Advisory Committee on Infant and Maternal Mortality

Draft Meeting Minutes of April 2-4, 2024

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

Hybrid (In Person and Virtual) Meeting
St. Louis, Missouri

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DAY ONE: Tuesday, April 2, 2024

Welcome and Introductions

***Vanessa Lee, M.P.H.,* Designated Federal Official (DFO), ACIMM**
***Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair**
***Tishaura Jones, M.H.A.,* Mayor of St. Louis, Missouri**

The DFO called the Advisory Committee on Infant and Maternal Mortality (ACIMM; the Committee) to order and welcomed attendees. The ACIMM Chair thanked Ms. ShaRhonda Thompson (ACIMM Member) for helping to facilitate the Committee meeting outside of the Health Resources and Services Administration (HRSA) in Rockville, Maryland. The Chair further explained that the Committee was meeting in St. Louis, Missouri to better understand maternal and infant health issues by hearing directly from communities from around the state, with a specific focus on the Black/African American community.

Mayor Tishaura Jones then gave welcoming remarks, stating that Missouri ranked 44th in the nation in terms of maternal mortality. She spoke about the disparities in maternal and infant health in the state and shared her personal connection to the issue. She expressed enthusiasm for the forthcoming discussions that she hoped would inform how the state could provide more resources to its communities and decrease its health disparities.

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 December 2023 meeting.

Maternal and Child Health Bureau (MCHB) Welcome and Updates

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

Dr. Michael Warren provided an overview of the MCHB program funding amounts in the FY 2024 budget that had recently passed. The budget total was $1.7 billion, including $145 million for the Healthy Start program. There was a $2 million reduction for special projects of regional and national significance, which typically funded emerging issues projects; state maternal health innovations; and workforce, research, and training programs. Other notable budget changes included an $18.7 million increase for the Maternal, Infant and Early Childhood Home Visiting program (MIECHV) and a $1 million increase for the Screening and Treatment for Maternal Mental Health and Substance Use Disorder program (MMHSUD).

Dr. Warren also reviewed the proposed President's budget for FY 2025, which requested an additional $135.7 million to improve maternal and child health, for a total of $1.8 billion. The proposed budget for MCHB programs included a $27 million increase for Healthy Start Peer Navigators, a $65.8 million increase for MIECHV, and a $6.3 million increase for Family-to-Family Health Information Centers. The budget also included a five-year extension for the

Autism and Other Developmental Disabilities programs, as well as additional funds for the Alliance for Innovation on Maternal Health (AIM) program, State Maternal Health Innovation awards, community-based social determinants of maternal health initiatives, the doula workforce, and the MMHSUD program.

Dr. Warren highlighted open MCHB funding opportunities, and described HRSA's Enhancing Maternal Health Initiative that launched in January of 2024. He concluded with remarks on the National Maternal Mental Health Hotline, the increasing rates of congenital syphilis in the past decade, and the HRSA Black Maternal Health Week campaign occurring between April 11 and 17, 2024.

Discussion

- A meeting participant asked for Dr. Warren's thoughts on facilitating partner engagement in support of maternal child health funding.
    - Dr. Warren drew upon his previous experiences in Tennessee as the state MCH Director and shared examples such as having an understanding of the different funding streams available and gathering stakeholders to share information and success stories about using federal funds. He emphasized that these efforts did not always require significant funds or resources, but rather a willingness to share and collaborate.
    - The Chair spoke about her experience engaging with partners in North Carolina. They recognized that they were working in siloes but were able to use the state's maternal health strategic plan to encourage partners to choose different actions to lead.
- A meeting participant asked whether funding mentioned by Dr. Warren was limited to current MIECHV grantees or if new partners could also apply.
    - Dr. Warren answered that the supplemental MIECHV funding was limited to current grantees, but that states could partner to help build capacity in communities in need. The grantee would need to have a memorandum of understanding (MOU) to do so.
    - The DFO added that there was an ongoing need for HRSA grant reviewers from the community, who would receive a stipend for their participation.

Emerging Issues in Infant and Maternal Health: Congenital Syphilis

Babak Yaghmaei, M.P.H. **(virtual), Deputy Director Region 3 & 4 Engagement Team, Office of Infectious Disease and HIV/AIDS Policy, Office of the Assistant Secretary for Health (OASH), Office of the Secretary, U.S. Department of Health and Human Services (HHS)**
Shannon Dowler, M.D., FAAFP, CPE **(virtual), Sexually Transmitted Infection (STI) Consultant to OASH, National Syphilis and Congenital Syphilis Syndemic (NSCSS) Federal Task Force, HHS**

Dr. Shannon Dowler spoke on the rising rates of syphilis in women and pregnant people. As a result of dramatic improvements in public health and treatment in the past century, syphilis numbers had been on the decline; however, rates began to increase in the 1990s and again in the past decade. Until the past few years, syphilis had a high male to female ratio, but recent increases among women have led to a rise in congenital syphilis cases. This rise was also

attributed to health inequities in minority populations. Many physicians trained during the mid-nineties had never encountered syphilis cases, which has further compounded the challenge. A significant number of stillbirth and infant deaths may have been caused by congenital syphilis infections, which are preventable with appropriate testing and treatment during pregnancy.

Dr. Babak Yaghmaei provided an overview of the National Syphilis and Congenital Syphilis Syndemic (NSCSS) Federal Task Force, which had more than 200 members across the federal government. NSCSS focused on three pillars: 1) data and surveillance; 2) prevent, screen and diagnose; and 3) treat. Each pillar had a subcommittee driving the work through a lens of health equity and community engagement. The Task Force recently focused on fourteen states and jurisdictions where reported syphilis cases were highest. Dr. Dowler reviewed several federal actions across the Task Force. She also reviewed key focus areas of the Task Force, which included treatment shortages and cost concerns, Point of Care Testing (POCT) and screening in emergency departments and urgent care settings, harmonization of testing recommendations for pregnant persons, and syndemic-related issues of substance use and stigma as barriers to prevention and treatment. Dr. Dowler reviewed opportunities to train providers, increase public awareness, and share best practices across providers and jurisdictions.

