Advisory Committee on Infant and Maternal Mortality

Meeting Minutes of December 5-6, 2023

Virtual Meeting

Table of Contents

DAY ONE: Tuesday, December 5, 2023 2
Welcome and Introductions 2
Review and Approve Minutes 2
Federal Updates 2
Infant Mortality in the United States: Provisional Data from the 2022 Period, Linked Birth/Infant Death File 4
Federal Health Start Program 4
Updates and Discussion: Recommendations to Improve American Indian/Alaska Native (AI/AN) Birth Outcomes 5
Community Voices 7
Partnership Panel of National Organizations 7
Effective Framing and Language for Recommendations 8
Systems Issues in Rural Maternal/Infant Health 9
Title V MCH Services Block Grant: Program Enhancements for Advancing Equity and Accountability 12
Preconception, Interconception, and Postpartum Health 13
Wrap-Up and Considerations 14
DAY TWO: Wednesday, December 6, 2023 14
Call to Order and Review of Day One 14
Workgroup Report Out 14
Charter Updates 16
Public Comment 17
Meeting Evaluation and Closing Observations 18
Adjourn 19

DAY ONE: Tuesday, December 5, 2023

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**

The DFO called the Advisory Committee on Infant and Maternal Mortality (ACIMM; the Committee) to order and welcomed virtual attendees. The Chair welcomed new ex-officio members, RDML Felicia Collins from the Office of Minority Health (OMH) and Ms. Gayle Goldin from the U.S. Department of Labor (DOL). The Chair also thanked Dr. Yanique Edmond for her service to the Committee as former ex-officio for OMH.

Review and Approve Minutes

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

The Committee unanimously passed a motion to approve the minutes of the June 2023 meeting.

Federal Updates

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

Dr. Michael Warren provided an overview of recent grant awards made in FY 2023. More than $90 million was granted to states and communities to improve maternal health and eliminate disparities. This funding included 35 State Maternal Health Innovation Program grants, 10 new Healthy Start Enhanced grants, the first Minority-Serving Institutions Research Collaborative with 16 individual research centers, 5 Integrated Maternal Health Services Program grants, 28 Alliance for Innovation on Maternal Health (AIM) Capacity program grants, and Screening and Treatment for Maternal Mental Health and Substance Use Disorders grants to 5 additional states. Additionally, MCHB funded a Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Workforce National Center. Dr. Warren talked about the FY 2024 recompete of the Healthy Start program, the Healthy Start Technical Assistance (TA) Center, and the TA Center for Maternal Health Innovation Program, as well as other open funding opportunities such as the Cooperative Newborn Screening System Priorities Program (Co-Propel). He emphasized that these funding opportunities were contingent on final congressional appropriations. Dr. Warren said that the reauthorization of the MIECHV Program would double funding over five years, much of which would be provided through a federal match of $3 for every state dollar provided. He also provided an update on the National Maternal Mental Health Hotline, which had received approximately 23,000 calls to date, and asked Committee members to help promote the hotline through their networks.

U.S. Department of Housing and Urban Development (HUD)
***Alicka Ampry-Samuel,* Regional Administrator, Region II**

Ms. Alicka Ampry-Samuel provided an update on maternal and child health activities from HUD's Field Policy and Management (FPM) team. The White House Blueprint for Addressing

the Maternal Health Crisis outlined three specific HUD activities: 1) connecting eligible families receiving housing assistance with access to health programs; 2) conducting partnership meetings in targeted cities to enhance delivery outreach, education, and care; and 3) educating grantees serving women experiencing homelessness or survivors of domestic or gender-based violence. In response, HUD developed a charter of field offices focused on improving maternal and infant health – the Maternal Outcomes Through Housing Environments Reimagined (MOTHER) Charter. The team started by identifying the six communities with the highest scores on the maternal vulnerability index and that also had a HUD EnVision Center. Then, the team created action plans for each community to organize mother-led discussions about health services for HUD-assisted housing, address community gaps, conduct onsite visits and listening sessions, and create an inventory of community providers. Some of the feedback they received from the mothers included the need for postpartum support, psychological help, parenting education, support services for subpopulations (e.g., other primary caretakers, fathers, addicted individuals), and training about rights and anti-discrimination laws. The MOTHER team also focused on funding strategies and sustainable resources, such as dedicated staff. Ms. Ampry-Samuel then reviewed the HUD Strong Families program and invited Committee members to consider partnerships with HUD toward supporting health and housing initiatives.

U.S. Department of Labor (DOL)
***Gayle Goldin,* Deputy Director, Women's Bureau**
***Bonnie Worstell,* Policy Advisor, Wage and Hour Division**

Ms. Gayle Goldin reviewed the mission of the DOL's Women's Bureau, which aims to support women in the workforce through policies and standards that safeguard the interests of working women; advocates for the equality and economic security of women and their families; and promotes quality work environments. The Women's Bureau focuses on work-related priorities such as gender-based violence and harassment, workplace breastfeeding, and pregnancy accommodations in the workplace—ensuring that women know their rights and have access to resources at the state-level. Some of their current activities related to the focus of the Committee include listening sessions with doulas to ensure there is a robust, diverse doula workforce, sample employment agreements that allow domestic workers to negotiate wages and employment terms, and research such as their recently updated Cost of Doing Nothing report and a report on the impact of unpaid caregiving on older women.

