Advisory Committee on Infant And Maternal Mortality (ACIMM)

Draft Meeting Minutes of October 16-17, 2024

These minutes will be formally considered by the Committee at its next meeting

Hybrid (In-Person and Virtual) Meeting
Washington, DC

DAY ONE: Wednesday, October 16, 2024

Welcome and Introductions

***Vanessa Lee, M.P.H.*, Designated Federal Official (DFO), Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS)**
***Belinda D. Pettiford, M.P.H., B.S., B.A.*, ACIMM Chair**

The Designated Federal Official (DFO) called the Advisory Committee on Infant and Maternal Mortality (ACIMM; the Committee) to order and welcomed attendees. Committee members then took turns introducing themselves. The Chair then provided an overview of the meeting agenda, including introducing the three Committee workgroups: Social Drivers of Health, Systems Issues in Rural Health, and Preconception/Interconception Health.

Review and Approve Minutes

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

The Committee unanimously passed a motion to approve the minutes of the June 2024 meeting.

Federal Updates

MCHB Updates

***Michael Warren, M.D., M.P.H., FAAP,* ACIMM Executive Secretary and Associate Administrator, MCHB, HRSA, HHS**

Dr. Warren provided an overview of recent initiatives and program funding aimed at improving maternal health across the United States. He highlighted the expansion of the state Maternal Health Innovation (MHI) program, which now covers 42 states and Washington, D.C., with $19 million in new funding to support initiatives that reduce maternal mortality and morbidity. Dr. Warren described how Illinois was addressing barriers to care by establishing clinics where patients could access obstetrics (OB) and pediatric care in one location, and was ensuring sustainability even after federal funding ends. Arkansas, another MHI grantee, had been implementing mobile "Centering Pregnancy" models and emergency OB training for providers in places where no maternity care existed any longer. The flexible approach in the state MHI program allowed each grantee to create solutions tailored to local needs.

Additionally, Dr. Warren described HRSA's Enhancing Maternal Health Initiative , which convenes local grantees and stakeholders in a state to enhance collaboration and share insights to addressing maternal mortality and morbidity. North Carolina hosted the first of these events, and HRSA had held nine additional events in various states, with three more planned for 2024. Dr. Warren also discussed the recent launch of a new National Center for Maternal and Child Health Medicaid Partnerships (CMMP) which focused on supporting states in strengthening partnerships between Medicaid and maternal health agencies. The Center would provide technical assistance, educational resources, and support in policy innovations. Dr. Warren concluded by mentioning updates on the Healthy Start program, increased funding for maternal health workforce training and leadership programs, and open funding opportunities in maternal and child health, underscoring HRSA's continued commitment to improving maternal nationwide.

Discussion

- A Committee member sought clarification on whether there was a Marshallese population in Arkansas.
    - Dr. Warren confirmed that Arkansas's Title V program had long recognized and addressed the unique needs of the Marshallese population in the state.
    - Dr. Lorch added that there were more Marshallese people living in Northwest Arkansas, than in the Marshall Islands, noting similarities to the Hmong population in Minnesota.
- A Committee member appreciated how the Enhanced Maternal Health Initiative in North Carolina allowed for the identification and connection with previously unknown HRSA-funded partners, facilitating future collaboration.
    - Dr. Warren noted that all HRSA grants are listed on the website and can be searched by state, making it easy to identify grants within specific locations.
- A Committee member expressed interest in expanding the emergency medical services for children program funding opportunity to include support for postpartum and pregnant mothers in addition to emergency services for children.
    - Dr. Warren explained that the Emergency Medical Services for Children (EMSC) program was specifically authorized by Congress to focus on pediatric readiness, with $24 million allocated to support states in ensuring emergency providers were equipped to treat children; he acknowledged, however, the growing need to address emergency services for pregnant women, especially in areas with no maternity care services, and mentioned existing efforts such as an OB readiness resource kit developed in partnership with the Alliance for Innovation on Maternal Health (AIM) TA Center.
- A Committee member shared that in New York State, an existing committee had recognized the need for improved obstetric training and was actively seeking it, while also collaborating with the Title V program to gain additional information and expertise.
    - Dr. Warren added that in the President's proposed 2025 budget, an additional $15 million had been requested under the AIM program to enhance obstetrical readiness in emergency care settings, pending final budget approval.