Discussion

- The Chair asked for recommendations that ACIMM should consider in addressing congenital syphilis.
    - Dr. Dowler said there should be consideration for cost barriers and how public payers and family planning benefits could help. Standardizing STI testing in obstetrics and gynecology care could also help by reducing social-based stigma.
    - Dr. Yaghmaei encouraged Committee members to use their platform to raise awareness about congenital syphilis in stillborn and infant death cases.
- A Committee member talked about disparities related to access to prenatal care and asked how to raise awareness among those who were most impacted.
    - Dr. Dowler suggested that webinars were no longer as effective as they were during the pandemic, as they tended to be resource intensive and people were now experiencing "webinar fatigue." Rather, new and creative ways for getting information out were needed – such as embedding identification and treatment into clinical trainings and training for prescribers as part of licensing.
    - Dr. Yaghmaei spoke about utilizing community outreach groups to promote messaging at the ground-level and to support reductions in stigma.
- A Committee member asked whether pediatricians should be screening adolescents for syphilis, in addition to chlamydia and HIV.
    - Dr. Dowler answered that there was not currently enough data for universal screening recommendations for adolescents. She also said that clinicians should test for syphilis continuously during pregnancy.
- A Committee member asked whether there were any states utilizing their home health care or community health workers to provide education during home visits.
    - Dr. Dowler said that one example of this was within the Indian Health Service (IHS), which had been engaging community health workers to provide information. However, there were many states in which Medicaid did not

reimburse community health workers. There could be other providers, such as paramedics, who could also provide in-home education.

- A meeting participant asked how the Task Force could activate community organizations to promote health literacy, particularly during preconception.
    - Dr. Dowler said that using public payers to financially support community organizations would significantly help because it would build off of the trust already built with large uninsured populations.
    - Dr. Yaghmai added that some states had found creative ways to leverage Ryan White funds for these efforts. Establishing channels between states that have established best practices in syphilis testing and states without those resources could also help. Additionally, federal agencies could partner with community organizations to scale efforts and pool resources.
    - Dr. Dowler added that there should be incentives for patients and providers to promote treatment. There was also a need to respect and acknowledge the history of syphilis practices in the U.S. and promote creative solutions that do not create more distrust and anxiety.
- Dr. Michael Warren spoke about Title V MCH Block Grant outreach efforts, commenting on how state Title V programs were encouraged to work with their state STI programs to promote best practices and leverage state resources.

Delmar DivINe™

***Maxine Clark, J.D.,* Chief Inspirator, Delmar DivINe**

Ms. Maxine Clark spoke about Delmar DivINe, which is an action-focused think tank that aims to foster community health and development in St. Louis. Delmar DivINe's name was an adaptation of the term "Delmar Divide," which symbolized the divide between race and socioeconomic status in St. Louis. Delmar DivINe serves as a hub for approximately 35 nonprofit organizations representing the fields of health and mental health, education, and community development. Ms. Clarke started the project as a result of Dr. Jason Purnell's report *For the Sake of All: A Report on the Health and Wellbeing of African Americans in St. Louis and Why It Matters for Everyone,* which highlighted health inequities in St. Louis. The goal of Delmar DivINe is to understand and address local challenges and draw on the collective strength of its nonprofit organizations to develop innovative solutions to health disparities. Ms. Clark highlighted their community programs that addressed topics such as healthy relationships and health education. She asked the Committee to help St. Louis understand how to best engage with federal agencies to help connect people with information and best practices.

Improving the Health of Black and African American Birthing People and Their Infants in St. Louis

***Matifadza Hlatshwayo-Davis, M.D., M.P.H.*, Director of Health, City of St. Louis Department of Health**

Dr. Matifadza Hlatshwayo-Davis reviewed data on preterm births from the March of Dimes 2023 Report Card, which gave Missouri a grade of D- due to its preterm birth date of 11.3% and significant disparities in preterm births among Black infants. Inadequate care and the lack of

health literacy were key factors in the state's disparities and negative birth outcomes. Dr. Hlatshwayo-Davis emphasized the need for solutions such as empowering communities (or "villages"), learning from community voices, promoting patient-centered care, improving provider training, fostering community partnerships, and developing policies that promote comprehensive and accessible prenatal care. She underscored the need for a data-driven approach to address health disparities among Black mothers and infants, a focus on systemic bias and racism, and social determinants of health interventions such as better access to health care and education. Dr. Hlatshwayo-Davis also discussed the need for reduced burden for grant applications, suggesting that providers do not have the capacity to write the grants they need to provide services.

***Kanika Cunningham*, *M.D., M.P.H.,* Director, St. Louis County Department of Health**

Dr. Kanika Cunningham shared her lived experience as both a patient, in which she faced bias and judgment, and as a provider, in which she observed the impact of systemic bias and how it affected patient interactions and decision-making. She called for systemic change in the health care system to eliminate racial biases and to ensure that Black/African American women received equitable, respectful care. She also emphasized community-based care models that integrated doulas and community health workers into health care teams, as well as the importance of data and surveillance that was transparent and accessible to providers and communities. Dr. Cunningham reviewed cross-cutting objectives to overcome racism in the 2023-2027 St. Louis Regional Health Improvement Plan (CHIP). She asked the Committee to promote sustainable funding for maternal and infant health programs, policy changes to facilitate improved access to health care among marginalized communities, improved data collection and processes for sharing data, a greater focus on community engagement and awareness programs, and physical health care infrastructures that support underserved communities.

Discussion:

- A Committee member said that equity efforts tended to either create equal improvement in Black and White communities or create improvement in White communities only. They asked what actions could disrupt these disparities.
    - Dr. Hlatshwayo-Davis said that metrics to define disparities were limited and archaic. Higher quality data would enable more effective analyses. For example, her team was limited to zip code-level data, which was insufficient for telling the full story. The COVID-19 pandemic created a more refined data system that helped support pediatric vaccine rollout—this helped them quickly identify a gap in certain age groups that they could then call out and address. She said funding that rolled out at the national level tended to not reach the communities. Efforts should start *with* the communities to understand the breadth and depth of what it meant to be a Black birthing person rather than having assumptions made about them. She talked about the outdated systems and infrastructures in her office that impeded quality data collection.
    - Dr. Cunningham talked about the historical trauma that Black birthing people experienced as obstetricians experimented on their bodies. The trauma was continual, as many of the instruments that were perfected on Black women were still in use today.