Ms. Bonnie Worstell talked about the DOL's Wage and Hour Division, which aims to promote compliance with labor standards, including protections such as federal minimum wage, family medical leave, and the right to express breastmilk. The division works with the Women's Bureau and the Equal Employment Opportunities Commission to support worker protections from pregnancy to birth and return-to-work. Some of their activities include webinars on protections for working mothers, enforcement of laws such as the PUMP Act and the Family and Medical Leave Act (FMLA). The PUMP Act became law in 2023 and protects the right to pump breastmilk at work without fear of discrimination or job loss. FMLA provides eligible employees with the right to take up to 12 weeks of unpaid leave with continued health insurance coverage. The Wage and Hour Division has been conducting outreach and education to ensure that individuals are aware of their rights and know how to file a complaint. Ms. Worstell reviewed how the division fields and prioritized complaints and provides technical assistance to educate

workers and employers on the requirements of these laws. The division also collaborates with other agencies on initiatives such as the Federal Interagency for Breastfeeding Workgroup.

Ms. Goldin highlighted DOL's Employee Benefits Security Administration, which enforces protections such as coverage of women's preventative services by most health insurance plans.

Infant Mortality in the United States: Provisional Data from the 2022 Period Linked Birth/Infant Death File

***Danielle Ely, Ph.D.,* Statistician, National Center for Health Statistics, Center for Disease Control and Prevention (CDC)**

Dr. Danielle Ely reviewed provisional 2022 data reports on fetal and infant mortality. The fetal mortality reports compared provisional 2022 data with 2020 and 2021 data on fetal deaths at 20 weeks of gestation or more. While there was no significant difference in fetal deaths between 2020 and 2021, there was a 5% decline in provisional 2022 data. There were no significant differences across race from 2020 to 2021 except for a small decline in fetal deaths among Black mothers. From 2021 data to provisional 2022 data, there were small declines in fetal mortality among White and Hispanic women. Between 2020 and 2021, there was an increase in fetal mortality in Pennsylvania and Utah. In provisional 2022 data, fetal mortality declined in California, Utah, Alabama, Florida, Pennsylvania, and Maryland.

Between 2021 data and provisional 2022 data, the infant mortality rate increased 3% from 5.44 to 5.60. There were significant increases in infant mortality among infants of American Indian/Alaska Native (AI/AN) and White mothers. There were also significant increases in infant mortality among mothers aged 25 to 29 and among infants born at less than 34 weeks of gestation. There were significant increases in infant mortality in Texas, Iowa, Missouri, and Georgia and a significant decrease in Nevada. Infant mortality increased 9% in deaths related to maternal pregnancy complications and 14% in deaths related to newborn bacterial sepsis. Dr. Ely said that the final 2022 data should be released by spring 2024.

Discussion

- A Committee member asked whether there were data specific to rural populations.
  - Dr. Ely answered that there were some data comparing rural and metropolitan populations that she could forward to the Committee.
- A Committee member asked whether Nevada had made any changes in their programming that might be related to the decrease in infant mortality.
  - Dr. Ely said that changes from year to year could be relative to the number of births, but that she could look at previous reports to identify if there was a trend, such as a previous increase that was being corrected.

Federal Healthy Start Program

***Lee Wilson,* Division Director, Division of Healthy Start and Perinatal Services, Maternal and Child Health Bureau (MCHB), HRSA**

Mr. Lee Wilson provided an update on the Healthy Start program. Since the June 2023 Committee meeting, there had been 10 additional grant awards issued for the Healthy Start Enhanced program. MCHB was also preparing for the recompete of the larger Healthy Start program and the Healthy Start Technical Assistance Center cooperative agreement. MCHB had conducted feedback sessions with stakeholders to hear the challenges and opportunities for improvement in anticipation of the Healthy Start program recompete. Three major takeaways from this stakeholder engagement included the need for 1) more flexibility in program design, number of clients, types of services provided, and reporting; 2) greater support for social determinants of health in the program; and 3) a reduced burden on data collection and reporting to free up more time for service provision. MCHB revised the program in response to the feedback by broadening the ability to provide group-based health and education services, providing support for a community consortia, and requiring a smaller number of performance measures, among other things. Mr. Wilson said that MCHB anticipates making up to 103 awards in FY 2024 at approximately $1.1 million per award.

Updates and Discussion: Recommendations to Improve American Indian/Alaska Native (AI/AN) Birth Outcomes

Moderator: ***Belinda D. Pettiford, M.P.H., B.S., B.A.,*** **ACIMM Chair**
ACIMM Members
Ex-Officio Members

The Chair invited former Committee members, Dr. Ed Ehlinger (also former Acting Chair), Dr. Janelle Palacios, and Dr. Magda Peck to provide updates on their efforts to promote and disseminate the Committee's report of recommendations for AI/AN mothers and infants.

Dr. Ehlinger emphasized that the Committee's recommendations provided hope to AI/AN communities because it demonstrated that there was federal attention. He talked about working with the Association of State and Territorial Health Officials (ASTHO) to embed some of the recommendations in their policies, and with CityMatCH to focus some of their annual meeting on AI/AN. The American Indian, Alaska Native, and Native Hawaiian Caucus of the American Public Health Association included a session on the Committee's report at their 2023 annual meeting and plan to do another session in 2024. Drs. Palacios, Peck, and he have also conducted podcasts, interviews, and lectures to socialize the report. Dr. Ehlinger talked about some of the feedback he had received from these activities, which highlighted how the community voices and stories brought context to the data and the need for champions from federal agencies to continue the momentum.

