These draft recommendations intended for the Secretary of the U.S. Department of Health and Human Services (HHS) will be finalized by the Committee at the January 7-8, 2025 meeting.

The Committee is interested in feedback on *whether anything critical is missing* from the draft recommendations.

- If you would like to submit a response **in writing** to the Committee, please email it to SACIM@hrsa.gov by January 2, 2025 at 12:00 PM ET.
- If you would like to provide **oral** public comments on anything critical that is missing, time will be available at the ACIMM meeting on Jan. 7th from 1:45 - 4:15 PM ET. Please register to speak using this link: https://acimmregistration.org/comment/ by January 2, 2025 at 12:00 PM ET.

Draft Recommendations from the Advisory Committee on Infant and Maternal Mortality (ACIMM) to the Secretary of Health and Human Services

January 2025

The US infant mortality rate in 2022 was 5.6 deaths per 1000 live births with leading causes being birth defects, preterm birth and low birth weight, and sudden infant death syndrome. The Non-Hispanic White rate was 4.5 deaths per 1000 live births with the **Non-Hispanic Black rate being more that twice that rate at 10.9 deaths per 1000 live births.** The 2021 US maternal mortality rate continues to rise. **The maternal mortality rate for Non-Hispanic Black women was 69.9 deaths per 100,000 live births, 2.6 times the rate for** non-Hispanic White of 26.6. To realize improvements in maternal and infant health outcomes, ACIMM has developed specific recommendations designed to improve Non-Hispanic Black maternal and infant outcomes related to **Preconception/Interconception Care and Rural Health Systems of Care.**

In developing these recommendations, considerations were given to the importance of **social drivers of health**. ACIMM acknowledges and believes in the importance of these non-medical drivers and plans to **release a second set of recommendations** specific to social drivers of health by summer 2025. This will be inclusive of, though not limited to, safe housing, transportation, racism, discrimination, and access to nutritious foods.

Focus – Preconception/Interconception Care (PCC/ICC)

Recommendation 1 – Surveillance, Research, and Data

1. Develop **standardized tools that measure, track, and identify** best practices for optimal reproductive health including:

    1A. Provision of high-quality PCC/ICC in primary care, prenatal/postpartum and community – based health care settings.

    - Funding for development of assessments of availability, accessibility and quality of PCC/ICC health care visits

    1B. Outcomes of current best practices for reproductive health care.

    - Support for standards of care that monitor PCC/ICC – such as funding for standardized monitoring of the 10 indicators for PCC (Kroelinger, 2018; Robbins, et al, 2018)

        1. Current Smoking
        6. Hypertension

2. Depression
3. Diabetes
4. Folic Acid Uptake
5. Heavy Alcohol Consumption
7. Normal Weight
8. Physical Activity
9. Postpartum Contraception
10. Unwanted Pregnancy

- Track specific indicators of health and conditions relevant for PCC/ICC health at the county level (MVI)
  1. Pre-Existing Hypertension
  2. Body Mass Index
  3. Smoking
  4. Mental Health
  5. Diabetes
  6. Substance use
- Funding for the development and dissemination of PCC/ICC Toolkits such as the Preconception Health Toolkit developed by the Reproductive Health National Training Center and funded by DHHS.

  (https://rhntc.org/resources/preconception-health-toolkit)
- Funding that supports collaboration of federal and state Maternal, Infant, and Fetal Mortality Review Committees and the incorporation of data to inform standards/indicators aimed at prevention of adverse outcome

1C. Data related to overall population health of all people, regardless of their gender or sexual identity through the creation of a standardized national surveillance, including tracking female death data during the reproductive years.

- Funding for CDC to expand the Behavioral Risk Factor Surveillance System (BRFSS) to include reproductive health questions specific to PCC/ICC

Rationale: Providing evidence-based, high-quality PCC/ICC depends on having accessible and reliable national data, by race and ethnicity. This requires data that document the provision of PCC/ICC, populations served and outcomes. Creation of a national surveillance system to track and monitor the provision and outcomes of reproductive health care, including PCC/ICC to nonpregnant individuals. Important is also adding to existing national surveillance systems such as Pregnancy Risk Assessment Monitoring System (PRAMS), or the Behavioral Risk Factor Surveillance System (BRFSS) survey.