    - Dr. Hlatshwayo-Davis added that there was a need to discard the old textbooks and focus on innovation. Black women researchers, clinicians, midwives, and doulas could help redefine the role of "the village" and save the health care system.
- A Committee member asked about the role of Medicaid managed care organizations in terms of funding in Missouri.
    - Dr. Hlatshwayo-Davis talked about the National Institutes of Health (NIH) policy to collaborate with a community-based organization, community health department, or historically Black college or university in order to use NIH grant funds to research Black/African American populations. Although it seemed performative at first, the policy had made a difference. Policies that required community engagement can likewise change public health funding, including Medicaid.
    - Dr. Cunningham added that it was important to de-stigmatize Medicaid because some providers did not want to see Medicaid patients—who were often be seen as second-class citizens. Further, a Medicaid package should be unique to the community it serves.
    - Dr. Hlatshwayo-Davis suggested that the Committee meet with the leadership of two organizations in St. Louis who were changing the landscape - the Integrated Health Network and the Regional Health Commission.
- A Committee member asked if "the village" included a designated health advocate or something similar.
    - Dr. Hlatshwayo-Davis answered that the village must have advocates. She talked about her experience of having to constantly advocate for her father while he was in the hospital, recognizing that there would be negative outcomes if they had not been there every minute. Until the system can be repaired, there must be "a village" and that "village" must be led by an advocate.

Advancing Racially Just and Equitable Outcomes in Black Maternal and Infant Health in St. Louis

***Kendra Copanas, M.M.,* Executive Director, Generate Health**
***Lora Gulley, M.S.W.,* Director of Community Mobilization/Advocacy, Generate Health**

Ms. Kendra Copanas introduced Generate Health, a St. Louis-based nonprofit organization that advocated for racial equity for Black birthing persons and their infants. Generate Health has operated for 25 years, but experienced a major organizational shift in 2018 to sharpen its focus on racial disparities in maternal and infant mortality. Ms. Copanas highlighted the organization's focus on positive language that centered on the vision of joy, vitality, and thriving. Their language also ensured that the change needed to reduce these disparities remained within the systems and structures that perpetuated them, rather than within the responsibilities of Black birthing people themselves. Generate Health does not deliver programs but organizes community leaders, providers, and organizations to utilize data to advocate for systems-level change. Ms. Copanas reviewed two of their initiatives: FLOURISH St. Louis is a community data and storytelling initiative and The Bloom Network convened community service providers to provide a referral network that seamlessly surrounded families with support.

Ms. Lora Gulley talked about how Generate Health fostered community leadership through capacity building efforts. She introduced some of their community leaders who helped bring context, advocacy, and decision-making to Generate Health's activities and emphasized the importance of their voices as people with lived experience. She provided more detail about how the FLOURISH initiative drove regional priority areas—for example, the initiative could use community data to better understand gaps in access to care and other social determinants of health, as well as the cultural competencies needed to promote patient-centered care. She also talked about how the Bloom Network used partner organizations to support perinatal behavioral health, promote safe sleep practices, and provide home visits to improve access to quality care.

Ms. Copanas reviewed lessons learned and recommendations for the Committee. First, it was important to center community leadership to create systems change. For example, HRSA required community engagement from Healthy Start grantees, but there was an opportunity to expand that practice into other federal agencies and programs. Second, there was a need to shift the narrative to a positive vision of vitality and equitable health. The Committee was in a position to help influence this narrative within its recommendations. Third, programs at the local-level were not sufficient for change. Rather, systems-level, ecosystem-wide coordination and increased federal investment were needed to improve the often fragmented experience of maternal and infant health. Finally, communities were in need of access to care that was designed for and by Black women, encouraging a broader definition of "evidence-based" practices to include "community-informed" practices.

Discussion

- A Committee member asked how ACIMM could make recommendations that helped remove barriers so that other organizations could do similar work.
    - Ms. Copanas said that Generate Health was supported through a long-term relationship with the Missouri Foundation for Health and other philanthropic entities. However, funding from these organizations did not last forever and there was an ongoing struggle to replace those funds. Some of the federal grant opportunities were too prescriptive for many organizations or focused on the state-level. As a previous Healthy Start grantee, she needed significant resources to manage the administration of the grant and they had to consider whether they could balance those responsibilities with their core activities. Additionally, the timeframe to respond to federal grants was too narrow for organizations to develop collaborative responses with the community. Therefore, longer lead times, more community members as grant reviewers, and smaller set-aside funds for organizations that would not otherwise qualify would help reduce these barriers.
    - Ms. Gulley added that there could be grant opportunities but not necessarily grant writers or available time. She shared an example of their own simplified grant application process, which resulted in interesting proposals that would not have otherwise been submitted.
- A meeting participant talked about their experience as a HRSA grant reviewer and made several suggestions for improvements to federal grantmaking. These included more proposals focused on political determinants of health, including stories from applicants as context for the data, and more funding for smaller organizations that did not have the

capacity to compete with the large universities and nonprofit organizations. Finally, they talked about how grant proposal questions could be better framed to focus on what could be learned from the community about what works or does not work.

State Approaches to Improving Outcomes for Black and African American Birthing People and Their Families

***Martha J. Smith, M.S.N.,* Maternal Child Health Director, Public Health Nursing Manager, Missouri, Department of Health & Senior Services**
***Heidi Miller, M.D.,* Chief Medical Officer, Missouri Department of Health & Senior Services**

Ms. Martha Smith and Dr. Heidi Miller talked about Missouri's efforts to align maternal and child health with broader state-level strategies to ensure that it was integrated across all facets of public health planning, including data modernization, partnership, and collaboration efforts. The state had also elevated the voices of people with lived experience in their planning and aimed to advance diversity and inclusion.

Ms. Smith reviewed the pregnancy-associated mortality review process, which began as a Title V MCH-supported program and since evolved to include support from other grant mechanisms. She highlighted some of the key insights from the 2020 mortality report. Although they had not yet released a more recent report, Ms. Smith said that maternal mortality had continued to increase since 2020. Notably, Black women in Missouri faced significantly and increasingly higher rates of maternal mortality. In response, Missouri had focused on public health initiatives and policies to address this disparity. In 2024, the Missouri Governor Mike Parson allocated $4.35 million to address maternal mortality, specifically to promote quality care, improve the maternal care workforce, optimize postpartum care, create a maternal health collaborative, and improve maternal health data quality.