U.S. Department of Health and Human Services (HHS) Postpartum Maternal Health Collaborative

***Ying Goh, M.D., M.H.S.R.,* Office of Women's Health, Office of the Assistant Secretary, HHS**

Dr. Goh presented an overview of a collaborative initiative led by the HHS Secretary to address postpartum maternal health, specifically targeting postpartum maternal morbidity and mortality. Her team, described as a "concierge technical assistance" group, worked closely with six states—Iowa, Massachusetts, Maryland, Michigan, Minnesota, and New Mexico—to implement strategies in the White House's blueprint for maternal health. Dr. Goh shared that, in her previous role as a senior policy advisor to Vice President Kamala Harris, she contributed to shaping this initiative, which now focuses on postpartum health through quality improvement (QI) methods. The collaboration involved a partnership with state health departments and local collaborators, including healthcare providers and community groups, to strengthen support systems and address postpartum challenges.

The collaborative efforts were structured as a "one-year sprint," where states would undergo stages of data review, environmental scanning, and hands-on testing of QI practices. States actively then would engage in PDSA (Plan-Do-Study-Act) cycles to test and refine improvement strategies across various settings, from clinics to community environments. The project aimed to create a sustainable infrastructure for postpartum health improvements, promoting communication and collaboration among state teams, especially epidemiologists. Dr. Goh highlighted that early outputs included strengthened partnerships,

published materials and reports, with plans to share findings across HHS and external stakeholders to ensure the lessons learned were widely disseminated.

Discussion

- A Committee member inquired about the ultimate goal of the collaborative and whether its outcomes would be shared widely to inform other states and communities of the work.
    - Dr. Goh responded that findings would be shared widely, and that the collaborative's findings would support ongoing maternal health efforts by other agencies, like the Centers for Medicare & Medicaid Services (CMS). She noted that participating states weremotivated to continue this work independently, with Minnesota, for example, planning to enhance its surveillance systems for identifying postpartum care needs.

State Example (Louisiana): Maternal Morbidity and Mortality: Pathways to Improvement

***Veronica Gillispie-Bell, M.D., M.A.S., F.A.C.O.G.,* Ochsner Health System; Louisiana Pregnancy-Associated Mortality Review and Louisiana Perinatal Quality Collaborative, Louisiana Department of Health**

Dr. Gillispie-Bell described the severe maternal health crisis in the United States, with particular emphasis on the disproportionate rates of maternal mortality among Black and American Indian/Alaska Native women, and those in rural communities. She highlighted that the U.S. had the highest maternal mortality rates among high-income countries, and these rates had worsened over recent years, especially during the pandemic. Dr. Gillispie-Bell discussed the prevalence of counties in her state that lacked access to OB-GYN services or birthing facilities, emphasizing the need for better support in these underserved areas. She also discussed the need for quality maternal health care that addressed racial disparities and place-based inequities, and the need for expanding the workforce to include providers such as midwives and family medicine physicians, to fill gaps in care and improve outcomes across rural and underserved regions.

She then outlined actionable steps to address these challenges through initiatives like Louisiana's Pregnancy Associated Mortality Review Committee (PAMR) and Perinatal Quality Collaborative (LaPQC), which reviewed maternal deaths to inform policy and created guidelines for quality improvement respectively. Dr. Gillispie-Bell emphasized the need for coordinated, respectful, and equitable care through expanded telehealth and postpartum home visits, and the need to address social determinants of health, which significantly impacted maternal outcomes. Programs she strongly recommended included mandatory screening for perinatal mood and anxiety disorders, Medicaid expansion, a doula registry, and better collaboration between community providers and emergency departments to ensure continuous care. Dr. Gillispie-Bell concluded that addressing maternal mortality required a collective effort involving healthcare providers, policy makers, and communities, all working through a framework of equity and public health collaboration.

Discussion

- A Committee member expressed appreciation for the presentation and highlighted issues with Medicaid reimbursement rates for primary midwifery care, noting that both federal and state authorities often shifted responsibility for addressing these challenges.
    - Dr. Gillispie-Bell described efforts to work with the Medicaid managed care organizations in her state.
- A Committee member asked about Louisiana's efforts to recruit healthcare providers to areas facing challenges in delivering evidence-based care, particularly for high-risk patients, while ensuring providers felt safe and supported in their practice.