Dr. Palacios spoke via a prerecorded video about the limitations of AI/AN data. Although Indian Health Services (IHS) collects data on maternal and infant outcomes, the data does not include all native people and therefore does not reflect the true scope of maternal and infant mortality. State data collection had only recently moved from a restrictive single race category to more inclusive multiple race categories to help overcome the significant undercounting in these populations. These efforts have contributed to more accurate data on AI/AN maternal and infant mortality in recent years; however, the last report of data from IHS was in 2009. Dr. Palacios highlighted the March of Dimes report on Maternity Care Deserts, which demonstrated severe maternity care deserts across federally-recognized tribal lands. She reviewed ongoing questions

that should be asked by Committee members, including the strategies and actions needed to improve data collection and reporting, methods used to evaluate his maternal and infant health outcomes, how this IHS contract with the American College of Obstetricians and Gynecologists (ACOG) was being evaluated, what social determinants of health were being addressed, and the actions needed to maintain momentum for improving AI/AN maternal and infant health outcomes.

Dr. Peck talked about colleagues who had been moved to tears by the report because they had not recognized the impact of policies and systems that had reduced AI/AN to small numbers by design. She provided Committee members with four action steps to continue the momentum: 1) read the report and commit its stories and data to memory, 2) act on Dr. Palacios' questions, 3) be pragmatic and action-oriented, and 4) become a reliable champion for the recommendations.

The Chair invited ex-officio members to provide updates on activities related to the Committee's recommendations for AI/AN that were being implemented/adopted or in progress.

Indian Health Service (IHS): Dr. Tina Pattara-Lau provided an overview of recent IHS activities related to the ACIMM AI/AN recommendations. The IHS Maternal and Child Health (MCH) Program prioritizes the inclusion of indigenous leaders, healers, and community members—ensuring that lived experience and community representation are embedded into programs such as Maternal Mortality Review Committees (MMRCs) and the Maternal Child Safety Work Group. In addition, IHS received advance appropriations for fiscal year 2024 which guaranteed health care services regardless of any lapses in federal appropriations. IHS is collaborating with the Office of Quality and the Office of Clinical Performance to develop metrics for the MCH Program, review policies, and build dashboards to better track maternal and infant outcomes. In response to the closure of approximately 300 rural labor and delivery units since 2018, IHS developed an obstetric readiness training for emergency departments. IHS has also developed guidance in response to the 32% increase in congenital syphilis in the AI/AN population. Dr. Pattara-Lau talked about the Indian Country ECHO program, their MCH website and newsletter, and their maternity care coordinator program that delivers telehealth and home visits. She also addressed the recommendation related to the contract between IHS and ACOG, reporting that the results of their site visits were confidential.

Centers for Disease Control and Prevention (CDC): Dr. Karen Remley of CDC's National Center for Birth Defects and Developmental Disabilities (NCBDDD) talked about the CDC's response to the significant increase in congenital syphilis, which had been occurring primarily in people who do not receive timely or insufficient prenatal care. CDC had been working with the Food and Drug Administration (FDA) to support point-of-care testing and treatments. CDC is also looking at women exposed to opioids and the rates of other sexually transmitted infections (STIs) in AI/AN. Dr. Ada Dieke of CDC's Division of Reproductive Health (DRH) reviewed CDC engagement efforts with tribal leaders and at the CDC Tribal Advisory Committee to better understand how to engage with tribes and ensure that MMRC approaches were appropriate for tribal communities. CDC also partnered with the National Indian Health Board (NIHB) and convened the first national meeting on tribal MMRCs on tribal land. Dr. Dieke talked about CDC's effort to update Healthy Native Babies Project materials with the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD). CDC and the HHS Office

of Minority Health are working with NIHB to fund tribes and tribal-serving organizations to implement the Hear Her Campaign for AI/AN locally, and grant opportunities centered on AI/AN communities were announced.

MCHB: Dr. Michael Warren said that the MIECHV tribal set-aside had doubled from 3% to 6%. MCHB partners with the Administration for Children and Families (ACF) to administer the tribal home visiting program. The MCHB-funded National Center for Child Death Review and Fetal Infant Mortality Review Technical Assistance Center recently hired a dedicated tribal lead and is working on a contract to develop learning guides on working with AI/AN families for review teams. MCHB had also worked with HRSA's Office of Tribal Affairs and Dr. Pattara-Lau on disseminating funding opportunities to Tribes and Tribal-serving organizations.

Community Voices

Moderator: *Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair
***Rebecca Burger, B.S.N., CLC*, System Care Coordinator, Bootheel Perinatal Network (Missouri), RMOMS Awardee**
***Heather Pawlik*, Community Voice Representative and RMOMS Patient**

Ms. Heather Pawlik talked about her experience as a patient/client of Ms. Rebecca Burger and the HRSA-funded Rural Maternity and Obstetrics Management Strategies (RMOMS) program. Ms. Burger assisted her with resources and connected her to other supports, such as a program that helped pay her electric bill, another one that gave free books for her child, and helped to correct an administrative error that affected her food stamps. Ms. Burger said that it was common in her community for parents to have to travel an hour or more each way to obtain medical care, but that the ability to connect with someone who could assist and identify helpful resources could make a real difference in their pregnancy outcome.

Discussion

- A Committee member asked whether RMOMS was involved with SSM Health.
    - Ms. Burger said that they worked with the Bootheel Perinatal Network, which was housed within St. Francis Medical Center in Missouri. However, they did work with a SSM Health consultant to provide level 4 perinatal services and education.
- A Committee member asked Ms. Pawlik if she had connected with a midwife.
    - Ms. Pawlik answered that she chose to see her regular obstetrician because she had chronic medical issues that needed to be monitored.