Dr. Miller discussed Missouri's Interagency Maternal Health Collaborative, which brought together stakeholders from the State Department of Health & Senior Services, Medicaid, the Hospital Association, and the Primary Care Association. This workgroup had reviewed more than 50 programs and policies related to maternal health care, access, and outcomes across the world in order to identify best practices that might adapt well in Missouri. They developed a short list of practices that included a 24/7 patient/provider call center, telehealth for maternal-fetal medicine, and postpartum home visits, as well as efforts to reform payment, support doulas and community health workers, and provide training and education. The short list of 12 priorities would be funded by the $4.35 million.

Ms. Smith reviewed the National Governor's Association initiative for improving maternal and child health in rural America, which included representatives from Missouri. She also talked about Missouri's 2021-2025 Title V MCH Block Grant priorities, which included funding for preconception, prenatal, and postpartum health care services; perinatal and infant health; and efforts to address social determinants of health through training and health literacy. She summarized some lessons learned, including: the synergy of partnerships and collaborations was the path to innovation; quality care included respect for culture and building trust; an educated workforce was needed to provide quality care; and all priorities and actions should be driven by

those with lived experience. She offered recommendations to the Committee, including targeted federal funding for communities with the highest maternal and infant mortality rates, a requirement for the state MCH Director to be involved in all federal initiatives, braided federal funding for systems-level change, and policies that targeted social drivers of poor maternal and infant health outcomes.

***Priscilla M. Mpasi, M.D., FAAP,* Chair, Delaware Healthy Mother and Infant Consortium (DHMIC); Member, Delaware Perinatal Quality Collaborative (DPQC)**

Dr. Priscilla Mpasi outlined strategies implemented in Delaware through its Healthy Mother and Infant Consortium. The goals of the Consortium were to eliminate racial disparities, reduce the rate of preterm birth from 11 to 7%, and develop an innovative model of care to support the first two goals. The Consortium was comprised of 21 members appointed by the governor, including two state Senate representatives, two House representatives, and one representative from the governor's office. The other members included state secretaries in departments involved in maternal and child health, as well as representatives from medical, social services, professional organizations, and the public. The Consortium also had four subcommittees or workgroups that focused on social determinants of health, maternal and infant morbidity and mortality, doulas, and well woman/Black maternal health. Additionally, the Consortium had a Perinatal Quality Collaborative with workgroups focused on maternal health and pediatrics.

Dr. Mpasi reviewed some of the Consortium's accomplishments. Their recent legislative achievement included the passage of the Delaware MOMNIBUS 2022 to extend Medicaid coverage to one year postpartum, protections for pregnant prisoners, coverage for doula services, and bias and competency training for health care workers. Their Healthy Women, Healthy Babies Initiative had served more than 500 women, primarily women of color, and they planned to launch their next round of grants in spring 2024. The Consortium had piloted a Guaranteed Basic Income program that provided $1,000 a month to help pay for essential items and services to promote healthy birth outcomes. In April 2024, they will hold their 18th annual summit.

As a volunteer organization, the Consortium had been an effective way to amplify voices of lived experience. Dr. Mpasi offered recommendations to the Committee, including creative federal funding, data on activities across different organizations, primary care approaches to reduce high risk pregnancies, funding to expand and diversify the workforce, doula integration in care teams, expanded education on sudden infant death syndrome (SIDS), and creative ways to use Medicaid expansion.

***Shelby Weeks, M.H.S.* (virtual), Infant and Community Health Branch, Head Division of Public Health, NC Department of Health and Human Services**

Ms. Shelby Weeks reviewed public health efforts to address maternal and infant health in North Carolina. She highlighted the state's collaboration with the HHS Office of Minority Heath Health to launch a *Healthy Baby Begins with You* event, a Preconception Peer Education (PPE) Training program, and the Perinatal Health Strategic Plan. The PPE program was a comprehensive program that worked with high school students, college students, and community members to improve preconception health and, consequently, reduced infant mortality and

improved birth outcomes. The PPE program promoted three main messages: making a life plan and taking action, living a healthy lifestyle, and seeing a health care provider at least once a year. Activities included training on reproductive and sexual health, work plan development, peer educator training, and campus and community activities. Each program participant partnered with local health departments and community organizations to ensure they could reach a broad audience.

PPE training was interactive and adaptable based on interest and need. For example, the program recently extended support for fathers and future partners, with a growing number of men interested in becoming peer educators. Peer educators received an intensive initial session and a curriculum covering a range of topics related to health equity and reproductive health. Peer educators then developed work plans to implement within their communities, which could include activities such as connecting individuals to local health resources and enhancing the community's resilience

Breanna Grant **(virtual), Perinatal Health Educator, Guilford County Health Department, Every Baby Guilford**

Ms. Breanna Grant talked about the Every Baby Guilford program in North Carolina, which focused on infant mortality reduction strategies through activities such as reproductive life planning, unified community mobilization, and strategic partnerships. She highlighted the implementation of an educational tool that was created in collaboration with a media relations team. The tool was designed to help individuals think proactively about their reproductive health, specifically on preconception and interconception care.

Their PPE program was conducted in collaboration with local universities to train students to become peer health educators in their communities. Ms. Grant noted that the PPE program had been adapted based on student feedback to shift from an intensive training model to a continuous education model. The students partnered with advisers, meeting weekly or bi-weekly to review their program planning activities. The constant stream of training and communication helped propel their program throughout the school semester.

Ms. Grant provided examples of how the program had promoted sustainability through partnerships with other community organizations to share the message about the need to increase reproductive health education and planning to improve birth outcomes. She invited Committee members to connect with Every Baby Guilford and join their movement.

Discussion

- A meeting participant asked about a recent news item related to pregnant persons in a correctional center.
    - Ms. Smith said that a sister agency in their department had proposed establishing a nursery in a correctional facility, but that it was still in the development process. There would likely be qualifications for participation, such as the number of years left in a sentence and transition plans. The nursery would be a designated space to help prevent mothers and their babies from being separated, which would foster bonding. Ms. Smith suggested that it would be a great opportunity to model and

train mothers who might not have had any other positive models for caring for newborns.

- A Committee member asked about Missouri's plan to unbundle Medicaid reimbursement for care, considering its impact on risk appropriate transitions of care.
    - Dr. Miller answered that they had learned that Medicaid was unable to track metrics on pregnant people because reimbursement was bundled. If it were unbundled, they could track services such as blood tests for syphilis or other quality metrics. With the old model, a patient could walk into the wrong Federally Qualified Health Center (FQHC) and be turned away. It was better to design a payment system where that did not happen.
    - Ms. Smith added that she had participated in a workgroup in which there was a discussion about unbundling both obstetrics care and certain units in the NICU. The discussion was centered on the motivation for doing so and whether it would incentivize transferring infants into NICU. The hope was to move away from bundling.
- A Committee member commented on CDC's leadership in supporting states to build capacity for data collection because it helped to build state-specific solutions.