    - Dr. Gillispie-Bell explained that Louisiana's Well-Ahead program offered loan repayment to recruit providers, though it did not directly address concerns around caring for high-risk patients, which providers generally did not cite as a major barrier to patient access.
- A Committee member inquired about any specific successes achieved in rural communities.
    - Dr. Gillispie-Bell highlighted the success of the Louisiana Perinatal Quality Collaborative in rural areas, where hospitals were required to participate in implementing evidence-based practices, with additional incentives through the "birth ready" and "birth ready plus" designations for hospitals that met high performance standards in key areas.
- A Committee member emphasized the importance of integrating care management with medical care and questioned how to establish consistent accountability with managed care organizations across states to ensure effective engagement in care management.
    - Dr. Gillispie-Bell acknowledged the complexity of achieving accountability with managed care organizations and suggested that including accountability measures in state contracts might help, while also expressing the need for federal guidelines to standardize expectations across states.
- A Committee member inquired about the choice of using improvement science instead of implementation science to accelerate changes in maternal health care within the state.
    - Dr. Gillispie-Bell explained that she sees improvement science and implementation science as similar, as both involve small tests of change and iterative PDSA cycles to evaluate, adjust, and refine practices based on outcomes.
- A Committee member expressed appreciation for the speaker's work and asked how Louisiana ensures fair and equitable substance use disorder screening, as well as how to encourage pediatricians to continue mental health screenings for mothers despite low reimbursement rates.
    - Dr. Gillispie-Bell explained that equitable substance use disorder screening is achieved through universal, verbal, validated screening rather than selective, biased approaches, as evidenced by Louisiana's program, which initially revealed racial disparities that were addressed over time.
    - Regarding low reimbursement for pediatric mental health screenings for mothers, she noted that Louisiana's progress relied on both Medicaid reimbursement (the "carrot") and state legislation (the "stick") mandating screenings at specific intervals.
- A Committee member asked if efforts were underway to make medical information more understandable for patients, as complex medical jargon could hinder self-advocacy and make it challenging for individuals without medical knowledge to grasp what their doctors were explaining.
    - Dr. Gillispie-Bell emphasized the importance of health literacy in patient care, noting that Louisiana's initiatives, like the Louisiana Perinatal Quality Collaborative, incorporated strategies such as the "teach-back" method and developed patient partnerships to ensure clear communication, respect, and understanding, which helps restore patient autonomy and addresses potential misperceptions or barriers in care.

SDOH Focus Area-Local Example: The California Abundant Birth Project

***Zea Malawa, M.D., M.P.H.*, Expecting Justice**

Dr. Malawa presented on the Abundant Birth Project (ABP), an initiative aimed at addressing racial disparities in maternal and infant health through guaranteed income support for pregnant individuals. The ABP provides regular, unconditional cash payments during pregnancy to alleviate financial stress, which has been shown to contribute to a reduction in adverse birth outcomes such as preterm birth. She explained that structural, individual, and cultural racism contributes to poor birth outcomes by creating chronic stress, limited access to resources, environmental hazards, and inadequate healthcare.

The ABP started in San Francisco in 2021 and has since expanded to other California counties. It provides resources beyond financial support, such as optional coaching to assist mothers with personal goals, emphasizing autonomy and dignity. Dr. Malawa shared testimonials from participants who experienced decreased stress and improved prenatal health due to the program's support. She also discussed partnerships, public and private funding sources, and the program's rigorous evaluation framework to measure outcomes on maternal health, stress, and infant development. Additionally, she highlighted other guaranteed income programs nationwide, which are part of a collective effort to drive policy change and provide systemic support for marginalized mothers. According to Dr. Malawa, the ABP's ultimate goal is to achieve widespread public funding for such programs, ensuring that any pregnant individual in need can access financial support to foster a healthy and empowered pregnancy.

Discussion

- A Committee member asked how to address skepticism toward guaranteed income programs, particularly among individuals who view them as "entitlements."
    - Dr. Malawa explained that, as a physician, she reframes guaranteed income as a clinical intervention rather than an entitlement, emphasizing its use during a critical time period (pregnancy) and not indefinitely.
- A Committee member inquired whether the coalition Dr. Malawa mentioned is considering making a business case for guaranteed income by highlighting cost savings from improved health outcomes.
    - Dr. Malawa stated that while the coalition will eventually address the economic impact of preventing conditions like preterm births, she resists framing the discussion solely in financial terms, emphasizing instead the broader societal losses incurred by health disparities among Black, Native Hawaiian, and Pacific Islander communities and the importance of valuing wellness without monetizing it.
- A Committee member asked whether it might be possible to leverage the program's contributory funding into investments to sustain its long-term financial stability.
    - Dr. Malawa highlighted that while leveraging funding into investments would be ideal, the primary focus remains on reaching the required number of participants to generate statistically significant data on health impacts, as ABP is conducting the most comprehensive evaluation among similar projects, though additional funding would greatly support the program's goals.

Public Comment

***Vanessa Lee, M.P.H.*, Designated Federal Official (DFO), MCHB, HRSA, HHS**

The DFO opened the public comment period. No comments were shared. Two members of the public, who had registered to speak in person, were not present at the session. A third individual, who stated an interest in making a public comment, declined to comment when called upon.