Partnership Panel of National Organizations

***Ericka Burns, Ph.D.*, Senior Director of Health Equity, National Family Planning and Reproductive Health Association (NFPRHA)**

Dr. Ericka Burns said that NFPRHA supports family planning providers and administrators with subject matter expertise and capacity building support. They had approximately 1,000 members who represented family planning councils, health departments, Planned Parenthood affiliates, private and nonprofit agencies, and federally qualified health centers. NFPRHA focuses their

efforts on three primary activities to improve maternal and infant health: 1) addressing the bicillin shortage, 2) extending Medicare postpartum coverage, and 3) advancing health equity. Bicillin is the only recommended treatment for preventing congenital syphilis, but there is a shortage that was predicted to extend into 2024. NFPRHA was working with their members in states affected by this shortage. NFPRHA also promoted extended Medicaid coverage for 12 months postpartum across all states and was working to prioritize Black and Indigenous populations who were facing a loss of coverage. Finally, NFPRHA launched a Health Equity Tool that provides family planning providers with resources and a needs assessment tool to identify gaps in services and evaluate their activities that support health equity. The purpose of the toolkit is to improve program design, data collection, and partnerships with the community and other family planning networks to change the internal, state, and federal policies that create barriers to care.

***Julie Wood, M.D., M.P.H., FAAFP*, Senior Vice President, Research Science and Health of Public, American Academy of Family Physicians (AAFP)**

Dr. Julie Wood talked about AAFP's efforts to address maternity deserts in rural areas by mobilizing the family physician workforce. Family physicians are trusted community members who see patients across the lifespan. Research has shown that family physicians provide maternity care in up to 63% of areas designated as maternity care deserts and are the only maternity care providers in 181 counties across the U.S. AAFP supports the Black Maternal Health Momnibus Act, the PUMP Act, and 12-month postpartum Medicaid coverage to help family physicians provide this care. AAFP also conducted research on the role of family physicians and developed continuing medical education. For example, The EveryONE Project provides education and resources to help family physicians advocate for health equity. AAFP also developed a new Center for Women's Health web portal and education modules to standardize skills across providers, such as the Basic Life Support in Obstetrics program and the Advanced Life Support in Obstetrics program. AAFP also prioritizes the fourth trimester and the role that family physicians can take to support a continuum of maternal health care. Dr. Wood played a video featuring Committee member Dr. Marie Ramas, a family physician.

***Deborah Frazier*, CEO, National Healthy Start Association**

Ms. Deborah Frazier provided an overview of the history of the Healthy Start program. Since its first demonstration projects, Healthy Start has grown to more than 100 programs that make a difference in maternal and infant health. Recent efforts to enhance the program included fatherhood programs, maternal health clinical interventions, and doula services. Ms. Frazier talked about how Healthy Start had made a difference across the country and stressed the importance of funding from House appropriations to continue Healthy Start. She called for the Committee members to be aware of what was happening in terms of appropriations and to maintain a sense of urgency to help keep the program adequately funded.

Effective Framing and Language for Recommendations

***Julie Sweetland, Ph.D.*, Senior Advisor, FrameWorks Institute**

The Chair introduced Dr. Julie Sweetland of the FrameWorks Institute, and said this session on framing was in anticipation of the Committee's development of recommendations within a highly-polarized environment. The FrameWorks Institute promotes evidence-informed communication strategies needed to enact social and policy changes. Dr. Sweetland introduced a concept of framing a conversation effectively and aimed to address the Chair's desire to frame the Committee's focus on Black maternal and infant health in a strategic way so that the public and policymakers would respond with a more open mind. She gave multiple examples of experiments FrameWorks had done where changes in the framing of an issue led to changes in public support. Dr. Sweetland emphasized that the right framing could close the gap between political parties. Framing considers factors such as tone, values, data, and the narrative emphasized in a message. She urged Committee members to consider three strategies toward a productive mindset as the Committee develops its next set of recommendations: 1) attribute responsibility carefully rather than not at all so that others do not make their own causal attributions, 2) emphasize explanation in terms of a clear cause and effect sequence, and 3) translate collective-level solutions in ways that make sense to non-experts. Dr. Sweetland suggested using plain language that is personalized and humanized and to invite the public's perspectives, which can incentivize a policymaker to change their mindset.

Discussion

- A Committee member asked how they could frame a conversation around equity among communities that have had less exposure to historically excluded populations.
    - Dr. Sweetland said that the conversation should express the idea that a community is better off if everyone has the resources to achieve their best health. Plain, trigger-fee language is important, as is an emphasis on the causal pathways that demonstrate how the environment can impact health. It is important to show that health disparities are not only uneven, but also unfair. The tone should also imply an invitation to solve the problem rather than a failure to prevent the problem.

Systems Issues in Rural Maternal/Infant Health

***Megan Cundari,* Senior Director, Federal Relations, American Hospital Association (AHA)**

Ms. Megan Cundari provided AHA's national perspective of systems issues in rural maternal and infant health. AHA represents approximately 5,000 hospitals in the U.S., from small rural hospitals to large academic medical centers. Rural hospitals made up 35% of all hospitals in the country—nearly half had 25 or fewer beds and only 26% had more than 10 beds. Because they were geographically isolated, rural hospitals had much lower patient volumes, treated patients who tended to be older or poorer, and often faced staffing challenges. Only 10% of physicians in the U.S. practiced in a rural hospital despite 20% of the U.S. population living in rural areas. Rural hospitals delivered 1 in 10 babies born in the U.S., but the number of rural hospitals that provided obstetric services has been declining. Ms. Cundari reviewed three reasons for the closure of obstetrics units: 1) the volume of services was low and skills were therefore harder to maintain, 2) the health care workforce shortage had hit rural areas hardest and was exacerbated by the need for specialized obstetric staff, and 3) rural hospitals depended more on Medicaid and Medicare—which underpays providers. AHA helped hospitals maintain access to obstetric services through webinars, podcasts, and case studies.

