30 a.m. until 4:30 p.m.

Monday, March 20, 2023

Attended via Zoom Webinar

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Reported by P. FLUTIE

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2

1 - COMMITTEE MEMBERS -

2

3 **Sherri L. Alderman, MD, MPH, IMH-E, FAAP**

4 Developmental Behavioral Pediatrician

5 CDC Act Early Ambassador to Oregon

6 Help Me Grow Physician Champion

7

8 **Steven E. Calvin, MD**

9 Obstetrician-Gynecologist

10

11 **Charlene H. Collier, MD, MPH, MHS, FACOG**

12 Associate Professor of Obstetrics and Gynecology

13 University of Mississippi Medical Center

14

15 **Tara S. Lee, PhD**

16 Senior Fellow and Director of Life Sciences

17 Charlotte Lozier Institute

18

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22 (CONTINUES ON PAGE 4)

1 - COMMITTEE MEMBERS -
2
3 **M. Kathryn Menard, MD, MPH**
4 Upjohn Distinguished Professor
5 Department of Obstetrics and Gynecology
6 Division of Maternal-Fetal Medicine
7 University of North Carolina at Chapel Hill
8
9 **Joy M. Neyhart, DO, FAAP**
10 Pediatrician
11 Rainforest Pediatric Care
12
13 **Belinda D. Pettiford, MPH, BS, BA** *(Chairperson)*
14 Women's Health Branch Head
15 Women, Infant, and Community Wellness Section
16 North Carolina Department of Health and Human Services
17
18 **ShaRhonda Thompson**
19 Consumer/Community Member
20
21
22 (CONTINUES ON PAGE 5)

1 - COMMITTEE MEMBERS -

2 **Marie-Elizabeth Ramas, MD, FAAFP**

3 Family Practice Physician

4

5 **Phyllis W. Sharps, PhD, RN, FAAN**

6 Professor Emerita

7 Johns Hopkins School of Nursing

8

9 **Jacob C. Warren, PhD, MBA, CRA**

10 Dean, College of Health Sciences

11 University Of Wyoming,

12

13 - EXECUTIVE SECRETARY -

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15 **Michael D. Warren, MD, MPH, FAAP**

16 *Health Resources and Services Administration*

17 *Maternal and Child Health Bureau*

18 Associate Administrator

19

20

21

1 - DESIGNATED FEDERAL OFFICIAL -

2

3 **Vanessa Lee, MPH**

4 *Health Resources and Services Administration*

5 *Maternal and Child Health Bureau*

6

7 - PROGRAM LEAD -

8

9 **Sarah Meyerholz, MPH**

10 *Health Resources and Services Administration*

11 *Maternal and Child Health Bureau*

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1 - EX-OFFICIO MEMBERS -

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3 **Wendy DeCourcey, PhD**

4 *Administration for Children and Families*

5 Social Science Research Analyst

6 Office of Planning, Research and Evaluation

7

8 **Kamila Mistry, PhD, MPH**

9 *Agency for Healthcare Research and Quality*

10 Associate Director, Office of Extramural Research,

11 Education & Priority Populations

12 AHRQ Lead, Health Equity

13 Senior Advisor, Child Health and Quality Improvement

14

15 **Amanda Cohn, MD**

16 *National Center on Birth Defects & Developmental*

17 *Disabilities, Centers for Disease Control & Prevention*

18 Director, Division of Birth Defects & Infant Disorders

19 CAPTAIN, United States Public Health Services

20

21 (CONTINUES ON PAGE 8)

1 - EX-OFFICIO MEMBERS -

2

3 **Charlan Day Kroelinger, PhD, MA**

4 *National Center for Chronic Disease Prevention & Health*

5 *Promotion, Division of Reproductive Health, Centers*

6 *for Disease Control and Prevention*

7 Chief, Maternal and Infant Health Branch

8

9 **Danielle Ely, PhD**

10 *National Center for Health Statistics, Centers for*

11 *Disease Control and Prevention*

12 Health Statistician, Division of Vital Statistics

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14 **Karen Remley, MD, MBA, MPH, FAAP**

15 *National Center on Birth Defects and Developmental*

16 *Disabilities, Centers for Disease Control & Prevention*

17 Director, National Center on Birth Defects and

18 Developmental Disabilities

19

20

21

22 (CONTINUES ON PAGE 9)

1 - EX-OFFICIO MEMBERS -

2

3 **Kristen Zycherman, RN, BSN**

4 *Center for Medicaid and CHIP Services, Centers for*

5 *Medicare and Medicaid Services*

6 Coordinator for the CMS Maternal and Infant Health

7 Initiative

8

9 **Suzanne England, DNP, APRN**

10 *Indian Health Service, Great Plains Area Indian Health*

11 *Service*

12 MCH Nurse Consultant, Office of Clinical & Preventive

13 Services

14

15 **Alison Cernich, PhD, ABPP-CN**

16 *National Institute of Child Health and Human*

17 *Development, National Institutes of Health*

18 Deputy Director

19

20

21

22 (CONTINUES ON PAGE 9)

1 **Yanique M. Edmond, PhD, MPA, CTRP-C**
2 *Office of Minority Health*
3 Lead Public Health Advisor, Division of Program
4 Operations
5
6 **Dorothy Fink, MD**
7 *Office of Women's Health*
8 Deputy Assistant Secretary, Women's Health
9 Director
10

1 WELCOME AND CALL TO ORDER
2
3 VANESSA LEE: Good morning, everyone
4 and welcome. This is the Advisory Committee on
5 Infant and Maternal Mortality, and I'd like to
6 call the meeting to order. I'm Vanessa Lee. I'm
7 the Designated Federal Official for the committee,
8 which is administered by HRSA's Maternal and Child
9 Health Bureau. It's so good to be with all of
10 you. We haven't met since, I think, December of
11 last year. So, this is technically our first
12 meeting of 2023. So, happy new year to all of the
13 committee members and ex officios, and members of
14 the public joining today. Thank you for being
15 here.
16 A lot has happened, and probably the
17 biggest update I wanted to share is that we have a
18 new committee Chair, Belinda Pettiford. So
19 hopefully all of you saw the announcement on our
20 committee website. Belinda is no stranger to all
21 of you, the committee, or to those of us in
22 maternal and child health. She has over thirty

1 years of experience in public health and currently
2 serves as the Chief for the Women, Infant, and
3 Community Wellness Section within the North
4 Carolina Department of Health and Human Services.
5 She was an Advisory Committee member also from
6 2018 to 2022 and served as the co-lead of the
7 Health Equity Workgroup of ACIMM or the Advisory
8 Committee on Infant and Maternal Mortality, and I
9 see a lot of virtual applause within the chat.
10 Congratulations, Belinda. I am so
11 excited to be working with you again. I had the
12 opportunity first back in 2012 to meet and work
13 with you on an infant mortality initiative called
14 the COIIN. It's kind of hard to believe ten years
15 have passed and we're sort of still here working
16 on a lot of the same issues, but I'm nevertheless
17 excited and happy to get to work with you in this
18 new and different capacity. I think there's a lot
19 that can be done with your leadership. So, again,
20 thank you for accepting the invitation to serve
21 another three-year term and to be the new chair.
22 And so with that, I'm going to turn

1 things over to you, Belinda.
2
3 INTRODUCTIONS
4
5 BELINDA PETTIFORD: Thank you so very
6 much, Vanessa, and thanks to everyone for all of
7 the positive comments, the e-mails, the text
8 messages that have come my way. Please know no
9 one was more surprised than me to get the request,
10 but here we are, and I truly look forward to
11 working with each and every one of you.
12 Can we put or remove the screen so we
13 can all see each other. Thank you. I like to see
14 people when I'm speaking. So, again, so very good
15 to see you all. I hope you had a wonderful
16 weekend and that your March has started off
17 amazing. As I tell people, my birthday is in
18 March, so I celebrate the whole month. I don't
19 want to rush people to feel like they've got to
20 get to me by March 14th. I do the whole month.
21 And so, it is so good to be with you all today.
22 And at this time, I think we'll go

1 into introductions and because this is March and
2 it is Women's History Month, we thought our
3 introduction today should connect to women's
4 history. So today, as you introduce yourself, if
5 you can talk about that one person, that one woman
6 in your life that has truly inspired you, been
7 influential in your life, and tell us a little bit
8 about why. And so everybody can think about that
9 while we're doing introductions, and I'll kick it
10 off since I knew about it and give the rest of you
11 a moment to think about it.
12 Again, I am Belinda Pettiford. Here
13 in North Carolina, I get to work with an amazing
14 team, and this was a very easy question for me.
15 Again, I had a birthday this month. My mother
16 lives with me and she is 89 years old, and she has
17 been inspiring me my entire life. She'll be 90
18 this year and she said if the Lord is willing,
19 she'll be 90 this year, and I can easily tell you
20 why.
21 My mother has been at the forefront
22 of everything in my life. She has been an

1 activist, as she would call herself, from early
2 on. I have two older sisters that actually
3 integrated the high school in my community, and it
4 was because my mother said you're going to do
5 this. I'm sure my sisters did not volunteer, but
6 she said no, you're going to do this, and every
7 time an issue came up, my mother was the first to
8 be on that school grounds making sure she was
9 protecting my older sisters. And they learned a
10 lot from it, and she was an advocate for that.
11 She's the person that's been doing
12 voter education and voter registration my entire
13 life. She inspired me to go and get into the work
14 and do voter registration and voter education and
15 to work as a judge in my poll in the community.
16 But mostly all is the love she shows
17 for her family. She loves us all. She has, you
18 know, my siblings, she's got great grands, she's
19 got great-great grands, and she has one great-
20 great-great grand. And so, the fact that all of
21 us can come together and she keeps us engaged, she
22 has always been an inspiration to me and continues

1 to do so, and we look forward to celebrating her
2 90th birthday coming up in June.
3 So at this time, I am going to turn
4 it over to Sherri Alderman for your introduction.
5 SHERRI ALDERMAN: Thank you very
6 much. Belinda, you are a big act to follow. I
7 will do my best to humbly follow your
8 introduction.
9 My name is Sherri Alderman. I am a
10 developmental behavioral pediatrician by training,
11 and I'm pleased to be here today. I'm located in
12 Oregon.
13 Also, the person that immediately
14 came to my mind was my mother for different
15 reasons. She was very resilient and very much a
16 survivor of multiple adverse childhood experiences
17 and really enjoyed life and liked to have a good
18 time. So she has been a very wonderful role model
19 for me. She passed away a couple of years ago at
20 97 years of age and was to the very end just very
21 engaged, loved her -- her children, her
22 grandchildren, and her great grandchildren as

1 well.

2 BELINDA PETTIFORD: Thank you so
3 much, Sherri, and we'll popcorn it over to
4 Phyllis.

5 PHYLLIS SHARPS: Good morning,
6 everyone. I'm Phyllis Sharps, Professor Emeritus
7 John Hopkins University, School of Nursing. Not
8 to break the tradition, but also my mom, and I
9 think primarily my mom was a wonderful and caring
10 woman as most folks have described their mom. But
11 she was -- she just finished high school but
12 implanted very early the seeds in my sister and I
13 that we were to be professional women, that we
14 were to go to college, and we were -- my sister
15 and I were the first women in our family to be
16 college graduates and we both went on to have
17 fabulous careers. So that's important that we all
18 know in maternal and infant health, those
19 important early years and making -- inspiring
20 people to do that.

21 And then I would also say a colleague
22 of mine who passed away unexpectedly in January,

1 Dr. Fanny Gaston Johansson at John Hopkins School
2 of Nursing. She accomplished many things. She
3 was 84 when she died and was educated in nursing
4 at a time when nursing -- when there were not many
5 nurses of color and certainly not many in
6 leadership positions and leading research, and it
7 has really inspired me also. Thank you.
8 BELINDA PETTIFORD: Thanks, Phyllis.
9 Tara -- Tara Sander Lee.
10 TARA SANDER LEE: Hi. Great to be
11 here with everybody. Belinda, again,
12 congratulations. We're really, really excited
13 that you're the chair.
14 I think, like everybody else, I look
15 to my mother. She's an amazing woman. She still
16 -- she's here today despite many health issues,
17 but she has just been an incredible source of
18 inspiration and support and encouragement. She
19 grew up on a farm in Iowa under very poor
20 conditions. She suffered a lot of hardships,
21 abuse, poverty, and despite all of that, I just
22 saw her and even, you know, under the age of 18,

1 she faced an unplanned pregnancy and then adopted
2 the boy out and it just, you know, hearing her
3 story and what she faced when she faced that
4 unplanned pregnancy and then, you know, all the
5 stress that she was under and the conditions, he
6 was born premature and there were health issues.
7 And so, I've seen her, despite all
8 these hardships, she's just worked really hard.
9 She's trusted the Lord. She has -- she went back
10 to school. She got an education. She made
11 multiple sacrifices so that her children would
12 have opportunities that she did not have. And so,
13 she has just been a constant source of inspiration
14 my entire life and continues to just be and to
15 encourage me along the way. So, lots of great
16 tributes to our moms.
17 BELINDA PETTIFORD: Thank you, Tara.
18 Charlene.
19 CHARLENE COLLIER: Hello, good
20 morning or afternoon, everyone. Charlene Collier.
21 I'm a general OB/GYN, public health professional
22 in Mississippi. So, great to see everybody.

1 Congratulations, Belinda. You are
2 one of my heroes. So, I'll just put that out
3 there. I've known her since the very, very
4 beginnings of my public health career and journey,
5 and she's always been there as just a kind face,
6 an expert, and just someone I'm so glad to see in
7 this role. So, we'll shout Belinda as part of
8 those women in history recognitions because she
9 truly has been an inspiration throughout,
10 especially as a Black woman in public health, like
11 Belinda's always been there through just AMCHP
12 meetings or this is from when I was getting my
13 MPH. I remember you being there even probably
14 before you knew me as even a student looking up to
15 you. So, thank you.
16 And then, of course, I have to
17 include my mother in case she somehow gets word
18 that I was the only one that didn't acknowledge
19 her. But my mother is an amazing inspiration.
20 Moved here to Mississippi to be here and support
21 me, someone who was a teacher and she was a
22 teacher of special needs children, who I was able

1 to shadow as a child and go to the school where
2 she taught in Jersey City, New Jersey, and see how
3 she led with compassion, not only with the
4 students she cared for, but how she treated all
5 her staff, and it's something I've always taken
6 with me, and she's like you make best friends of
7 everyone that's in your office and department from
8 the janitor to the principal. They're all people
9 that you value, and that's something she taught me
10 for a very young age, and just someone who has
11 always valued treating individuals with kindness.
12 And so, I honor my mother and thank her for that.
13 But again, thanks to Belinda, and if
14 I had one more shoutout, it's to Dr. Menard as
15 well, because there's not a lot of OB/GYNs who are
16 -- as many role models in public health, and she
17 has always been one for me too.
18 BELINDA PETTIFORD: Thank you,
19 Charlene. We'll try to make sure your mom gets
20 word that you did shout her out, okay?
21 All right, Kate Menard.
22 KATE MENARD: I took a chance on the

1 camera, folks. There it goes. I'm Kate Menard.
2 I'm a maternal and fetal medicine specialist based
3 at the University of North Carolina, and pleased
4 now to be in my -- sort of beginning of the second
5 year on this committee. You know, I think it's
6 the month of May instead of March. Belinda and I
7 share a March birthday, but May is when you
8 celebrate your mother's right?
9 And I have to go with that same
10 theme. I think it's pretty apparent of the women
11 that spoke so far that they have pretty strong
12 women in their, you know, that raised strong
13 women. So that's a wonderfully cool thing, and
14 I'm going to follow suit.
15 My mom was -- raised six kids while
16 she worked full time. You know, she was a
17 dedicated educator. She taught special ed and
18 education was a really important thing to her and
19 she inspired that into all of us. She was a woman
20 of great faith and taught -- I think taught me,
21 taught all of my sibs, you know, that the gifts we
22 were given, we were given to share, so I sort of

1 followed that like suit, you know, under her
2 direction, and it's -- she also raised six kids
3 where we had to collaborate a lot to, you know,
4 get the household stuff done. So I think I
5 learned that from her at around age 2 that that
6 was a really important part of being and leading
7 and being professional and I often tell people who
8 ask that I learned everything about -- everything
9 I know about leadership from my mom because she
10 led with her heart, you know, that took -- that
11 took priority, and when you do that, it works.
12 So, hats off to all our moms. And we
13 can go onto to the next person.
14 BELINDA PETTIFORD: Thank you, Kate.
15 I'm going to jump over to Jacob.
16 JACOB WARREN: Hi, everyone. I'm
17 Jacob Warren. I'm Dean of the College of Health
18 Sciences at the University of Wyoming. So, I'm
19 coming to you from Laramie today, where it's going
20 to be 40-something degrees. We're very thrilled
21 that it's not going to be sub-zero. So that's
22 going to be great.

1 And I'm going to continue the
2 tradition. I have to, right, so I have to
3 acknowledge the role that my mother played in my
4 life. She taught me from a very early age the
5 value of hard work and the importance of that.
6 She was a diploma RN and worked her way all the
7 way up to be a very large practice manager in a
8 hospital system despite having what some would say
9 was "no degree." And so being in higher
10 education, I've always tried to make sure that we
11 don't over-emphasize the value of degree over
12 personality and drive and hard work. So, that's
13 something that she taught me in addition to in her
14 60s become a CrossFit trainer and a national
15 champion weightlifter. So, just a little bit to
16 live up to, right? But I just have to thank her
17 for everything and for showing me how hard work
18 pays off and that we always need to look at
19 people's assets and strengths rather than what
20 someone might put on a piece of paper about them.
21 BELINDA PETTIFORD: Thank you so
22 much, Jacob.

1 ShaRhonda. ShaRhonda, if you are
2 speaking, you are muted dear.
3 SHARONDA THOMPSON: Yeah, I'm sorry
4 about that. I was trying to start my video and
5 hit the mute button. It was all going on. Let me
6 get my video together.
7 BELINDA PETTIFORD: We can see you
8 now, ShaRhonda.
9 SHARHONDA THOMPSON: Yeah, I didn't
10 know that at all. Okay, there we go. Can you
11 hear me?
12 BELINDA PETTIFORD: We can.
13 SHARHONDA THOMPSON: Okay. So, I am
14 ShaRhonda Thompson, and I am a community member,
15 and my motivation, I'm sticking with the theme, my
16 mother. My mother was a single parent. She
17 honestly had her first child when she was fourteen
18 and the man should have been arrested, but that's
19 a whole other time and another conversation. And
20 she had -- I was her rainbow baby. She had a
21 miscarriage and then she had me. So my brother
22 and I are 7 years apart.

1 But she was a single mother. She has
2 mental health issues, had them her whole life.
3 She attempted suicide as a teenager. She did not
4 get the help she needed but somehow, she pushed
5 through. She was always, when I was younger,
6 working multiple jobs to make sure that I had
7 everything that I needed and still somehow was
8 physically there for me as well. You know, we had
9 -- I had anything for school, she was there. She
10 always was home to cook meals every night. So
11 even with her working those two jobs, even with
12 her mental health issues, she never skipped a beat
13 to be there to support me through whatever it was
14 that I had going on in life.
15 And so, that was a starting point for
16 me, and I always said okay, well, I'm going to
17 make sure if I ever have children, I'm going to do
18 better. Like, I can't do less than what my mother
19 did. Each generation has to do better, so she was
20 my motivation to do it.
21 So, yeah, to me, those were big shoes
22 to fill, you know, to be able to completely

1 provide for your children, plus still be there
2 physically and emotionally when they need you.
3 That was a lot. And with her dealing with mental
4 health issues, I can't imagine how hard it was for
5 her. But it never affected me. And so, I commend
6 her for everything that she has done and today, I
7 do everything that I can to help her and that is
8 why I am the person that I am today.
9 BELINDA PETTIFORD: Thank you so
10 much, ShaRhonda, for sharing your story as well,
11 and we'll get to hear a little bit more from you a
12 little bit later today.
13 Joy.
14 JOY NEYHART: I'm trying to figure
15 out how to get this going. We might not -- oh,
16 there we are. Okay. Good morning, I am Joy
17 Neyhart. I have been a pediatrician in Juno,
18 Alaska for twenty-three years in a small
19 independent practice and then last year joined the
20 Tribal Health Organization here in Southeast
21 Alaska Regional Health Consortium. So, now I care
22 for the same kids I cared for before plus a whole

1 lot more especially complicated kids. So, I'm
2 happy to be on this committee and help do this
3 work.
4 So, as soon as you, Belinda, said
5 that we were going to be celebrating women or role
6 models, of course, I thought of my mom too. So,
7 it's sort of apt. My mom was young when she
8 married and came from a whole family with a
9 mentally ill mother and then married a mentally
10 ill husband and still persevered and even though
11 there were lots of bumps and some trauma along the
12 way, she raised three children, and here I am.
13 Unfortunately, she developed
14 Alzheimer's and died a little over a year ago,
15 just before she turned 80. And so, she is no
16 longer with us, but without her I wouldn't be who
17 I am and where I am and be able to do this work
18 with you guys. So, thank you.
19 BELINDA PETTIFORD: Thank you, Joy.
20 I'm trying to make sure I'm not
21 missing any committee members. Marie. I know
22 you're just joining us. So, this is part of

1 Women's History Month, so we are asking each
2 community member as you introduce yourself to
3 share a little about the woman in your life that
4 has inspired you the most and a little bit as to
5 why.
6 MARIE RAMAS: Sure. Good morning,
7 everyone. I apologize for joining in a little bit
8 late. My name is Marie Ramas. I'm a family
9 physician and living in New Hampshire and
10 practicing in primary care. I am doing work with
11 the American Academy of Family Physicians around
12 women's health and work on the Commission of
13 Health of the Public and Science as a physician
14 representative.
15 There are so many women that have
16 encouraged me and inspired me in my life. I think
17 most recently, I have been channeling the example
18 that my own mother has brought to me in my life.
19 She was an immigrant coming from the Caribbean.
20 She and my father came to America, leaving a very
21 comfortable life in Haiti during the dictatorship
22 in order to create a better future for their

1 family.
2 She was an innovator. She was an
3 empath. She was a visionary beyond what her
4 culture in her time expected of woman at that
5 time, and she reminded me that no matter one's
6 title, that we must not forget the humanity of
7 others. And regardless of the experience or the
8 impressions that we may have, that everyone is a
9 child of a mother somewhere, and that is what
10 inspired me to become a family physician, to be a
11 family physician that took care of, you know, the
12 whole spectrum of a family continuum, and a family
13 physician that advocates frankly on behalf of
14 those that are unable to advocate for themselves,
15 for which I find myself here in this group to make
16 sure that those who are unborn and yet to be born
17 in the most marginalized communities in our
18 country are seen, are heard, and are given the
19 best opportunity to be the best forms of
20 themselves, and those who birth them. So, that's
21 my example.
22 BELINDA PETTIFORD. Thank you, Marie.

1 Have I missed any committee members
2 before I go into ex officio? I want to make sure
3 we haven't missed anyone. Okay, we'll go into ex
4 officios then. Charlan, are you good to go next?
5 CHARLAN KROELINGER: Good morning,
6 everyone. I'm Charlan Kroelinger, and I'm here
7 representing the Division of Reproductive Health
8 from the Centers of Disease Control and
9 Prevention.
10 BELINDA PETTIFORD: Do you want to
11 tell us about your inspiration?
12 CHALAN KROELINGER: Sure. I'll just
13 briefly mention my great-grandmother, Margaret
14 Day, who was an inspiration to me as a child. She
15 was a single mom in the 20's and 30's and had a
16 pretty steep uphill climb with my grandmother.
17 She had wanted to get a doctoral degree in library
18 science but found, with a baby, she was unable to
19 complete that degree and so always wished for her
20 grandchildren and great-grandchildren to seek
21 further education. So that really helped me focus
22 in obtaining my degree, and I hope I've made her

1 proud. Thank you, Belinda.
2 BELINDA PETTIFORD: Thank you. Thank
3 you so much.
4 We'll go to Ashley, and if you are
5 speaking, you are muted.
6 I will move on to Wendy.
7 WENDY DECOURCEY: Hello, everyone.
8 Wendy DeCourcey from the -- can you hear me?
9 Sorry, thanks -- from the Administration for
10 Children and Families from the Office of Planning,
11 Research, and Evaluation. I'm looking forward to
12 the new committee season.
13 I am going to mention, among all the
14 lovely ladies in my life, my grandmother, my dad's
15 mom, who was an amazing member of her community,
16 which was an international community, and she
17 really created a unique and friendly and
18 interactive environment there, and I just loved
19 hearing the stories about it. So, thanks.
20 BELINDA PETTIFORD: Thank you so
21 much.
22 Amanda.