Recommendation 2 – Workforce and Training

2. Prioritize funding that increases and expands the diversity of the reproductive healthcare workforce.

   2A. Provide funding opportunities for health care professional educational programs, loan forgiveness, and training programs aimed at **increasing the number of health care providers** from traditional underrepresented Black, Indigenous People of Color (BIPOC) and gender non-conforming populations that provide PCC/ICC based on a life course reproductive health framework.

   - Develop new funding mechanisms to support increasing the number of PCC/ICC professionals overall, with specific efforts to increase the number of BIPOC professionals, thereby increasing access to PCC/ICC

   2B. Provide funding opportunities for health care professional educational programs, loan forgiveness, and training programs aimed at **increasing the variety of providers** (i.e., physicians, advanced practice nurses, certified nurse midwives, doulas, and community health workers) prepared to deliver evidenced based PCC/ICC, and who are competent in providing culturally congruent care based on a life course reproductive health framework.

   2C. Provide funding opportunities that support educational materials for continuing education professional development for health care, social services and lay health providers on topics of PCC/ICC and reproductive health and wellbeing across the lifespan.

   - Develop new modules and other training materials that can be incorporated into professional education programs and/or continuing professional educational units
   - Funding for updating existing online training modules available for practicing professionals, such as https://beforeandbeyond.org/modules/-

   2D. Provide funding opportunities for the creation of standards of training for community health workers (CHW) and doulas on best practices that are culturally congruent PCC/ICC (Altschul, Deborah & Samuels, Judith & Zeitlin, Wendy. (2008).

   2E. Provide funding opportunities directly to community-based organizations (CBOs) that provide training for community-based health providers and enhance their ability to provide evidenced -based and culturally appropriate PCC/ICC.

Rationale: There is a need to expand the number and variety of health care providers that can implement appropriate high-quality PCC/ICC counseling and care. Published data

indicates that access to PCC/ICC improves outcomes for pregnant people and their infants (Atrash, Johnson, Adams, Cordero, Howse, 2006). Studies indicate that among those states that expanded ACA associated Medicaid showed increased health insurance coverages, access to care, including PCC/ICC counseling and contraceptive services. The most significant impacts were for low-income women, Black women and women without dependent children (Johnston, Strahan, Joski, Dunlop, &Adams, 2018; Margerison, MacCallum, Chen, Samani-Hank, & Kaestner, 2020; Myerson, Crawford, Wherry, 2021). In addition, encourage funded partnerships between other entities such health departments, hospitals and universities that also receive funding for health care professional education programs and training to partner with CBOs to provide training. There is also a need to ensure that all individuals despite where they live geographically (urban, suburban, rural) have access to evidence-based, high-quality PCC/ICC counseling and care. Expansion of the PCC/ICC workforce should be expanded so that PCC/ICC care is accessible, across all settings, including primary care clinics, community health centers, well women centers, adolescent health care centers, gender diverse communities, midwifery care, with a specific emphasis to improve and ensure access to comprehensive PCC/ICC for potential Black birthing populations. Increasing the number of providers who are from underrepresented populations is desired by many potential Black birthing people. Funding that supports education and training to expand the number of BIPOC professionals across the spectrum of PCC/ICC is a direct desired response, noted within listening sessions and among community voices. There is evidence that shows patients who receive healthcare from a provider with whom they share culture have improved outcomes. Increasing the number of BIPOC professionals may be an important strategy for addressing the Black MCH Crisis. Health care organizations supported published study findings are recognizing the importance of diversity, equity, inclusiveness and belonging (DEIB) are core principles for improve health outcomes and lower health care costs (Byas, 2024; Moore, Coates, Watson, de Heer, McLeod, & Prudhomme, 2023). Studies also provide findings that racial concordance between providers and patients result in increased patient satisfaction, improved communication and greater trust in the healthcare system (Byas, 2024; Moore, Coates, Watson, de Heer, McLeod, & Prudhomme, 2023).). Provider-patient interactions including these factors are associated with improved adherence to treatment plans, less fear of coming into the health care setting and improved health outcomes. Also, racial/ethnic concordance provider-patient interactions often include more understanding of cultural practices that may impact health behaviors and practices (Ayala-Luna, 2023).