National Partner Organization Update: National Association of Nurse Practitioners in Women's Health

***Susan Kendig, J.D., W.H.N.P.-B.C., F.A.A.N.P.*, National Association of Nurse Practitioners in Women's Health**

Dr. Kendig highlighted the critical role of nurse practitioners, specifically women's health nurse practitioners, in maternal health and mortality prevention. Dr. Kendig introduced the National Association of Nurse Practitioners in Women's Health (NPWH), emphasizing its mission since 1980 to advocate for comprehensive healthcare for women. She noted that nurse practitioners are often under-recognized in discussions around maternal health despite their involvement in pre-pregnancy, prenatal, postpartum, and

inter-pregnancy care. Dr. Kendig discussed the NPWH's collaboration with key federal programs, like the Alliance for Innovation on Maternal Health and the Women's Preventive Services Initiative, to improve care quality and address gaps in maternal and environmental health knowledge. She also mentioned NPWH's contributions, including their well-woman app and partnerships with organizations like March of Dimes, aimed at supporting maternal health in underserved communities and expanding environmental health assessments.

Dr. Kendig also detailed the growing yet unevenly distributed workforce of women's health nurse practitioners and their unique competencies in supporting maternal care. Despite growth projections, the number of certified women's health nurse practitioners had remained relatively flat, posing challenges for rural and underserved areas. She elaborated on the diverse settings where these practitioners provided care, from high-risk hospital units to rural telehealth services, underscoring their expertise in complex maternal and fetal care. Dr. Kendig advocated for greater inclusion of nurse practitioners in federal maternal health initiatives, highlighting their comprehensive training in obstetrics, fetal assessments, substance use disorder treatment, and other competencies essential to supporting maternal health across the perinatal period. She concluded by calling for recognition of nurse practitioners within federal programs to ensure they receive adequate resources and education, contributing to a well-rounded and resilient maternal health workforce.

Discussion

- A Committee member expressed concern about the national movement toward requiring doctorate degrees for nurse practitioners, noting that this requirement has led to program hiatuses due to a lack of faculty with doctorates, despite an urgent need for more providers.
    - Dr. Kendig stated that her organization supports the Doctorate of Nursing Practice (DNP), acknowledging its importance in academia for evidence-based practice and research, while also emphasizing the need for more PhDs within specialized fields to strengthen the research foundation.
- A Committee member inquired about the impact of doctorate requirements on the workforce.
    - Dr. Kendig noted that workforce impacts of doctorate requirements depend on guidelines from organizations like the National Organization of Nurse Practitioner Faculty, with some flexibility in faculty roles, such as allowing master's-prepared professionals to oversee clinical sites.
- A Committee member emphasized the importance of distinguishing academic requirements from clinical practice needs, noting that while universities may require doctorates for faculty advancement, practice settings vary in their requirements, and many nurse practitioners pursue clinical roles over academia due to better financial incentives.
- A Committee member asked how the organization includes transgender women, transgender men, and non-binary individuals in its competencies, work, and practice, given its inclusive approach to the term "women."
    - Dr. Kendig explained that the organization's competencies have included care for transgender and non-binary individuals for several years, supported by an extensive position statement and a dedicated session at their recent national conference.
    - Dr. Kendig explained that the organization was founded on advocacy for inclusive, comprehensive care and has increasingly expanded its focus to support the LGBTQ+ community, with multiple experts working on these initiatives, details of which are available on their website.
- A Committee member asked if the association had recommendations or plans to address the growing provider shortage in their profession.
    - Dr. Kendig explained that the organization is addressing the provider shortage by raising awareness of the roles of various nurse practitioners, promoting diversity within the

workforce, implementing student ambassador and mentorship programs, collaborating with universities, and working with historically Black colleges and universities to recruit and support a more diverse range of students and preceptors.

- A Committee member inquired if the organization, being national, has state chapters.
    - Dr. Kendig explained that, while the organization does not have state chapters, it has state representatives who can be called upon, particularly for state-based programs, boards, and commissions, utilizing their member database to connect experts as needed.
- A Committee member asked whether there are requirements for a supervising physician with the increasing utilization of nurse practitioners or if their work will be considered independent.
    - Dr. Kendig explained that nurse practitioner supervision requirements vary by state, with over half allowing autonomous practice, while others require collaborative or written agreements with a physician; she invited further inquiries on this topic to be directed to her at NPWH.

Workgroup Breakout Sessions

ACIMM Members

The Committee broke out into their three ACIMM workgroups (Social Drivers of Health, Systems Issues in Rural Health, and Preconception/Interconception Health) to discuss and refine recommendations aimed at improving birth outcomes among Black or African-American mothers and infants.

Committee Reflections / Open Discussion / Overnight Considerations

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

The Committee returned from the breakout sessions of the three ACIMM workgroups and workgroup co-leads reported out on what had been discussed.