1 AMANDA COHN: Good morning, everyone.
2 I am Amanda Cohn. I'm the Director of the
3 Division for Birth Defects and Infant Disorders
4 and a pediatrician, and I'm happy to be here.
5 I'm going to switch it up a little
6 bit and say that the biggest inspiration in my
7 life right now are actually my three young adult
8 daughters, almost 17, 20 and 20, and I guess
9 they're bringing me so much inspiration now
10 because I feel like there is so much -- there are
11 so many different challenges that they're facing
12 growing up, and I appreciate that they are doing
13 it in -- they bring such an open perspective and
14 really a place of nonjudgment that I wish that all
15 of us had been able to experience growing up, and
16 so, I'm just really proud of the women they are
17 becoming.
18 BELINDA PETTIFORD: Wonderful, thank
19 you.
20 Alison.
21 ALISON CERNICH: Well, it's funny
22 because I was going to say the same thing as

1 Amanda. I have a 19-year-old and a 14-year-old
2 girl, and I feel like I learn something every
3 single day for how they have navigated. Both how
4 they navigated the pandemic and getting to college
5 in some a weird time and just they are so
6 different than myself in terms of their
7 professional leanings and they are willing to
8 audition for their jobs every day, which I think
9 is something that we don't all do all the time.
10 And so, I am actually am inspired by them
11 constantly, and I'm also inspired by their
12 willingness to call me out when I am doing too
13 much and telling me when to slow down, which I
14 don't think I would have ever dared to tell my
15 mother. And so, I think I'm very much in Amanda's
16 space because they are really looking at a very
17 different climate than the one we grew up in, and
18 they are leading in such an inspirational way.
19 So, those are my inspirations.
20 And I didn't say, I'm the Deputy
21 Director of the Eunice Kennedy Shriver National
22 Institute of Child Health and Human Development at

1 the National Institutes of Health.
2 BELINDA PETTIFORD: Thank you,
3 Alison.
4 Yanique.
5 YANIQUE EDMOND: Good morning,
6 everyone, I am Yanique Edmond, and I represent the
7 Office of Minority Health and currently work on
8 different projects related to maternal health and
9 so I'm glad to represent the Office of Minority
10 Health on this particular committee.
11 This was a hard question for me, and
12 so I'm going to be very brief. It had me do a
13 whole lot of processing, so not all of us, right,
14 have mothers who represent everything. And so, in
15 my life I've developed mother pies so that I was
16 able to get what I needed at different stages of
17 my life. And so, my mother pies is a
18 configuration of strong women as well as women who
19 did the best that they could because I feel like
20 Women's Month is not just those who forged the way
21 but regular everyday women who, you know, dealt
22 with trauma but still kept going. So, in that

1 sense, I'd put my great-great-grandmother, who is
2 from -- I'm from Haiti -- from my village who was
3 a medicine woman and, you know, raised seven
4 children and lost half of them because of those
5 conditions. I lift my mother, who is an immigrant
6 to this county and brought us here with hope. And
7 then I lift my first grade and kindergarten
8 teacher, Madame Enosa, who as an immigrant child
9 talked in my language and helped me find my space
10 in kindergarten through third grade. And then I
11 lift my godmother as a teenager, who is an Irish
12 nun, who did not have her own children but showed
13 us how to mother and nurture all children. And
14 so, that's my mother pie.
15 And in college, Dr. Vivian Gordon,
16 who told me that I could become, you know, a Ph.D.
17 like her, and who set the path for my future.
18 And so, all these regular women are
19 my inspiration every day as well as those today
20 who continue to face battles that we thought we
21 had won and face them boldly. And so, that's my
22 inspiration every day by those women and the

1 future women that's to come.
2 BELINDA PETTIFORD: Thank you,
3 Yanique, and everyone needs a whole mother pie, so
4 thank you for sharing your pie with us.
5 And last, but definitely not least,
6 we'll go to Danielle.
7 DANIELLE ELY: Hi, Belinda, thank
8 you. So my name is Danielle Ely, and I'm from the
9 Division of Vital Statistics in the Reproductive
10 Statistics Branch, and I manage the linked infant
11 death file.
12 I suppose I also will discuss my own
13 mother, partially because I'm thinking about her a
14 lot right now because after our meeting tomorrow,
15 I leave for the airport to go visit her for her
16 birthday, as March is her birthday month as well.
17 She was just always a very steady and supportive
18 person in my life. So, thank you.
19 BELINDA PETTIFORD: Thank you,
20 Danielle. Did I miss any other ex officios? And
21 we would love to hear from the staff, and maybe
22 we'll find time later in the day, because I don't

1 want to leave you all out, but I know we're
2 already a little behind on the schedule. So, I'll
3 try to get us back on focus. So, any other ex
4 officios? Okay. Thank you all.
5 VANESSA LEE: I think he's --
6 BELINDA PETTIFORD: And I'm looking
7 right at you, Michael Warren, right in the middle
8 of the screen. Thank you.
9 MICHAEL WARREN: No worries. This
10 has been so great, and I think for me, it just
11 grounds why this work is so important to this
12 committee, hearing about the impact of mothers and
13 children and thank you all for sharing.
14 I was fortunate too. I was
15 reflecting on family. I grew up knowing all four
16 grandparents and six of eight great-grandparents,
17 and in fact, many of them lived pretty close, and
18 I had the great fortune of knowing both of the
19 grandmothers and all four of the great-
20 grandmothers. So, that notion of family really
21 resonates with me, but certainly, my mother rises
22 to the top of that.

1 And when I think about her, I think
2 the thing that -- there's so many wonderful
3 qualities she has. One of them is her ethic of
4 service and some of my earliest memories of her,
5 one of my great-grandmothers lived about 30
6 minutes away from us. She was widowed, and we
7 would get up every Saturday morning and drive to
8 her house to clean her house and run her errands.
9 And so, I remember that from toddlerhood all the
10 way through high school doing that. I was so
11 grateful when my brother came along because I
12 didn't have to be the one to dust. I hated
13 dusting, and so I could give him the dusting, and
14 I would do something else. But that was just the
15 expectation she instilled in us that we did this,
16 and we did it for others who had done things for
17 us. And I saw that whether she was working in the
18 church or being the leader of the 4H club or being
19 on the civic board. This was just always
20 important to her.
21 She worked to make sure that we had
22 opportunities even when she didn't have them. So,

1 neither she nor my dad went to college, but she
2 was always insistent that that was important that
3 my brother and I do that and that we prepare to do
4 that.
5 She still works full time. She just,
6 in the theme of birthdays, she turned sixty-seven
7 over the weekend, still works full time. She's an
8 office manager for a family farming organization
9 back in Eastern North Carolina, and so, I am
10 grateful for her instilling that commitment of
11 service and serving others.
12 BELINDA PETTIFORD: Thank you so
13 much, Dr. Warren. We appreciate that.
14 And so, I think we've got everyone.
15 And again, I'll try to get others in when we have
16 a moment to do so.
17 So, I have been asked many times over
18 this last couple of weeks why did I say yes to
19 being chair for SACIM. Some people may have
20 thought I bumped my head because there's a lot
21 going on and what were you thinking. But in
22 reality, I did take time to think about it. You

1 know, I spoke with some people that are really
2 near and dear to me. I spoke with the team and
3 yet, even though I was surprised, to me, it was
4 important. You know, I think, you know, the group
5 that just -- many that just left SACIM, you know,
6 with Ed and Magda and specifically Janelle, we
7 spent a lot of time with that version of ACIMM
8 really trying to elevate the work of American
9 Indians/Native Americans and making sure that we
10 elevated to the point that people understood the
11 story but they were also willing to do something
12 about it, and I don't want us to lose that.
13 But I also think of my own history in
14 public health. I've been doing this for thirty-
15 plus years. I started in a local health
16 department in North Carolina in a small community,
17 where I had a health director straight out of
18 college that told me I could try anything in that
19 community I wanted to as long as I didn't get in
20 trouble and most importantly, I didn't get him in
21 trouble. And so he allowed me to be out in the
22 community and listen to people to hear the stories

1 and to hear the voices. And I've been able to
2 continue to do that even in my time here in state
3 government in North Carolina, and I think one of
4 the challenges I struggle with, and I think all of
5 us do, is I think people are tired of
6 recommendations. I think our communities are
7 ready for us to move things into action. And I
8 think we need to think as we're making additional
9 recommendations, our recommendations need to
10 really focus on how do we move the work forward.
11 And so, one of the reasons that I
12 said yes is because I really wanted us to be able
13 to align some of our work with some of our
14 national partners. You know, we can make
15 recommendations to Secretary Becerra as other
16 recommendations have been made to other
17 secretaries over time, but without the political
18 will, without the boots on the ground, and without
19 listening to people with lived experience that are
20 living this every day, it's not going to move
21 forward. We're not going to be able to move it
22 forward. So I am hoping under this time that we

1 will really focus on actionable things that we can
2 move forward where people can actually see
3 movement. But I also want to make sure we're
4 spending that time listening to communities, being
5 engaged with communities, and actually trying to
6 address what they view as their top priorities
7 around maternal and infant health. And I think we
8 have started that and I truly want us to be able
9 to continue to move that forward.
10 So if you all have ideas on how to do
11 this as ACIMM members, please share. I am always
12 open to new ideas. I don't think there is one
13 person that knows how to do all of this, and I
14 think we have a great team here that are willing
15 and committed to move this work forward.
16 And as you will see with all of our
17 agendas, we started this under our former interim
18 chair under Ed. We want to make sure we're
19 listening to people and we're taking that time.
20 So hopefully we will be able to do that more and
21 more with this go around.
22

1 REVIEW AND APPROVE MINUTES

2

3 BELINDA PETTIFORD: So, at this time,
4 I would like to move to the review and approval of
5 our minutes. So you should have the minutes in
6 your briefing book from our last meeting.
7 MARIE RAMAS: Motion to move the
8 minutes.
9 BELINDA PETTIFORD: Thank you, Marie.
10 Do we have a second?
11 JACOB WARREN: I'll second.
12 SHARHONDA THOMPSON: I'll second that
13 motion.
14 BELINDA PETTIFORD: Thank you, Jacob
15 and ShaRhonda. Thank you both. For those in
16 favor of this motion, if you'll say aye or wave
17 your hand.
18 [Chorus of Ayes.]
19 BELINDA PETTIFORD: And hands are
20 waving. Thank you. Any opposers? Any
21 abstentions? Thank you. Then the minutes -- the
22 motion passes, and our minutes have been approved.

1 Excellent, thank you all.
2 And now, we're going to go straight
3 into our Federal Updates, and Michael, we're going
4 to turn it right back over to you, Dr. Warren, to
5 give us an update on what is happening with the
6 Maternal and Child Health Bureau.
7
8 FEDERAL UPDATE
9
10 MICHAEL WARREN: Thank you so much,
11 Belinda, and I'm sharing my screen. Can you all
12 see the slides?
13 BELINDA PETTIFORD: Yes.
14 MICHAEL WARREN: Okay, great. So
15 just a few updates from MCHB, and I want to start
16 by congratulating Belinda again and thanking her
17 for her service to ACIMM over the years, she
18 served as a member and an expert in the field, and
19 now in your time as chair. We are so looking
20 forward to getting to work with you, to learn from
21 you, and to all benefit from your leadership. So,
22 thank you for saying yes, and we look forward to

1 continuing this work together.
2 I'm going to spend just a few minutes
3 sharing some high-level updates from the Bureau.
4 As you all are probably aware, the budget for
5 fiscal year '23 passed at the end of the last
6 calendar year with a number of exciting increases.
7 Overall, the budget increased $127 million
8 compared to last fiscal year. That includes about
9 $823 million for the Maternal and Child Health
10 Block Grant, which includes both the Title V Block
11 Grant to states as well as special projects of
12 regional and national significance. The
13 Appropriations Law also reauthorized the Maternal
14 Infant and Early Childhood Home Visiting or MIECHV
15 program, reauthorized for five years and will
16 double the MIECHV investment over the course of
17 five years.
18 And I want to note this is
19 particularly tied to the recommendations that the
20 committee submitted recently with regards to
21 American Indian/Alaska Native populations. When
22 MIECHV was reauthorized, the set-aside for tribal

1 populations doubled from 3% to 6%, which aligns
2 with one of the recommendations of this committee.
3 And I'm happy to share that Healthy
4 Start received $145 million, which is about a $13
5 million increase that is focused on reducing and
6 eliminating disparities in maternal and infant
7 health outcomes.
8 I'm going to talk about a few
9 specific funding opportunities that are related to
10 maternal and infant health. We saw increases
11 across a number of lines. We saw a $3 million
12 increase in the Alliance for Innovation in
13 Maternal Health or AIM project, $3.5 million
14 increase in Screening and Treatment for Maternal
15 Mental Health and Substance Use Disorders, this is
16 the state teleconsultation program, a $26 million
17 increase in State Maternal Health Innovation
18 Grants, $3 million for the new Maternal Mental
19 Health Hotline on top of the existing investment,
20 and then nearly $3 million in new funds to address
21 Sudden Infant Death Syndrome.
22 There were also several items that

1 received funding for the first time. So there was
2 $10 million to create research networks with
3 minority-serving institutions and $10 million in
4 new funding to support integrated maternal health
5 service demonstration. So this includes
6 demonstration projects that would replicate models
7 like the pregnancy medical home and be able to
8 test those and have those go to scale.
9 Several of these are now out on the
10 street. So we recently have posted funding for
11 AIM Capacity projects, we're expecting to fund
12 around twenty-nine of those at $200,000 each.
13 This is a great opportunity for states and
14 jurisdictions to be able to get basic support to
15 be able to advance the work of AIM in their
16 states. We'll also be funding one technical
17 assistance center at a national level to support
18 this.
19 I do want to note the funding
20 deadline is May 9th on these. Typically in the
21 Bureau, we like to have a 90-day application
22 window. Because of the timing of the budget this

1 year, we weren't able to do that. So these are on
2 the street for 60 days and that clock is already
3 ticking. So, I encourage you to make sure that
4 your networks are aware of these and meet that May
5 9th deadline.
6 We also -- the funding opportunity
7 for the Integrated Maternal Health Services
8 project is open. We anticipate making five awards
9 at about $1.8 each. Again, these are those
10 demonstrations kinds of projects that would
11 replicate models like pregnancy medical home to be
12 able to show improvements in maternal health
13 outcomes and reduction of disparities.
14 So, these are out on the street now.
15 I do want to make you aware of a number of other
16 ones that are going to be following very soon. We
17 hope anytime now for some of these.
18 The Maternal Health Research
19 Collaborative for Minority-Serving Institutions, I
20 mentioned that. We anticipate making sixteen
21 different research network awards, as well as one
22 award for one coordinating center. We hope to get

1 those funding opportunities posted later this
2 month.
3 We will also be competing the
4 Screening and Treatment for Maternal Mental Health
5 and Substance Use Disorders program. Previously,
6 we had seven states funded under that program. We
7 anticipate making up to fourteen awards with this
8 new iteration of the program, and that funding
9 opportunity should post later this month.
10 We will be competing new State
11 Maternal Health Innovation awards. We've got a
12 number of states that are already participating in
13 this for some of them. They're reaching the end
14 of their performance cycle, but we also, with that
15 significant bump in the budget, will be offering
16 new awards. We anticipate over twenty awards to
17 be made up to $2 million each, depending on the
18 work that they are doing.
19 And then we are very excited to be
20 able to compete a new round of funding for Healthy
21 Start. The whole of the Healthy Start program
22 will recompete next year in fiscal year '24. So,

1 stay tuned for that. But we did get new funding
2 to support about ten enhanced projects that are
3 looking at the core work that Healthy Start does
4 but also thinking about social and structural
5 determinants of health and those drivers of core
6 maternal and infant health outcomes and, in
7 particular, disparities.
8 And in particular, as was noted in
9 the President's budget proposal, getting in those
10 communities that have the highest number of excess
11 infant deaths. So, really going to places where
12 the need is great.
13 Lastly, we'll be competing a National
14 Home Visiting Workforce Development Center. This
15 was included in the reauthorization. Part of that
16 includes the Jackie Walorski Center for evidence-
17 based case management, and we anticipate that
18 being released in early May.
19 So the team has been incredibly busy
20 drafting these funding announcements that we call
21 NOFOs. There will be a lot of work going on by
22 our state and community partners over the next few

1 months in preparing applications and submitting
2 those, and then all of these will be awarded by
3 the end of the fiscal year on September 30th,
4 which seems like a long time away, but it will be
5 here before we know it. So I wanted to make sure
6 that all of you were aware.
7 We've been trying really hard to get
8 these out so that folks are aware of them,
9 particularly because the timelines are tight. We
10 just did a webinar last Thursday with
11 stakeholders. We had five hundred folks on the
12 webinar to hear about these funding opportunities.
13 So I think there is a lot of interest and
14 appreciate anything you can do to spread the word
15 there.
16 Lastly, I just want to share with you
17 some work that we've been doing. There's a lot
18 going on, but just a couple of highlights.
19 We've recently completed a request
20 for information process on Healthy Start. As I
21 mentioned earlier, the entire Healthy Start
22 program will be recompeting next year in fiscal

1 year '24 and we wanted to understand from the
2 field broadly how things are working, where folks
3 might have feedback on the Healthy Start program.
4 So we specifically put out a request for
5 information hoping that we'd get feedback from
6 grantees, community members, people with lived
7 experience, health care providers, community
8 health workers, birthing people, parents, and
9 other members of the public. And the goal is that
10 this would inform future iterations of the Healthy
11 Start program.
12 We got over a hundred responses for
13 that RFI and some of the broad themes that came up
14 included increasing the emphasis on how Healthy
15 Start programs might address social and structural
16 determinants of health, and in particular, the
17 need to have multiple strategies to be able to do
18 this. A theme around supporting Healthy Start
19 programs to address racism and bias in health care
20 through education and training, family engagement,
21 and cross-sector partnerships, a theme around
22 considering the needs of rural and boarder

1 communities and Healthy Start program design. A
2 recognition of the value of a single Healthy Start
3 database and challenges that switching to new
4 databases may pose for some grantees. And then
5 other related suggestions around the data
6 collection system.
7 So our team is compiling those for
8 considerations as we think about again that next
9 iteration of Healthy Start and that notice of
10 funding opportunity will be posted as we move into
11 FY-24.
12 Lastly, I just wanted to share with
13 you that at the end of the last calendar year, we
14 released updates to the Women's Preventive
15 Services Initiative Guidelines and our Bright
16 Futures Periodicity Schedule. As you all know, in
17 the Affordable Care Act, we are tasked with
18 supporting these guidelines as well as the Newborn
19 Screening Guidelines through the Recommended
20 Uniform Screening Panel. In particular, on the
21 Women's Preventive Services, there are updates
22 related to diabetes screening during and after

1 pregnancy and, as you all know, once the
2 guidelines are accepted by the HRSA Administrator,
3 within a year from that, insurance companies are
4 required to provide coverage for those preventive
5 services without cost sharing. So, this goes a
6 long way as we think about improving access and
7 improving equitable care. So, the coverage for
8 these most recent changes will go into effect
9 starting January 1, 2024.
10 That is it for me. Please don't
11 hesitate to reach out if you have any questions.
12 And I know we're going to be sharing some updates
13 over the course of the next couple of days about
14 our work across the federal agencies with respect
15 to the recommendations the committee shared
16 regarding American Indian and Alaska Native
17 populations. So I look forward to that and with
18 that, I'll pass it over to my colleague, Dr.
19 Alison Cernich.
20 ALISON CERNICH: Great. Thanks,
21 Michael, so much. So, thank you for pulling up my
22 slides. I appreciate that.

1 So, I was asked to just give an
2 update about what is going on at NIH and
3 specifically at NICHD in the areas that are
4 covered by this committee. So, I want to thank
5 Vanessa and Michael and team for welcoming me with
6 this update. Next slide, please.
7 So the first thing I just want to
8 make sure everybody knows about is our NIH-wide
9 initiative called Implementing a Maternal Health
10 and Pregnancy Outcomes Vision for Everyone. If
11 you can go to the next slide, please.
12 So, our IMPROVE Initiative, this is
13 an NIH-wide effort, and we're really focused on
14 reducing preventable causes of maternal deaths and
15 improving health for women before, during, and
16 after delivery.
17 We have a major emphasis, as
18 reflected in the most recent maternal health
19 numbers, specifically our maternal mortality
20 numbers. We continue to have an ongoing crisis in
21 communities of color with respect to maternal
22 health, especially in the Black community and the

1 American Indian/Alaska Native community.
2 And so, we really are thinking about
3 those communities as well as communities that are
4 disproportionately affected. So, for example,
5 those that are in maternity care deserts.
6 So we started this -- we received new
7 appropriation in FY-22. So in '21, we had started
8 this just sort of organically to respond, and we
9 had put together $13 million across NIH from own
10 base appropriations to think about maternal
11 health, and we included the impacts of COVID-19 on
12 maternal health, as well as structural racism and
13 discrimination in the context of COVID-19. We
14 were able to fund a number of grants in this area.
15 We recently hosted a workshop last
16 week on some of the awardees that received
17 funding, which was absolutely incredible to see
18 some of those results moving forward.
19 In FY-22, as I mentioned, we had a
20 new appropriation and so what we were asked to do
21 in the President's budget and also by our sponsors
22 from Congress was to really concentrate on ways to

1 get evidence-based interventions in the community
2 and to establish Maternal Health Research Centers
3 of Excellence.
4 And so, what we have done in this
5 program is establish a number of different streams
6 of work. So, the Centers of Excellence are core.
7 They were announced last year, and we are getting
8 close to awarding. We had a really robust
9 response to these requests for applications, and
10 it includes a coordinating center that will focus
11 on dissemination and implementation research, a
12 data coordinating hub, and also some data
13 methodology hubs that will support up to seven
14 Centers of Excellence across the country.
15 We also have funded a number of other
16 novel things in FY-22. So we put out a notice of
17 special interest for projects on dissemination and
18 implementation research to advance evidence-based
19 implementation of, you know, evidence-based
20 practices for maternal health and we've received
21 those applications, and those will be reviewed
22 very soon and awarded this year.

1 We have funded through the National
2 Heart, Lung, and Blood Institute community-
3 implementation programs. Those are under a new
4 kind of award, which is another transaction
5 authority. So, these are collaborations between
6 academic centers and community organizations to
7 bring evidence-based care into communities, and we
8 should be funding two to three of those
9 collaborations this year.
10 We're also working with the Office of
11 the National Coordinator to do standards for the
12 electronic health record. And so, we are working
13 to pilot some things that we have done to bring
14 these standards to bear. This allows researchers
15 to use health record data for real world research.
16 And so, we are trying to establish that as a core
17 set for those of you who are familiar with these
18 standards, USCDI and USCDI-plus, they are common
19 data element sort of approaches, and that is what
20 we're working with the Office of the National
21 Coordinator for Health Technology on.
22 We have also sponsored two challenges

1 under a prize authority. So, the first is to
2 drive technology, either point-of-care technology
3 or in-home technologies. So we are using the same
4 framework that NIH used for COVID diagnostics. So
5 if you guys remember that sort of Shark Tank
6 approach, we're doing that with a number of
7 technology companies to get either at-home or
8 point-of-care diagnostics for maternity care
9 deserts in place to detect risk for people who are
10 pregnant.
11 And then we also have a community
12 partnership challenge, and I'll update on this.
13 But this is a challenge where we're actually not
14 funding academic organizations. We are working
15 with community organizations that are looking to
16 build a research infrastructure, and we're
17 providing them training and mentoring and how to
18 move into the research space. And so, we are in
19 an exciting phase of this challenge right now.
20 So, if you could go to the next slide.
21 So, recently we awarded prizes to
22 fifteen organizations. So we had about eighty-six

1 organizations come in and get some initial
2 training on how they might build their research
3 infrastructure. Each organization received
4 $10,000 and an invitation to participate in the
5 proposal phase. So, we're working with these
6 fifteen organizations. They're getting one-on-one
7 mentoring as well as webinars every week to talk
8 about how would you go about building a research
9 piece of your organization, proposing for grants
10 in the federal space, what would you need to think
11 about, and then in the next phase for those who
12 advance, we're going to have ten organizations
13 advance. They will receive a prize and they will
14 then be invited to conduct their research, and at
15 the end of that, there will be a final prize for
16 those organizations.
17 And so, we're actually looking
18 forward to building some research -- on-the-ground
19 research teams through this challenge, and it's
20 been really great to see communities that are
21 really underrepresented building research in the
22 field where they have some experience, but they

1 really just need some mentoring.
2 As I mentioned, RADx Tech for
3 maternal health, we had fifteen organizations that
4 were announced as the winners of the Viability
5 Assessment Phase, meaning they've gone through a
6 number of commercialization, scientific as well as
7 sort of usability look for some of their
8 technologies, and actually, I think some of them
9 have also participated in our sister
10 organizations, HRSA's initial prizes, so they were
11 kind of ready to go here. And so, it's a great
12 way that we could see some translation.
13 And so now we're in the deep dive
14 assessment phase. They've received $20,000, and
15 so we're trying to move some technologies forward
16 relatively rapidly. Yeah, and I'll put the
17 website in for the Connecting the Community for
18 the fifteen organizations that were announced as
19 the winners for sure, Belinda. So, I said the
20 others were in review. So that is our IMPROVE
21 Initiative. Next slide, please.
22 The other thing that we've been

1 working a lot on, we had been asked to establish a
2 working group to produce recommendations for the
3 federal government to address stillbirth. Next
4 slide, please.
5 And so, we know that stillbirth is a
6 major issue in the United States. We have so many
7 families that have been affected by this, you
8 know, real tragedy where, you know, people are
9 being, you know, confronted with carrying
10 pregnancy almost to term or to term and then they
11 are either asked to deliver or have an emergency
12 cesarean section to deliver a child that is not
13 alive. And so, we have been working with a
14 working group of our council on this. We had four
15 working group meetings that were held from 2022 to
16 2023 thinking about the different ways that we
17 could address what was being asked of us by the
18 Congress, meaning, you know, what is the scope of
19 the problem, what are our current barriers to
20 collecting data, who is at risk, what is the
21 psychological impact, and also, you know, who is
22 at risk including communities at higher risk, and

1 then how do we need to treat mothers after
2 stillbirth, and this is something that we really
3 need to pay better attention to, specifically for
4 the psychological impact. We heard from many
5 families in our meeting in January about the long-
6 term impacts of a stillbirth on the family, the
7 effects it has on subsequent pregnancies or even
8 subsequent desire for pregnancy, as well as not
9 just on the immediate parents of the child, but
10 also the extended family, and the need for fetal
11 autopsies, the need for really a reason for that
12 death is such a central need for many of these
13 families, and we do not cover this right now.
14 We put also out a request for
15 information that was published in November, and
16 we've received responses through that. Next
17 slide, please.
18 So last week, we published our
19 recommendations, and I want to thank my federal
20 colleagues also for their tremendous work as ex
21 officios on this group because they also assigned
22 themselves work and we truly appreciate it.

