Advisory Committee

on Infant and Maternal Mortality

Virtual Meeting

12:00 p.m. until 6:00 p.m.
Tuesday, December 5, 2023

Health Resources & Services
Administration (HRSA)

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P R O C E E D I N G S

Welcome and Call to Order

MS. VANESSA LEE: Hello, everyone. Welcome. This is a meeting of our Advisory Committee on Infant and Maternal Mortality, and I'd like to now call the meeting to order.

I'm Vanessa Lee, and I'm the Designated Federal Official for the Committee, which is administered by HRSA, the Health Resources and Services Administration. I work specifically in HRSA's Maternal and Child Health Bureau.

It's so good to be with you all, as we've not met since June. I want to welcome, first, our appointed Committee members, our federal ex-officio members, our wonderful Committee Chair, Ms. Belinda Pettiford, and hello to members of the public who have dialed in to observe the Committee meeting. Thank you, again, to all of you for being here. I know we have a lot to cover in the next two days, so I'm just going to turn it right over to our Committee Chair, Ms. Belinda Pettiford. Belinda?

MS. PETTIFORD: Thank you so very much, Vanessa, and welcome everyone. Thank you all so very much for joining our Secretary's Advisory Committee on Infant and Maternal Mortality meeting today. I know many of you were looking forward to us meeting in person, but it is still good to be together in this

virtual land.

I have heard from some that are running a little bit late this morning and some that are having some conflicts with other meetings, but we will proceed, either way, but again, it is so good to see so very many of you all and thank you always for your time and your expertise.

We have a pretty full agenda today, as well as tomorrow. If you will look at your agenda, you will see that we will have some updates. It's always nice to get our federal updates. We also have some very specific time where we're going to talk about some of the last round of recommendations where we were prioritizing American Indian and Native Alaskan challenges, so we wanted to make sure we have time for that.

We'll get to hear from some former SACIM members, as well as some of our current ex-officio members. We're going to also further delve into a couple of key areas. We want to spend some time looking at the infant mortality data, the provisional data that has been released for 2022.

We have a standing item on our agenda to talk about the Federal Healthy Start Program because we are the advisory group for that program as well, so we want to make sure that that also is on our agenda.

We will also spend some time always making sure that the community voice is heard, so we're very excited to have Heather

Pawlik with us today as our community voice for this meeting and look forward to being able to spend some time with her.

We have several other partners that will be joining with us to share some of the work they're doing around infant and maternal mortality, and then we will have, today, some time with the Frameworks Institute so we can talk a little bit about the framing of the work, and then we will move into some areas that are directly connected to our workgroups.

We have three workgroups currently. One related to social determinants of health, or those social drivers of health, or those non-medical drivers. We also have a workgroup focused on rural health, so the conversation today will include some of that information, as well as a workgroup on preconception and interoception health.

So, we want to elevate those three workgroups and we will spend time tomorrow meeting with those workgroups and letting others join the workgroups that are interested in being subject matter experts and strong interests. And as we focus on those workgroups, this go around we are elevating the challenges that have really been experienced by African American and Black communities.

So, as we proceed, next on the agenda, we get to do some introductions, so as for introducing ourselves, I'm going to first ask the appointed Members. I will call on you to introduce

yourselves, and then I will definitely ask the ex-officio members to please introduce yourselves.

As you're preparing to introduce yourselves, I ask that you will give your name, your role, where you're from, but this is December, so this holiday season, so if you can share one family tradition that your family participates in on the holiday or one thing that you enjoy about the holiday season. I'll give you an option, so whichever one you prefer.

And I will start. I am Belinda Pettiford. I am in the State of North Carolina. I serve as the Section Chief for Women, Infant, and Community Wellness within our State Title V Program and I guess our claim to fame is that on December 1st, this past Friday, we had Medicaid Expansion go into effect in North Carolina, so we are beyond overjoyed here in our state that we'll have the opportunity to provide insurance coverage for over 600,000 individuals that live in our state.

So, our holiday tradition is my 90 year--old mother lives with me, so everyone comes to us. I don't have to travel. Everyone comes. You never know how many are going to show up, but they come. But no matter what we do, when we gather for our blessing, we make sure that every person, no matter what age they are, if they can speak, they have to share one thing that they feel fortunate to have experienced during the year or one blessing that's in their life.

And then, one of my great great nieces always leads us in my grandmother's favorite song, which is Go Tell It on the Mountain. So, that was my grandmother's claim. She kept that tradition in our family, and we have passed it on to two generations after me to make sure that that same song is sung before anyone can eat anything. So, I'm going to now pass it to Steve.

DR. CALVIN: Hello, I'm Steve Calvin. I am a maternal fetal medicine specialist physician here in Minneapolis, and I am a proud member of a group that's run by midwives, so I am a midwife advocate.