Social Determinants of Health/Social Drivers of Health
Dr. Alderman reported that the workgroup had an in-depth discussion about social drivers of health, focusing on revisiting rather than restarting previous work. They reviewed a wide range of social drivers, such as housing, unemployment, transportation, child care, environmental health, and issues around home visitation and social isolation. Although they were slightly behind other workgroups, they aimed to catch up and provide more than five recommendations based on the social determinants of health (SDOH) workbook, acknowledging the expectation of an extensive list. They intended to finalize their recommendations and make them available for broader sharing by the next day.

Hannabah Blue added that the SDOH workgroup discussed the importance of ensuring that their recommendations explicitly addressed racism as a significant determinant, particularly impacting Black and African American populations. The group emphasized the need to center this issue to better identify and address health disparities. They encouraged other workgroups to consider this perspective in their own recommendations. Additionally, she requested attention to inclusive language, advocating for terms that encompass non-binary, transgender, and Two-Spirit people. The suggestion included possibly introducing an inclusive language statement at the beginning of the document to clarify terminology and intent.

Systems Issues in Rural Health
Dr. Menard and Dr. Jacob Warren reported that the workgroup's draft had expanded rather than condensed, covering key areas while remaining open to refining the structure. They identified four main domains: supporting a diverse workforce in rural areas, with a focus on doulas and midwives; promoting

regionalization and risk-appropriate care models; addressing the stabilization of labor and delivery services in rural areas, particularly in cases where such services closed to ensure continued access to care; and leveraging telehealth to improve service access in underserved regions, especially for maternal and child health (MCH). The group considered organizing their recommendations by specific financial and reimbursement policies that could facilitate these objectives, aiming to present actionable steps for implementation across these domains rather than broader goals.

Preconception/Interconception Health

Dr. Sharps reported that the workgroup had an extensive discussion on workforce training, emphasizing the importance of standardizing and certifying training and establishing models for reimbursement to create sustainable career paths. Their recommendations were categorized into three areas: surveillance, research and data, and workforce training. The group recognized the U.S. as a leader in developing early indicators for surveillance systems and discussed collaborating with global entities. They focused on extending diversity among providers, particularly for preconception and interconception care, and ensuring accessible training for both providers and the public. Additionally, they addressed access challenges, especially in areas with limited broadband. A key discussion point was broadening preconception care beyond traditional OB-GYN settings to ensure comprehensive health support across the lifespan, particularly for those transitioning out of pediatric or foster care, and for individuals with chronic conditions or pregnancy losses.

Dr. Blue reported that the workgroup discussed the importance of ensuring that their recommendations explicitly addressed racism as a significant determinant, particularly impacting Black and African American populations. The group emphasized the need to center this issue to better identify and address health disparities. They encouraged other workgroups to consider this perspective in their own recommendations. Additionally, Dr. Blue requested attention to inclusive language, advocating for terms that encompass non-binary, transgender, and Two-Spirit people. The suggestion included possibly introducing an inclusive language statement at the beginning of the document to clarify terminology and intent.

Discussion

- A Committee member inquired if the discussions included considerations about access to broadband internet.
    - Dr. Jacob Warren confirmed that there had been some discussions regarding access to internet in the rural health workgroup.
- A Committee member asked if the rural health discussions also addressed transportation, a topic raised in the social drivers of health conversation.
    - Dr. Jacob Warren noted that transportation was not explicitly included in any current categories but suggested it could fit under social drivers of health, as it pertains to resources and social infrastructure.
- A Committee member highlighted the need for developing doula support and ensuring smooth transitions of care from preconception to primary care, especially for individuals requiring ongoing management of conditions like diabetes and hypertension.
    - Dr. Sharps agreed and emphasized the importance of ensuring that individuals transitioning out of prenatal care are reconnected with appropriate providers to manage any ongoing health conditions.

Meeting Adjourn

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

The Chair emphasized the importance of communicating recommendations to relevant partners to ensure awareness and potential feedback. She mentioned that planning for this communication would begin in the January meeting.

The Chair adjourned the meeting at 5:15 p.m. ET.

DAY TWO: Thursday, October 17, 2024

Call to Order and Review of Day One

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

The Chair welcomed Committee members and meeting participants for Day Two. She reflected on the previous day's presentations, which included updates on projects like the Abundant Birth Project and the HHS Postpartum Maternal Health Collaborative. She invited Committee members to share any resonant points or insights. Reflections that were shared included: the need for strong transitions of care and team-based approaches to care; how racism and historical income inequities were the root causes of health disparities and how resources could be creatively applied to address these underlying issues; the potential impact of guaranteed basic income projects; and how social drivers of health could be framed through an equity lens in crafting recommendations to the Secretary.