Recommendation 3 - Increase public awareness and knowledge of PCC/ICC

3. Comprehensive, intentional, widespread and accessible reproductive health and well-being education campaign aimed at increasing public knowledge.

3A. Provide reproductive health/well-being including PCC/ICC information across the USA using a multimodal approach including video ad campaigns, social media and public service announcements that reach all populations, regardless of age, sexual orientation, or gender orientation.

3B. Provide funding opportunities for the creation of education materials that are culturally sensitive, multi-lingual and built on existing best practices.

3C. Provide funding opportunities that support the national scale up of existing best practice educational materials that include reproductive health and PCC/ICC.

- Example – Show Your Love website - https://showyourlovetoday.com/ or funding to support the development of and widespread national awareness campaign and modules that address women, men, and special populations

Rationale: All individuals need reproductive health knowledge that includes their reproductive health care rights and knowledge that dispels misinformation and myths, as inadequate and false information is a barrier to seeking appropriate and timely care. A comprehensive educational campaign should be inclusive and specific for all genders and identities, culturally appropriate, and based on a life course approach. The comprehensive public education campaign should include human biology, healthy and safe intimate partner relationships, methods for preventing pregnancy and sexually transmitted infections, management of chronic illnesses, appropriate use of alcohol, tobacco and other drugs, and medical insurance options.

The comprehensive education program should be based on literacy needs and should address limited broadband access and be available in multiple settings such as primary care medical homes, FQHC's, community health centers, libraries, schools, universities, workplaces, and religious/faith-based settings.

Focus – Rural Health Systems of Care

Recommendation 1 - Create a sustainable financial model for high-quality, holistic maternal and infant care in rural communities that meets the needs of all residents

1A. Provide enhanced reimbursement for facilities and providers serving in maternity care shortage areas, including adequate support for low volume rural facilities

- Establish a Critical Access Labor and Delivery Unit designation that provides low volume payment adjustments/standby payments for

rural hospitals that serve communities in need of local access to comprehensive maternity care*

- Provide enhanced reimbursement to maternity care providers** who practice in rural maternity care shortage areas

1B. Implement payment structures that incentivize the development and maintenance of regionalized care systems that emphasize quality care as close to home as possible

- Designate funds and payment/reimbursement policies to establish and maintain formal regionalization structures that ensure access to the full continuum of perinatal care for rural families including transfer and back-transfer of to appropriate levels of care
- Revise the global fee model for perinatal services to provide appropriate compensation to all individuals who are part of the continuum and cycle of care
- Develop telehealth-specific payment structures, including payment parity, for remote specialty support for rural maternity teams, including provider-to-patient as well as provider-to-provider telehealth communications.
- Collaborate with Housing and Urban Development (HUD) and US Department of Agriculture (USDA) to enhance access to affordable and reliable high-speed internet and related telehealth equipment in rural areas.

*****Maternity care includes prenatal care and standard diagnostics, childbirth, and postpartum care inclusive of support services such as lactation consultation, doula services, behavioral health services, and nutrition consultation.
**Maternity care providers include obstetricians, family medicine physicians, licensed midwives, anesthesia providers, nurse practitioners and physician assistants who provide prenatal care and/or attend births or provide postpartum care.

Rationale - As described in the introduction to this section, rural hospitals are facing extreme financial pressures that are increasingly resulting in either closure of the hospital or closure of labor and delivery units in an effort to preserve the broader hospital. Addressing the financial challenges faced by rural, low-volume maternity units and care providers is essential to sustain access to equitable access to high-quality perinatal care. This need is particularly acute as low-volume rural hospitals are often unable to sustain the high fixed costs of staffing a labor and delivery unit. Absent systemic change and intentional stabilization efforts focused directly on preserving access to labor and delivery services, current trends are likely to continue, resulting in increased places without maternity care, which have also been referred to as “maternity deserts.”