1 But we presented the initial findings
2 at our National Advisory Committee for feedback
3 discussion, and then the report was published last
4 week. And so, essentially our recommendations are
5 four-fold.
6 One is to improve the quality of
7 vital statistics, surveillance, and epidemiologic
8 data on stillbirth at the local, state, and
9 national level.
10 To think about how to use those
11 insights as well as from clinical data, to think
12 about disparities and identify prevention
13 opportunities.
14 To conduct implementation research to
15 help develop culturally sensitive interventions to
16 support families that have experience stillbirth.
17 And for us to establish a research
18 agenda for risk factors, mechanisms that surround
19 stillbirth, as well as definitely other ways that
20 we can prevent stillbirth.
21 So we are going to be starting to
22 implement some of these recommendations, but we've

1 also received additional language from the
2 Congress related to other areas where they would
3 like recommendations. So we will be continuing
4 with this group to work on stillbirth. So, more
5 to come here. Next slide, please.
6 The other thing that some of you may
7 have been aware that we did a while back is the
8 Taskforce on Research Specific to Pregnant Women
9 and Lactating Women, otherwise known as PRGLAC.
10 Next slide, please.
11 So, we originally started this work
12 in 2016 as part of the 21st Century Cures Act, and
13 we really were trying to address knowledge gaps
14 regarding safe and effective therapies and
15 vaccines for pregnant and lactating women, and we
16 had great representation not only from our federal
17 partners but we also had our professional
18 societies, industry, academia, and nonprofit
19 organizations, and NICHD was the lead for this.
20 In 2018, we provide fifteen
21 recommendations to the Secretary about how to
22 promote the inclusion of pregnant and lactating

1 women in clinical trials, and after that, the
2 Secretary extended the charter, and they wanted us
3 to move towards implementation recommendations.
4 And so, we published those implementation
5 recommendations in 2020, and we have been working
6 on this ever since. And so, we are really
7 thinking about in this work how to protect women
8 through research rather than from research,
9 because we know that some of the, you know, we
10 make decisions based on information, and if we
11 don't have information, it's very difficult to
12 make decisions. So, next slide, please.
13 So, what we've done to start
14 implementing at the NIH level and this is through
15 NICHD is we've established the MPRINT Hub, which
16 is Advancing Frontiers in Health Through Maternal
17 and Pediatric Precision in Therapeutics.
18 And so, what this did was it
19 established both the knowledge core and Centers of
20 Excellence. We have two Centers of Excellence at
21 the University of California San Diego and
22 Vanderbilt, and then a partnership between Indiana

1 and Ohio State, which serves as the central
2 coordinating center for that entire hub.
3 And they are thinking about how to
4 conduct and foster therapeutic-focused research
5 and obstetrics, lactation, and pediatrics, and
6 they also want to include people with disabilities
7 as part of this. It also addresses the
8 underrepresentation of women and children in
9 clinical trials. So, we're thinking about how to
10 make the knowledge available, the regulatory
11 science behind this, and also drug development
12 tools that we can use to accelerate this work, and
13 really hoping to facilitate safer, more inclusive,
14 and more cost-effective trials.
15 So, a couple of examples, we're
16 looking at the effects of maternal antibiotics on
17 breastmilk and infant outcomes. We're looking at
18 electronic health records as a way to phenotype
19 how pharmacogenomics work, and we're also thinking
20 about how to use real world data for things like
21 neonatal opioid withdrawal syndrome. And so,
22 these are just a few examples of what the MPRINT

1 Hug is doing, and I think this is going to be a
2 really exciting program moving forward. Next
3 slide, please.
4 And we continue to do our work too
5 globally. So, NICHD is one of the largest
6 sponsors of work in this area in maternal health
7 in the international space, and our Global Health
8 Network has been working with the Bill and Melinda
9 Gates Foundation. We just recently published a
10 transformational trial looking at whether a single
11 oral 2-gram dose of azithromycin could reduce
12 postpartum sepsis and death. The study actually
13 was really successful. In enrollment, we had
14 29,000 women in seven low- and middle-income
15 countries in the study, and it was stopped because
16 there was a clear maternal benefit. It reduced by
17 one-third the risk of postpartum sepsis and death.
18 Now, we did note that it did not
19 reduce the risk of stillbirth, newborn sepsis, or
20 newborn death. But for maternal health, it had a
21 very significant impact. So, we stopped that
22 study early and those results were recently

1 published with the citation there. Next slide,
2 please.
3 And so, to continue our work in this
4 area, in looking at the effects of therapeutics in
5 pregnancy and lactation, we have been asked now to
6 recreate an Advisory Committee to monitor and
7 report on the implementation recommendations from
8 PRGLAC. And so, we are going to reconstitute this
9 likely as a working group of our council this
10 year, and we've been working with the Office of
11 Women's Health in HHS and we will again include
12 our partners here to start this committee to
13 monitor our implementation efforts. Next slide,
14 please. And just a couple other updates, next
15 slide.
16 Just to let you all know, we do have
17 two major networks that we do research through.
18 One is the Maternal-Fetal Medicine Units and the
19 other is the Neonatal Research Network. And so,
20 we're hoping to announce the awardees for these
21 networks very soon. But we did change the
22 structure of these networks. They've been around

1 for a really long time, and they are one of the,
2 you know, biggest catalysts for clinical practice
3 recommendations. But we're hoping to broaden and
4 diversify the groups of investigators who can
5 propose projects to use the network.
6 We're also thinking about how enhance
7 review and approval for this. So, we will be
8 reviewing protocols in a different way to make
9 sure that we have the standards that we need for
10 rigor and reproducibility and we will be reviewing
11 those protocols through scientific review. They
12 used to go through the networks themselves, and
13 we're bringing them back to the NIH level just to
14 make sure that we have some input because these
15 are cooperative agreements in terms of the
16 sciences being conducted and ways that we can make
17 sure that we are including diverse populations as
18 well as making sure that the science is of the
19 utmost quality, because these are major
20 investments for us. Next slide, please.
21 So with that, I will close, and I'm
22 happy to answer any questions in the chat. I'll

1 wait on any for now, but thanks.
2 BELINDA PETTIFORD: Thank you so
3 much, Dr. Warren and Dr. Cernich. Does anyone
4 have questions? We'll take a quick moment and try
5 to answer one or two. Yes, Tara.
6 TARA SANDER LEE: Hi, just a real
7 quick question. Thanks, Alison. For the PRGLAC,
8 I was really interested in what you presented
9 there and when you're looking at therapies, are
10 you also including opportunities that women might
11 have for fetal surgery? Are you going that far,
12 because, I mean, like, you know, CHOP is major for
13 offering fetal surgery, like women that, you know,
14 with a baby finds out that they have superficial
15 or something like twin-to-twin. So, just
16 wondering how broad are you looking when you start
17 talking therapies?
18 ALISON CERNICH: Yeah. So the -- so
19 PRGLAC is really focused on pharmacotherapies,
20 Tara. But we have -- so we -- we're the major
21 sponsor for the studies that looked at spina
22 bifida repair prenatally. So we do engage in that

1 research and it could potentially be a part of the
2 networks if that was thought to be an area of
3 scientific focus that we wanted to pursue. Those
4 networks might be a perfect place to propose a
5 surgical trial through the MFMU or through the
6 NRN, but we can also sponsor those trials through
7 our regular mechanisms.
8 The MOM study was one of the major
9 interventional studies that we did to look at the
10 efficacy of those surgeries. So it's within our
11 purview but not a focus for PRGLAC. PRGLAC is
12 really focused on pharmacotherapies.
13 TARA SANDER LEE: Excellent. Thank
14 you so much.
15 BELINDA PETTIFORD: Does anyone else
16 have a question?
17 SHARONDA THOMPSON: I do.
18 BELINDA PETTIFORD: Yes, ShaRhonda.
19 SHARHONDA THOMPSON: Okay. So, for
20 someone that's not in the medical field, what's
21 pharmacotherapy?
22 ALISON CERNICH: That is a great

1 question. So, drugs.
2 SHARHONDA THOMPSON: Okay.
3 ALISON CERNICH: So, medications that
4 -- so a lot of the medications that are used
5 during pregnancy, interestingly, have never been
6 studied in pregnancy. And so, drugs like those
7 that we use to treat depression, epilepsy, you
8 know, common conditions that people have going
9 into a pregnancy often have not been studied both
10 on their effects during pregnancy on the mom as
11 well as the effects during pregnancy on the fetus.
12 And so, what we are looking at is safety and
13 efficacy and label changes that we could support
14 research on to tell, you know, not only providers,
15 but also pregnant people about what risk that they
16 are taking on, both for treatment or without
17 treatment, and also how the drugs behave
18 differently. As you know, women's bodies undergo
19 a lot of changes during pregnancy, right? And so,
20 the way that drugs are essentially behaving in the
21 body, those change as well.
22 And so, what we are trying to do is

1 study some of that to see, you know, does the dose
2 change? Does the duration of the dose change?
3 Does the, you know, those sorts of things are
4 pretty important for people to understand when
5 they're trying to make a decision about do I keep
6 on the same antidepressant or do I not? Is it
7 better for me to not be depressed during my
8 pregnancy and take this medication, or is it
9 better for me to go off this medication because
10 it's safer for my child, or use a different
11 medication that may be safer and more effective.
12 So, that's what we're talking about. Thanks for
13 the question.
14 BELINDA PETTIFORD: Thanks, Allison
15 and ShaRhonda. Thank you for keeping us on point.
16 ShaRhonda, did you have another follow-up?
17 SHARHONDA THOMPSON: I would. Does
18 that include -- I know you said during a
19 pregnancy, so has it -- does this mean it's a
20 study that's already been done? Does it pass on
21 through breastmilk?
22 ALISON CERNICH: So, that's the other

1 reason that we're doing -- yeah, we're doing
2 pregnancy and lactation. So we are looking at
3 whether and how much of a drug goes into
4 breastmilk, and we have a number of studies. We
5 have a really interesting study that's looking at
6 multiple medications at the same time. So they're
7 studying breastmilk in people who are already
8 coming back for visits, and they are getting
9 samples of breastmilk, samples of maternal blood,
10 samples of infant blood to see what the
11 transmission is through breast milk of a number of
12 common -- commonly used medications. So that
13 study is underway now. It's called the Cuddle
14 Study.
15 SHARHONDA THOMPSON: Okay, thank you.
16 BELINDA PETTIFORD: Thank you. I
17 don't see any other questions. Michael, for these
18 -- all of those grant awards that are coming out,
19 are they all five-year awards or is there some
20 variation?
21 MICHAEL WARREN: There may be some
22 variation. I'd have to go back and look. We

1 generally try to do four- or five-year awards.
2 But let me go back and look at that list
3 specifically to make sure I'm not misspeaking.
4 What we can do is we can put the link
5 to the grants.gov site or our MCHB funding site,
6 and folks can go because in that notice of funding
7 opportunity, they'll all be listed there. I was
8 looking down the list to see -- let me double
9 check because I don't want to misspeak.
10 BELINDA PETTIFORD: Okay.
11 MICHAEL WARREN: Generally, they are,
12 but I don't want to misspeak for all of them.
13 BELINDA PETTIFORD: Understood.
14 Thank you so very much. And thank you, Alison,
15 for dropping that in the chat, the winners for the
16 community version of it, so that's really
17 exciting.
18 So at this time, we're going to go on
19 and continue with our agenda and we're going to
20 turn it over to Vanessa and to Sarah to talk about
21 the ACIMM Charter Renewal and Bylaws.
22

1 ACIMM CHARTER RENEWAL AND BYLAWS

2

3 VANESSA LEE: Thank you, Belinda.
4 Hello again, everyone, and I just want to
5 introduce my colleague, Sarah Meyerholz. She is
6 the new ACIMM Program Lead in our Division of
7 Health Start and Perinatal Services at MCHB, where
8 I work. So, before I turn it over to her to help
9 walk us through some of the changes that happened
10 in the last two charters, I just want to give
11 everyone a quick update on what's going to happen
12 this year.
13 So, if you did have a chance to look
14 over the charter, you'll see they expire every two
15 years. So, this current charter that we're under
16 right now will expire September 30th. And so, we
17 are -- Sarah and I are working toward submitting
18 the package of paperwork to renew the committee's
19 charter in June. So we knew the June meeting
20 would be a little too late to ask you guys for
21 feedback, so we're presenting it now at the March
22 meeting, and as we did two years ago with Ed and

1 the other committee members, we wanted to take
2 some time to hear your feedback and input into the
3 charter, as again, we plan to renew it.
4 The key areas that most of the time
5 the members are most interested in are obviously
6 the committee's objectives and scope, what your
7 duties are, and the membership section of the
8 charter. That's where the ex officio agencies are
9 listed. So, I just want to point you to those
10 areas if you are sort of time-limited, but we
11 welcome feedback and input on any parts of the
12 charter.
13 Like I said, Sarah is going to walk
14 us through what has changed in the last two
15 versions of the charter just to see if there are
16 any new changes that are needed, or if you guys
17 think, hey there's been a lot of work already,
18 we're pretty good with how things are.
19 The other last thing I'll say before
20 turning it over to Sarah is that ultimately, this
21 will be HRSA and HHS's decision. So we can't
22 guarantee that the feedback you send us will

1 necessarily be incorporated. But we still welcome
2 it and last time, I think the majority, if not all
3 of it, was actually taken. We got really good
4 input from the committee members. But again,
5 there's no guarantees. It will ultimately be
6 HHS's decision.
7 And then, this is not your only
8 chance to give us feedback or input. We will take
9 your thoughts after the meeting. I think we
10 talked to Belinda about having committee members
11 send her any thoughts, ideas, or suggestions you
12 have for the charter, and she'll compile it all
13 and send it to Sarah and I and we will give you
14 guys, I think we said, about the next thirty days.
15 So, you'll have a month to sort of digest and
16 process what we're sharing today. Read through
17 things, ask us questions, and then again, ideally,
18 we'd get your feedback in the next thirty days or
19 so just so we have time to prepare that package
20 for submission in June.
21 Sarah, is there anything you want to
22 add before you walk us through the charters?

1 SARAH MEYERHOLZ: I don't think so.
2 Yeah, thanks, Vanessa. I'm happy to go ahead and
3 share my screen with our first charter.
4 2019 to 2021 is the first one I'll be
5 pulling up. This was included in your briefing
6 book, and you should be able to see it now.
7 VANESSA LEE: Yes.
8 SARAH MEYERHOLZ: So, what you may
9 have seen in this particular charter was that it
10 demonstrates the trends in growing maternal
11 mortality rates, and you can how it's further
12 flushed out addressing maternal health outcomes,
13 especially in the objectives and scope of
14 activities, you'll see more focus on improving
15 maternal health outcomes including preventing or
16 reducing maternal mortality and maternal
17 morbidity. So, this is a change from the previous
18 charter, the 2017 to 2019 charter, which was more
19 focused on infant mortality.
20 Moving down just a little bit in
21 Section 4, Description of Duties, again, this just
22 reflects that further focus on maternal morbidity

1 and mortality and further reflects the description
2 of duties by the committee to provide
3 recommendations to the Secretary in both infant
4 and maternal mortality.
5 And I don't want to make you too
6 dizzy, but going all the way down to the bottom,
7 there was nothing -- no changes from 2017 to 2019
8 to this current -- or this charter of 2019 to 2021
9 that I'm showing now, except for this one last
10 little sentence at the end just describing how
11 subcommittees operate within the context of the
12 broader ACIMM committee. So, this is the 2017 to
13 2019 charter.
14 I'm going to switch over to the 2019
15 to 2023 charter, the charter that the committee is
16 operating under currently, and we'll walk through
17 the changes from this one, the 2019 to the 2021
18 charter.
19 So, most exciting, you'll see that
20 the first line here, the official designation,
21 really calls out that maternal mortality, and as
22 the committee is known today, the Advisory

1 Committee on Infant and Maternal Mortality. So,
2 that was a big change from the previous charter.
3 In the objectives and scope of
4 activities section, these updates were suggested
5 by the former acting chair and committee members
6 and really reflect the priority areas of further
7 addressing social and structural determinants of
8 health.
9 And in the description of duties,
10 you'll see that these were edited to just really
11 reflect what has been updated in the scope of the
12 work to be further outlined here.
13 The Title V MCH Block Grant Program
14 was also added within the description of duties
15 because it had not been previously, and that is
16 the largest MCHB investment, as well as the
17 Healthy People Objectives. Healthy People 2030
18 Objectives were always included in previous
19 charters, but it was called something different
20 before. So it was further clarified in this
21 current charter that we are operating under now.
22 Moving on down to Section 8 regarding

1 the Designated Federal Officer or Vanessa, as we
2 all know and love, just a brief sentence here was
3 added in the most recent charter to describe what
4 would happen with the committee operations in the
5 event that she is unable to fulfill any duties,
6 and as Vanessa noted, I am now the part-time
7 support to the committee, so very excited to be
8 working with everyone here, especially Belinda as
9 our new chairperson.
10 Moving down to Section 9, there was a
11 small adjustment here to the number of meetings
12 per year. Historically, I think it was two
13 meetings per year -- and Vanessa, correct me if
14 that's wrong -- but the committee wished to
15 provide the operation for more opportunities to
16 convene each year because there's just so much
17 work to be done, and it's difficult to continue
18 these discussions that need to be had to create
19 these wonderful recommendations and actions if
20 there aren't more times to do so.
21 Moving down finally, the last update
22 from 2017 to 2019 to this current -- I'm sorry,

1 2019 to 2021 to this current charter, 2021 to 2023
2 is in the membership and designation section,
3 number 12, which clarifies that the ex officio
4 members that you heard from this morning are non-
5 voting and a representative from the Substance
6 Abuse and Mental Health Services Administration
7 was added. That had not been included previously.
8 That was just a very high-level
9 overview of the changes that were made from the
10 previous charter to the current charter. So we do
11 want to pause here and just ask if there is any
12 initial feedback, thoughts, comments, questions,
13 that you'd like to provide to us now, and like
14 Vanessa said, you do have the opportunity to reach
15 back out to us. We're happy to meet and talk
16 about it, whatever works for you. We do ask that
17 you share your feedback with Belinda, who will
18 then pull everything and submit to us by April
19 20th. But we are here right now if you have
20 anything else to share.
21 And Vanessa, anything that I missed?
22 I'll stop sharing so we can see each other.

1 VANESSA LEE: No, that was a great
2 overview. Thank you, Sarah. I think you hit all
3 the highlights of, again, what the feedback and
4 types of changes we've made in the last two
5 renewals. Thank you.
6 TARA SANDER LEE: I just have a quick
7 -- oh, sorry.
8 BELINDA PETTIFORD: No, go on, Tara.
9 I was going to see if anyone had questions.
10 TARA LEE SANDER: Sorry. Yeah, just
11 a quick question. When I first joined the
12 committee, I know at the time, I was told that we
13 would be meeting about, you know, twice a year and
14 then that changed. I guess my question, since I
15 don't have a lot of -- since I wasn't a member of
16 the committee for very long before it changed to
17 four, can we -- do we have any like stats or
18 outcome measurements to say whether, you know, was
19 a lot more work done with meeting four times a
20 year? Do we feel like this is working, it's a
21 good use of time and government money and
22 resources? So, I'm just wondering like what are

1 people's thoughts on that?
2 BELINDA PETTIFORD: I'll chime in,
3 but Vanessa, because I will say that under the --
4 just before you came on, Tara, we did feel the
5 need to do more meetings because there were things
6 that we wanted to make sure we were following up
7 in between, but also, it gave us more
8 opportunities to get other presentations and have
9 conversations about the issues that were on the
10 table, and they are so critical. So I think we
11 felt like twice a year, it was just a long ways in
12 between trying to follow-up on the different
13 recommendations and the things that we were moving
14 forward.
15 I don't know, Vanessa, if you were
16 going to say something.
17 VANESSA LEE: Yeah. Just that --
18 thank you, Belinda, and good question, Tara, and I
19 think we are definitely open to your feedback and
20 thoughts and input on how many times and it
21 doesn't have to be super precise. We can say, you
22 know, up to or approximately as we did with this

1 last one.
2 I will say I did notice that with
3 this sort of group in the last two years, there's
4 been three sets of recommendations that were
5 submitted to the Secretary. So you started with
6 the ones looking at COVID and the impact on
7 maternal and infant health, and then you had the
8 other recommendations mostly around workforce, you
9 know, migrant, environmental conditions, those
10 were August of 2021, and then you had the 2022
11 recommendations focused on improving birth
12 outcomes of American Indian/Alaska Native. Prior
13 to those, that's three sets of recommendations.
14 The last I could find, you know, on our website
15 were back in 2013. So, I think that, to me, just
16 demonstrated there was definitely a lot of work
17 that you all did for the previous group as well.
18 Again, not to say that it's still needed, I don't
19 know what the right maybe number of meeting is,
20 but I will say, I think, in terms of
21 recommendations and those as an "output" of the
22 committee, there certainly was a bump up.