Voices of the Community

***Devin Bailey-Nicholas, B.A.S.*, Community Birth Companion**

Ms. Bailey-Nicholas shared her personal journey of navigating pregnancy and childbirth as a Black woman in rural Louisiana. She discussed the unique challenges she faced, including a series of miscarriages and the emotional and medical complexities of having a successful pregnancy following those losses. Ms. Bailey-Nicholas emphasized the importance of her "circle of care," which included an obstetrician, a midwife, and a doula who worked collaboratively and inclusively to support her physical and emotional needs. This team-based, community-centered approach allowed her to have a safe and empowering home birth despite being in a rural setting with limited medical resources. Even when complications arose post-birth, requiring transfer to a hospital over 30 minutes away, her care team remained involved, underscoring the importance of continuous, culturally sensitive, and personalized care.

Ms. Bailey-Nicholas highlighted the need for community-based maternal health programs tailored to specific areas rather than one-size-fits-all solutions. She stressed that healthcare for Black mothers should be individualized and should not be treated as a scalable, impersonal model. Recognizing doulas, midwives, and community health workers as essential contributors to maternal health outcomes, she also addressed barriers to care, such as inconsistent internet access in rural areas and misconceptions about socioeconomic status. Ms. Bailey-Nicholas called for a broader, more inclusive understanding of Black maternal health, urging healthcare providers and policymakers to provide resources that resonate across socioeconomic backgrounds. This would ensure Black women of all income levels receive the support they need. Last, she described her own community-based health programs called Community Birth Companion, which provided critical support and accessible care to mothers in rural Louisiana.

Discussion

- A Committee member asked for insights on the significance of having a multifaceted support team in shaping both health outcomes and personal satisfaction with the birthing experience.

    - Ms. Bailey-Nicholas emphasized that having a collaborative, supportive circle of care was essential to her health and well-being during her birthing experience, allowing her to feel fully informed, supported, and connected to a team that understood her history and needs.
- A Committee member acknowledged the strong support received from both a midwife and a physician but inquired about the potential outcomes if an emergency had required immediate care at the local hospital instead of transferring to a higher level hospital in Lafayette, LA.
    - Ms. Bailey-Nicholas explained that if she had required urgent care at her local hospital, she would have been treated by an on-call hospitalist unfamiliar with her medical history and unique needs, unlike her own physician, with whom she had an established relationship.

Committee Update: AI/AN Recommendations

***Tina Pattara-Lau, M.D., F.A.C.O.G.*, Indian Health Service (IHS), HHS**

Dr. Pattara-Lau provided an update on the recent initiatives led by the Indian Health Service (IHS) to improve maternal and child health in American Indian and Alaska Native (AI/AN) communities. Over the past two years, IHS has focused on expanding access to safe maternity care with an emphasis on cultural safety, tailoring programs to be led by and for the communities they serve. In response to the closure of rural labor and delivery units, IHS implemented the OB RED (Obstetric Readiness in Emergency Departments) program to equip sites in places without maternity care with tools and training to safely stabilize and transfer pregnant individuals. This initiative included creating a manual with protocols and policies, technical assistance, and training for over 230 staff across 40 sites. Additionally, IHS launched the Maternal Care Coordinator program, adapted from a Veterans Affairs model, which supports families through prenatal and postnatal periods, reaching an estimated 12,000 families over five years with the help of community-trusted health workers in diverse settings, from rural clinics to remote areas like Supai, Arizona.

Furthermore, IHS partnered with the Northwest Portland Area Indian Health Board to create the Indian Country ECHO series, a cultural safety-focused educational program for healthcare providers. This program offered webinars covering topics such as indigenous birthing practices, maternal mental health, substance use, and hypertension in pregnancy, with substantial participation across 35 states and 266 tribal communities. Early reports indicated a high rate of increased understanding and intentions to adapt practices among participants. Additionally, Dr. Pattara-Lau highlighted IHS resources for healthcare providers, including toolkits for over-the-counter contraceptive options, care for substance use during pregnancy, sexually transmitted infection (STI) testing, and Respiratory Syncytial Virus (RSV) guidance for home visitors. The next webinar will focus on pregnancy loss, underscoring IHS's commitment to comprehensive and culturally sensitive maternal health education.

Discussion

- A Committee member inquired about the average award amounts of Indian Health Service funds allocated for maternity care coordination, seeking to understand whether the funding is substantial enough to be beneficial.
    - Dr. Pattara-Lau stated that each site will receive about $200,000 annually over five years, totaling $1 million, noting that this is the first phase aimed at evaluating the model's effectiveness and potentially expanding it based on community needs and observed outcomes.
- A Committee member sought clarification on whether the million-dollar funding was allocated per site over five years or for the entire program.
    - Dr. Pattara-Lau confirmed that the funding of one million dollars was allocated per site over the five-year period.