***Jeffrey Strickler, D.H.A., R.N.*, Vice President, University of North Carolina (UNC) Hospitals, Hillsborough Campus; Adjunct Professor, UNC School of Nursing; Adjunct Professor, Department of Health Policy and Management, Gillings School of Global Public Health, UNC-Chapel Hill**

Mr. Jeff Strickler provided a local perspective from Chatham Hospital, which was in a rural area of North Carolina and was part of the University of North Carolina (UNC) health care system. UNC provided initial funding to remodel a five-room maternity suite, which opened in 2020. This effort was an experimental, cost-sustainable model to address maternity unit closures that could be replicated in other rural counties. Chatham is a rural area that is adjacent to counties that provide higher levels of care and was therefore able to obtain support from those counties for higher risk deliveries and pre- and post-natal care. These higher resourced hospitals were also integral training sites for Chatham providers, who were able to obtain experience with skills such as Cesarean section care. Mr. Strickler talked about ongoing challenges in the program, such as financial sustainability as a result of high numbers of uninsured or Medicaid-insured patients, low patient volume and difficulties maintaining provider skills, and the number of support staff needed to support a maternity program. Staffing was the most difficult challenge, particularly throughout the pandemic when the unit was often one staff resignation away from closure. Maintaining competency was also difficult because staff tended to seek environments where they could be more active. Additionally, staff needed to be near enough to the hospital to be immediately available when needed.

Mr. Strickler offered recommendations for improving the state of rural maternal health care. First, maternal health care should be made affordable and accessible by expanding care to the uninsured, increasing Medicaid reimbursement, improving funding for maternal and child health care, and addressing racial inequities. Second, telehealth was effective for reaching rural communities and should be supported through Medicaid reimbursement and efforts to increase reliable broadband internet. Finally, workforce shortages should be addressed through loan repayment programs, rural residency programs, support for practicing at the top of one's license, training across competencies, and support for provider burnout.

Discussion

- A Committee member asked whether it was too early to understand the impact the program had on trainees.
    - Mr. Strickler suggested that they were just beginning the third year of the program and were only now involving the residents. Therefore, it was too early to evaluate the impact.

***Kathryn Umali,* Director, Community-Based Division, Federal Office of Rural Health Policy, HRSA**

Ms. Kathryn Umali gave the background and an overview of HRSA's Federal Office of Rural Health Policy, which is mandated to increase health care access to rural areas through grants, partnerships, and capacity building support, as well as advise the HHS Secretary on rural health issues. People who live in rural areas experience health disparities, including higher maternal mortality. More than half of rural counties lack obstetric services, rural hospitals are often at risk

of closure, and there were significant obstetrics workforce shortages. The RMOMS Program within FORHP was created because of a study in 2018 that revealed that more than half of rural counties lacked OB services.

Carey Zhuang, M.H.A.**, RMOMS Program Coordinator, Community-Based Division, Federal Office of Rural Health Policy, HRSA**

Ms. Carey Zhuang provided an overview of the RMOMS program, which funds awardees up to $1 million of startup funding per year for four years to support a state's capacity to improve maternal care in rural communities. The RMOMS program had five overarching goals: 1) implement evidence-based and sustainable maternal delivery models, 2) enhance access to maternal and obstetric services in rural hospitals, 3) provide provider training in hospitals without specialty maternity care, 4) collaborate with academic institutions to obtain clinical expertise, and 5) address disparities in maternal and infant health outcomes. The program emphasized financial sustainability, including coordination with state Medicaid agencies and other payers. The first cohort of RMOMS awardees provided maternal and obstetric care to nearly 5,000 rural RMOMS participants, including more than 3,000 deliveries. Ms. Zhuang invited Committee members to subscribe to HRSA email updates to learn more about their rural health programs.

Barb Gleason, R.N., M.S.N.**, Project Director, Bootheel Perinatal Network (Missouri), RMOMS Awardee**

Ms. Barb Gleason said that maternal mortality was going in the wrong direction for Missouri, like the rest of the nation. They continued to see Black women were more than three times as likely to die than their White counterparts in the state, and saw an increase in women who were on Medicaid versus women on private insurance dying. Maternal health was Missouri's top underlying cause of mortality in women. Pregnancy-related mortality in Missouri was 32 deaths per 100,000 live births—84% of which were determined to be preventable. Bootheel County had a higher than average number of premature or low birth weight babies compared to the state of Missouri, which was already among the top ten states with the worst birth outcomes. Approximately 60% of the county's pregnancies were covered by Medicaid. The county had not only experienced birthing unit closures, but also the closure of a large production plant in the county that resulted in more than 800 jobs being lost. With RMOMS funding, the county had been able to work closely with community partners to implement clinical care coordination, ultrasound and telehealth services, a closed-loop electronic resources and referral platform, a mapping of social determinants of health codes, and emergency childbirth training. These capabilities had helped the county offer resources and provide services to support healthy pregnancies—including addressing social drivers such as transportation and housing.