1 TARA SANDER LEE: Yeah, that's helps.
2 Thank you, Vanessa, that's a good point.
3 BELINDA PETTIFORD: Any other
4 thoughts? If not, if you'll take the time to just
5 review them in detail and then send me any
6 recommendations, any edits, any changes that you
7 would like to see, we'll forward back to the
8 Bureau. If you'll send it to me by April -- what
9 did we say -- April 20th, and we'll send out a
10 reminder.
11 VANESSA LEE: Yes.
12 BELINDA PETTIFORD: Just to be on the
13 safe side.
14 Vanessa, is there anything else that
15 you all were going to add? Thank you so very
16 much.
17 So, we are now down for a break. We
18 are scheduled to come back at 1. Let's plan to
19 come back at 1:15, and then we'll shorten -- I'll
20 work during the break to try to shorten the
21 frameworks conversation so I think we'll still be
22 on track with our time. So, if everyone could

1 plan to come back at 1:15 Eastern Time and then
2 apply it to whatever time you have, and we'll see
3 you in a little bit. Thank you, all.
4 (BREAK.)
5 BELINDA PETTIFORD: I am showing 1:15
6 on my end. That was quick, but hopefully you all
7 were able to at least take a short break. If it's
8 lunch time where you are, grab a bite, and if you
9 need to be off camera to eat, we definitely
10 understand. Well, some of you may be eating
11 breakfast now.
12
13 FOLLOW-UP: RECOMMENDATIONS TO IMPROVE AMERICAN
14 INDIAN/ALASKA NATIVE (AI/AN) BIRTH OUTCOMES
15
16 BELINDA PETTIFORD: So, we're going
17 to follow back through on the agenda, and now
18 we're going not go into our Follow-up to
19 Recommendations to Improve American Indian/Alaska
20 Native Birth Outcomes.
21 We wanted to have this session
22 specifically so we can follow-up on what has been

1 going on with the recommendations -- the last
2 group of recommendations that we made to the
3 Secretary. We did reach out to Ed, our former
4 interim chair as well as to Janelle and to Magda
5 to get some feedback from them. I think some of
6 it they sent out to you all, but others, they may
7 not have. But I did want to just kind of share a
8 little bit about what I've heard from them, and
9 then we'll go into our own discussion and say what
10 the rest of us have been doing related to this
11 work.
12 I know Janelle is planning, next week
13 she will be presenting on these recommendations as
14 part of her presentation with the National Healthy
15 Start Association's Spring Conference. So I know
16 she will be there next week, so I know that is one
17 of the things that she is focused on, not to
18 mention numerous other speaking engagements that
19 she's been invited to to continue to elevate the
20 work and the work of those recommendations.
21 Ed did share with us that he had been
22 working, him, Janelle, as well as Magda. They had

1 authored a commentary piece that was recently
2 published in the Minnesota Post. And so, he did
3 share that link with the committee, so you all
4 should have it, *Time to Make Amends, Improving the*
5 *Health of American Indian and Alaska Native*
6 *Mothers and Infants*. So, he did share the link.
7 If you have not had a chance to look at it, please
8 take a moment to do so because it was a very well-
9 written piece, as we would expect.
10 Ed also shared a dissemination effort
11 that had gone on. Otherwise, you know, a letter
12 had been sent to kind of the heads of like AMCHP,
13 the National Healthy Start Association, CityMatCH,
14 ASTO, NCHCU, and many other entities in the public
15 health field. They have been sent a copy of the
16 report for them to share with their members and
17 specifically have conversations with their boards.
18 APHA did -- had a webinar where it
19 was mentioned more recently for a State of Public
20 health.
21 We know Dr. Warren has mentioned
22 several maternal health webinars. We also know

1 that Ed did a presentation for all state health
2 officers in our ASTHO all state health officers
3 call and a similar presentation was made to the
4 ASTHO Healthy Mothers -- excuse me -- Healthy
5 Babies subcommittee. ASTHO is also planning a
6 podcast focused on the report and there are
7 numerous other areas.
8 Plans are being discussed for a
9 session of the report at an APHA annual meeting as
10 well as with the CityMatCH Conference coming up in
11 September. A journal article is being drafted
12 with hopes of a publication for JAMA as well as
13 contacts are being made with the Association of
14 Schools and Programs in Public Health, equity
15 curriculum and member institutions and other
16 places.
17 Magda was able to share a few things
18 as well. She's been working again with the
19 CityMatCH board to make sure that it is included
20 in their work and their ongoing efforts. They're
21 also exploring a symposium again for CityMatCH,
22 MCH-EPI in September on Translating and Making

1 Amends Into Actual Actions. I'm excited to hear
2 about that as well as the National Center for
3 Fatality Review and Prevention Strategic Story-
4 Telling Learning Collaborative is using this
5 report in its team-based leadership and capacity
6 building initiative. And so again, it's an
7 example of strategic story-telling for policy
8 change.
9 So the work that has happened with
10 this last report and others, you know, this is
11 just one iteration, continues to move forward.
12 But today we want to hear from
13 everyone else. We'll talk a little bit about what
14 have we been doing with the recommendations from
15 the last report since we met in December. So just
16 a couple of questions for everyone, so you're
17 going to want to get ready to try to chime in, and
18 if you haven't done anything, talk about what you
19 plan to do. So, we'll go either direction.
20 So, what specifically has been done
21 around spreading awareness of this report since
22 December? That is basically the first question.

1 And then the second question we want
2 to roll into right after that is, you know, one of
3 the things we keep saying around the work that we
4 are doing is we want to make these
5 recommendations. We submit them to the Secretary,
6 but what does accountability from the Department
7 look like from the committee's perspective? When
8 we submit them, we're really in reality, what are
9 we expecting from our recommendations? Are we
10 expecting them to immediately move them into
11 implementation? Are we expecting them to provide
12 us a regular update? Specifically, what are we
13 thinking accountability is?
14 And then what else needs to be done
15 to move these recommendations forward?
16 So, we'll leave the questions up on
17 the screen so everyone can see them, but I will
18 take time now to see if there are committee
19 members that would like to chime in on any of
20 these areas.
21 Thank you, Maria -- Marie.
22 MARIE RAMAS: Thanks, Belinda. Yeah,

1 so a lot of work has been done over the last few
2 months on my behalf. I have shared this article
3 with the New Hampshire Endowment for Health to
4 help with cross-collaboration discussions within
5 the state department -- Health Department, as well
6 as the State Health Assessment/Health Improvement
7 Plan Advisory Council, which is Governor-directed.
8 I also have shared this with the American Academy
9 of Family Physicians, and they shared this
10 material to its members and made a particular
11 focus within the maternal health member interest
12 group.
13 I'll be working on the collaboration
14 CME project on Fourth Trimester for Women and
15 Infants and in part of my particular presentation
16 will be discussing different aspects of cultural
17 sensitivity regarding fourth trimester and
18 including some of the references from our piece as
19 well as it relates to indigenous practices.
20 We have done some work as well with
21 national indigenous organizations for the American
22 Academy of Family Physicians as well, enlisting

1 our indigenous members within the organization to
2 provide additional support and to provide
3 additional resources for current members on
4 indigenous practices and considerations for their
5 particular populations of service.
6 Within the value-based care spectrum,
7 a lot of the discussion on health equity surrounds
8 community health centers, so rural health centers
9 and federally qualified health centers, but it's
10 very rare to discuss Indian Health Services and
11 how value-based care, alternative payment models
12 can be incorporated in order to help expand
13 resources for those particular communities that
14 Indian Health Services takes care of and
15 represents.
16 So those are a few areas that I've
17 been working on personally. I'm looking forward
18 to doing some cross-collaborative social media
19 pieces and joining on some podcasts as well to
20 talk a little bit further about the project.
21 BELINDA PETTIFORD: Wonderful Maria,
22 thank you so much for sharing.

1 Sherri, we'll jump over to you.
2 SHERRI ALDERMAN: Thank you very
3 much. I have also shared it with various
4 organizations. I've shared it with the National
5 Nonprofit Organization Zero to Three, a Policy
6 Center, who advocates on The Hill and supports
7 families, provides resources to families as well
8 through briefs and other family resources, as well
9 as in contact with other organizations that have
10 similar interests and missions and goals.
11 I have also shared it within the
12 American Academy of Pediatrics, specifically the
13 Council on Early Childhood, which is charged in
14 part with writing policy statements that are very
15 widely received across the country by multiple
16 early childhood professionals and with the Council
17 on Healthy Mental and Emotional Development, which
18 is charged with education and advocacy and
19 promotion of the health and well-being of all the
20 pediatric population.
21 I have shared it with Oregon's
22 Maternal and Child Health Division and have

1 received word back in one instance that they are
2 looking at how it can be implemented within the
3 visiting program in the state. And I have also
4 shared it with multiple early childhood leaders
5 within the state as well, across disciplines in
6 early childhood fields.
7 BELINDA PETTIFORD: Wonderful. Great
8 sharing and making sure that the word is getting
9 out.
10 Does anyone else want to share how
11 they've been able to elevate the work and moving
12 it throughout their community, their state, their
13 national affiliations or what you plan to do if
14 you have not had a chance to do anything yet?
15 I will say in North -- oh, go on.
16 TARA SANDER LEE: Yeah. No, I'll
17 just -- I just think, you know, it's such
18 important work and whenever, you know, I interact
19 at the legislative level, because we're involved
20 in science policy and any measure that's going to
21 involve measures of health for women and infants
22 and the unborn, and so moms and babies. And so,

1 anytime I interact with legislators, either at the
2 state or the federal level, I make them aware
3 that, you know, we've been involved in this work
4 and that they -- they need to consider what we've
5 written in the report, especially within the
6 Indigenous population. So, I just want you to
7 know that definitely it's -- it's definitely in
8 multiple conversations and I plan to continue the
9 conversation and share the work that's been done.
10 BELINDA PETTIFORD: Great. Thank
11 you, Tara.
12 Go on, Phyllis. I see you coming off
13 mute.
14 PHYLLIS SHARPS: Yeah. Being a very
15 new member, I was -- I had to go through a list of
16 nursing organizations and leadership that I plan
17 to send to because, you know, nurses are 80% of
18 the health care workforce, and we have several
19 professional groups that are really focused on
20 women's health.
21 But I did reach out to Ed to see if
22 there was a template or suggested wording when you

1 contact individuals formally with the link because
2 I just, you know, I don't want to misstep. And
3 so, he said there is none, but if folks have used
4 a letter or, you know, an introductory e-mail, I
5 would appreciate seeing something like that. You
6 know, I don't -- I don't know if there are, you
7 know, ramifications or are there limits on how we
8 say things about being -- making sure we're not
9 saying the wrong things. Thank you.
10 BELINDA PETTIFORD: I understand,
11 Phyllis, and I can share something with you if you
12 don't hear from anyone else.
13 PHYLLIS SHARPS: Okay.
14 BELINDA PETTIFORD: Because I have --
15 yeah, I have shared it in a couple of places
16 myself.
17 And I see Sherri dropped something
18 else in the chat. She has also shared it with the
19 Alliance for the Advancement of Infant Mental
20 Health. Wonderful, thank you, Sherri.
21 I know in my own state, I shared it
22 with our Commission on Indian Affairs as well as

1 our Office of Health Equity, not to mention the
2 folks within our State Title V entity, making sure
3 that they're all aware, and I made sure I had a
4 conversation with the Board of the National
5 Healthy Start Association, sharing it with them,
6 as well as with the Board of AMCHP, the
7 Association of Maternal and Child Health Programs.
8 I have plans to make sure that it is distributed
9 more widely, especially within my own state
10 through provider support networks through some of
11 the work that our Perinatal Health Collective
12 does, and so looking to have the presentations
13 there so that they can see that the work -- how it
14 impacts the work we're doing in North Carolina.
15 Any others? Yes, Jacob.
16 JACOB WARREN: One thing I've been
17 working on is getting it disseminated within rural
18 health networks, so that's my particular
19 background, so working with rural agencies
20 because, of course, they're not one and the same,
21 but there is a significant amount of overlap
22 obviously. So that's been one element trying to

1 get that out in the National Rural Health
2 Association and other organizations that focus on
3 rural in particular.
4 And then locally, here in Wyoming,
5 I've been working with one of the tribes to look
6 at how we can again translate this into action and
7 how we can work together to develop the advocacy
8 approach that they can use, as this particular
9 tribe took over their own health services by IHS,
10 so they're able to be a lot more nimble in what
11 they can implement, and so that's part of what
12 we're doing here in Wyoming.
13 BELINDA PETTIFORD: Thank you, Jacob,
14 for sharing that and specifically also for
15 bringing up rural health. That is one of the
16 other areas that I need to reach out in my own
17 state with the Office of Rural Health. We work
18 with them on numerous efforts and I just have not
19 shared this with them. So, thank you for the
20 reminder.
21 Okay. If no one else has anything to
22 share, you can always drop it in the chat.

1 But the other part of the
2 conversation is the accountability question. So
3 once, you know, we have submitted these
4 recommendations, you know, we work as a committee
5 to develop them. We submit them to the Secretary.
6 What are we thinking accountability looks like?
7 What are we asking of the Secretary once they get
8 the recommendations? Is it, you know, are we
9 saying we just want to get an update at every one
10 of our meetings or every other meeting on the
11 status of how the work is moving forward? Is
12 there something more specific we're looking for?
13 Or do we even know what we're looking for? I do
14 think we should have this conversation so that,
15 you know, we are clear of what we're asking, but
16 also we can pass it on to the Secretary for his
17 information. Has anyone thought about this?
18 Should I assume we haven't thought about this?
19 Yes, Jacob.
20 JACOB WARREN: I think it -- for me,
21 it ties into a broader conversation as well. When
22 I've talked to other groups, part of the question

1 I get is, well, what can we do? What are you
2 specifically asking? How can we directly help?
3 And so, I think that's something that I think it
4 ties into something you're going to bring up a
5 little later, but how are we translating this into
6 actionable -- very concrete actionable things
7 we're asking people to do, and to me that comes
8 back even with this accountability piece of are
9 there specific things we're wanting to see come
10 out of the Secretary's Office, and can we be a
11 little more concrete with very specific actions
12 that could be taken that we think would help
13 translate those items. I don't know what those
14 are offhand, but to me it sort of ties into that
15 discussion.
16 BELINDA PETTIFORD: No, that's an
17 excellent point. Thank you, Jacob.
18 Are our recommendations specific
19 enough or how do we take the recommendations and
20 move them into actionable steps? And then, what
21 are you doing with those actionable steps?
22 Yes, Marie.

1 MARIE RAMAS: Yeah, to that point, I
2 know we talked about at the end of the December
3 meeting what departments are already working on
4 some aspect of the recommendations that we have,
5 and can we get point people to either give us
6 updates, yes, but what are -- what are specific
7 concrete items as far as appropriations are
8 concerned, as far as key influencers within each
9 of those subsections are concerned so that we can
10 make sure that we are speaking to the doers and,
11 you know, the actual deliverable entities of the
12 work, and then the other area that we talked about
13 in December was what are -- what are ways that on
14 a state level potentially, people can advocate in
15 their specific state. So, what part of the
16 recommendations can be enacted and worked upon at
17 a state and local level versus federal level. So,
18 that's some things that I recall.
19 BELINDA PETTIFORD: Thank you, Marie.
20 That is a good point, you know, we make the
21 recommendations to the Secretary, but many of
22 these same recommendations, you know, could easily

1 be recommendations that are made to states that
2 will ultimately probably involve implementation in
3 a community. So how are we wording that in our
4 recommendations? Are we asking the Secretary to
5 bless them? Are we asking him, you know, to just
6 elevate them more broadly throughout his sphere of
7 influence? I think all of that is part of that.
8 Yes, Sherri.
9 SHERRI ALDERMAN: I'm curious to have
10 a deeper understanding of what the parameters are
11 that HRSA has to be able to implement these
12 recommendations, what barriers or challenges that
13 they encounter to be able to act upon them, and
14 what influences outside of HRSA impact either
15 positively or negatively of their ability to be
16 able to act on these recommendations.
17 BELINDA PETTIFORD: Great point. You
18 want to know what are the challenges to acting on
19 the recommendations. I was trying to take notes
20 at the same time you were talking, Sherri. So, I
21 know we're being recorded, but I want to make sure
22 I get them as well. And I don't know if there is

1 anything that -- I don't if Vanessa -- is there
2 anything that you all want to chime in to say as
3 to -- because, you know, we know that these are
4 recommendations coming from the Advisory
5 Committee. But once they go to the Secretary, is
6 there something more that the Secretary needs? We
7 know, again, they're just recommendations from our
8 perspective.
9 MICHAEL WARREN: Yeah, I think it's a
10 really good question, and for me a couple of
11 things come to mind. One is there -- there are
12 many recommendations and they're not actually just
13 limited to HRSA. So many of them apply to other
14 components of HHS and we've got other colleagues
15 on the call.
16 I think one of the ones that jumps
17 out for us often is whether there are any
18 statutory limitations. So, for example, in grant
19 programs, sometimes folks have questions about who
20 is eligible or can you -- can you set aside
21 specific funds or can you change the way those are
22 done, and sometimes the department has the ability

1 to do that within the existing legislation and
2 sometimes not. Sometimes the legislation is so
3 prescriptive that it spells out exactly who is
4 eligible and what format and exactly how the funds
5 are to be given. So that's one example where, I
6 think you always go back to what do we actually
7 have the legislative authority to do as an
8 executive branch agency and from there.
9 Beyond that, I think it depends on
10 the nature of the specific recommendation. But
11 the legislative authority is one thing that comes
12 to mind.
13 WENDY DECOURCEY: This is Wendy. I
14 just want to emphasize something that Sherri said,
15 which was understanding -- I think Sherri said it
16 -- the understanding what are the pathways that
17 HHS and HRSA and the other agencies could be using
18 as well as the obstacles then to using them? So,
19 I think it's two layers. First, what are the
20 potential pathways, but then what are -- what are
21 the things, you know, that we didn't need to be
22 specific about and work around or can't work

1 around? I just want to make sure that it's not
2 just finding the obstacles but finding the paths.
3 BELINDA PETTIFORD: Thank you, Wendy.
4 And were you getting ready to say something? Oh,
5 maybe I lost her. We lost her, okay.
6 VANESSA LEE: Belinda, I'll just add
7 in a quick update. The ex officios and MCHB, we
8 did hold a meeting in early March to specifically
9 talk with each other about how we might be already
10 implementing or adopting some of the
11 recommendations or have plans to in the near
12 future or which ones may be goals for our agency,
13 and so we had a really great conversation amongst
14 each other, the ex officios, and we agreed to
15 continue meeting probably in conjunction with when
16 the committee meets to continue to update each
17 other on the work that's happening or planned to
18 happen around the recommendations, but also to be
19 able to lean on each other for support or looking
20 for areas we could collaborate or synergize, again
21 to move any of these recommendations forward.
22 And so I don't know if other ex

1 officio members want to mention one or two things
2 that you had shared on that March call, because I
3 was personally very impressed with the work that
4 was already happening related to the
5 recommendations. And I know, Tina, not to put you
6 on the spot, but I know you had another meeting
7 and commitment to go to, and so your time was
8 limited with us, if we haven't already lost you.
9 So I just wanted to see if Tina wanted the floor
10 before she had to hop off from IHS.
11 TINA PATTERA LAU: Hello, everyone.
12 I'll go ahead and just present some brief updates
13 from IHS. Just again, I have another commitment
14 at the top of the hour.
15 I'm Tina Pattara Lau. I'm a maternal
16 child health consultant for the Indian Health
17 Service and also an OB/GYN providing care to
18 American Indian/Alaska Native patients here in
19 Phoenix, Arizona. I'm currently on the Ancestral
20 Homelands of the O'odham Tribe. Thank you for the
21 opportunity to participate and present updates
22 from HIS today.

1 So, thank you again for being very
2 specific in the committee's recommendations. It's
3 certainly something we at IHS are listening to and
4 using to craft our path forward.
5 I'm specifically looking at three
6 areas that were involving programs and policies
7 for IHS recommendations 15 through 17 to evaluate,
8 fund, and improve oversight for IHS. I wanted to
9 call to your attention that last year in December,
10 the Consolidated Appropriations Act for fiscal
11 year 2023 was the first time in history that IHS
12 has received advanced appropriations to guarantee
13 health care services for the agency, and that will
14 not cease during a lapse in government
15 appropriations and align IHS with other federal
16 health care providers. So, thank you to our
17 Tribal Nations, tribal and urban Indian
18 organizations and others across Indian country
19 that have advocated on behalf of IHS for this
20 important support.
21 Simultaneously, in January of this
22 year, IHS leadership implemented the 2023 work

1 plan. This outlines critical priorities that will
2 guide agency improvements over the next year and
3 complement ongoing activities to improve patient
4 safety and provide critical oversight of our
5 plans. The work plan also prioritizes important
6 partnerships with tribes and Urban Indian
7 organizations including communication. So we are
8 turning this forward into regular updates on our
9 IHS website and we will be launching an MCH
10 specific website as well as continuing our twice-
11 monthly E-mail to the field that does share
12 resources.
13 With regards to recommendations to
14 expand and diversify the workforce and, as always,
15 the strength of IHS in the collaborative practice
16 that we see especially in our rural settings with
17 midwives as well as our family medicine providers.
18 And so, our agency work plan does prioritize
19 implementing the workforce development plan as
20 well as development of diversity and equity and
21 accessibility of programs.
22 We also continue to support our

1 internship program for midwifery students and
2 expanded partnerships with academic centers
3 including some fellows and a lot of training
4 rotations at IHS.
5 And then lastly, a recommendation to
6 strengthen our approach to adapt social
7 determinants of health, as you are aware, and as
8 my patients will tell me, with IHS' unique
9 delivery care system, many patients to reside in
10 maternity care deserts. Often there are barriers
11 to accessing care in the clinic, and these include
12 transportation, child care, housing. And so, we
13 are mindful of that as we create our policies and
14 programs moving forward. We are looking to work
15 with maternity care coordinator programs to
16 provide telehealth and home visitation support to
17 help supplement the work we do in our clinics and
18 hospitals and really support the parent and child
19 dyad from preconception through pregnancy as well
20 as postpartum, hopefully again to increase patient
21 access to care, as well as screening and education
22 and intervention, when possible. This will be

1 done in partnership, of course, with our public
2 health nurses, community health workers, doulas,
3 and birth support workers.
4 Thank you for the opportunity to talk
5 to you today.
6 BELINDA PETTIFORD: Thank you, Tina.
7 And thank you for joining us today.
8 Does anyone else want to share
9 anything quickly? Any of our other ex officios?
10 You don't have to be shy. We'll take whatever you
11 have done so far, whatever you're planning to do.
12 I see you, Charlan.
13 WENDY DECOURCEY: This is Wendy from
14 -- oh, go ahead. Go ahead, Charlan.
15 CHARLAN KROELINGER: Thanks, Wendy.
16 I'm sorry, I was trying to find the hand raise.
17 WENDY DECOURCEY: Yeah, exactly.
18 CHARLAN KROELINGER: Thanks so much
19 to Michael and Vanessa for convening us as a
20 group. It was really helpful to hear from
21 everybody in planning for this session. I'll talk
22 about a few things that are going on across the

1 agency just to update those.
2 CDC is committed to disaggregating
3 data by race ethnicity with recent attention to
4 categorization for American Indian and Alaska
5 Native populations specifically and to date, as I
6 mentioned, DRH has published the brief pregnancy-
7 related deaths among American Indian or Alaska
8 Native persons, data for Maternal Mortality Review
9 Committees in thirty-six U.S. states.
10 CDC has implemented methods for
11 classification of AIAN persons with advising from
12 tribal organizations to better capture those that
13 identify as American Indian or Alaska Native and
14 will continue to use this methodology in future
15 work.
16 CDC's Division of Reproductive Health
17 will also continue to develop a tribal-led
18 Maternal Mortality Review Committee in partnership
19 with tribes.
20 CDC will extend funding this year to
21 increase support for these activities and once
22 implemented, the tribal-led MMRCs will receive

1 technical support to use the Maternal Mortality
2 Review Information Application or MMRIA platform.
3 CDC encourages MMRCs to identify all
4 pregnancy-associated deaths among all populations
5 to determine which are pregnancy-related and
6 report those findings as appropriate. Though some
7 state laws and legal processes may prohibit
8 reviews of deaths under certain circumstances,
9 like homicide, deaths with suicide and overdose as
10 a manner of death, are regularly reviewed by
11 MMRCs. This year, CDC will provide funding to
12 MMRCs for key informant interviews of surviving
13 family and friends as appropriate and as state
14 laws allow, as it is important to listen to the
15 stories of these individuals.
16 Also this year, CDC will partner with
17 the National Institute of Child Health and Human
18 Development to update materials for the Healthy
19 Native Babies Project and will focus on efforts on
20 prevention to sleep-related deaths. The update of
21 the Healthy Native Babies Project will engage
22 tribes, tribal leaders, and tribal organizations

1 in review of current materials and will use
2 feedback to inform development of new culturally
3 appropriate materials for use by these
4 populations.
5 CDC's Division of Reproductive Health
6 continues to support the Hear Her Campaign as
7 well. To date, we've launched Hear Her personal
8 stories of pregnancy-related complications from
9 American Indian people and CDC will continue to
10 amplify the voice of the pregnancy and postpartum
11 persons who experience complications during or
12 after pregnancy.
13 And to further support engagement
14 with AIAN populations, the Division of Population
15 Health, which is a division located within the
16 National Center for Chronic Disease Prevention and
17 Health Promotion, where DRH is also located,
18 maintains the Healthy Tribe Program to promote
19 health, prevent disease, and strengthen cultural
20 connections to improve health and promote
21 wellness. This year, the Division of Population
22 Health is launching a new funding cycle for the