- A Committee member expressed excitement about the initiative and requested information on tracking the fiscal impact of the funding, specifically regarding maternal and infant outcomes and the reduction of avoidable costs of care, to support the case for potentially expanding the program.
    - Dr. Pattara-Lau acknowledged the recommendations and explained that each site will track metrics such as prenatal care visits and postpartum returns, while a national effort will aim to implement dashboards to monitor these metrics for assessing both cost savings and risk reduction in their unique population.
    - She also noted that all sites have begun implementing HRSA's AIM bundles focused on hemorrhage and hypertension, which align with the OB RED program, while also collaborating on the obstetric readiness toolkit.
- A Committee member inquired about available resources from the OB RED program.
    - Dr. Pattara-Lau indicated that they hope to release that information soon.

***Charlan Day Kroelinger, Ph.D., M.A.*, Division of Reproductive Health (DRH), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC), HHS**

Dr. Kroelinger provided an update on the efforts of the Centers for Disease Control and Prevention (CDC) Division of Reproductive Health, highlighting their transition of the Healthy Native Babies Program to the National Institutes of Health (NIH). To initiate this transition, they focused on obtaining tribal feedback in 2023 for the review and updating of program materials, with plans for ongoing revisions and implementations in partnership with tribes. Additionally, she reported on the exploration of a tribal maternal mortality review committee program, mentioning a scheduled tribal listening session in December to gather further input. Finally, she introduced new resources from the Hear Her campaign aimed at raising awareness of urgent maternal warning signs and improving communication between healthcare providers and patients, emphasizing the availability of these resources in various Indigenous languages.

Discussion

- A Committee member expressed appreciation for the information, noting that partners in North Carolina, specifically the Cherokee tribe, would find it valuable.
- A Committee member mentioned that a panel discussing the Committee's Making Amends report would be hosted by former ACIMM member Janelle Palacios and others at the upcoming American Public Health Association Conference.

Healthy Start Update

***Benita Baker, M.S.,* Healthy Start Program, MCHB, HRSA, HHS**

Ms. Baker presented updates on the federal Healthy Startinitiative aimed at improving maternal and infant health outcomes, particularly for underserved populations at highest risk for infant mortality. In her talk, she highlighted the purpose of the Healthy Start program, which focuses on reducing racial and ethnic disparities in infant mortality and other adverse perinatal outcomes. Ms. Baker detailed the allocation of funding in fiscal year 2024, which included 115 grantees—83 continuing from previous cycles and 22 new organizations. She emphasized the program's critical role in transforming community-based care delivery and discussed the need for better technical assistance for smaller community-based organizations applying for federal grants. Key themes from stakeholder engagement conducted by MCHB included the need for flexibility and the importance of addressing social determinants of health.

The update also covered changes to program implementation, including updates to the services offered by Healthy Start grantees and the introduction of the Alumni Peer Navigator program. Ms. Baker noted the

successful outcomes from the previous cohort of grantees, highlighting the positive feedback from families and grantees about the assistance provided by the navigators in enrolling families in benefits. She outlined the program's goals for the coming year, including developing community consortia and partnerships with federal agencies, and focusing on maternal health issues like hypertension. Ms. Baker concluded by discussing future evaluation plans aimed at creating more targeted assessments of the program's effectiveness and solicited input from attendees on innovative evaluation approaches.

Discussion

- A Committee member expressed interest in the current status of tribal grantees within the Healthy Start program and inquired about efforts to increase their representation in the new cohort.
    - Ms. Baker noted that there are currently two grantees serving tribes and acknowledged ongoing efforts to increase this number while addressing the challenges posed by existing eligibility requirements.

Workgroup Breakout Sessions

ACIMM Members

The Committee broke out into their three ACIMM workgroups (Social Drivers of Health, Systems Issues in Rural Health, and Preconception/Interconception Health) to continue their discussions of drafting recommendations.

Discussion of Draft Recommendations

Preconception/Interconception Health
***Joy M. Neyhart, D.O., F.A.A.P.,* ACIMM Member**
***Phyllis W. Sharps, Ph.D., RN, FAAN,* ACIMM Member**

Dr. Neyhart, one of the workgroup Co-Leads, discussed the outcomes of their breakout session. The group identified some areas of overlap with other work groups regarding rural and social determinants of health, particularly the lack of access to healthcare. Dr. Neyhart emphasized that healthy pregnancies relied on the pre-pregnancy health of individuals, highlighting the necessity of access to high-quality, evidence-based medical care to combat rising mortality rates among Black women and infants. She shared that the recommendations the workgroup was drafting fell into 3 major buckets: data and surveillance; workforce and training; and education and training.