Public Comment

***Vanessa Lee, M.P.H.,* Designated Federal Official (DFO), ACIMM**

The DFO opened the floor to individuals who had requested to provide oral public comments. Five individuals who had registered to were not in attendance to make comments.

Joia Crear-Perry

Dr. Joia Crear-Perry discussed the lack of transparency in Medicaid payments related to birth centers and midwifery care, suggesting that managed Medicaid organizations held data crucial for public health but often did not share the data with state governments. She also noted systemic issues with health care financing and management, particularly on how private companies managed federal funds without accountability. Dr. Crear-Perry talked about the Birth Equity Index, which aimed to address social determinants of health and the root causes of health disparities such as racism, classism, and gender oppression. Finally, she emphasized that there was a need for community-driven accountability for maternal health care providers to move beyond punitive measures and towards more constructive community involvement and oversight.

Federal Healthy Start Program: Missouri Grantees

***Cynthia Dean*, CEO/Project Director, Missouri Bootheel Regional Consortium, Inc.**

Ms. Cynthia Dean talked about the geographic location of Missouri's Bootheel and highlighted success stories from their program, emphasizing the importance of engaging males in their program. She talked about their Community Action Network (CAN) that leveraged stories and data to develop community-based solutions, a successful community vaccination program, and their social media and education efforts to help increase client engagement. She reviewed challenges and lessons learned, such as the need for systemic change and adequate infrastructure, policies that promote health equity, and increased education and collaboration. Ms. Dean offered

recommendations to the Committee, including recognizing the impact of not addressing unconscious bias in terms of quality care, the importance of integrating people's voices and opinions, and the need for increased capacity to advance health equity.

Discussion

- The Chair asked for specific detail about Missouri's CAN.
    - Ms. Dean said that the CAN met every month and also held an annual appreciation day for their volunteers.
- A Committee member asked what incentives were provided for participating in the CAN.
    - Ms. Dean answered that the incentives varied. In the past, participants received a $25 gift card.

Committee Reflections and Open Discussion

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

The Chair invited Committee members to reflect on the presentations.

- Mr. Lee Wilson talked about the Healthy Start funding opportunity or recompetition, which would award 103 grants by May 1, 2024. He thought the presentations demonstrated the importance of tailoring a program to the needs of the community and that programs like Healthy Start could help to drive community leadership to create change.
- A Committee member asked how Healthy Start addressed equity in their funding approach.
    - Ms. Dean answered that it was important to hire people who came from the community and understood its dynamics and challenges. Staff was their biggest asset in the program; and she emphasized the importance of staff education and training.
    - The Chair said that their state supported community organizations and local health departments by providing grant writing and subcontracting support. This took some of the burden off of the community level staff and the community benefited from the funds that were passed down.
    - Mr. Wilson added that HRSA also provided epidemiology technical assistance for grant writers and had invested $1 million in developing client level intake and tracking tools that integrated directly with the grantee's system. If a grantee did not have a tracking system of their own, they could use HRSA's system and were also provided technical assistance to support infrastructure needs related to the grant.
- A Committee member asked Ms. Dean for words of inspiration for other organizations that aspired to have the success that the Bootheel Regional Consortium has had.
    - Ms. Dean answered that an organization must understand all of the challenges that come with being a grantee. While the benefits were rewarding, there also had to be enough desire to do the work, as well as partnerships and subcontracts to help support the work. It took a lot to manage a Healthy Start program and it helped to be community-driven because everyone in the community could play a part if they chose.

- A meeting participant who was part of the Bootheel Regional Consortium talked about the daily challenges they faced and the need for cross-trained staff and strong leadership to guide them toward success.

DAY TWO: Wednesday, April 3, 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 and provided a brief overview of the presentations and discussions from Day One.

- A Committee member spoke about the importance of disseminating information to the public in a way that someone without a medical background could understand.
- Several Committee members spoke about the importance of developing recommendations that could be put into practice at the community level in ways that did not detract from or overburden their primary work.
- A Committee member talked about the need to address systems-level issues and how individual-level interventions will always be needed if the systems did not change.
- A Committee member said that it was important to address the similarities and differences between rurality and urbanicity in their recommendations.

Federal Updates

***RDML Felicia Collins, M.D.* (virtual), Deputy Assistant Secretary for Minority Health; Director, Office of Minority Health, U.S. Department of Health and Human Services**

RDML Felicia Collins talked about the mission of the Office of Minority Health (OMH) and its strategies and initiatives for improving health disparities among racial and ethnic minorities, including American Indian and Alaska Native (AI/AN) individuals. OMH's unifying goal was based on promoting success, sustainability, and spread of activities that reduce disparities through policies, programs, and practices—otherwise known as S^3P^3. She reminded the Committee that April was National Minority Health Month. She spoke about OMH's alignment with federal initiatives such as the White House Blueprint for Addressing Maternal Health and Healthy People 2030.

RDML Collins reviewed how OMH addressed disparities in maternal and infant health. In September 2023, it awarded more than $13 million in grants to 11 organization to develop models of integrating community-based maternal health services into perinatal systems. OMH also offer a free two-hour maternal health e-learning program to increase cultural competency among health care providers. Additionally, OMH promoted national standards for Culturally and Linguistically Appropriate Services (CLAS) through 15 steps designed to advance health equity and eliminate disparities. OMH collaborated with CDC and other federal agencies in developing the Hear Her campaign for AI/AN individuals. She summarized by reiterating OMH's dedication to addressing the social determinants of health that impact maternal and infant health outcomes.

Discussion

- A Committee member talked about the increase in congenital syphilis rates, particularly among AI/AN individuals and asked what OMH is doing to address it.

- RDML said that OMH was working to move education and information into communities, where the gap tended to be. They funded one position in each of the 10 regions focused on minority health to assess what might be driving these increasing rates. OMH also offers its grantees in perinatal with resources and information to support their efforts to reduce primary, secondary, and congenital syphilis.