1 Good Health and Wellness in Indian Country
2 Program, while also maintaining funding for Good
3 Practices for Wellness Indian Country Program and
4 the Tribal Epidemiology Centers Public Health
5 Infrastructure Program.
6 The National Center on Birth Defects
7 and Developmental Disabilities, Surveillance for
8 Emerging Threats to Mothers and Infants or the
9 SETMT is looking at ways to engage directly with
10 tribal epicenters to include AIAN communities and
11 surveillance to protect mothers and infants from
12 infectious disease threats and to ensure that
13 public health recommendations that are based on
14 SETMT findings are developed specifically for
15 these populations with a focus on cultural
16 sensitivity.
17 And finally, the Center for State
18 Tribal, Local, and Territorial Support has
19 published a new funding cycle for strengthening
20 public health systems and services in Indian
21 Country for tribes and tribal organizations to
22 improve the quality, performance, and

1 infrastructure of tribal health systems including
2 workforce, data, and information systems and
3 programs and services.
4 And that's just a snapshot of what
5 we're doing here at CDC to implement the very
6 thoughtful recommendations made by the committee
7 to the Secretary. Thank you.
8 BELINDA PETTIFORD: No, thank you,
9 Charlan. I was trying to keep up and takes notes
10 with everything you were saying, so thank you.
11 CHARLAN KROELINGER: I'll drop some
12 notes in the chat, Belinda.
13 BELINDA PETTIFORD: Thank you so much
14 for reading my mind.
15 Wendy, are you still there? Do you
16 want to chime in?
17 WENDY DECOURCEY: Hello. I just
18 wanted to say that I met, you know, I'm from the
19 Administration for Children and Families and I've
20 met with the Administration for Native Americans
21 at ACF and we've had a series of meetings and we
22 are developing, basically, a letter, sort of, to

1 outline the various channels we're sharing the
2 information out on and various activities, much as
3 Charlan has done and others have done here, and
4 the various activities we're working on.
5 We're a little -- we weren't able to
6 make it to the meeting, but we're working on
7 getting that information back to the committee.
8 BELINDA PETTIFORD: Thanks for
9 letting us know, Wendy. We appreciate that.
10 And I see Danielle's hand is up as
11 well.
12 DANIELLE ELY: Yeah. I was just
13 going to follow-up. So, technically, I'm also a
14 part of CDC, although a little bit separate based
15 on some funding structures. However, one of the
16 things I'm trying to do is start a special report
17 looking at AIAN infants and during pregnancy, some
18 of the birth items that we have with the birth
19 certificate and with the linked birth and infant
20 death file, and one of the -- one of the things
21 that I do remember being discussed in some of the
22 earlier meetings is how for American Indian/Alaska

1 Natives, they in many cases don't always identify
2 as just singularly American Indian or Alaska
3 Native. And so including multiple race as a
4 category is something I'm going to be trying to do
5 in an upcoming project.
6 BELINDA PETTIFORD: Well, thank you
7 so much, dear.
8 And Michael, I see your hand is up.
9 MICHAEL WARREN: Sure, just an update
10 from MCHB. So our team regrouped after the
11 recommendations were published. Of the fifty-nine
12 recommendations, we think twenty-nine of them
13 directly apply to the work of MCHB and nineteen of
14 those 29 are things that either we or our grantees
15 are currently doing or we think they could do in
16 the near-term. So just a few examples of those.
17 One, I mentioned in the overview this
18 morning, the MIECHV, the Maternal Infant Early
19 Childhood Home Visiting Program was reauthorized,
20 and that included a doubling of the tribal set
21 aside. We've already operationalized those
22 agreements with our partners at ACF, the

1 Administration for Children and Families. They
2 administer the tribal portion of MIECHV, and so we
3 have already worked to transfer those funds so
4 that the program can grow.
5 We're broadly looking across all of
6 our funding opportunities to make sure that we are
7 more inclusive in our language and our funding
8 opportunities and being very direct about who is
9 eligible to apply, specifically when that includes
10 tribes, tribal organizations, and urban Indian
11 organizations. We are working to increase the
12 utilization of consultation with tribes. So that
13 happens at the HHS level with the Secretary. HRSA
14 also has a Tribal Advisory Committee that we meet
15 with regularly and the various bureaus within HRSA
16 can hear directly from tribes as well as share
17 updates on programming.
18 And then we all felt that the value
19 of being invited onto tribal lands for the meeting
20 in September was just so incredible, and we look
21 forward to thinking about future Advisory
22 Committee meetings in communities that can provide

1 great input for the work that we're doing on the
2 various advisory committees we host.
3 Lastly, just a few things that we're
4 planning on either expanding through existing
5 grant programs or incorporating into future
6 funding announcements were specific
7 recommendations, for example, around increasing
8 the number of tribal entities that received
9 Healthy Start funding, investing in training of
10 AI/AN doulas and traditional birth workers,
11 encouraging the inclusion of universal screening
12 and referral for intimate partner violence
13 substance use disorder, depression, and anxiety,
14 and identifying strategies to facilitate access to
15 and engagement with maternal mental health
16 services.
17 So, just a snapshot of the work that
18 we're doing across our grant programs in response
19 to these recommendations.
20 BELINDA PETTIFORD: Excellent. Thank
21 you so much for sharing that. You said nineteen
22 of the twenty-nine, you're already moving forward

1 into implementation. That is wonderful. Thank
2 you.
3 Anyone else want to share? I think
4 this is part of the accountability is definitely
5 being able to just kind of share what is going on
6 and how the work continues to move forward.
7 I think the last question we want to
8 take a moment as a committee is to talk about else
9 do we need to do to move these recommendations
10 forward. I mean, it seems like all of us are
11 going down different paths trying to make sure
12 that we are sharing the information, partnering
13 with others to try to get the recommendations
14 moved into implementation. It sounds like quite a
15 few of them are in the implementation phase, so
16 that is always great to hear. But what else do we
17 need to do as a committee or what else should we
18 be doing? Any thoughts?
19 If no thoughts, we'll take some time.
20 Thank you, Marie.
21 MARIE RAMAS: Thanks, Belinda. The
22 only other thing I could think of, if it would be

1 of benefit, and I'm asking for those who have been
2 in the committee for some time or have history,
3 has there been opportunity for committee members
4 to share particular aspects of the work within
5 different departments? And so, we have the luxury
6 of having different departments that affect this
7 Advisory Committee's work come to report to us.
8 Is there bidirectionality where committee members
9 can also provide added support in reporting back
10 the work and the importance of the work from our
11 frame?
12 BELINDA PETTIFORD: So you're asking
13 of the committee members, are they ways that we
14 can do it, or are you asking more from an HHS
15 perspective? I just want to make sure I'm
16 understanding correctly, Marie.
17 MARIE RAMAS: Yeah. I'm asking if
18 there has been precedent of committee members
19 reporting to our actual stakeholders within the
20 government to share our particular diverse
21 perspectives as it relates to the recommendations.
22 Is that helpful? Has that been done? And if not,

1 would that be an opportunity to add further
2 accountability in the work?
3 BELINDA PETTIFORD: I don't know.
4 I'm going to ask Vanessa if there's anything you
5 can think of. I can see like with the meeting,
6 you all convened in -- what did you say, March
7 with all of the ex officios? January?
8 VANESSA LEE: The March meeting of ex
9 officios.
10 BELINDA PETTIFORD: March meeting?
11 Okay.
12 VANESSA LEE: I don't think -- well,
13 Dr. Warren, I'll let you weigh in as well. What
14 Marie is describing doesn't ring a bell to me in
15 terms of the members themselves getting the change
16 to almost contribute to that response or joint
17 accountability, I guess, of the recommendations.
18 It has been more in the direction of, you know, us
19 either through the ex officios or inviting other,
20 for example, bureaus within HRSA to come speak to
21 the committee to show again that we are taking
22 your recommendations, here's how we are adopting

1 or trying to implement them. But yeah, I think
2 it's a great idea. Dr. Warren, I don't know if
3 you want to add anything.
4 MICHAEL WARREN: I think you're
5 exactly right, Vanessa. Dr. Ramas, I think it's a
6 great suggestion if I'm understanding correctly,
7 and I think the meetings, I mean, almost like
8 expanding what you all did earlier where you all
9 talked about what you're doing to disseminate the
10 recommendations to date as folks move more into
11 implementation, being able to share that as part
12 of your role as committee members. I don't see
13 there being an issue with that.
14 I think it also really speaks to the
15 fact that tackling issues like the ones that we
16 bring before this committed require much more than
17 just a government solution, that the solutions
18 really require partnerships across all levels, and
19 this could be a venue for discussing that.
20 WENDY DECOURCEY: This is Wendy from
21 ACF. I do want to ask, we are planning to send
22 the report out on multiple channels to present on

1 the report on multiple channels, and we were sort
2 of wondering if PowerPoint presentation was
3 available, like something that -- or maybe it's
4 even something that the committee would want to
5 review and decide what they wanted to emphasize in
6 the report. But I was just thinking, all of us
7 going down all of these different channels and
8 each of us creating a PowerPoint, I just wondered
9 if there was one out there already or if HRSA had
10 developed one for presenting to HHS or the like.
11 So that was just one question I have.
12 BELINDA PETTIFORD: Thank you, Wendy.
13 I am not aware of one, Vanessa, of a PowerPoint
14 that you all have developed. I think different
15 ones of us have used different variations when
16 we've shared it with other groups, and I'm not
17 even sure if most of the time we're using an
18 official PowerPoint. I think it's more of a
19 conversation and then sharing the recommendations.
20 But if you think that would be helpful, I don't
21 know if Vanessa or Sarah, is that something we
22 could work together on that could be shared back

1 with the committee?
2 WENDY DECOURCEY: I was even thinking
3 that some of the partners I would present with
4 would then want to grab those slides and be using
5 them right on down their channels. So, it's just
6 a thought.
7 BELINDA PETTIFORD: I think it's
8 pretty much in line with what Phyllis was asking
9 earlier, did we have any templates for any other
10 work we're trying to move forward just to make
11 sure we've got consistency going across the board.
12 So, thank you, Wendy, for the question.
13 And I don't know, Vanessa, if you
14 want to chime in now or think about it. I'll go
15 onto Phyllis while you're thinking, okay, Phyllis?
16 PHYLLIS SHARPS: Yeah, one of the
17 things is, you know, we're in -- it sounds like we
18 are all working very hard at why dissemination of
19 the report and recommendations and I keep thinking
20 about, you know, the so what is of course we all
21 expect that health is going to improve for these
22 women and mothers and babies, but are there, as a

1 part of the accountability, you know, I keep
2 thinking what would it look like if these fifty-
3 nine recommendations were all widely implemented
4 and is there some type of metrics with not being
5 so prescriptive, but, I mean, are there indicators
6 that we should be looking for or thinking about
7 long-term that shows a difference?
8 I'm working with another federal
9 advisory group that's doing a strategic plan, and
10 we all had to come up with metrics, and they were
11 pretty general kinds of things, but, you know, I'm
12 thinking about, for instance, grants that some of
13 Dr. Warren talked about, do we look at how many
14 more women -- indigenous women and babies were
15 included in programs or demonstration grants where
16 it's appropriate or, you know, just what should we
17 be looking at that -- kind of that so what they we
18 really made a difference?
19 BELINDA PETTIFORD: That's a really
20 good point, Phyllis, you know, is there something
21 -- if I'm hearing you correctly, is there
22 something we're tracking to show the movement of

1 the work, you know, is there some metric or
2 something of that nature. And I think, you know,
3 I think Dr. Warren gave a really good example when
4 he went in and start sharing that twenty-nine of
5 the fifty recommendations kind of set in his shop
6 and then of those, nineteen of the twenty-nine
7 were actually moving forward. So having more of
8 those kinds of things that actually have a way to
9 clearly see what is actually moving forward with
10 the work. I think that is important. I don't
11 know if you have other thoughts about how to move
12 it forward or certain recommendations around that,
13 Phyllis. I am taking notes on what you just said.
14 PHYLLIS SHARPS: Well, again, and not
15 to put Dr. Warren on the spot, but, I mean, in his
16 report, he talked about, you know, increased
17 funding across several programs and I think I
18 heard something about increased funding for home
19 visits for indigenous women and those populations.
20 So I think that then says yes, somebody was
21 listening to the recommendations. So, not to be,
22 I mean, I don't think it should be onerous or that

1 kind of thing, but are there things that we should
2 be looking at or thinking about as we or maybe as
3 people report back on what's happened, you know,
4 in their state kind of thing or whatever or
5 agencies or that kind of thing. But just
6 something to think about, I think.
7 BELINDA PETTIFORD: Thank you,
8 Phyllis.
9 Jacob.
10 JACOB WARREN: This might be a
11 classic case of misremembering, but one thing I
12 wanted to check in, because, you know when Marie
13 was saying, you know, what can we do -- I'm sorry
14 to paraphrase you, Marie, but like where we can be
15 more active, right, as committee members going out
16 and spreading this more broadly. Something
17 tickled in the back of my brain though about that
18 we, as committee members, are not to speak on
19 behalf of the committee. Am I misremembering that
20 in some way? I felt like that was something that
21 we had been, you know, that the chair of the
22 committee spoke for the committee. And so, I just

1 want to be sure, you know, what framework we can
2 operate in. You know, I'm a state employee, and
3 there are things I can and can't do as a state
4 employee. So, I'm just curious what our role can
5 be in being more active in that way or if there
6 are restrictions and parameters that we need to
7 think about.
8 BELINDA PETTIFORD: No, that is an
9 excellent point, and I don't know if I can answer
10 that questions. I think it -- I think the
11 conversations we've had in the past have been more
12 in line with, you know, it's one thing if you're
13 sharing these are the recommendations as a
14 committee that we all came up with together and we
15 view them as important because we, you know, we
16 have moved them onto the Secretary. I think
17 anyone on the committee could say that. I don't
18 think there's anything there that would be
19 construed as controversial or anything.
20 And like you, Jacob, I'm also a state
21 employee, so I'm always cautious of which
22 direction I'm going. But, you know, if you stand

1 behind the fact that, you know, these are the
2 recommendations we've moved forward, I think we're
3 all fine. So if there is something you get
4 nervous about or you're not comfortable sharing,
5 then maybe let's have a conversation about it.
6 But I don't know if there's any special guidance,
7 Vanessa or Michael, that came to us, that I'm not
8 remembering right now.
9 VANESSA LEE: I am not thinking of
10 anything in particular, but we can look into it,
11 and Dr. Warren, I saw you go off mute as well. I
12 don't know if you were going to say something, but
13 I will make a note to see if there is anything
14 I've missed.
15 MICHAEL WARREN: Yeah. The only
16 couple of things that come to mind for me is one
17 if there are media inquiries. We typically ask
18 folks to come back and work with staff and the
19 chair if there are media inquiries related to the
20 work of the committee. And then the other is just
21 always being mindful of conflicts of interest and
22 any of those that may come up in the work you're

1 doing. But we can certainly work with Vanessa and
2 Belinda both on packaging some of this into like a
3 slide deck that folks could share or use to
4 present. We can work with the team on that.
5 BELINDA PETTIFORD: Thank you.
6 Jacob, does that get to what you were needing?
7 JACOB WARREN: It does. Thank you so
8 much.
9 BELINDA PETTIFORD: Wonderful,
10 thanks.
11 Okay. As we wrap up this session, I
12 don't want to cut anyone off. Thank you all so
13 very much, and especially thanks to our ex officio
14 members for the work that you were able to share
15 with us today that you're moving the
16 recommendations forward. So, we greatly
17 appreciate that.
18
19 DISCUSSION: FRAMING / LANGUAGE MATTERS
20
21 BELINDA PETTIFORD: Now we're going
22 to go into a very short discussion around framing,

1 and, you know, I think one of the things, when I
2 think of framing, you know, it's always what we
3 say and how we say it is so important as we need
4 to, you know, make sure we're having engagement at
5 all levels in this work. I don't know about you
6 all, but in my, you know, community and in my
7 state, and I'm hearing from others in other states
8 and other communities around some of the, you
9 know, some of the how things are being framed and
10 how things are not moving forward in a way that
11 they thought they would move forward because some
12 of these things have become controversial for
13 whatever reason, and we all know on this committee
14 the importance of maternal and infant health and
15 making sure that we are moving that work forward,
16 and we also know that how we see it is important
17 because we need engagement at all levels. We know
18 this work is important, and I don't know if you
19 all have been hearing things in your communities
20 or if you just turn on the TV and you're just
21 like, oh my goodness, I can't believe this is an
22 issue that someone would not support.

1 But one of the things that we have
2 spent time really thinking through and some other
3 areas that I work in has been around how we are
4 framing our conversations, how we are framing our
5 discussions, how we're framing them in a way that
6 we can get engagement and some level of buy-in
7 from as many individuals and entities as possible.
8 And so I don't know how many of you
9 all are familiar with like the Frameworks
10 Institute or if any of you have worked with them.
11 We have worked with them in our state in a couple
12 of areas, I think probably the area where we spent
13 the most time working with them in our state has
14 been around the issue of tobacco use and how we
15 frame the whole conversation around, you know,
16 utilizing tobacco products and things of that
17 nature, especially when we are in a state that for
18 years and years has been known to be a high
19 tobacco-producing state. So I know we have pulled
20 in frameworks and other types of entities of that
21 nature.
22 I wanted to talk a little bit today

1 around any examples that you all are hearing in
2 your own communities around the language around
3 how equity is being perceived and how we can kind
4 of get ahead of this as we're thinking through our
5 next level of work and what we're doing first and
6 how we want to really elevate maternal and infant
7 health in a way that no one should be against it.
8 It is such an important part of everything that
9 we're doing.
10 In your briefing book, you should
11 have received some information around -- I think
12 it is -- I can't remember what page in the
13 briefing book -- but some information around some
14 of it. There's some very short video clips that
15 Frameworks does. I think they have like seven or
16 eight short video clips. They're like five
17 minutes each. They really talk about how do you
18 frame your message in a way that is reaching the
19 population you're trying to get it to reach.
20 And so, they've done a really good
21 job of pulling these together, and I wanted to see
22 if this is something that you all would be

1 interested in maybe us trying to get Frameworks or
2 some type of entity like Frameworks to come and
3 talk to us around our messaging approach as we
4 move forward some of this work around maternal and
5 infant health.
6 So, I guess my first question to you
7 all is are you hearing these messages in your
8 communities and are you struggling with it,
9 especially as you're looking at issues of maternal
10 and infant health and especially as you roll it
11 into health inequities, and if so, how are you
12 dealing with it in your own communities or your
13 own state?
14 CHARLENE COLLIER: Belinda, just one
15 thing I would just share is hearing pushback about
16 maternal mortality in particular, like skepticism
17 from the OB community that the numbers are maybe
18 real, and by that, being like, oh, well the
19 definitions have changed, it goes out to a year,
20 it includes overdosing, it includes a lot of
21 things have "nothing" to do with obstetric care.
22 Because it's really hard for OB providers, it

1 seems, to move past that understanding of like
2 scope and pregnancy relatedness, not being like an
3 indictment of their practice and care and even
4 among ACOG's Regional Maternal Mortality Review
5 Committee and the whole conversation seemed to
6 shift to like preventability seeming as a threat
7 to like providers and that, you know, not around
8 the scope where preventability is presented to the
9 CDC, which is truly like communities being safer
10 and healthier, you know, lives from the very
11 beginning.
12 They're looking at it like I hear
13 preventability as like the doctor didn't do
14 something right. And so, there's this like
15 general skepticism and like defensiveness. I've
16 seen OB practices where they, rather than saying
17 like yes, we're broadening our understanding of
18 maternal mortality. We are taking accountability
19 for the lives of the people we care for through
20 that twelve months. We want to see moms get
21 through and we're not going to be like not just
22 because it's an overdose or a car accident. We're

1 going to like try to take accountability for it in
2 order to make, you know, that entire period safer.
3 So, I do see that happening a lot
4 around rather than sort of embracing the
5 recommendations, it's this general pushback around
6 what preventability means and what those rising
7 numbers truly mean. And so, I do think there's
8 some understanding of like those definitions are
9 not tied to how they used to be, which is truly
10 like pregnancy-related being like what happened
11 related to care alone, that is really is an all-
12 encompassing perspective around society. Care for
13 pregnant and postpartum people.
14 I don't have a great answer for it
15 apart from like addressing it one at a time. But
16 it does become -- it's definitely something
17 particularly among like I would say OBs not very
18 involved with like academics and public health.
19 Like they're just, you know, in practice when they
20 see the numbers and they hear the stats, you know,
21 it gets back to like a not it type of feeling. So
22 I do think that maybe just general education or

1 outreach to organizations like ACOG, like rank and
2 file OB/GYNS, like to not -- to better understand
3 that -- this newer perspective on maternal
4 mortality.
5 BELINDA PETTIFORD: That's a really
6 good example, Charlene, and thank you for sharing
7 it because in reality, you know, we've got this
8 Maternal Mortality Review Committee and people are
9 out, you know, reviewing the deaths and making
10 recommendations. If people aren't open to the
11 recommendations, how does it change the process
12 that, you know, we've put in place? So, that's a
13 really good example and I appreciate you sharing
14 it.
15 Marie, I see your hand is up as well.
16 MARIE RAMAS: Yeah. The work that
17 the Academy of Family Physicians is working on
18 currently speaks just to that, Charlene, that this
19 fourth trimester, we say it loosely, but it's
20 really that year postpartum in recognizing that
21 part of maternal and infant morbidity and
22 mortality, it is the continuum from being pregnant

1 and then turning back into, you know, chronic
2 conditions that can yield into worsening health
3 outcomes as well. So, how to -- you know, how do
4 we share the importance of understanding
5 postpartum care and the issues related to maternal
6 mortality and morbidity to health care clinicians
7 that just see adults, as often times, if there is
8 anything related to female organs, it is reverted
9 back to the OB/GYN community, and it's not
10 considered a part of just continuity of care and
11 preventive care in general for those who have
12 uteri.
13 So I think that is part of the
14 messaging that this is primary care, that this is
15 essential for public health, which means that it
16 needs to be foundational information and in the
17 front of mind when anyone with a uterus comes to
18 the office. So I appreciate your words, Charlene,
19 and hopefully that adds some context as well.
20 BELINDA PETTIFORD: Thank you, Marie.
21 Jacob, I see your hand.
22 JACOB WARREN: We talked about this a

1 little before and I sort of want to bring it back
2 in the context of what you're discussing, Belinda,
3 is that, you know, our states are in very
4 different places in this conversation just across
5 the whole country and, you know, just as an
6 example -- I want to be very careful with my
7 wording here -- but, you know, our most recent
8 legislative session in Wyoming, we finally
9 expanded postpartum Medicaid for twelve months and
10 it passed 16 to 14. It was one vote. So, we
11 still have a lot of baseline education that we'd
12 have to do to accompany some of the
13 recommendations sometimes. I think that packaging
14 is important to be kind of strategic and targeted
15 to where our target audience is in the process
16 because, you know, of course we all agree with the
17 need of health equity, but some people aren't even
18 at that point of the conversation if we're passing
19 by one vote for Medicaid expansion. So that's
20 sweet, and that's what I like what you're saying
21 about framework, if we can make that flexible and
22 adaptive to where an individual state is, I think

1 that's how we could get help move the needle in
2 some places too.
3 BELINDA PETTIFORD: Thank you, Jacob.
4 And again, another great example there. And
5 congratulations for expanding and extending
6 Medicaid for twelve months in the postpartum
7 period. We're just at our one year anniversary in
8 North Carolina, so we understand. Thank you.
9 Phyllis.
10 PHYLLIS SHARPS: Yeah, you know, and
11 I think -- I think it would be helpful too that we
12 get people to think about it's the childbearing
13 year and while we are focused on the pregnancy and
14 the postpartum, but there's also preconceptual
15 care that needs to be included and as we see
16 assaults on abortion and contraception and that
17 kind of thing, you know, there needs to be
18 probably some thought about that. And I also
19 think framing is going to be really important
20 because this is newer data that's looking at some
21 of the outcomes of the pandemic that had
22 particularly devastating impact on Black maternal

1 health and some of it is not new. We've known for
2 a long time that, you know, we had -- and so I
3 think this committee probably will again think
4 about looking at is there something else we need
5 to look at or that kind of thing.
6 So I think framing -- and also, we
7 think about too what's going on in the larger
8 society about how we teach history for other
9 people that are non-white that have contributed,
10 and looking at that tie in to help outcomes, I
11 think framing how we talk about that is going to
12 be really important.
13 BELINDA PETTIFORD: Thank you,
14 Phyllis.
15 Joy, I see your hand.
16 JOY NEYHART: I want to thank Jacob
17 for sort of opening up the door to discussion
18 about how policy makers fit in because we have so
19 much information about the good that comes when
20 pregnant mothers and newborns through the first
21 two years of life before they become eligible for
22 public school services, when funding is provided

1 for quality programs, health and education and
2 childcare, everyone's outcome is better. And so,
3 it's sort of like we keep talking about it over
4 and over about what's going to help the situation,
5 but it's the policy makers that have to make this
6 happen. And so, can we just start drafting
7 legislation? I know that's sort of not -- no, we
8 can't -- but how do we get beyond the Secretary to
9 the people who can draft the legislation to
10 improve the outcomes?
11 BELINDA PETTIFORD: Thank you, Joy.
12 And I do think that again is part of how we frame
13 the message and, you know, how do we move closer
14 to the political will, which, I think, of course
15 differently in every community. You know, I think
16 it's one thing what may happen in Congress, but we
17 all have our own state legislators, we have our
18 communities. And so, I do think that's a very
19 good point.
20 You know, I think this is a longer
21 conversation that we want to have, but I do think
22 it would be helpful if you all are in agreement,

1 if we can try to bring in someone like Frameworks
2 or some entity that can kind of help walk us
3 through this piece and help us think through it a
4 little bit more clearly about how do we get the
5 message out, realizing that the message will be
6 different from each community. One community may
7 be prepared to hear the message this way, the next
8 may be prepared to listen to it in a different
9 perspective. So, do you all have any thoughts
10 about that? Is it something you would want us to
11 try to move forward? I will work with Vanessa and
12 Sarah on that for a future meeting. Just let me
13 know.
14 TARA SANDER LEE: I'd like -- I think
15 it just has to be bipartisan. That's my only
16 request that it can't be too left or right-
17 leaning, that it has to be a message that, you
18 know, that if we really want this to move forward,
19 we have to -- we're going to have to be really
20 careful. So I'm a little cautious about what
21 Frameworks is going to do. I'd be curious to see
22 what their plan is. Like are they actually going

1 to listen to us and what we're saying and then
2 like take our recommendations? So, I'm cautiously
3 optimistic.
4 BELINDA PETTIFORD: Thank you, Tara.
5 And again, as I'm sharing, I do think it's
6 different from community to community. So, I
7 think what Frameworks does, based on my
8 experience, is they help you craft your message
9 for your multiple communities, because different
10 communities are prepared to hear messages
11 differently. So, I do think that your thought is
12 noted. So, thank you.
13 Does anyone have an issue with moving
14 forward with this? You can drop it in the chat or
15 come off of mute and say so now or, as they say,
16 forever hold your peace.
17 I don't see anyone coming off. I
18 don't see any movement in the chat. If you want
19 to reach out to me privately, you have my e-mail,
20 so you can also do that also.
21 Okay. So, we are closer to getting
22 back on time, but we are down for a short break.