And the Christmas tradition that I can share: I come from kind of a Scandinavian background and my grandfather was born in 1905 and is long gone. He loved lutefisk and I don't know if any of you know what lutefisk is, but it's basically cod soaked in lye. It's like eating kind of a jelly sponge, and we used to joke that the way to cook lutefisk is you bake it for two or three hours on a tar shingle, and then you throw the lutefisk away and eat the tar shingle. So, we don't eat it here. We eat baked cod and that's much better and lefse, which is a potato pancake. And I enjoy that with. My wife and I have 11 grandchildren. Our three children have been quite busy, so that's our tradition.

MS. PETTIFORD: Thank you so very much, Steve. Now, we'll go to Phyllis.

DR. SHARPS: Good morning, everyone. I'm Phyllis Sharps. I am a maternal and child health nurse and professor emerita of Johns Hopkins University School of Nursing. And I think our family tradition is the baking in preparation for the holidays. And it started with me as a granddaughter from my grandmother and then my mother picked up the tradition and now, I'm the grandmother, so I pick up the tradition with my granddaughters.

We start a couple weeks before Christmas, and sometimes we don't have any cookies by Christmas, but it's fun.

MS. PETTIFORD: Thank you so much, Phyllis. Now, we'll go to Joy.

DR. NEYHART: Good morning. I'm coming to you from Montana. I am a board-certified pediatrician, who's been practicing for over 20 something years in Alaska. I currently work for Tribal Health at the Southeast Alaska Regional Health Consortium.

And let's see, my favorite thing about the holidays is seeing my family together and all the cookies, but I can completely relate to the lutefisk and lefse, given that I married into a Scandinavian family.

MS. PETTIFORD: Thank you, Joy. Sherri?

DR. ALDERMEN: Good morning, everyone. My name is Sherri Aldermen. I am currently in Portland, Oregon, and I am, by

training, a developmental behavioral pediatrician and currently working with Zero to Three national organization.

My favorite aspect of this holiday season is a cookie exchange that I began organizing. This is now the ninth annual year here in Oregon and about three more years tagged onto to that where it originated when I was living in Albuquerque, New Mexico, after a house fire and all of the incredible warmth and generosity that the neighbors provided. When we got back into our house, I wanted to give back and started this tradition of cookie exchange, and it has grown, continued in Albuquerque since I left.

And I carried the concept with me to Oregon when I moved here and now, we have two places in Oregon, so we have two cookie exchanges and the neighbors, family, and friends come each year and share their favorite cookie recipe and just have a warm and fun time together.

MS. PETTIFORD: Thank you, Sherri. ShaRhonda?

MS. THOMPSON: Hello. My name is ShaRhonda Thompson. I'm from St. Louis, Missouri, and I represent the community voice on this Committee, and one thing I love to do is represent the community.

For my family, for Christmas, we do a nacho/taco bar on Christmas Eve and a hot cocoa bar. And this year we're adding a dessert bar, so we're going to have brownies and ice cream and all the toppings for those. Then we usually watch movies. We're

having a cookie decorating contest and an ornament painting contest this year, so we'll have all of the messy fun as we're watching movies and eating and listening to music and everything.

MS. PETTIFORD: Thank you so much, ShaRhonda. You're going to have us wanting to all come to St. Louis for the holidays. Okay, I'm trying to make sure I haven't left off anyone. Kate?

DR. MENARD: Good morning, all. Kate Menard. I am based at the University of North Carolina in Chapel Hill. And we're talking about our favorite Christmas traditions, right?

I think one of the things that I love to do is I love to go Christmas caroling, so I grew up where it was a little bit colder, but we still put on our warm hats, put some cookies in hand, and go around Christmas caroling with my daughters. They used to call us when we were younger the Menard Family Singers because six kids, we could all sing in harmony, but my kids aren't quite as good at that, but we work at it anyway. We have fun with it anyway.

MS. PETTIFORD: Thank you, Kate. Marie?

DR. RAMAS: Hi, everybody. My name is Marie Ramas. I am a family physician and work in New Hampshire with an accountable care organization and also with the Academy of Family Physicians.

My Christmas tradition is, one, I still have younger

kids, so every year we make handmade Christmas gifts for all of their 20 some odd teachers and each child from ages sixteen to eight are required to hand deliver their Christmas handmade gift to each of their teachers, to the teenagers' chagrin. And they also have to write a handwritten thank you note to their teachers.

We also have in my culture; we have a liqueur that we make that's coconut milk based. It's called cremas, and I usually make a batch of that and provide a batch of holiday liqueur for all of our friends and neighbors, and so, we love Christmas in my household.

MS. PETTIFORD: Thank you so much, Marie. I don't see Jacob, but I want to make sure I haven't overlooked him. So, Jacob, if you are there, I don't see you. So, that is the appointed members.

I do need to share with the group that Tara Sanders Lee, she has resigned from being a member of the Secretary's Advisory Committee on Infant and Maternal Mortality. She did send a nice note, so I just wanted you all to know that she was thinking of us, but at this time has she has decided not to continue with the Advisory Committee.

At this point, though, I want to make sure we recognize and have our appointed members, give them the opportunities to also say hello and share their holiday greeting.