Health Resources and Services Administration (HRSA) Remarks

***Carole Johnson, M.A.,* Administrator, HRSA**

Administrator Carole Johnson talked about how the Committee's recommendations can make an impact and encouraged Committee members to continue to think big. She provided HRSA updates, speaking about the importance of a recent Cabinet meeting on maternal and infant mortality that took place with Secretary-level representatives from across the federal government. HRSA had funded several initiatives to improve maternal and infant health, such increasing the number of doula and midwifery programs, offering loan repayments for obstetricians practicing in historically underserved areas, and funding dedicated to grants focused on quality improvement and expansion of services. HRSA was also continuing to support the Maternal Mental Health Hotline, and expanding the Maternal Mental Health and Substance Use Disorder program into more states.

The President's FY 2025 budget proposed funding for training of more labor and delivery nurses, focusing on maternity care deserts. HRSA was also working to adapt and respond to changes happening in the larger environment that were going to impact what service delivery looked like going forward and could diminish specific maternal and infant health services. Administrator Johnson called for the Committee to provide bold recommendations that address specific issues such as reducing the number of maternity care deserts across the U.S. and preparing for deliveries that happen in the emergency department.

Discussion

- A Committee member asked if Medicaid could be expanded to pay for doula and midwives to support labor and delivery services in maternal health deserts.
    - Administrator Johnson answered that there had to first be better workforce recruitment in those fields, as well as training for both community-based tools and accreditation to work in hospitals. For example, HRSA had a program in New Jersey that funded recruitment, training, and accreditation for community-based doulas, and the program's demonstrated success helped support a Medicaid benefit for those services. She asked the Committee to consider recommendations to make community-based doulas a viable career path.
- A Committee member talked about the importance of involving family physicians, who provided obstetric and infant care, with hospital accreditation to help fill gaps in maternal and infant care.
    - Administrator Johnson agreed that including family physicians was an important approach to reach rural and minority communities and said that there was a need for more data to support this as a nationwide option.

- The Chair commented on the importance of expanding the concept of evidence to include promising practices in order to not to miss important opportunities.
- A Committee member asked if HRSA was doing anything to mitigate any detrimental effects from restrictive state laws impeding obstetricians from providing care for pregnant people until the second trimester, therefore exacerbating pregnancy and birthing complications that could be mitigated if caught earlier.
    - Administrator Johnson said that HRSA was working with federally-funded health centers in states with more restrictive laws to ensure they had protections when providing early prenatal care.

Federal Updates

***Kevin Koenig M.A.,* Health Insurance Specialist, Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services (CMS)**

Mr. Kevin Koenig provided an overview of the new Transforming Maternal Health (TMaH) model. The initiative reflected CMS's comprehensive effort to address the multifaceted challenges in maternal health, aiming for significant long-term impacts on maternal and infant care in participating states. CMS will issue awards to up to 15 state Medicaid agencies. Each selected state Medicaid agency will be eligible to receive up to $17 million in funding to support model implementation over the course of 10 years. The goal of TMaH is to enhance Medicaid programs to improve patient experience, reduce avoidable adverse outcomes, and expand access to services like midwifery and doula care.

TMaH grants are intended to support Medicaid staff, technology infrastructure, training, and partnership development. TMaH will also offer technical assistance for quality improvement and workforce development, aiming to increase the capacity and sustainability of maternal health services. Specific activities in the program included enhancing data integration, developing reimbursement strategies, and implementing evidence-based patient safety protocols. CMS plans to release a notice of funding opportunity in spring 2024, with applications due in summer 2024. TMaH grantees would launch their programs in January 2025.

Discussion

- A Committee member asked how TMaH would be rolled out in Medicaid expansion states versus non-expansion states.
    - Mr. Koenig answered that any state could submit an application. The model could be implemented statewide or within specific regions within a state. Therefore, a non-expansion state could test the program in a smaller area.
- A Committee member talked about the challenge of obtaining population-based data and asked how that data could be obtained through managed care organizations (MCO).
    - Mr. Koenig said data exchange with MCOs varied per state. However, they aimed to coach states that were newer to MCOs and offer technical assistance to improve data exchange and aid in the types of initiatives that are required for TMaH.
- The Chair asked for clarification on the requirements for community engagement, or working with individuals with lived experience (i.e., Medicaid beneficiaries).

- Mr. Koenig said there was a proposed rule that would require states to set up their own beneficiary advisory groups, and CMS would support those states in incorporating beneficiary feedback for any initiatives. There was also a doula advisory council requirement, which would include community representation of doulas and others with lived experience.

Black Women's Health Panel

***Kanika Harris, Ph.D., M.P.H.*, Senior Director of Maternal and Child Health, Black Women's Health Imperative**

Dr. Kanika Harris spoke about her work implementing a full-spectrum community doula program for Historically Black Colleges and Universities (HBCUs) with the New Opportunity to Uncover our Resources, Intuition, Spirit and Healing (N.O.U.R.I.S.H.) program. N.O.U.R.I.S.H. was dedicated to improving health outcomes for Black women through comprehensive education on maternal health that spanned from preconception, prenatal, to postpartum and beyond reproduction. N.O.U.R.I.S.H.'s focal approach was to decolonize information and center healing determinants of health, in addition to considering the social determinants of health that affect Black women's lives.

N.O.U.R.I.S.H. provides extensive doula training and removes financial and education barriers by providing textbooks, doula bags, food, and a transportation and related-expenses stipend—ensuring trainees were fully equipped to focus on learning and certification without additional financial strain. The program was designed to be culturally relevant and incorporated community-specific practices, leading to more effective and accepted health interventions within communities. Doulas were also required to create their own resource list and write about their training and experiences. The program had shown significant impact with a high retention rate and successful graduation outcomes. Dr. Harris hoped to expand this model to other campuses and secure more funding to support broader implementation. She offered recommendations for systemic changes to support scalability, including increased funding for HBCUs and consideration for community-specific needs in standardized health training and certification processes.

Discussion

- A Committee Member asked how much it cost to run the program.
  - Dr. Harris shared that it cost between $1,500 to $2,000 per student,
- A Committee Member asked for more information about the gap between training and certification.
  - Dr. Harris responded that the gap existed from finding mentors, especially among community-specific doulas. The program helped to remove any barriers to mentoring. For example, N.O.U.R.I.S.H. provided experienced doulas with a $600 stipend to help with transportation and supplies to encourage them to mentor. Doulas had to work with at least three families to obtain certification, and other certified doulas or midwives had to sign off on those hours

***Ronke Faleti,* Founder & Chief Experience Officer (CEO), korédé House**

Ms. Ronke Faleti shared a story about her personal struggle with postpartum depression, and the familial support that led to her recovery and eventual founding of korédé house, which focused on enhancing social connections and support for mothers. Postpartum depression and loneliness affected women across all demographics, regardless of socioeconomic status. She spoke about the prevalence of loneliness in the nation, pointing out that the lack of social connection was as dangerous to health as smoking up to 15 cigarettes a day. Women with postpartum depression had 90% higher healthcare costs, but new mothers with strong social supports had a 36% lower risk of developing postpartum depression and experiencing loneliness.