1 So why don't we just shorten our break and to ten
2 minutes instead of fifteen so some people can get
3 up and stretch. It's cool here today as well,
4 Jacob. Our version of cool, not your version of
5 cool. So if we can all come back at 2:30, we'll
6 be right back on track. So, thanks everyone.
7
8 (BREAK.)
9
10 DATA REFRESHER ON INFANT MORTALITY, MATERNAL
11 MORTALITY, SEVERE MATERNAL MORBIDITY, AND
12 PREGNANCY-RELATED MORTALITY
13
14 BELINDA PETTIFORD: Welcome back,
15 everyone. I am showing 2:30 on my end on the East
16 Coast. I hope we had a nice short break there.
17 As we continue on with our agenda, our next
18 session is on data. We're doing a Refresher on
19 Infant Mortality, Maternal Mortality, Severe
20 Maternal Morbidity, as well as Pregnancy-related
21 Mortality. And so, we are very fortunate to have
22 with us an awesome data team to share with us

1 today, and we're going to pass it onto them.
2 So, first we have Danielle Ely will
3 start, then Donna Hoyert, Ashley Busacker, and
4 Ashley Hirai, and anyone's name that I
5 mispronounced, please forgive me right from the
6 beginning and pronounce it correctly so I will
7 learn better for the next go around. So, we'll
8 start with Danielle.
9 DANIELLE ELY: Thank you, Belinda.
10 So, my name is Danielle Ely, and I'm from the
11 Division of Vital Statistics. It's in the
12 Reproductive Statistics Branch, and today I'm
13 going to be discussing data and then some basic
14 statistics on infant mortality by a variety of
15 maternal and infant characteristics. Next.
16 So currently the 2021 final data for
17 births, fetal deaths, and infant mortality from
18 the general mortality file is available. We also
19 have provisional estimates through quarter 3 of
20 2022 for births and for infant mortality from the
21 general mortality file.
22 We're expecting to release a

1 provisional birth report with the 2022 data in
2 May, and the final data should come out in August,
3 like it has in the past couple of years.
4 Additionally, we expect to release a
5 provisional fetal death report with 2022 data in
6 the fall and the final death -- the final fetal
7 death data will be released by the end of this
8 year. Next.
9 The linked birth and infant death
10 data, which is the file that I manage and where
11 most of the information for this presentation
12 comes from, is available through the 2020 period
13 and 2019 cohort data. We're hoping to release the
14 2021 period and 2020 cohort data by the end of
15 May; however, we have run into some delays this
16 year.
17 We're also developing a provisional
18 linked file report, and we hope to release it for
19 the first time later this year with the 2022
20 provisional data. Next.
21 So the linked file matches infant
22 deaths with their corresponding birth

1 certificates, which allows for a more in-depth
2 analysis of factors related to infant death, and
3 this can include things such as the maternal
4 demographic characteristics or pregnancy risk
5 factors. Next.
6 In general, the maternal race and
7 ethnicity data from the linked file is considered
8 more accurate than the race information from the
9 general mortality file because the mother is self-
10 reporting this information.
11 In general, regarding the linked
12 file, we've been trying to work on more timely
13 releases of the data, and one way that we have
14 done this for data users is to release a single
15 file that can be used for a period of cohort
16 analysis rather than having two separate files we
17 have to look over and then release. And this
18 began with the 2017 period and 2016 cohort data.
19 Next.
20 Over time, the overall improvements
21 in the timeliness of the linked file data are
22 related to the improvements in the timeliness of

1 the mortality file. We're continuing to try to
2 release the final linked files earlier. There
3 have been some limitations to this and some of
4 this is related to IT resources.
5 Additionally, one of the things we're
6 hoping to do is release this provisional data in a
7 report which should get some of the linked file
8 infant mortality information out about six months
9 earlier than the final data currently. Next.
10 So, this is the last little bit
11 before I actually show some data, and that's on
12 the fetal death data that we have in our branch.
13 We recently released the 2021 fetal death file,
14 which includes both demographic and cause of death
15 information. We are now able to release
16 demographic and cause of death at the same time
17 because of improvements overall in the cause of
18 death coding.
19 So, national cause of fetal death
20 wasn't available until 2014 -- the 2014 data year,
21 that is -- and we've released demographic and
22 cause of fetal death at the same time for the

1 first time starting in 2017. Next.
2 So, this figure is showing the total
3 early fetal and late fetal mortality rates from
4 2000 to 2021. Over this time, total fetal
5 mortalities declined 13% to 4.73 deaths per 1,000
6 live births and fetal deaths and the early fetal
7 mortality rates declined 11% and late fetal
8 mortality rates went down 16%. However, even
9 looking at these and these declines have been
10 relatively small over time. Next.
11 This figure is showing the declines
12 in perinatal, total infant, neonatal, and
13 postnatal mortality rates from 2000 to 2020. The
14 total infant mortality rate declined 21%. The
15 perinatal rate declined 19%. Neonatal declined
16 23%, and the post-neonatal rate went down 18% over
17 these two decades. Next.
18 Here, you can see the infant,
19 neonatal, post-neonatal, and perinatal mortality
20 rates for just the most recent years. So, from
21 2015 to 2020, the perinatal rate declined 6% to
22 5.64. The overall infant mortality rate declined

1 8% to 5.42. The neonatal rate declined 10%, and
2 the post-neonatal rate went down 5%. Next.
3 This figure comes -- this figure came
4 from a perinatal report and showed declines for
5 non-Hispanic Black, non-Hispanic white, and
6 Hispanic women from 2017 to 2019. For each of
7 these groups, rates declined between 4 and 5% over
8 that time frame. Next.
9 One of the things that many of you
10 probably know is that infant mortality does vary
11 by maternal age. Infants of the youngest mothers,
12 which are those that are under 20 years of age,
13 had the highest mortality rates and infants of
14 women in their early 30s have the lowest. Next.
15 The four years of data included on
16 this slide, 2017 to 2020, are the years that we
17 have national reporting on single race known
18 Hispanic race data. So, during this time period,
19 rates declined 5 to 8% for infants of Black,
20 Native Hawaiian or other Pacific Islander,
21 Hispanic, and white women. Infants of American
22 Indian or Alaska Native women and infants of Asian

1 women had even larger declines over this time
2 period, which were closer to 17%. Next.
3 The next couple of slides are focused
4 on gestational age data. So, in 2020, 10% of
5 infants were born at less than 37 weeks gestation
6 and this varies by maternal race and Hispanic
7 origin. The percent preterm was lowest for Asian
8 women at 8.5% and highest at 14.4% for Black
9 women. Next.
10 Infants born preterm have
11 substantially higher mortality rates than infants
12 born at term. And those born at the lowest
13 gestational ages have the highest infant mortality
14 rates. In fact, if we break this down even
15 further than what is here, you would see even
16 higher rates for those at 28 weeks or less
17 gestation. Next.
18 Similar to the percent born preterm,
19 preterm infant mortality rates vary by maternal
20 race and Hispanic origin, and infants of Asian
21 women have the lowest mortality rates, which were
22 about half of the rates that we see for infants of

1 Black women, who had the highest rates. Next.
2 The next few slides are showing
3 infant mortality by a few select maternal
4 characteristics that I thought might be of
5 interest to this group. Infant mortality by WIC
6 receipt vary by race and Hispanic origin. So
7 infants of white women who received WIC had higher
8 mortality rates than infants of white women who
9 did not receive WIC. This is different from the
10 infants of Black and Hispanic women. So, infants
11 of Black and Hispanic women who received WIC had
12 lower mortality rates than infants of Black and
13 Hispanic women who did not receive WIC. Although
14 there were differences in WIC receipt for American
15 Indian and Alaska Native or infants of Asian
16 women, these differences were not statistically
17 significant. Next.
18 So, when looking at infant mortality
19 by source of payment, infants of all maternal race
20 and Hispanic origin groups had similar patterns.
21 Specifically, infants who used Medicaid had higher
22 mortality rates than infants born to women who had

1 private health insurance. Although you can see
2 there is great variation across the groups in
3 terms of the actual infant mortality rates. Next.
4 When looking at infant mortality by
5 source of payment, infants of all maternal race
6 and Hispanic origin groups had similar patterns.
7 Infants born to women who used Medicaid had higher
8 mortality rates than infants born to women who had
9 private health insurance. Next.
10 Oh, you know what, I just completely
11 -- yeah, sorry. I skipped over something.
12 By timing of prenatal care, infants
13 of women who received late or no care, and that is
14 the prenatal care in the third trimester or
15 receiving no care, had higher mortality rates than
16 infants of women who received care in the first
17 trimester of pregnancy. So, the rates for infants
18 who were born to women who received late or no
19 care were between 66 and 187% higher than those
20 who received care in the first trimester. Next.
21 So, I'm going to quickly go through
22 some of the leading causes of death, and the next

1 couple of slides look at this. This slide looks
2 at the five leading causes of total infant death,
3 both in 2015 and 2020. So, in both of these
4 years, they have the same five leading causes of
5 death, which included congenital malformations,
6 low birth weight, maternal complications, SIDS,
7 and unintentional injuries. So, compared with
8 2015, the rates declined for four of the five
9 leading causes, but there was a slight increase
10 for unintentional injuries in 2020 compared to
11 2015. Next.
12 Here were the five leading causes of
13 neonatal death in 2020. These included low birth
14 weight, congenital malformations, maternal
15 complications, PCM complications, and bacterial
16 sepsis. Next.
17 The five leading -- these are the
18 five leading causes of post-neonatal death in
19 2020, which included SIDS, congenital
20 malformations, unintentional injuries, diseases of
21 the circulatory system, and homicide. So, the
22 leading causes of death for overall infant and by

1 age of death have generally been the same for at
2 least the last decade of data that we have
3 available. Next.
4 These next few slides focus on
5 geography. So, in 2020, infant mortality rates
6 ranged from 3.92 in California to 8.12 in
7 Mississippi. As you can see in the map, the rates
8 were generally lower in states in the west and the
9 northeast and higher in the states in the south.
10 Next.
11 So, while the infant mortality rate
12 has declined over time throughout the United
13 States from 2015 to 2020, thirteen states and the
14 District of Columbia had declines in rates that
15 were statistically significant. In this map,
16 those states are filled in with blue to make them
17 easily seen. Next.
18 So, infant mortality rates also
19 varied by urbanization level. From 2015 to 2020,
20 the infant mortality rate declined for all
21 urbanization levels, but non-metro counties had
22 the highest infant mortality rates in both time

1 periods.
2 In 2015, rates in non-metro counties
3 were 6% higher than the rates in small or medium
4 metro counties and 25% higher than the rates in
5 large metro counties. And in 2020, the non-metro
6 rates were 4% higher than small or medium metro
7 counties and 27% higher than those in large metro
8 counties. Next.
9 This was a quick stat publication
10 that looked at infant mortality by maternal race
11 and Hispanic origin using a metro and non-metro
12 dichotomy. So, infant mortality rates were higher
13 in non-metro counties for all groups; however,
14 they were only statistically significantly higher
15 in non-metro counties for infants of white,
16 Hispanic, and American Indian or Alaska Native
17 women. Next.
18 So, to kind of wrap up and conclude,
19 over the last couple of decades, fetal, infant,
20 and perinatal mortality rates have declined.
21 There have been declines in rates by maternal race
22 and Hispanic origin. Next.

1 Mortality rates continue to be
2 highest for infants of Black, American Indian, or
3 Alaska Native and Native Hawaiian or other Pacific
4 Islander women, and infants of Black women have
5 mortality rates that are nearly twice as high or
6 more than those for infants of white, Hispanic, or
7 Asian women. Next.
8 Black, American Indian, or Alaska
9 Native and Native Hawaiian, or other Pacific
10 Islander women had the highest percentages of
11 preterm births, and their infants have the highest
12 mortality rates among those who were preterm.
13 Next.
14 Infants of Black and Hispanic women
15 who received WIC had lower mortality rates than
16 infants of Black and Hispanic women who did not
17 receive WIC. The opposite was true for the
18 infants of white women. Infants of women who
19 received Medicaid had also had higher mortality
20 rates than those of women with private health
21 insurance, which was the case across all maternal
22 race and Hispanic origin groups. Next.

1 Infants of women who receive late or
2 no prenatal care had higher mortality rates than
3 those of women receiving care in the first
4 trimester, which was also true across all race and
5 Hispanic origin groups. Next.
6 Here is just a quick review of the
7 five leading causes of infant mortality and by age
8 of death, and something to note that I did not
9 necessarily talk about completely earlier was that
10 the same five leading causes of infant mortality
11 have been the five leading causes since 2006 with
12 some minor changes in order.
13 For neonatal mortality, these have
14 generally been the same five leading causes since
15 2007; however, in one year, bacterial sepsis did
16 fall off, but it did come right back on the next
17 year. And for postnatal mortality, they have had
18 the same five leading causes since 2010. Next.
19 From 2015 to 2020, thirteen states
20 and DC had declines in infant mortality and
21 overall, infant mortality rates are higher in non-
22 metro counties than in metro counties, and this is

1 generally true by maternal race and Hispanic
2 origin. Next.
3 In kind of looking ahead a little
4 bit, we're going to continue to work on the
5 timeliness of the period and cohort final data and
6 not just in terms of the file releases, but also
7 by trying to publish on provisional data.
8 And that is all I have for today.
9 Thank you.
10 BELINDA PETTIFORD: Thank you,
11 Danielle. We're just going to hold off on
12 questions to the end and move on to Donna.
13 DONNA HOYERT: Yes, I can start with
14 what's going to be on the title slide. So, I'm in
15 the same division as Danielle. I'm going to talk
16 about maternal mortality data from the National
17 Vital Statistics System. Next slide.
18 The National Vital Statistics System
19 maternal mortality data from MCHS comes from death
20 certificates and the cause of death statements,
21 which are completely by physicians or medical
22 examiners principally. The quality of the

1 information depends on the persons completing the
2 death certificates. MCHS uses the World Health
3 Organization International Classification Diseases
4 or ICD in the definition of maternal mortality in
5 that, which focuses on deaths occurring while
6 pregnant or within 42 days of the end of the
7 pregnancy. The measures we typically present in
8 publications are numbers of maternal deaths and
9 maternal mortality rates, which are calculated as
10 the number of maternal deaths per 100,000 live
11 births. Next slide.
12 MCHS statistics on maternal mortality
13 go back to the early 1900s with periodic points of
14 disjuncture whenever a new revision of the ICD was
15 adopted. However, 2003 marked the beginning of an
16 unanticipated protracted period of disjuncture for
17 reason other than a change in ICD revision.
18 Research that had access to additional information
19 would identify more maternal or pregnancy-related
20 deaths than found in the file statistics data, and
21 it was suggested that adding a separate checkbox
22 asking about recent pregnancies would be a way to

1 increase the numbers identified using death
2 certificates. A national consensus process agree
3 and recommended adding such an item. So the
4 expectation was that states would make this
5 addition in a relatively short timeframe around
6 2003. Numbers of maternal deaths identified would
7 increase substantially. Our data would be more
8 similar to other maternal mortality data sources,
9 and we could move on from there.
10 However, it took a long time for all
11 states to add this checkbox to help identify
12 maternal deaths, and during this 15-year period,
13 it was found that the checkbox was being marked
14 more often than appropriate, especially as the
15 decedent age increased.
16 In 2018, MCHS restarted publishing
17 maternal mortality data after all states had added
18 the supplemental checkbox to help identify
19 maternal deaths. Some modifications were made to
20 mitigate the impact of likely reporting errors
21 with the checkbox at the same time. But as you'll
22 note, I used the word mitigate. The states differ

1 in the practices that they follow to work on data
2 quality. For our part, we have tended to this in
3 a long list of potential problems back to the
4 states for review, but that hasn't been terribly
5 productive.
6 In the past year, we revisited
7 current data with respect to data quality,
8 confirmed some of the choices we made in the
9 mitigation strategy based on earlier look at data
10 quality, and are shifting to a more targeted list
11 to ask states to focus on, the idea being that
12 they will have a smaller number of records to
13 follow-up on and we're more confident that these
14 particular records really need to be corrected.
15 Last year, we also created a separate
16 reporting guidance document that specifically
17 focused on these types of events and additionally,
18 it took some time to integrate these changes into
19 our systems. So, 2021 data is the first year that
20 the maternal records are getting fully processed
21 as the year goes on. Next.
22 Since 2018, maternal data have been

1 available in annual Health E-Stats, a table in the
2 annual deaths data for each year's reports and
3 data files.
4 A number of the following slides are
5 based on information released last week in a
6 Health E-Stats report for 2021 data. Next.
7 The Health E-Stats shows that there
8 are a number of disparities in maternal mortality
9 in the U.S. Maternal mortality rates increase as
10 age increases. In the MCHS data, the rate for
11 women forty and over was nearly seven times that
12 for women under twenty-five. Next.
13 Maternal mortality varies by race and
14 Hispanic origin. In 2021, the rate for non-
15 Hispanic Black women is 2.6 times the rate for
16 non-Hispanic white women. The rate for non-
17 Hispanic white and Hispanic women are roughly the
18 same. The Health E-Stats only focuses on these
19 three groups. In some of our other reports and
20 releases, we share more groups, although the size
21 of the groups is a common issue. Even combining
22 years, we need one more year than we have to get

1 large enough numbers to calculate reliable rates
2 for the Native Hawaiian or other Pacific Islander
3 groups. These smaller groups cover the range with
4 lower rates for Asian women and higher rates for
5 American Indian or Alaska Native women. Next.
6 Maternal mortality differs by
7 urbanization level with rates decreasing as one
8 moves left to right on the slide from rural
9 towards large metropolitan counties. Next.
10 In 2021, maternal mortality was
11 similar for women with and without a GED or high
12 school diploma, lower for those with some college
13 but no degree, and lower yet for those with a
14 degree. Next.
15 So, in the short time since we
16 restarted publishing maternal mortality
17 statistics, the trend is increasing with the
18 largest increase between 2020 and 2021. We also
19 have provisional data as we are building towards
20 the final data. Provisional data are not complete
21 and final and are subject to change.
22 In the case of maternal mortality,

1 there isn't anything unusual about the flow into
2 the file, but the coding is reviewed multiple
3 times and numbers might change during these extra
4 reviews.
5 Provisional data have been available
6 in the file for roughly a year now, and that
7 reflects the numbers as they build up and change
8 during the course of the year. Next.
9 Last Thursday, we also released a new
10 data visualization that presents numbers of
11 provisional maternal deaths through October of
12 2022. This visualization shows a series of counts
13 for 12-month periods. The visualization is
14 presented overall and by age, race, and Hispanic
15 origin. I'm just going to show the overall
16 figure.
17 So, in this, the December date will
18 correspond to the time period shown in the Health
19 E-Stats publications using final data. And this
20 reflects that the increases that we have been
21 showing in the recent Health E-Stats and that the
22 2021 calendar year pretty much captured the height

1 of the increase in maternal mortality. But then
2 we see a decreasing pattern in 2022 in vital
3 statistics data. Next.
4 So MCHS's maternal mortality data
5 soared during the pandemic but in 2022, it looks
6 to be returning to the levels we were calculating
7 pre-pandemic. With respect to COVID-19 being
8 reported as a cause, I'm next looking at mentions
9 in the multiple cause data.
10 For 2020, about 100 maternal deaths
11 reported COVID-19. For deaths overall, comparing
12 2021 to 2020, COVID-19 deaths increased and
13 shifted to younger age groups, where there are
14 more likely to be women who are pregnant or
15 recently pregnant. Both the number and percentage
16 of maternal death records mentioning COVID-19 were
17 substantially greater in 2021 than in 2020 and
18 then if we look forward to the provisional data,
19 that indicates that it will be less again in 2022,
20 again reflecting shifts in numbers observed more
21 broadly with COVID-19 deaths.
22 Some of the longstanding disparities

1 such as age and race were just ever so slightly
2 worse in 2020 but more like before in 2021. Next.
3 So, in conclusion, MCHS resumed
4 releasing maternal mortality statistics with 2018
5 data and has expanded data access with the Healthy
6 E-Stats provisional data and the maternal data
7 visualization. Long-observed differentials such
8 as by age or between race and Hispanic origin
9 groups persist. Our current trend is not very
10 long but shows that maternal mortality rates
11 increased substantially during the pandemic and
12 provisional data suggests that the rates will
13 return to pre-pandemic levels in 2022. Thank you.
14 BELINDA PETTIFORD: Thank you so
15 much, Donna, and now we'll go onto Ashley.
16 ASHLEY BUSACKER: Hi. Good
17 afternoon. I'm Ashley Busacker. I'm the senior
18 epidemiologist on the Maternal Mortality
19 Prevention Team within CDC's Division of
20 Reproductive Health. I think my slides are
21 coming. Okay, perfect.
22 So, today, I'm going to share with

1 you data from our recent report, Pregnancy-Related
2 Deaths: Maternal Mortality Review Committees in 36
3 U.S. States from 2017 through 2019. Next, and the
4 next too.
5 So, to begin, I want to provide some
6 background on the enhancing reviews and
7 surveillance to eliminate maternal mortality, our
8 ERASE MM Initiative and our national reporting.
9 Maternal Mortality Review Committees,
10 our MMRCs, are multidisciplinary committees
11 comprised of diverse clinical and nonclinical
12 expertise. MMRCs use a standardized process for
13 data collection through committee deliberations
14 and record them from MMHS standardized data
15 system, which was call MMRIA.
16 So, CDC analyses and reports of MMRIA
17 data both focus on pregnancy-related deaths.
18 These deaths occur during pregnancy or within one
19 year of the end of pregnancy and are from any
20 cause related to or aggravated by the pregnancy.
21 This focus is because this is a
22 population with unique causes of death. Pregnancy

1 associated but not related deaths tell us that an
2 individual died during or within one year of
3 pregnancy, but the death was not causally related
4 to the pregnancy. While pregnancy associated but
5 not related deaths mirror causes of death among
6 women of reproductive age, you cannot interpret
7 the findings from these deaths to be
8 representative of deaths among individuals of
9 reproductive age because there are a small
10 proportion of those deaths that occurred among
11 specific populations.
12 Every death is a tragedy and CDC is
13 focused on preventing pregnancy-related deaths
14 because this is a unique prevention space that
15 Maternal Mortality Review Committees fill. Next.
16 So before we look at the data, I do
17 want to take a moment to acknowledge that there
18 are lives lost behind these data. Each member
19 represents a tragic loss to a family in a
20 community. Next.
21 So, in this presentation, we'll see
22 data from 1,018 pregnancy-related deaths occurring