Recommendation 2 - Advance maternal and infant health equity in rural communities by ensuring access to high-quality, team-based, risk-appropriate care

2A. Provide states with financial resources and technical support to adopt standard definitions, implementation guidelines and verification of maternal and neonatal levels of care. Create a public portal for hospitals' resources for care and the meaning of those levels.

2B. Incentivize regionalized systems to provide support to rural hospitals and clinicians through payment and licensure agreements, provide ongoing training, quality improvement efforts, onsite rotations for skills maintenance, and on-demand telehealth consultation

- Financially support collaboration among hospitals and emergency medical services (EMS) that ensure timely maternal and neonatal transport to a higher level of care when indicated
- Financially support establishment of multi-state Medicaid coverage agreements for perinatal services and state licensure reciprocity
- Financially support regional centers to collaborate with referring hospitals in their region by providing support for higher-risk pregnancy, labor and delivery, and newborn care, as well as outreach education, skills training, and leadership for data driven quality monitoring and improvement
- Require and provide financial support for obstetric readiness training in non-birthing facilities including Rural Emergency Hospitals, and for EMS services
- Support mental/behavioral and other specialty/subspecialty providers to become part of regionalized systems

2C. Provide financial support for rural hospitals and clinics to engage in evidence-based/evidence informed quality improvement efforts

- Provide ongoing financial support to rural hospitals and clinics to actively participate in statewide perinatal quality collaborative and regional perinatal center quality improvement initiatives such as adopting AIM and AIM CCI bundles, or those seeking birthing-friendly and baby-friendly designations
- Provide direct financial support to providers, organizations, and systems that implement community care bundles

2D. Enact policy that requires and provides financial support to hospitals that close labor and delivery units to create a new continuum-of-care plan for residents in the hospital's catchment area.

Rationale - Even with efforts to stabilize access to perinatal services in rural communities, it is not feasible to maintain direct access to all levels of care in every location. As such, it is critical to support the establishment and sustainability of

regional systems of care with intentional and continuous collaboration between local and distant providers. Such access to risk-appropriate care is a key element to improving the outcomes for pregnant patients and their infants. Collaboration rather than duplication can advance quality and cost efficiency. In creating these systems, it is critical that they be designed in a way that supports rural hospitals and providers who are living and working in rural communities to better meet the needs of their patients, while also supporting high-volume perinatal centers in having the resources necessary to support local rural providers.

Recommendation 3 - Achieve cultural safety in the rural health care system by developing and supporting a diverse workforce, creating integrative and collaborative community support systems, and advancing cultural humility.

3A. Seek input from rural community members regarding barriers and facilitators to accessing what they perceive as high quality, respectful care.

3B. Create systems that support financial viability and universal accessibility of doula, community health worker, and licensed maternity care providers.

- Create a system that supports the establishment of integrated comprehensive teams, including doulas and CHWs in rural areas
- Incentivize states to allow doulas and community health workers to bill for perinatal-related services under Medicaid
- Ensure doulas, licensed midwives, and community health workers are fully covered by public and private insurance to remove financial barriers in accessing such services

3C. Increase the availability of healthcare workforce training opportunities within rural communities

- Provide sustainable, continuous financial support for precepting and training health professions students in rural communities
- Increase support for family medicine residency rural training tracks that incorporate OB skills

3D. Increase the availability of cultural humility continuing education opportunities for rural providers.

Rationale - Rural areas contain highly diverse populations that in many cases have racial and ethnic groups as the majority population. It is well-established that Black, Hispanic, Native American, and multiracial pregnant individuals are more likely to report mistreatment and disrespect during pregnancy and postpartum. This can lead to avoidance of and disengagement during receipt of care, exacerbating the risk of negative

outcomes. It is therefore critical to support systems that focus on ensuring that care is not only available and accessible, but also acceptable and supportive for all pregnant people.

Summary – ACIMM believes that without improvements in non-Hispanic maternal and infant outcomes, the country will not continue to see overall improvements in these outcomes. ACIMM realizes that infant and maternal mortality are multifactorial, complex health issues rooted in many factors. The focus on Preconception/Interconception Care and Rural Health Systems of Care are only part of this intricate story. We also continue to acknowledge the importance of social drivers of health and are committed to the release of these recommendations by mid-2025.