Rebecca Burger, R.N., B.S.N., CLC**, System Care Coordinator, Bootheel Perinatal Network (Missouri), RMOMS Awardee**

Ms. Rebecca Burger talked about the Bootheel Perinatal Network's effort to better understand the needs and stories of mothers through their You Matter! Your Voice Matters! campaign. This effort helped their understanding of mental and physical risk factors, as well as the social drivers

of health that were impacting the community. Ms. Berger explained the importance of words and their choice to use the phrase *local blessings* because of the negative connotation associated with the word *resources*. Another result of these engagement efforts was the purchase of ultrasound equipment, which was housed locally and enabled their participants to save more than 62,000 miles of transportation that would have been needed to obtain ultrasound in another county. Individuals not showing up for appointments were a common concern in the county, which improved more than 50% after setting up VPN telehealth services and transportation support. During the program, the county experienced an increase in the percentage of birthing individuals receiving prenatal care in the first trimester and a decrease in premature and low birth weight infants. Their community engagement also identified the need for an electronic resource and referral platform. In response, they created the Bootheel Resource Network, a community-led platform that not only supported the referral process, but also collected data that could track the services that clients obtained and the gaps they experienced when a referral was rejected. The closed-loop capability of the referral platform also allowed providers to coordinate referrals with case workers and between organizations. Ms. Burger said that they intended to expand their program and obtain more care coordination capacity.

***Kristen Zycherman, R.N., B.S.N.*, Quality Improvement Technical Director, Division of Quality and Health Outcomes, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services (CMS)**

Ms. Kristen Zycherman talked about the CMS Birthing-Friendly Hospital designation, which was a component of the CMS Maternity Care Action Plan that supported improving access to, and the quality of, maternity care. CMS began identifying Birthing Friendly hospitals and health systems in November 2023, and gave them a special icon on their Care Compare online tool. Care Compare allows users to filter their search by distance or other factors and compare more than one hospital at a time. The designation identified hospitals and health systems that participated in a statewide or national perinatal quality improvement collaborative program and implemented evidence-based care. The designation was not meant to be static. Instead, CMS would continue to collect data from hospitals to update Care Compare with eligible hospitals. In 2023, 66% of hospitals and health systems that reported to CMS had received the Birthing-Friendly designation. Ms. Zycherman said that CMS may add other qualifying measures in the future.

Title V MCH Services Block Grant: Program Enhancements for Advancing Equity and Accountability

***Keriann Uesugi, Ph.D., M.P.H.*, Division of State and Community Health, MCHB, HRSA**

Dr. Keriann Uesugi reviewed proposed enhancements to the MCHB Title V MCH Block Grant program for its next three-year guidance period. In addition to the three existing core guiding principles, MCHB proposed the addition of a principle focused on health equity and assurance that all maternal and child health populations achieve their full health potential. MCHB also proposed the addition and revision of measures in their Title V Performance Measure Framework. Under their National Outcome Measures, they proposed revising existing measures to remove those that were not truly outcome-based, adding mental health status measures, adding a sub-measure for women's health, and adding stillbirth rate as an outcome measure. Under the

National Performance Measures, they proposed organizing measures by domain of action; adding measures for social determinants of health, mental health, and reproductive health; and moving less frequently used measures to the Standardized Measure Set. Dr. Uesugi said that these proposed changes were developed in conversation with state partners, which identified the need to place less emphasis on clinical care and toward a more balanced approach.

There were fewer proposed changes to the Perinatal/Infant Health measures. The proposed changes included the ability to prepopulate measures with federally-available data, the use of birth certificate data and the National Survey of Children's Health for breastfeeding initiation, and the addition of social determinants of health measures (i.e., discrimination in perinatal care, food insecurity, and a housing related measure). Dr. Uesugi emphasized that states could also include measures to address state-specific priorities. Proposed changes to the Standardized Measure Set included measures that were formerly outcome measures, including revised questions related to drinking during pregnancy. In addition, MCHB proposed to require reporting of two Universal National Performance Measures—postpartum visit and medical home for children. The proposed guidance also provided states with the option to select a priority population for National Performance Measures to address health equity. Dr. Uesugi said that these changes were contingent on Office of Management and Budget (OMB) approval and that full implementation of these changes was expected to occur over the next two years (with most changes occurring in 2025, the Title V needs assessment year). She welcomed Committee members to read more on their resource page.

Preconception, Interconception, and Postpartum Health

Sarah Verbiest, Dr.P.H., M.S.W., M.P.H., Adjunct Assistant Professor, Department Of Maternal and Child Health, Gillings School of Public Health, University of North Carolina (UNC), Chapel Hill; Director, Jordan Institute for Families, UNC School of Social Work; Executive Director, Collaborative for Maternal and Infant Health, UNC School of Medicine

Dr. Sarah Verbiest said that the definition of preconception had shifted from a narrow focus on pre-pregnancy to a broader framework of equity-centered wellness—a shift that emphasized thriving and living your full potential over risk reduction before pregnancy. This message also incorporates a sense of health justice—acknowledging, for example, that the ability to reduce stress or control a sleep environment is not an option for all people. She talked about UNC's Show Your Love initiative which is a national campaign that seeks to reinforce the message that a person's health matters. The Show Your Love campaign considers the whole person, including life course (from menstrual care for adolescents to menopause care), social determinants of health, mental health, and substance use.

The Show Your Love initiative also engaged communities through surveys and national convenings to gather data about what matters to people of reproductive age. For instance, Dr. Verbiest and her team conducted a national panel survey with more than 2,000 participants of reproductive age. They found that 56% of participants experienced one or more chronic conditions, 79% felt it was important to talk to a provider about reproductive goals, and 25% did not know that pre-pregnancy health was important. The survey also revealed that participants wanted their provider to offer education about multiple mental and physical health concerns. Other community engagement findings included the need to be self-reliant, not feeling seen or

heard resulting in a lack of trust in the health care system, and the negative effects of discrimination on mental health.