Discussion

- A Committee member sought clarification on whether the workforce and training recommendations were referring to clinicians and the education and training pertained to patients.
    - Dr. Neyhart clarified that the recommendations on workforce and training would be focused on clinicians, including community health workers who could provide culturally appropriate information; and the education and training recommendations were related to patients.

Systems Issues in Rural Health
***M. Kathryn Menard, M.D., M.P.H.,* ACIMM Member**
***Jacob C. Warren, Ph.D., M.B.A., C.R.A.,* ACIMM Member**

Dr. Jacob Warren, a workgroup Co-Lead, gave an overview of the three main categories of recommendations being drafted. The first emphasized creating a sustainable financial model for high-quality maternal and infant care, including proposals for critical access labor and delivery units and enhancing reimbursement for providers in a regional care structure. The second category of recommendations would be aimed at ensuring access to high-quality, culturally competent care by

supporting regional centers and providing financial assistance for community care bundles, as well as planning transitions for patients when local services were unavailable. Lastly, the third area focused on achieving cultural safety within the rural healthcare system through workforce diversity, community support systems, and advancing cultural humility, which included establishing independent practices for doulas and community health workers and improving data systems for better analysis of maternal and child health outcomes.

Discussion

- A Committee member sought clarification on the role of telehealth and artificial intelligence (AI) within the workgroup's recommendations and how these technologies could complement the efforts of the social determinants workgroup.
    - Dr. Jacob Warren explained that the group had developed telehealth-specific recommendations within each of the three areas of focus, addressing the need for technology and Internet access in rural care, while noting that AI had not been specifically discussed but may be included in broader telehealth implementation strategies.
    - A Committee member suggested that while the social determinants of health recommendations should focus on issues like broadband access and partnering with other federal agencies like the U.S. Department of Housing and Urban Development (HUD), the rural health workgroup could contribute insights on the provision of telehealth care in rural areas, emphasizing the need to determine the appropriate categorization of these elements.

Social Determinants of Health/Social Drivers of Health
***Sherri L. Alderman, M.D., M.P.H., I.M.H.-E., F.A.A.P.,* ACIMM Member**
***Marie-Elizabeth Ramas, M.D., F.A.A.F.P.,* ACIMM Member**

Dr. Ramas, a workgroup Co-Lead, discussed the challenges faced by the social drivers of health work group in addressing the complexities of their topic without compromising its significance. During the session, the group identified three overarching themes to focus on: economic security, access, and safety. Under economic security, they highlighted issues such as housing insecurity and guaranteed income. The access theme included discussions on housing, transportation, childcare, and nutrition services, emphasizing the need for these supports for overall health. Safety encompassed structural racism, intimate partner violence, substance use disorders, and the criminalization of pregnancy. The workgroup aimed to develop specific programmatic and policy recommendations in these areas, while acknowledging the need to collaborate with other workgroups and gather additional context before their next meeting in December.

Dr. Alderman, the other workgroup Co-Lead, reiterated the importance of focusing on the key social drivers of health that affect societal well-being, particularly concerning infants, while considering insights gained from their presenters in shaping their recommendations.

Planning for January 2025 Meeting and Next Steps

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

The Chair outlined a revised timeline for completing a final draft of the recommendations, which was initially set for January and submission was planned for March. She emphasized the need to expedite the submission to the current Secretary as early as possible in January, recognizing that it could take several months for a new Secretary to be appointed. To facilitate this, the Chair requested that the workgroup leads submit their draft recommendations by December 6. The January Committee meeting would then focus on gathering feedback from impacted communities, particularly those representing African American mothers and babies, before finalizing the recommendations and taking a vote. She stressed the

importance of completing this process during the January meeting to ensure timely submission to the Secretary and prevent the recommendations from getting lost in the transition to a new administration.

Discussion

- A Committee member sought clarification on whether the current Secretary would remain in place regardless of the election results.
    - Dr. Michael Warren expressed that it was uncertain whether the current Secretary would remain in position following the upcoming election, highlighting that transitions often lead to delays in activities and advisory committee operations, which necessitated ensuring the committee's work was completed beforehand.
- A Committee member sought clarification on the timeline for gathering reactions from partner organizations and whether those discussions should be incorporated into the work group conversations.
    - The Chair confirmed that plans were being made to involve partner organizations in the January meeting and that discussions with them could also happen during upcoming workgroup meetings.

Wrap-Up and Considerations

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

The Chair expressed gratitude for the participants' contributions and emphasized her appreciation for everyone's involvement. She particularly recognized Devin Bailey-Nicholas for her insightful contributions representing the community, emphasizing the importance of remembering individuals with lived experience to sustain motivation and commitment to this work. The meeting concluded with Committee members sharing their reflections on the meeting and the Chair thankingall attendees.

Adjourn

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

The Chair adjourned the meeting at 4:00 p.m. ET.