1 from 2017 through 2019 to residents of thirty-six
2 states, which are shown here on this map. Not all
3 Maternal Mortality Review Committees submitted
4 data for all three years and partial years of data
5 were received. I also want to acknowledge that
6 we'll be showing you per portion and not category-
7 specific pregnancy-related mortality ratios. We
8 are not able to calculate the pregnancy-related
9 mortality ratios using these data, but these would
10 be the more appropriate measure for understanding
11 disparities. Next.
12 So, this slide shows the breakdown of
13 race and ethnicity among the pregnancy-related
14 deaths. While you are taking in the numbers, I do
15 want to walk through how these categories come
16 about.
17 Race and ethnicity data are from the
18 birth or fetal death records, when available, and
19 from death records when a birth record or a fetal
20 death record was unavailable. All deaths with a
21 notation of Hispanic origin are classified as
22 Hispanic. For non-Hispanic persons, race was

1 classified as non-Hispanic single race American
2 Indian or Alaska Native, non-Hispanic single race
3 Asian, non-Hispanic single race Black, non-
4 Hispanic single race Native Hawaiian or other
5 Pacific Islander, and non-Hispanic single race
6 white. Deaths which were missing race ethnicity
7 include those of missing notation of Hispanic
8 origin. Those with a notation of non-Hispanic
9 origin but missing information on race, and those
10 missing notation for both race and ethnicity.
11 Next.
12 This graph shows the distribution of
13 pregnancy-related deaths be age. Over 70% of
14 pregnancy-related deaths occurred among persons
15 ages 25 to 39. Next.
16 Here we see the distribution of
17 pregnancy-related deaths by educational
18 attainment. Over half of decedents had an
19 educational level of high school graduate or less.
20 The next slide looks at timing of
21 deaths in relation to pregnancy. Over 50% of
22 pregnancy-related deaths occurred one week to one

1 year after the end of pregnancy, which is a time
2 when most individuals would have left the
3 hospital. Next slide.
4 So now moving into underlying cause
5 of pregnancy-related death. This refers to the
6 disease or injury that initiated the chain of
7 events leading to the death or the circumstances
8 that the accident or event which produced the
9 fatal injury.
10 The Maternal Mortality Review
11 Committee uses the information from the death
12 record along with information from medical
13 records, social service records, autopsies, and in
14 some cases key informant interviews to determine
15 the underlying cause of death. The MMRC uses all
16 of the information available to code the
17 underlying cause of death using the systems shown
18 on this slide. Next.
19 The ten most frequent underlying
20 causes of death among the pregnancy-related deaths
21 are shown on this slide. The most frequent cause
22 was mental health conditions which include deaths

1 to suicide and overdose or poisoning related to
2 substance use disorder. That was followed by
3 hemorrhage and then cardiac and coronary
4 conditions. Next slide.
5 To identify opportunities for
6 prevention among disproportionately impacted
7 populations, it is important to look at the
8 underlying causes of death by race and ethnicity.
9 Among non-Hispanic Black persons, cardiac and
10 coronary conditions, and cardiomyopathy are the
11 two most frequent underlying causes of death.
12 When combined, these causes that involve the heart
13 represent almost one-third of pregnancy-related
14 deaths among non-Hispanic Black persons. Next.
15 Among Hispanic persons, the most
16 frequent underlying cause of pregnancy-related
17 death was mental health conditions. Next slide.
18 Among non-Hispanic Asian persons,
19 hemorrhage was the most frequent underlying cause
20 of pregnancy-related deaths. Next.
21 And among non-Hispanic white persons,
22 mental health conditions were the most frequent

1 underlying cause of a pregnancy-related death.
2 Next.
3 A preventability determination was
4 made by the Maternal Mortality Review Committee
5 for 98% of the pregnancy-related deaths. A
6 preventable death is defined as a death with at
7 least some chance of the death being averted by
8 one or more reasonable changes, patient,
9 community, provider, facility, and/or system
10 factors. Among those pregnancy-related deaths
11 with this determination, 84% are determined to be
12 preventable. Next slide.
13 So for the next few slides, we'll
14 focus on pregnancy-related deaths to American
15 Indian or Alaska Native persons using the same
16 data. Next.
17 As I mentioned, understanding
18 differences in the underlying causes of pregnancy-
19 related death by race and ethnicity is important
20 for identifying prevention opportunities to reduce
21 pregnancy-related deaths.
22 Accurate classification of race and

1 ethnicity can be challenging. Methodological
2 decisions about racial classification can affect
3 the size and the characteristics of the population
4 used in the analyses.
5 This slide describes an alternative
6 approach our team took for classifying pregnancy-
7 related deaths among all American Indian and
8 Alaska Native individuals. This approach is
9 consistent with assessments from other groups,
10 which have demonstrated the importance of
11 examining deaths among all American Indian or
12 Alaska Native persons regardless of notation of
13 Hispanic origin or other or multiple races.
14 So, as you can see, there were nine
15 pregnancy-related deaths classified as non-
16 Hispanic single race American Indian or Alaska
17 Native, and then there was one death with a
18 notation of Native American written in the
19 specified other free text field. Five American
20 Indian, Alaska Native deaths with a notation of
21 Hispanic ethnicity or missing ethnicity, and two
22 American Indian or Alaska Native deaths with a

1 notation of more than one race.

2 So, with this alternative approach,

3 we did see an increase in identification of

4 pregnancy-related deaths to the seventeen number

5 you see, but because of known limitations with

6 vital records for identifying American Indian and

7 Alaska Native persons, seventeen is still likely

8 an undercount of pregnancy-related deaths among

9 American Indian and Alaska Native persons.

10 The next two slides will describe

11 these seventeen pregnancy-related deaths. Next.

12 Sixteen of the seventeen pregnancy-

13 related deaths among American Indian or Alaska

14 Native persons had a known underlying cause of

15 death. Among these deaths, mental health

16 conditions were the most frequent underlying cause

17 of death.

18 And on the next slide, we see an MMRC

19 preventability determination was made available or

20 was available for fifteen of the seventeen

21 pregnancy-related deaths. And among those, 93% of

22 these deaths were determined to be preventable.

1 Next.
2 So, in summary, pregnancy-related
3 deaths occurred during pregnancy, delivery, and up
4 to one year after the end of pregnancy. The
5 leading cause of pregnancy-related death varied by
6 race and ethnicity. Over 80% of pregnancy-related
7 deaths were determined to be preventable and
8 methodological decisions about racial
9 classification can impact the size and character
10 of the population used in analysis. Next.
11 So, I want to thank everyone
12 throughout the country and maybe some of you on
13 this call for taking the time to review maternal
14 deaths, put together the reports, and drive
15 implementation of the prevention activities. Next
16 slide.
17 And you can e-mail if you have
18 questions or want some more information. Thank
19 you.
20 BELINDA PETTIFORD: Thank you so
21 much, Ashley. I did drop you a note in the chat.
22 So, now we're going to go to Ashley

1 Hirai as we wrap up this session and get ready for
2 questions.
3 ASHLEY HIRAI: Thanks, Belinda. I'm
4 Ashley Hirai. I'm a senior scientist in MCHB's
5 Office of Epidemiology and Research. Next slide.
6 Okay, I think I can control mine.
7 Some of you are probably familiar
8 with this pyramid showing maternal mortality and
9 morbidity. Maternal and pregnancy-related deaths
10 that were just discussed are really the tip of the
11 iceberg. For every maternal death, it's estimated
12 that there are fifty to a hundred cases of severe
13 maternal morbidity and thousands of complications
14 such as pre-pregnancy and gestational conditions
15 like diabetes and hypertension.
16 Just for some background on how kind
17 of HRSA comes into the surveillance space is
18 really for the Title V State Block Grant Program
19 where we have a National Outcome Measure for
20 Severe Maternal Morbidity or SMM, and we
21 collaborate with the Agency for Healthcare
22 Research and Quality or AHRQ as the data purveyor

1 and CDC as measure developer to populate national
2 and state estimates for monitoring and
3 surveillance.
4 The data comes from the Healthcare
5 Cost and Utilization Project and all paired
6 databases of hospital discharge records from all
7 non-federal acute care hospitals in nearly all
8 states.
9 So this graphic depicts the levels of
10 our performance measure framework and at the
11 center are our national performance measures,
12 which states select to improve over a five-year
13 needs assessment to action cycle, and these are
14 shorter-term performance measures of health care
15 access, quality and behavior, which in turn helps
16 to improve longer-term outcomes of morbidity and
17 mortality. So, those are within the Maternal and
18 Women's Health domain are well-women visit, low-
19 risk cesarean, and full-term pregnancy, which
20 influence our North Star measures of severe
21 maternal morbidity and maternal mortality.
22 We employ evidenced-based informed

1 strategies measures to make progress on these
2 performance measures such as improving insurance
3 outreach and enrollment, social media campaigns,
4 and hospital participation, and quality
5 improvement efforts.
6 So what I'm going to be covering
7 today is related to the definition of SMM that we
8 use, trends, types, disparities, and some
9 measurement issues.
10 So, moving to the definition that we
11 use is that developed by CDC researchers.
12 Unexpected outcomes of labor and delivery that
13 result in significant short- or long-term
14 consequences to a woman's health. And how we
15 measure that is from those hospital discharge
16 record codes with twenty-one different indicators
17 including sixteen diagnosis codes and five based
18 on procedure codes. So these are just the overall
19 indicators of twenty-one, but there are over four
20 hundred individual codes that are used in these
21 discharge records.
22 Recent analyses do exclude cases of

1 blood transfusion only due to poor predictive
2 value in the absence of other SMM indicators. So,
3 four or more units of blood product is usually
4 considered severe and the number of units just
5 aren't available in hospital discharge data.
6 You can find the full list of codes
7 at the links included here for HCUP Fast Stats,
8 Title V, and our AIM program, Alliance for
9 Innovation on Maternal Health.
10 So, all of the data that I'm
11 presenting here was pulled from HCUP Fast Stats or
12 Title V, highlighting three recent AHRQ, CDC, or
13 HRSA publications. I led the first two with
14 colleagues from AHRQ looking at trends across the
15 ICD coding transition and state-level
16 correlations, and I'll present data from those
17 near the end.
18 And then there's also just to note
19 two forthcoming publications. AHRQ has an
20 analysis of COVID-related SMM increases that will
21 be coming out, and CDC has been working on a paper
22 on SMM indicators that account for the larger

1 share of in-hospital deaths.
2 Okay, moving to trends. Over the
3 last decade, we can see here that we're not moving
4 in the right direction. There's been an increase
5 of nearly twenty per 10,000 or 26% in the last
6 decade, mostly since 2017 and there was really
7 little or no difference across that coding
8 transition.
9 The largest single year change was in
10 2020 with the COVID-19 pandemic and increase of
11 about 8 per 10,000 or 10%. Prior analyses from
12 both CDC and AHRQ showed increases mostly
13 beginning in 2000 with substantially larger rises
14 including transfusion-only cases.
15 So what's kind of behind these
16 trends, it's unclear. It may be related to
17 increases in chronic conditions and maternal age.
18 However, a study in California showed that
19 maternal characteristics and comorbidities
20 couldn't explain the rise in that state.
21 Artifactual increases are also
22 possible due to improvements in recognition and

1 coding with quality improvement initiatives or
2 increases in certain indicators with poor
3 predictive value that may not be truly severe.
4 So, the latest increase in 2020 does
5 appear to be directly related to the COVID
6 pandemic. This table shows indicators in order of
7 incidence. So, hemorrhage is the most common
8 cause or type of SMM, followed by renal and
9 respiratory failure and sepsis. Between 2019 and
10 2020, respiratory and acute renal failure had the
11 largest increases on both an absolute and relative
12 scale and this is consistent with what we know of
13 clinical impacts of COVID.
14 Looking at race and ethnicity, we can
15 see the Black women have the highest rates of SMM,
16 twice that of white women, who have the lowest
17 rates. Black Hispanic and Asian/Pacific Islander
18 populations have the largest increases from 2019
19 to 2020 of about 10-15%. This is not completely
20 consistent with maternal mortality as
21 Asian/Pacific Islanders did not have an increase
22 in 2020. The recent CDC data from HCUP and

1 hospital discharges may not always be self-
2 reported and not all states have adequate
3 reporting.
4 And I also want to mention that
5 although American Indian and Alaska Native are
6 represented here and do have elevated rates, IHS
7 facilities don't participate in HCUP, so this
8 isn't a complete picture of their data.
9 Looking at expected payer, SMM is
10 higher for Medicaid or Medicare billed delivery
11 hospitalizations compared to those privately
12 billed or having no charge or no insurance or
13 other public insurance billed such as military.
14 Increases in 2020 were larger for
15 this latter category and Medicaid/Medicare insured
16 compared to privately billed patients.
17 So, contrary to what we saw for other
18 indicators including infant and maternal
19 mortality, we see that SMM is actually higher for
20 residents of large metropolitan counties than
21 small to medium metro counties or non-metro
22 counties. And the large metro residents increase

1 larger increases in 2020. Why is this data
2 inconsistent? I think it does speak to some
3 measurement problems here for SMM, and if we look
4 at trends by hospital location and teaching
5 status, increases in the last decade only occurred
6 at metropolitan teaching hospitals, raising the
7 possibility of improved diagnostic ascertainment
8 or recognition of the billing records, perhaps
9 through quality improvement activities or
10 increases in indicators with poor positive
11 predictive values. So concerns have been noted
12 beyond transfusion as some indicators require a
13 greater clinical judgement and examination of
14 signs and symptoms to truly determine severity.
15 In a paper just published last year,
16 you can see slide 5 that had the citation and
17 link. We looked at correlations between state SMM
18 rates and other perinatal indicators that may
19 preceded, coincide with, or result from SMM. So,
20 this is a bubble graph with the size of the
21 bubbles corresponding to the size of the
22 correlation with statistical significance noted in

1 the glowing edge and negative correlations in
2 white.
3 And we found that SMM was
4 significantly correlated with only two of seven of
5 other perinatal indicators, pre-pregnancy
6 hypertension and low-risk cesarean section. By
7 contrast, there were stronger and more consistent
8 correlations among all other perinatal indicators
9 including maternal mortality.
10 And just as a side note, it's
11 interesting to see the relatively high correlation
12 between infant and maternal mortality at the state
13 level, that's 0.56. So we know they share common
14 and social structural determinants and this is
15 consistent with the alignment in addition to
16 maternal mortality in this committee.
17 So why isn't SMM associated with
18 maternal mortality geographically? Theoretically,
19 SMM should be most strongly linked to maternal
20 mortality as a near-miss event originally
21 constructed using conditions associated with
22 mortality. However, what we see is little

1 geographic patterning with the highest rates in
2 certain states on both coasts that's indicated by
3 shades of orange and red, unlike maternal
4 mortality, which is highest in the southeast,
5 indicated by the size of those blue circles.
6 So, the overall correlation is
7 negative and non-significant. California is one
8 of several outliers with a high-rated SMM but low
9 maternal mortality. In all states with those
10 darkest shades of red, they have experienced
11 recent rapid increases in SMM. Those were
12 highlighted in our other study that was also
13 listed on a previous slide.
14 Again, this may be consistent with
15 improved diagnostic ascertainment through quality
16 improvement or increases in indicators with sub-
17 optimal D-predictive value. Specific concerns
18 have been raised about disseminated intravascular
19 coagulation and acute renal failure.
20 So until more is known, caution
21 really should be used when comparing SMM rates
22 geographically, whether by state or urban or rural

1 residents.
2 In addition to potential coding
3 variation or indicator level issues that require
4 more investigation, it's also important to
5 recognize that most studies only capture SMM at
6 delivery. A recent CDC analysis of publicly and
7 privately insured patients in IBM MarketScan data
8 showed that 15% of de novo or new onset SMM
9 occurred in the postpartum period. It is unclear
10 how much may be occurring in the antepartum
11 period. But an earlier study indicated it may be
12 about one-third as common as during delivery.
13 Also, mental health conditions and
14 hospitalizations have not been included in SMM
15 definitions to date. So we really have much work
16 to do in refining and advancing measurement for
17 SMM. CDC recently held a federal partners meeting
18 on the topic, and we're working collaboratively
19 across HHS to improve measurement, surveillance,
20 and prevention, and I just wanted to give a
21 shoutout to Charlan, whose branch is really
22 leading this work and whose slides I borrowed from

1 her. So I want to give credit where it's due.
2 And that does conclude my
3 presentation, and I welcome questions along with
4 the other panelists. Thank you.
5 BELINDA PETTIFORD: Thank you, Ashley
6 and thanks to the amazing team, and Charlan's
7 wonderful data. So, we appreciate you all giving
8 us a refresher.
9 I know there have been a couple
10 questions that have been in the chat, and I think
11 you've been answering as you go, but I want to
12 make sure if anyone has a question, if you'll just
13 come off. Okay, Tara, I see your hand.
14 TARA LEE SANDER: Yeah, thank you.
15 Those were great -- great presentations. I was
16 scribbling a lot of notes.
17 I think the biggest question I have
18 after digesting it quickly, my first question is,
19 okay, so when we look at Maternal Mortality Review
20 Committee data, you know, the latest report is
21 from -- data from 2017 to 2019, and you said it's
22 based on thirty-six states. So, does the CDC

1 obtain and report in-depth analysis from the
2 others states? And if they don't, how can we
3 ensure that they do so that we have the most
4 complete dataset that we possibly can to get the
5 best picture? So, that's my first -- that's my
6 first question.
7 ASHLEY BUSACKER: Thank you, Tara.
8 So that was thirty-six states, and each time we've
9 done a data call, we've increased the number of
10 states, so that's good news. And now I think
11 we're up to -- let me pull this up, I have a
12 hidden slide -- the number of states participating
13 in MMRIA, we have forty funded states and
14 jurisdictions and I think we're up to like forty-
15 five or forty-six data-sharing agreements. Don't
16 quote me on that, but I'll get that number to you.
17 But the good news is that we are increasing as
18 time goes on with funded jurisdictions and
19 jurisdictions who are using MMRIA. So not every
20 jurisdiction who is using MMRIA right now is
21 funded.
22 Those states have data-sharing

1 agreements with us, which allow us when we do a
2 data call to download and then analyze their data.
3 So with our next data call -- we just did a data
4 call at the end of 2022 -- we hope to have data
5 from more states.
6 TARA SANDER LEE: That's great,
7 because I think that that's one of the key pieces
8 here. I think we can make -- we can infer some
9 trends that are important, but I think if we're
10 really going to dig into the data, I think we need
11 to get as much state data as we can, because we
12 keep saying how there's differences throughout the
13 country. Well, there's going to be differences in
14 that data too. So, we need to gather that. And I
15 think, you know, trying to standardize the data
16 that they, I mean, because you guys have all said
17 it, right? There is discrepancy between the
18 states. They're not all reporting the same type
19 of data. And so, I think this is -- this is
20 something that I think this committee can help
21 with or with your help, obviously, because you
22 guys are in this data, right? So, we need your

1 help. But I do think that this is -- this is big.
2 This is big.
3 And then just with the NVSS data,
4 because that's just kind of like a snapshot,
5 right, of what happened in 2021. So what's the --
6 and then the maternal mortality data that you
7 presented is from 2017 to 2019. So, what's the
8 plan to kind of now dig deeper into that data from
9 the NVSS to get PMSS data and to really, you know,
10 really understand? Because, you know, that NVSS
11 data is great, but it's just a snapshot. So, kind
12 of when are we going to get a report, you know,
13 like we have from 2017 and 2019 to really
14 understand the impact of COVID-19?
15 ASHLEY BUSACKER: So, a couple
16 things. One, I want to let you know with MMRIA,
17 we're hoping to expand with new funding to all the
18 states. I put the forty-eight states are using
19 MMRIA.
20 And then the question about when is
21 new data coming from PMSS, we are soon to be
22 releasing data, which will include 2019. How PMSS

1 works right now, we are still receiving data from
2 2020. So, as we receive that data, we're able to
3 do our medical epidemiology review and are working
4 on increasing the speed of access, our Speed and
5 Access Initiative, to get data transferred to CDC
6 quicker and to do a case identification with NCDC
7 should help improving the timeliness of that data,
8 but it does require that medical epidemiology
9 review as the states transferring data to us. So,
10 hopefully that's helpful with --
11 TARA SANDER LEE: It is, yeah. And I
12 think -- and maybe we can talk offline or I can e-
13 mail you. But I just -- I think it would be
14 really great to kind of, you know, how can we help
15 you with that timeliness, right, because I think
16 we're going to -- that data is so critical to us,
17 understanding what's happening. I think, like I
18 said, it's important to see these trends, but if
19 we really want to dig into that data, then let's -
20 - especially if we're going to start looking at
21 like when a pandemic hits, right, what happened,
22 you know, like so yeah, if there's any way that we

1 can help you to get that data fast and to get it
2 processed fast, let us know.
3 ASHLEY BUSACKER: Okay, thank you.
4 And one other point I did want to bring up is our
5 team does work very extensively with the
6 jurisdictions to offer that standardized process
7 to work on training, have office hours, have tools
8 available. So we are getting standardized data
9 from these very diverse states across the U.S.
10 So, thank you for your questions.
11 TARA SANDER LEE: Thank for your
12 answer. Great answer.
13 BELINDA PETTIFORD: And I was just
14 going to give an example. So, Tara, like our
15 state in North Carolina, we're one of the states
16 that participate with the MMRIA data system, and
17 it does help with the standardized process, and
18 you have a Maternal Mortality Review Committee.
19 But just realize, it's not something that happens
20 quickly because you have to realize the steps that
21 occur.
22 We have legislation that requires

1 providers and health systems to send us the
2 records, but then when they send them to us,
3 depending on where it is, you could get a box of
4 paper and then you've got to have staffing that
5 can actually extract the cases, go through each
6 sheet and move it into a format where the actual
7 committee can then review it, and then that
8 committee is the one that, you know, makes the
9 determination with pregnancy-related or pregnancy-
10 associated. So, that's some of the variation that
11 happens from state to state.
12 So, I think Ashley and the team there
13 at CDC is doing -- they're doing an awesome job
14 and helping keep it as standard as possible, but
15 you have to realize, each system is different in
16 each state as to how they move that data forward.
17 So, that's just one example. But it was an
18 excellent question.
19 Sherri, I see your hand is up now.
20 SHERRI ALDERMAN: Yes, thank you very
21 much for the powerful story that your data
22 presents. It's so important that we have data to

1 direct us and inform us as to where we can make
2 positive changes.
3 My question is first assumed on -- it
4 includes the assumption that both of your
5 organizations and agencies recognize that health-
6 related social needs are also contributing factors
7 to infant and maternal mortality, whether it's
8 causal or associated to pregnancy in terms of
9 maternal mortality.
10 My question is for both of your
11 agencies and I'd like to open it up to HHS as well
12 when I ask, where is the system prepared to begin
13 to collect health-related social needs, and where
14 are the barriers or challenges to doing that?
15 BELINDA PETTIFORD: Is anyone -- is
16 everybody going to answer at once?
17 TARA SANDER LEE: Yeah. Thanks,
18 ASHLEY BUSACKER: Sherri, that's a great question.
19 So, we at CDC have fairly recently introduced the
20 Community Vital Signs Dashboard in terms of the
21 Maternal Mortality Review Committee processes.
22 So, this is a dashboard, which holds community

1 context indicators, and there's a paper I can put
2 in the chat from Dr. Michael Kramer. And these
3 indicators are based on where the individual last
4 lived and gives some idea of the social factors.
5 So, there's a large group of them. They're split
6 into domains and the idea is that the Maternal
7 Mortality Review Committee can look at these
8 dashboards to give that community a social context
9 to the review.
10 The other thing that the MMRIA data
11 system has -- is a place to collect what we call
12 social and environmental profiles, so a place to
13 know information that the committee or the
14 abstractor finds for the case. This could come
15 from kind of a next-of-kin interview or an
16 informant interview, but it's also noted in social
17 records and other sources.
18 So, the Maternal Mortality Review
19 Committee data, I think, has the potential to look
20 at some of those social determinants of health and
21 drivers of health that we maybe can't get to with
22 just the vital records alone.

1 And then we've also used those
2 community indicators, the vital signs indicators
3 in an analysis of our PMSS data, again based on
4 the place of residence at death.
5 So, I can put those two papers in,
6 but we really hope with our coming analyses that
7 you'll see more of that data from our team.
8 BELINDA PETTIFORD: Sherri, does that
9 answer your question?
10 SHERRI ALDERMAN: It does. Thank you
11 very much. I'm also curious if there are
12 challenges with coding to be able to capture the
13 health-related social needs.
14 BELINDA PETTIFORD: And if you want
15 to drop the response in the chat while you all are
16 thinking about it. Sherri, I'm going to go onto
17 Jacob while they're thinking on that one, okay?
18 Thanks.
19 Jacob.
20 JACOB WARREN: Thank you. I just
21 wanted to thank all the representatives for all
22 this very, very helpful information.