Some of the opportunities for change Dr. Verbiest discussed included the need for comprehensive care clinics, care coordination, expanded insurance coverage, improved educational materials, improved provider training on trust-building and women's health care, increased research funding, sex and gender disaggregated data, de-siloed funding structures, and innovative models for care and reimbursement. Dr. Verbiest reviewed some of the federal initiatives that supported this shifting focus and emphasized the need for more support and funding.

Wrap-Up and Considerations

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

The Chair reminded Committee members to join one of the three workgroup sessions in Zoom breakout rooms at the start of the meeting tomorrow.

DAY TWO: Wednesday, December 6, 2023

The three ACIMM Workgroups (Systems Issues in Rural Health, Preconception/Interconception Health, and Social Determinants of Health/Social Drivers of Health) met in Breakout Sessions for an hour and a half at the start of Day 2.

Day 2 Welcome

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

The Chair welcomed Committee members back from their workgroup sessions and provided an overview of Day One. The Chair also introduced a new ex-officio member, Dr. Nima Sheth from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Workgroup Report Out

ACIMM Workgroup Leads/Co-Leads

Systems Issues in Rural Health

Dr. Kate Menard provided an overview of the Workgroup's discussion on rural health issues. The scope of their conversation also included the overarching issue of health disparities, particularly among Black birthing people. Workgroup members were interested in overlaying a map of maternity deserts with a map of maternal and infant mortality rates, as well as racial disparities across states. They were also interested in identifying literature on financing rural birthing facilities. An important point that was discussed was the lack of real-time information on hospital closures, which would be important for informing recommendations. There was also a need to define the term *birthing facility* and to identify gaps in services that resulted from closures. In particular, there was a need to understand the readiness and preparedness of communities to meet obstetric emergencies when there was a closure or a lack of obstetric units.

Finally, the Workgroup discussed the importance of intersectionality between race, income, and rural geography when developing recommendations such as financing care, supporting a rural workforce, and other potential recommendations for change. The Workgroup decided to spend the first 3-4 months earning about the key issues by inviting people to present on a monthly basis. After this initial learning period, the Workgroup planned to meet monthly to narrow their focus and identify potential recommendations.

Discussion

- A Committee member commented on the wealth of information that Dr. Julia Interrante had brought to the Workgroup, and added that the perspectives from family medicine that Dr. Julie Wood and Mr. Jeff Strickler brought to the Committee also had a significant impact on rural health.
  - The Chair added that state Offices of Rural Health received reports of hospital closures, which would be a good resource.
  - A Committee member recommended exploring credentialing standards for maternity care to support family physicians who wanted to provide maternity care. Often, certified nurse midwives had more flexibility and agency to deliver maternity care than family physicians with maternity care training.
  - Dr. Menard agreed that credentialing processes were important because there were disparities within and across states. Hospital credentialing could be very different and often was not logical in terms of requirements.
  - A Committee member said that family physicians did receive credit for providing maternity care in terms of the National Health Service Corps loan repayment program. However, it had become increasingly difficult for family physicians to receive loan forgiveness because it was difficult to justify or identify their work in the hospital as compared to their work in an ambulatory setting.
- Dr. Menard talked about the March of Dimes report on maternity care deserts and how it did not include family medicine. Analyzing billing codes for birth and prenatal care could identify the family physicians who provided obstetric care and those who did not, which could be a more accurate method than analyzing data such as licensing. It was important to consider the strengths and limitations of data sources.
  - A Committee member added that while HRSA might not be able to implement a direct recommendation about credentialling, it could put an emphasis on workforce funding to prepare providers for certain types of care.
  - The DFO suggested inviting HRSA's Bureau of Health Workforce to the Rural Health Workgroup.
  - The Chair also recommended inviting a representative to talk about CLAS standards, as well as a representative from the Office of Minority Health.

Preconception/Interconception Health

Dr. Joy Neyhart said that the Preconception/Interconception Workgroup identified two priority topics specific to Black birthing people: the impact of expanded Medicaid coverage for 12 weeks postpartum and the level of paid maternity leave that was needed to maintain postpartum health. The Workgroup decided to meet on the third Wednesday of each month from 2:00 to 3:00 PM ET.

Discussion

- A Committee member asked whether there was a conversation on birthing parents who identified as transgender or non-binary and implications to their care.
    - Dr. Neyhart answered that there had not been a specific conversation, but would welcome any specific suggestions that could be taken back to the Workgroup.
    - A Committee member suggested reaching out to national organizations focused on gay, lesbian, and transgender care in general, as well as for information on breast- and chest-feeding services.
    - A Committee member added that they had talked about inclusivity and priority populations including the use of gender neutral terms, transition-aged youth, women who were incarcerated, and women with disabilities. She suggested that it would be important to narrow down the scope of this broad range of priority populations.

Social Determinants of Health/Social Drivers of Health

Dr. Ramas reviewed the topics discussed by the Social Determinants of Health Workgroup, which included current frameworks being used to structure social determinants of health, the scalability of nonmedical interventions and resources that had support and funding from different departments, the ability to support an adequate workforce, and the need for a closed loop system of referrals to track and follow up with high-priority patients. Another topic was emerging areas of social determinants and drivers, such as stress and other emotional-psychological factors, environmental factors, public health crises such as the pandemic, and social isolation and the impact on continuity of care—the group discussed how these factors specifically affected Black birthing parents and their infants. The Workgroup also acknowledged the significant work being done on the drivers of infant mortality, particularly with sudden infant death syndrome (SIDS), low birth weight, and premature births, and they hoped to gather more information on these topics over the next few months. Finally, the Workgroup discussed the concept of payment reimbursement for nonmedical clinical supports and how it could create models of sustainability in support of social determinants of health. Specifically, the Workgroup would consider innovative insurance or fee structures. The Workgroup planned to meet every other month at 4:00 PM ET on the fourth Tuesdays of the month.