Korédé house created a physical "third" space for mothers to find community, support, and practical assistance by reintroducing communal and supportive mothering practices that were less prevalent in more individualistic Western societies. This systemic approach to maternal health and well-being incorporated strong social networks that encompassed peer support, professional counseling, and practical and useful in-home assistance.

Workgroup Report Out

ACIMM Workgroup Leads/Co-Leads

Social Determinants of Health/Social Drivers of Health

Dr. Sherri Alderman provided an overview of Workgroup deliberations to date. The Workgroup had been thinking about how to broaden what constitutes a social determinant of health to include often overlooked factors such as social isolation, which the Surgeon General called out as a public health concern. Dr. Alderman also noted a book called *The Political Determinants of Health* by Daniel Dawes as an important reference. To further explore these factors, the Workgroup wanted to invite the Surgeon General and Mr. Dawes to speak to them. Dr. Alderman encouraged the other two Workgroups to identify intersections of their priority topics with social determinants of health in order to develop a unified set of recommendations.

Discussion

- A Committee member commented on the disparate impacts of social isolation across different groups, suggesting that the Workgroup consider this further in their future meetings and recommendations.

Systems Issues in Rural Health

Dr. Jacob Warren said their Workgroup had focused on four main themes: 1) rural hospital closures and maternity care deserts, 2) the recruitment and retention of a diverse rural workforce, 3) the expansion of telehealth and regionalization of care, and 4) the crucial role of data given that it is often suppressed in rural areas. The Workgroup had invited a number of guest speakers, including Harold Miller, CEO of the Center for Healthcare Quality and Payment Reform to talk about rural hospital closures; and Elizabeth Cherot, CEO of the March of Dimes about their report on maternity care deserts. Dr. J. Warren outlined how telehealth could be pivotal for regionalizing care, particularly for improving access to prenatal, postpartum, and family medicine services. The Workgroup intended to focus its recommendations on rural Black pregnant women, and had used CDC WONDER data to support an analysis of which states had the highest number of Black rural births.. He called on the Committee to help them identify individuals with lived experience to contribute to the Workgroup discussions.

Discussion

- A Committee member emphasized the need to focus recommendations specifically on targeted geographical areas to maximize impact.
    - Another Committee member highlighted the importance of having data and heat maps to help address specific regional needs..
- A Committee member spoke on the importance of equipping emergency departments in rural areas with the necessary training to manage births and potential complications. This was especially critical in rural areas where there were not enough births to justify a robust specialty-trained workforce.
- A Committee member asked for recommendations for an expert in obstetrics telemedicine to help craft rural telehealth recommendations.
    - A Committee member suggested speaking to Dr. Emily Baker, a senior physician at Dartmouth University in New Hampshire.
    - Another Committee member suggested speaking to Dr. Erica Werner from the Society for Maternal and Fetal Medicine, who was an expert on preconception and interconception.

Preconception/Interconception Health

Dr. Phyllis Sharps reviewed recent Workgroup activities, which focused on exploring broad and impactful strategies to improve reproductive health among underserved populations. She emphasized the need for a broad range of community voices to help shape recommendations for effective health messages and policies. She highlighted the importance of integrating male perspectives and said that the Workgroup heard a presentation on the PRAMS for Dads initiative. The Workgroup also heard insights from the Planned Parenthood Federation of America, which had a new Black Health Equity initiative and was focused on overcoming barriers to care and misinformation. Dr. Sharps reviewed the Workgroup's conversations on challenges related to access to reproductive health care. The Workgroup also reviewed issues such as syphilis, the implications of federal restrictions on telehealth, and health literacy. Dr. Sharps asked the Committee to help them identify gaps, as well as community voices they could invite to speak.

Discussion

- A Committee member raised concerns about recent spikes in misinformation about contraception, particularly on platforms such as TikTok, and suggested that the Workgroup consider this issue in future meetings.
- A Committee Member asked how to ensure that the recommendations from each Workgroup remained unique without too much overlap.
    - The Chair answered that there would be a few more meetings before the recommendations were finalized. Since the focus areas of each Workgroup were not silos, recommendations could be merged in the final report.

Panel of Community Voices

Moderator: *ShaRhonda Thompson*, ACIMM Member
***Okunsola Amado* (virtual), Founder, Jamaa Birth Village**

***Ronda Smith Branch*, Community Organizer, Generate Health; Health & Wellness Coach & Founder, Worthy of Well-Being, LLC**
***Kyra Betts*, Certified Doula, Policy and Advocacy Manager, Generate Health**
***Carolyn Davis*, Case Manager Supervisor, MO Bootheel Regional Consortium, Inc.**

Ms. ShaRhonda Thompson moderated a panel discussion of diverse speakers who shared their perspectives on maternal health challenges and successes. Ms. Thompson emphasized the importance of community input in shaping health policies and improving maternal health outcomes. The panelists spoke about personal experiences with systemic barriers in healthcare and issues such as racial discrimination, lack of transportation, and inadequate postpartum support.

Ms. Caroline Davis underscored the importance of community support, culturally sensitive-care, and education about maternal and infant health, which were vital for ensuring that mothers and families received adequate care from their health care providers. She highlighted the interconnectedness of these components and the role they played in promoting compassionate care.

Ms. Okunsola Amado stressed the need to extend maternal care beyond the typical postpartum period and advocated for integrated services such as midwifery and mental health support as a holistic, comprehensive care approach. She also emphasized the need for women and girls to have more health education earlier in life.

Ms. Ronda Smith Branch focused on the importance of internal healing and increased awareness for maternal wellbeing. She advocated for emotional and psychological support that was tailored to cultural needs. For instance, education should be developed to resonate with the realities that patients experience in order to avoid a sense of alienation.

Ms. Kyra Betts shared insights about the need to advocate for empowering patients through education to help them navigate the health care system. She noted that providers needed to learn how to treat each patient as an individual with unique needs.