1 I have a quick question for Danielle.
2 I was looking at the infant mortality and I was
3 trying to -- you had a lot of wonderful data and I
4 was trying to very quickly synthesize it as you
5 were going through. Are you seeing any -- even if
6 it's not statistical -- numeric trends in closing
7 the inequity gaps? So, you know, it's great that
8 we have our infant mortality down-turning, but is
9 it just going down equally across all the groups
10 where we're not actually closing our disparity
11 gaps, or I don't know if you had any indication
12 from your data that you commented on.
13 DANIELLE ELY: So, if you're thinking
14 back across the many, you're right, I included a
15 lot of information because I know there are a lot
16 of things that people are interested in, and so
17 going quickly was the best I could do on that.
18 So, if you think back in terms of
19 inequities by maternal race and Hispanic origin on
20 that slide that I included from 2017 to 2020 just
21 using the single race, the fact that we're seeing
22 infant mortality rates decline at different

1 percentages or different rates -- I had saying
2 rates multiple times -- but, you know, comparing
3 like some groups at the 5 to 8% level, which is a
4 little more equal, but then we're seeing these
5 larger declines of, you know, 17% for some of the
6 other groups. Then if you're looking at declines
7 by, you know, place in terms of states, we see
8 states with greater declines. Granted, some of
9 that is because some states have further to go
10 compared to other states over time.
11 So in general, I think you could say
12 that some of the disparities are closing while
13 others might be getting larger, and some of that
14 will depend on what groups you're looking at, what
15 kind of information you're trying to get to. But,
16 in general, I think you can easily say that there
17 are some improvements, but also probably some
18 places where it's getting worse.
19 BELINDA PETTIFORD: Thank you.
20 Any other questions? I know we're
21 running at little bit overtime, but I know this
22 data conversation is so important, as it drives

1 our work as we continue to move forward. I know
2 there was one question, I think, Phyllis, you
3 dropped in the chat. I don't know if you got your
4 answer or not. It was around, I want to say
5 injury.
6 ASHLEY BUSACKER: Yeah, Belinda, I'm
7 working on typing a response.
8 BELINDA PETTIFORD: Oh, okay.
9 ASHLEY BUSACKER: I can type it, or I
10 can talk, whichever.
11 PHYLLIS SHARPS: Yeah, just my own
12 interest is domestic violence and pregnancy
13 outcomes, and we did see during the pandemic a lot
14 more calls from women who were, you know, forced
15 to be at home with abusers and I have written a
16 paper on pregnancy-associated deaths. But I was
17 just wondering if there is any systematic tracking
18 of that data also.
19 ASHLEY BUSACKER: So, within the
20 Maternal Mortality Review Committee data, we do
21 have data on pregnancy-related deaths, but the
22 manner of death was intentional, so suicide or

1 homicide. We would have some recommendations
2 there. Is that helpful or are you looking for --
3 okay, so yeah. Let me -- I'll put some
4 information in the chat and then I also see the
5 question about the MMRIA states, so I'm going to
6 drop a photo of the map.
7 BELINDA PETTIFORD: Thank you all so
8 much. Sarah and Emma, one of you all, can we make
9 sure we grab the chat before the meeting is over
10 because we're getting really good information in
11 the chat, especially all of the links that are
12 placed there so that we can get them back later.
13 That would be really helpful.
14 EMMA KELLY: Yes, we will.
15 BELINDA PETTIFORD: Thank you, Emma.
16 And if you call can join me in
17 thanking this awesome panel, you all did an
18 amazing job. So, thank you all so very much for
19 this great data. We've got a long ways to go, but
20 we appreciate you all sharing the data with us.
21 And now that we've had a chance to
22 really review the data, now we're going to go into

1 our next session on Where Does The Committee Go
2 From Here.
3
4 WHERE DOES THE COMMITTEE GO FROM HERE
5
6 BELINDA PETTIFORD: And again, we
7 just spent time reviewing this data in great
8 detail, answered all of our many questions, and
9 I'm sure more questions will come. But I wanted
10 us to take some time today to just think about
11 what are our next steps as the ACIMM committee.
12 Where do we want to go next? I want to have a
13 short conversation with this committee about those
14 things.
15 So, one question that kind of comes
16 to mind is first of all, is there any work that we
17 have left kind of unfinished that we need to wrap
18 up from the last committee? If anyone can think
19 of anything, if you will come off of mute and
20 share that, we by all means will continue to keep
21 our eye on the options for American Indian/Alaska
22 Native as we want to make sure that work continues

1 to move forward and we prioritize that. So, we
2 will definitely continue that.
3 But did we leave anything out that we
4 might bases? Vanessa, we hope you feel much
5 better soon. Thank you for dropping that in the
6 chat.
7 And if we haven't left anything off
8 that we need to wrap up, I want us to now talk
9 about where do we want to focus on next. So, as
10 we shared earlier, I know everyone came on at
11 different points in time into this committee, so
12 this last go around, we actually have had three
13 sets of recommendations that we moved forward to
14 the Secretary. But at this point in time, now
15 that we've looked at the data, we've had some
16 conversation around framing, and we're going to
17 try to bring in someone to share a little bit more
18 information and guide us through the framing
19 process.
20 I really want us to think through
21 what areas do we want to focus on next to improve
22 maternal and infant health in this country. We

1 definitely want to make sure that the voices of
2 individuals with lived experience are elevated,
3 and we'll get to hear more of that tomorrow when
4 ShaRhonda is prepared to share her story with us,
5 and we want to continue to make sure we're doing
6 that as part of each one of our meetings.
7 But is there an area that resonates
8 with you all right now that you think, oh gosh, I
9 can't believe we haven't delved deeper into this
10 or do we want the team to kind of help us research
11 it a little further? Do we want to bring in a
12 speaker? Is there a specific area -- and I see
13 your hand, ShaRhonda.
14 SHARHONDA THOMPSON: Well, for me,
15 one of the things that jumped out and kept jumping
16 out for me with the data was how the mortality
17 rate was higher when the mother was receiving
18 benefits from the state like WIC, like how it was
19 higher than the ones who had private insurance,
20 and it -- I'm -- I have my personal idea as to
21 why, you know, that kept sticking out. But I
22 don't know if this is something that has been

1 looked into in the past or if it's something that
2 we could dive into a little more. Because the
3 whole purpose of this supplemental benefit is to
4 help and for someone reason, it's just not -- it's
5 not sufficient enough. So, is that something that
6 has been looked into?
7 BELINDA PETTIFORD: That's a
8 wonderful question, ShaRhonda. And, you know, I
9 think you probably have some ideas of what the
10 answer is realizing, you know, I think it was -- I
11 can't remember who was presenting, I don't
12 remember if it was Danielle, if you were
13 presenting when you were overlaying what I call
14 maps one on top of the other that basically says
15 some of the challenges that we're dealing with
16 are, again, not just the clinical part of the
17 world, but we're dealing with our social
18 determinants of health, which is our determinants
19 of health. So, we're looking at issues of
20 socioeconomic status, and we're looking at issues
21 around how does housing impact this. How are some
22 of the larger issues that are impacting it and I

1 think the ones like you had, Danielle, was related
2 to WIC, but we know WIC is one piece of the
3 puzzle. We help some with making sure that we are
4 dealing with food insecurities. But we know
5 again, it is one component and realizing many of
6 our families need more. So, that's a great point,
7 ShaRhonda, and I'm putting it down as a note for
8 just some more follow-up on that.
9 And Kate, I see your hand.
10 KATE MENARD: Yeah, Belinda, I'm, you
11 know, I'm still relatively new to the committee
12 and was so impressed that the -- that the
13 committee focused so intently, you know, kind of
14 on one topic and produced the report that you all,
15 you know, the people that have been on this group
16 did for a while, and I'm just wondering what the
17 next big thing is as you're perhaps asking. And
18 in listening to what you said, Belinda, you, you
19 know, you're -- you're seeing the need to, you
20 know, not putting recommendations out there but --
21 but put out actions, and how do we get there? I
22 mean, how would it get there in a public health

1 field where we need to be, you know, totally
2 focused on health equity and the importance of
3 that and I think you believe, and I've become more
4 appreciative of the fact that the community
5 engagement aspect of our work and how we implement
6 change is -- is as important or even more
7 important than how we kind of discover what change
8 should be, you know, the different practices that
9 can make a difference.
10 And I'm wondering -- I'm wondering if
11 there's, you know, a possibility for the group to
12 enter into an exercise where we look at, you know,
13 community-engaged implementation and what -- what
14 strategies, you know, what -- what emphasis might
15 be out there that we could most -- could most
16 impact change if we took that approach. I'm just
17 kind of throwing out an idea, but I'm listening
18 and wondering what can be our next big thing, and
19 it may be community engaged implementation of
20 selected things and how we go about that, and
21 having almost a, you know, a playbook to do that.
22 BELINDA PETTIFORD: Thank you, Kate.

1 You know me well, don't you, here in North
2 Carolina. So, thank you, Kate.
3 KATE MENARD: You taught me a lot.
4 BELINDA PETTIFORD: We'll do it
5 together. Thank you.
6 Phyllis, I see your hand as well.
7 PHYLLIS SHARPS: Yeah, I guess I was
8 kind of thinking along the same lines and picking
9 up on something that Dr. Warren said about based
10 upon the recommendations from the report we just
11 did the value of going to communities. And so I
12 was thinking, in those thirteen states that had
13 the most significant changes in maternal mortality
14 and, you know, those indicators, are there best
15 practices? Is there a consistent trend? Could we
16 do some deep research to see what might be related
17 to those things, and do we eventually go to one of
18 those -- one or two of those communities and just
19 kind of look at what that best practice looks like
20 or convene, you know, a meeting where those people
21 implementing those best practices or initiatives
22 or integrated health care, whatever it was, they

1 come and talk about their programs so that maybe
2 we develop some recommendations that would be
3 actionable steps that other communities struggling
4 might consider.
5 BELINDA PETTIFORD: Great point,
6 Phyllis. Thank you so much. I'm really trying to
7 think through. So, what is working in different
8 parts of this country, especially when we're
9 talking about a part of the country that is
10 diverse, because some of our challenges is the
11 fact that in certain communities, we're going to
12 see worse outcomes. So, how do we make sure we
13 are connecting with those entities, those states,
14 those communities, those organizations that are
15 actually seeing improvements and what are the
16 lessons learned from them. So, I like that idea,
17 Phyllis. Thank you.
18 Anyone else?
19 TARA SANDER LEE: I think one thing I
20 noticed is that, you know, mental health was just
21 a huge indicator. That was associated with a lot
22 of just mental health issues came out. So, I was

1 associated with maternal mortality and I just
2 wonder if we need to dig deeper into that and the
3 reason. I think -- I personally would like -- I
4 think since that just continued to come up,
5 especially -- and that there were, you know, I
6 just think that that's something that was
7 consistent, and it would be nice to kind of dig
8 deeper and to find out why. And maybe we -- and
9 if that data is there, maybe we need to look
10 closer at that.
11 And I guess I would like to
12 understand too better when the data is analyzed,
13 like can they actually pull that data out. Can --
14 is there enough data there to actually understand
15 how mental health issues were associated with the
16 deaths. So, those are just some of the questions
17 that I have.
18 BELINDA PETTIFORD: Thank you, Tara.
19 And I see Kate dropped in the chat the fact that
20 mental illness is not part of SMM data. So, they
21 are maternal morbidity data, and I don't know if
22 many of us have thought about the fact that it is

1 not even included, and it definitely should be.
2 TARA SANDER LEE: That's a great
3 point.
4 BELINDA PETTIFORD: Yep. Anyone
5 else? Anything going on in your part of the world
6 that is working or that you're struggling mightily
7 with?
8 Yes, Jacob.
9 JACOB WARREN: I apologize. I know I
10 sort of beat this drum every time, but it's even
11 more relevant now that I've moved from Georgia to
12 Wyoming.
13 You know, as we continue our
14 conversations about magnitude of impact, just
15 figuring out how we balance that with places like
16 the mountain west where we're never going to pop
17 big on numbers, but it doesn't mean that we don't
18 still have challenges to work through, so how
19 we're balancing that size and count issue with,
20 you know, there are only 500,000 people in my
21 state. So, we're never going to pop high on a
22 raw, and when we start to look even at rates and

1 just the fact that we're so sensitive to ups and
2 downs that our data is suppressed, just thinking
3 about how some regional thought about that could
4 happen as well. So, we're looking at, you know,
5 the Dakotas with Idaho, maybe there's some
6 regional -- regionalization we need to think about
7 in some of the smaller places because, you know,
8 we have one of the largest reservations in our
9 state, so we could do some important work in
10 equity, but sometimes the smaller states get
11 overlooked. We're a big state but a small
12 population. So, just how we balance that in this
13 whole conversation, I think, is something to keep
14 in mind as well.
15 BELINDA PETTIFORD: No, that's a
16 great point, Jacob, and thank you for bringing it
17 back to everyone's attention.
18 ShaRhonda.
19 SHARHONDA THOMPSON: For me,
20 communication, right? We want more community
21 involvement, but how? How do we go about reaching
22 them? I know there was a big push for technology,

1 but is that -- is social media the right way? Is
2 something in the doctor's office maybe a better
3 way? How are we communicating that we want the
4 community to help us? And how are we getting that
5 word out? I think that's what's lacking, at least
6 in my area, I know that's one of the things that's
7 lacking. People have no idea that this committee
8 exists. So, how are we getting the word out?
9 BELINDA PETTIFORD: Thank you,
10 ShaRhonda.
11 And I see, Kate, you've dropped in
12 the chat improve on regionalization and risk-
13 appropriate care.
14 Charlan, thank you for your note in
15 the chat as well. So, health conditions.
16 And Jacob, I see your hand.
17 JACOB WARREN: Yeah, sorry. Just one
18 last comment. One thing too just putting on the
19 other hat that I wear is how we start integrating
20 this better into health professions education
21 because I think we've got a real opportunity to
22 translate this into how we're training across the

1 whole health care spectrum. So we do everything
2 from community health workers to physicians here,
3 and I think if we look at how we can make
4 recommendations maybe even out -- it might be
5 outside of our scope technically, but ways that
6 educational institutions could play a role in this
7 process, I think, is something that we could think
8 through, sort of building on what ShaRhonda was
9 saying about how are we getting messaging out. It
10 might be another way for us to look at this.
11 BELINDA PETTIFORD: Thank you, Jacob,
12 and I don't think it's outside of our purview. I
13 think we can make a recommendation related to it.
14 I know one other thing. I don't know
15 how many of you all are familiar with the work in
16 your states or communities with your area health
17 education centers, you know, AHECs. They now,
18 they have a Scholars Program where, you know, they
19 work with students like in the freshman and
20 sophomore year in college and trying to encourage
21 them to remain in the health field. One of the
22 things we've been doing in North Carolina is

1 trying to get them to consider the maternal and
2 infant health fields, so trying to even narrow the
3 focus down. And more recently, we've been working
4 with our state AHECs to do it further upstream to
5 work with high school students because we've got
6 to get to the workforce earlier before people, you
7 know, have already decided what they want to do,
8 but also decided how they want to do it. So,
9 great point, Jacob.
10 And Marie, I see integrate and
11 transition from maternity to extended postpartum
12 for high-risk communities. Thank you, Marie.
13 And HRSA funds, AHECs through --
14 thank you -- the Bureau of Health Workforce. So,
15 there is a great opportunity for collaboration.
16 Wonderful, we probably want to invite them to a
17 future meeting. Sarah is going to help me
18 remember that, aren't you Sarah? Thank you. She
19 is not just relying on my memory alone, bless her.
20 Okay. I don't want to cut anyone
21 off. These are all great ideas, and if you think
22 of something else tonight, you can always shoot me

1 an e-mail and I'll have it in the morning, or you
2 can e-mail in the morning. But I want us to
3 continue this part of the conversation.
4 And as we're thinking about what we
5 want to move forward with, we also need to think
6 about any specific resources or support that we
7 need maybe related to these areas to make sure
8 that we're, you know, that we're getting the best
9 information that we can have in the decisions that
10 we're trying to make.
11 And Michael, I saw your hand go up
12 and then I saw it go down. So, I'm assuming you
13 really wanted it to be up.
14 MICHAEL WARREN: Sure. I think a
15 tag-on to that ask is I think there are a number
16 of efforts, not just in the Bureau, but across
17 other partners within HHS and other parts of the
18 federal government that are working to address
19 both maternal and infant health outcomes, and I
20 think one of the key jobs of this committee is to
21 advise the Secretary on HHS programs, specifically
22 Healthy Start, but also others. But I think there

1 is a great opportunity with these themes of like
2 what's working out in the field and what can we
3 learn from that. Similarly, where are these
4 challenges to bring back to guide us as we think
5 about these funding opportunities?
6 I shared a number at the beginning of
7 the funding opportunities we're putting out. You
8 know, at MCHB, we're primarily like a grant-making
9 entity. And so, if we want to think about
10 changes, changes to those funding opportunities
11 are key at hearing from you all on suggestions for
12 how to do that is a great way for us to leverage
13 the wisdom of this committee and your
14 partnerships.
15 BELINDA PETTIFORD: Thank you for
16 chiming in to share that, Michael.
17 And I think -- I can't remember who
18 presented earlier and they talked about, was it
19 Alison, when she talked about the community
20 organizations that they have been working with to
21 do research and they've given these fifteen kind
22 of like challenge grants. To me, that is a great

1 opportunity to pull other people into the
2 discussion that may normally never be part of the
3 conversation. And these are probably entities
4 that can reach people, but they've never been
5 given the opportunity to actually get some
6 resources to support the work. So, I know I was
7 very excited, Alison, when I heard you start to
8 talk about that, and I was writing notes
9 everywhere.
10 ALISON CERNICH: I think the other
11 thing we could do too is we have the groups that
12 said that they want to be part of that and HHS at
13 large has those names. So, Michael, maybe we
14 could even think about how to engage some of these
15 groups moving forward because, you know, it may be
16 a good opportunity at that level.
17 BELINDA PETTIFORD: And I wonder, are
18 you all in that same conversation as you're trying
19 to work more with community organizations and
20 maybe representing historical and marginalized
21 populations may or may not be how you are giving
22 them access to funds. Because, you know, I know

1 with many systems, you spend the money, and then
2 we pay you back, and that doesn't work for
3 everyone. That doesn't --
4 ALISON CERNICH: Yeah, this changes
5 the way we do that for sure, Belinda.
6 BELINDA PETTIFORD: Okay.
7 ALISON CERNICH: We changed the way
8 the prize authority works and the reason we
9 decided to use that is because -- so they have to
10 do some work, but we staged the challenge in such
11 a way that we were giving them money throughout as
12 they moved so that they could -- we can't tell
13 them how to use the money at all. We essentially
14 give them a check with the prize, and HRSA has
15 also done some of these through the prize
16 authority. So, the way that it is structured is
17 that we decrease the administrative burden so it
18 was a page for their first application to this,
19 and we brought them in and trained them some for
20 free, but it was short. Then the next phase, we
21 gave them a check. Now, again, they can use it to
22 build their infrastructure, they can use it

1 another way, it's up to their discretion. But as
2 they move, we're giving them money to potentially
3 support what they're doing in the next phase to
4 get to that final prize. But really, the only
5 thing they need to give us is a bank account
6 that's a domestic bank account. They have to be a
7 domestic organization and they have to have a bank
8 account.
9 BELINDA PETTIFORD: That is awesome.
10 You need to share that with some other entities.
11 ALISON CERNICH: Well, Michael has
12 done it at HRSA, I know for sure. So it's not --
13 it's just, you know, I think it's the way that we
14 structure some of these things and trying -- what
15 we've talked about in our community is we can't
16 keep trying to get to these communities the
17 traditional way because if we keep doing the same
18 thing, we're going to keep getting the same
19 results, and we're not engaging these communities
20 in a way that is sensitive to what they need,
21 especially small organizations, and we also have
22 to think about how we give them money to move them

1 into a research infrastructure that's respectful
2 of a small group's ability to develop.
3 So, we worked a little bit with some
4 nonprofit partners, like at March of Dimes, and at
5 Commonwealth to think about how to structure the
6 prizes as well so it was respectful of those
7 groups.
8 BELINDA PETTIFORD: Thank you.
9 MICHAEL WARREN: And I think, if I
10 could add, the prize mechanism is a great
11 opportunity that we have. We also were looking at
12 our traditional grants and where we have
13 flexibility. So, simple things like we've heard
14 from community-based organizations requiring us to
15 spend so much money on evaluation, which takes
16 money away from direct services, and so, how can
17 you simplify that or think about supporting
18 awardees in other ways to do that.
19 We've heard things like just the
20 number of pages you're requiring in a grant
21 application is overwhelming. And so, for folks
22 who are very focused on service delivery, it may

1 be difficult to do that.
2 And so, we're trying to revise our
3 grant-making process where we've got the authority
4 to be more flexible so that it opens up the door
5 for more folks to apply.
6 BELINDA PETTIFORD: That is
7 wonderful. And actually, Alison, I was thinking
8 you should share it with some states. I wasn't
9 really talking about Michael. I'm thinking of
10 some other places that need it.
11 ALISON CERNICH: I don't know if
12 states have -- yeah, that's interesting because I
13 know the federal agencies have prize authority. I
14 don't know if states have given themselves prize
15 authorities, but I'm sure they have flexible ways
16 to get funding out that may be different.
17 BELINDA PETTIFORD: We're working on
18 it. We'll see but thank you so much.
19 And also, I do remember years ago,
20 Michael, that through the Healthy Start world,
21 there used to be capacity building grants. Those
22 entities would have like a year to plan and get

1 ready for a larger grant and, you know, that is
2 one of those other areas that I really felt like
3 you could give like communities or small entities
4 the opportunity to actually apply for those
5 resources, and I think those -- that's another
6 opportunity I just look at it as.
7 Okay. I don't want to cut anyone off
8 because Belinda could keep talking about this
9 topic and she will move on. We do have an agenda.
10
11 OPEN DISCUSSION
12
13 BELINDA PETTIFORD: But we're open
14 discussion now. So, we didn't plan anything
15 specific for open discussion. We wanted to use it
16 as an opportunity if there's anything you want to
17 share, anything about today's meeting, anything
18 about tomorrow's part of the conversation,
19 anything that you're concerned about, anything
20 that excites you, your plans for the evening. You
21 will quickly learn that Belinda does not believe
22 in just holding you here for a meeting because we

1 put fifteen minutes down for open discussion if
2 you don't have anything specific to discuss.
3 This has been an awesome meeting
4 today. You all have done a really good job of
5 being engaged, and please know I appreciate that.
6 It's really hard to chair a meeting when you look
7 down and there's no one there, and you're like
8 okay, I can only talk to myself for so long. So,
9 thank you all so very much.
10
11 WRAP-UP AND OVERNIGHT CONSIDERATIONS
12
13 BELINDA PETTIFORD: I don't really
14 have an assignment for tonight or anything that
15 we're encouraging you to do. But if you get a
16 chance in your spare time, we're working on trying
17 to shorten the size of the briefing books so that
18 they don't feel so overwhelming when we receive
19 them. So, if you get a chance to, you know,
20 glance through a page or two, the information on
21 the Frameworks, I think is on page 124 if you want
22 to just look at it, but you will not be quizzed on

1 it tomorrow. We probably won't even bring it up.
2 But if you will look at that if you get a moment.
3 Otherwise, anything else we need to
4 share for today? Thank you all for the notes in
5 the chat.
6 Otherwise, we will adjourn for today.
7 We will start back tomorrow at our same time.
8 Keep in mind, tomorrow's focus will start off with
9 ShaRhonda, and we really appreciate ShaRhonda for
10 her willingness to share her story and her journey
11 that has brought her to this committee. But we'll
12 also spend most of our day really listening to our
13 partners. We've asked our partners to come in and
14 share specifically what they're doing through
15 their networks to address maternal and infant
16 health to see if there is an area that may
17 resonate with us that we want to try to move
18 forward and try to elevate with them. So just
19 know that that is going to be much of our
20 conversation tomorrow, and we look forward to
21 seeing you all.
22 Please enjoy your evening. Try to

1 get outside for a moment if it's not too cold
2 where you are, and otherwise, I look forward to
3 seeing you all tomorrow. Take care.
4
5 (WHEREUPON THE MEETING WAS
6 ADJOURNED AND WILL CONTINUE ON
7 MARCH 21, 2023 AT 11:30 A.M. ET)