Discussion

- The Chair commented on the use of 1115 waivers in North Carolina as payment reimbursement for non-medical drivers, such as transportation, food insecurity, housing, and intimate partner violence.
    - Dr. Ramas talked about National CLAS (culturally- and linguistically-appropriate services) Standards, which had a robust program for maternal and infant care that provided CEUs.
    - A Committee member suggested inviting a CMS representative to present to the Committee on 1115 waivers and other innovative models.
    - An ex-officio member offered to find a CMS representative to provide that information.

Charter Updates

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

Ms. Vanessa Lee said that the Committee Charter had been renewed in September 2023 for another two years. There were two minor changes to the Charter: 1) meetings could be either virtual or in-person and 2) the federal ex-officio membership had been updated, which was done periodically, to reflect the Committee's current priorities.

Public Comment

***Vanessa Lee, M.P.H.*, DFO, ACIMM**

The DFO introduced three individuals who had requested to provide oral public comments.

Emily Price

Ms. Emily Price, CEO of Healthy Birth Day, Inc., thanked HRSA for their inclusion of stillbirth as a Title V MCH Program national outcome measure. Her organization was founded 15 years ago and was known for their creation of the Count the Kicks stillbirth prevention program. One in 175 pregnancies ended in stillbirth in the U.S., but that number was 1 in 97 among Black families. She called for continued efforts to elevate stillbirth in the discussions to improve maternal health and birth outcomes, and highlighted ACOG's recent newsletter featuring a study on stillbirth and its association with increased risk of severe maternal morbidity. She also called for the same urgency, prevention awareness, and level of funding dedicated to stillbirth as other issues related to maternal and infant mortality. Ms. Price reviewed the Count the Kicks initiative, which raised awareness about the importance of paying attention to a baby's movements in the third trimester. She invited Committee members to order their prevention materials.

Joia Crear Perry

Dr. Joia Crear Perry is CEO of the National Birth Equity Collaborative. She highlighted several Committee priorities and offered suggestions such as viewing the Committee recommendations as a roadmap for a potentially new HHS Secretary in 2025, including birth center and home births when addressing rural maternal health, shifting Committee language toward reproductive wellbeing as suggested by Dr. Verbiest, and the importance of inclusive and appropriate language when addressing the social determinants of health.

Amy Stiffarm

Dr. Amy Stiffarm is a descendent of the Chippewa Cree and Blackfeet Tribes of Montana and the Native American Initiatives Program Manager at Healthy Mothers, Healthy Babies: the Montana Coalition. Dr. Stiffarm emphasized the importance of the Committee's *Making Amends* report, which she had cited in her dissertation and spoke about during several presentations across different groups. She specifically pointed out the recommendation about data surveillance and the importance of working with tribal communities to include indigenous perspectives. For example, words used in Pregnancy Risk Assessment Monitoring System (PRAMS) could be very different than words used in tribal communities. It would therefore be very important to support Tribal PRAMS efforts to help tribal communities collect data. It was also important to recognize that Montana did not have many local community-based organizations, which was often a requirement for grant funding. Dr. Stiffarm added that their communities needed support for training indigenous doulas and for reclaiming their birth support so that families did not have to leave the reservation to give birth and or to seek prenatal care. Finally, she highlighted that there

were no AI/AN people on the Committee and that it was necessary recognize that coming from a perspective of saviorism only added to the perception that there was something wrong with Native communities. Rather, the highlight should be on the strengths and protective factors prevalent in Native America culture.

Discussion

- An ex-officio member asked what barriers existed for states to expand Medicaid coverage for Certified Professional Midwives (CPMs), which was an optional benefit.
  - Dr. Crear Perry answered that some states did not separate CPMs from nurse midwives and used standard language for all midwives. Other states prioritized the use of nurse midwives, which resulted in the inability for CPMs to be added to their Medicaid.
- A Committee member agreed with Ms. Price about the need to prioritize stillbirth and highlighted current efforts, such as Wellcome Leap's research on fetal status and a Washington University effort to understand placental function and its relationship with stillbirth. He pointed out that the number of fetuses lost due to stillbirth (after 20 weeks) was greater than the numbers in maternal and infant mortality.
- The Chair invited Ms. Price to present more about Count the Kicks to the Committee.
- An ex-officio member talked about the NICHD Interagency Stillbirth Working Group, which recently published a request for information on strategies for stillbirth prevention and a Fetal Monitoring Challenge grant. NICHD was also working with CDC to increase the availability of data related to stillbirth.
- Dr. Ada Dieke thanked Dr. Stiffarm for her recommendations on Tribal PRAMS.
- The Chair said that HRSA was in the process of reviewing new Committee appointments and that she hoped there would be at least one AI/AN representative.

Meeting Evaluation and Closing Observations

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

The Chair reflected on the presentations over the last two days and opened the floor for Committee members to discuss framing their recommendations in terms of some of the best practices shared by The FrameWorks Institute.

- A Committee member suggested engaging The FrameWorks Institute while the Committee wrote their recommendations. In particular, there should be thought toward language about risk-appropriate care and levels of care within the context of closing rural hospitals.
- A Committee member talked about the challenge of crafting clear messages across diverse groups while ensuring that the language conveyed respect for women's rights and their autonomy.

The Chair discussed the dates and locations of the 2024 Committee meetings. The April 2024 meeting will be in person in St. Louis, Missouri. The June 2024 meeting would likely be at HRSA Headquarters Rockville, Maryland.

Adjourn

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

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