Collectively, the panelists advocated for empowering mothers through better education to help them navigate the health care system; the treatment of patients as individuals with unique needs; and systemic changes such as better funding allocation, risk-appropriate care, and training of providers in cultural competency and implicit biases.

Discussion

- Ms. Thompson asked about strategies to support mothers and babies so they thrived after birth.
    - Ms. Betts highlighted the crucial time after the initial postpartum month, noting the importance of regular check-ins with new mothers to assess their mental health.
    - Ms. Amado pointed out discrepancies in recommendations for postpartum care duration. While the World Health Organization recognized the critical parts of postpartum extending to two years after birth, the standard American model

typically thought of the period as six weeks. As a result, many health concerns were missed and this negatively impacted Black mothers in particular.
    - Ms. Davis talked about the critical role of education for new mothers to help prepare them for the postpartum period. This could help set realistic expectations and prepare for potential complications.
- Ms. Thompson asked about specific strengths, supports, or assets the panelists had seen in their community.
    - Ms. Betts said that community gardens, access to free midwifery care, and community organizations that connect families to essential resources such as diaper banks have all been successful in supporting maternal and infant health.

Wrap-Up and Considerations

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

The Chair expressed appreciation for the robust discussion and said that the insights that were shared would help the Committee form recommendations to the Secretary.

DAY THREE: Thursday, April 4, 2024

AI/AN Recommendation Updates

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

The Chair delayed this agenda item to later in the morning. The DFO provided updates to the Committee on behalf of Dr. Tina Pattara-Lau, the Ex-Officio member from the Indian Health Service. Their Maternal Child Health program was working on initiatives to expand access to safe, quality maternity care in the community and reduce maternal and newborn morbidity and mortality. Examples that were provided included: funding by IHS for Maternity Care Coordinators (MCCs) at federal sites to increase access to screening, education, and intervention through telehealth and home visiting during pregnancy and postpartum; an Obstetric Readiness in the Emergency Department (ObRED) program to provide sites in maternity care deserts with the tools and resources to safely triage, stabilize, and transfer pregnant persons and newborns; and an Indian Country ECHO Care and Access for Pregnant People series that provides virtual on-demand education and clinical consultation to all 12 IHS areas.

Sarah Meyerholz of MCHB then shared how the State Maternal Health Innovation (SMHI) Program awardees were conducting activities that aligned with the ACIMM AI/AN recommendations. For example, the Washington state SMHI program was doing work related to recommendation *#26-Invest in training of AI/AN doulas and traditional birth workers*. In addition, Montana and Arizona had grant activities related to recommendation *#1.d.-Include consultation and partnership with AI/AN Elders and others with relevant lived experiences to gain historical context and perspective on factors related to high rates of AI/AN infant mortality and poor maternal health and identify solutions*.

Discussion of Workgroups

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

ACIMM Members

The Chair led a review of Workgroup discussions and the intersection of topics across all three. Several intersecting themes emerged:

- **Broadband and Telehealth:** The Committee engaged in a thoughtful discussion on access to broadband and its impact on health care delivery in both rural and urban settings. They emphasized the importance of broadband for telehealth services, which had become increasingly important for perinatal care and the management of chronic conditions.
- **Cultural Competency:** The Committee talked about the importance of culturally competent care and community engagement in planning health care delivery strategies They commented on the need for approaches that were respectful and tailored to specific cultural practices and needs.
- **Workforce Development:** The Committee mentioned the need for provider education to improve their understanding of culturally appropriate care. Committee members suggested training for long-acting reversible contraceptives and other family planning services in the context of an environment of increasing mistrust and misinformation.
- **Systemic Barriers:** The Committee spoke about the need to address systemic barriers to care, including social and political determinants of health that impact policy and access to care.

Next Steps & Assignments

ACIMM Members

The Chair reviewed the timeline for developing amd finalizing a set of recommendations for the Secretary. The Committee agreed to develop a draft of the recommendation by the end of 2024, with a review period that would start in January 2025. Final recommendations would be targeted for completion by early March 2025.

The DFO shared that six Committee nominees were still under review by HHS. Committee appointments were expected later in 2024 and these nominees had responded to the 2021 solicitation. A large number of nominations from a 2023 solicitation had been received and were being reviewed by MCHB.

- A Committee member asked about community or consumer representation in the nominee package under review.
    - The DFO responded that the composition of the nominees could not be disclosed at that time. However, efforts had been made to include nominees that met the Committee's recommendations for representation, particularly from AI/AN communities.
- A Committee member noted that Committee turnover could coincide with the March 2025 target for final recommendations.
    - Dr. Warren added that the 2024 election could also lead to a new HHS Secretary.

- A Committee member expressed gratitude for the thoughtful participation of all members and emphasized the Committee's role in bridging traditional maternal and child health practices with innovative community perspectives.
- A Committee member expressed concern about placing the burden of education for receiving adequate care on patients, suggesting that there should be consideration for who the education should target.

Planning for June 2024 Meeting

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

The Chair reminded Committee members that the next meeting would be in person on June 26th and 27th in Rockville, Maryland. The members agreed to meet for two full days rather than ending early on day 2.

The Committee offered recommendations for future meetings. These included:

- **Invited Experts:** The Committee discussed inviting different experts to add context to their recommendations. For instance, Committee members mentioned inviting experts in systems thinking to understand interconnected factors; a representative from CDC's Office of Rural Health to review their perspectives and initiatives; a representative from the Federal Communications Commission to address broadband access and its impact on telehealth services; and community members from the DC metro area. There were also suggestions to invite a representative from the American College of Obstetricians and Gynecologists (ACOG) to address maternal isolation.
- **Innovative Health Care Models:** Committee members talked about the need for more education on innovative health care delivery models or successful community engagement strategies that could be adapted for rural communities.
- **Political and Social Determinants of Health:** Committee members suggested taking a deeper dive into how political and social determinants of health can align with policy and advocacy to address barriers to health care.

Meeting Evaluation and Closing Observations

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

The Chair reflected on the robust and informative presentations over the last three days and thanked all of the speakers. Dr. Michael Warren and the DFO thanked Ms. Thompson (ACIMM Member) for connecting the Committee and meeting planners with local organizations, including the meeting site venue.

Adjourn

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

The Chair adjourned the meeting at 12:00 p.m. CDT.