As we start, though, I would like to recognize our

newest ex-officio member, Dr. Felicia Collins. So, Dr. Felicia Collins is Rear Admiral in the Commission Corps of the U.S. Public Service. She is the new ex-officio member representing the HHS Office of Minority Health. In this role, she's the Director and Deputy Assistant Director for Minority Health. So, please join me in welcoming Rear Admiral Collins to the meeting today. And as she is getting ready to share her holiday traditions and does a more formal introduction, we definitely want to thank Dr. Yanique Edmond for her time. She has been serving with us the last two years and really appreciate everything that Yanique brought to the table and make sure that we'll stay connected to her some kind of way down the road. Dr. Collins, turning it over to you.

DR. COLLINS: Well, good day everyone. Again, my name is Rear Admiral Felicia Collins. I have the honor of serving as the Deputy Assistant Security for Minority Health within the Department of Health and Human Services and the Director of the Office of Minority Health within the Office of the Secretary.

I'm a pediatrician by training, so an issue that's very near and dear to my heart, but I often call myself a public health practitioner at heart and really have been honored to have the opportunity to serve in public health spaces, thinking about underserved and vulnerable populations for my entire career.

And I think for my holiday tradition, it's a newer one, but one that we're excited about is that we now have a particular

movie that we watch every year, and it's a movie called The Christmas Candle. And so, it's a really nice movie that showcases hope and community and all of the goodness that the season has for us. So, thank you for the warm welcome, Belinda, and it's really a pleasure to be able to join the group.

MS. PETTIFORD: Thank you so much, as I'm jotting down the name of that movie because we're a movie-watching family as well. So, thank you so much.

So, I'll turn it over to Danielle, if you'll introduce yourself.

DR. ELY: Belinda, thank you. My name is Danielle Ely, and I am the manager for the Linked Birth and Infant Death File at the National Center for Health Statistics within the Division of Vital Statistics, so we’re under the branch of CDC and HHS, overall.

A holiday tradition that we have that’s more recent since we moved a few years ago, is we have someone in the neighborhood who is one of those people who puts up an outrageous amount of lights on their house, and it’s actually on Google Maps as a destination, their home is. And so, every year we walk the two and a half blocks over to their house. They have an entire light display, and it’s set up with music and so we like to go over there, and they give out hot cocoa and free popcorn and so we check that out every year.

MS. PETTIFORD: Wow, we'll have to look them up. Thank you. Go onto Alicka. We're going to come back to you, Alicka, and we'll let you work on your sound. Why don't now we go to Wendy?

DR. DECOURCEY: I'm Wendy DeCourcey. I'm from the Administration for Children and Families, which is under HHS and our office is involved in a wide range of services for children and families at risk, so that includes TANF and Child Support Children's Bureau, Office of Head Start, Office of Childcare, and my particular office is the Office of Planning, Research, and Evaluation, which works on evaluating all those efforts. So, I look forward to this year's activities and the next actions of this Committee.

I, as a holiday tradition or a winter tradition, I would say we've gone sort of from zero to 50 on our light shows, and we plan it months ahead now and are strategically thinking about we will tweak our light show, and it's very elegant, I assure you, and then we give away half of it to the neighbors because I know we're not doing those lights anymore, so that's been a sort of a fun, new game, honestly, for the holiday season. And I think we've talked our neighbors into a lot more lights too, so we've changed the neighborhood a little bit.

MS. PETTIFORD: Competition. Thank you, Wendy.

DR. DECOURCEY: Exactly.

MS. PETTIFORD: Okay, we'll now go to Karen.

DR. REMLEY: Happy Holidays, everybody. I'm Karen Remley, and I'm the Director of the National Center on Birth Defects and Developmental Disabilities. I'm very happy to be with you.

And I would say your holiday tradition, which is three generations now, is my mother and father had a village they put under tree which maybe had 10 houses. We're up to over 100, many that have been gifted to me from people around the world. I have houses from Cuba, houses from Nigeria, houses from Greece, houses from Eritrea, and we have lots of people from lots of different places too, and so, we start every Christmas with, we think, somehow in the middle of the year those people that are in boxes their heads break off, their arms break off. We march them all in front of the hospital we have with a glue gun and spend a day with clinic putting everybody back together again, but our big push is that it doesn't really matter how young you are or how old you are, if you can get down on the floor, you can play with the village and tell any story you want to tell. Thank you.

MS. PETTIFORD: Wonderful. I just started collecting houses a couple of years ago. I am nowhere near 100, so thank you for sharing.

DR. REMLEY: Belinda, we should talk. I have an aircraft carrier and the Niña, the Pinta, and the Santa Maria and

pirates, so I can give you things you'll never even imagine.

MS. PETTIFORD: Wonderful. Thank you. We will chat. We'll go now to Caroline.

DR. DUNN: Hi, everyone. My name is Caroline Dunn, and I am coming to you guys from USDA where I work in the Food and Nutrition Services in our Office of Policy Support where I primarily work with the WIC program or our Special Supplemental Nutrition Program for Women, Infants, and Children, which serves families with children through age five, if they qualify.

I'm so happy to be here and also will share my Christmas tradition. So, every year Santa Claus writes us a poem about what's in our stockings. And every Christmas morning we read the poem and the person who has that stanza opens their stocking in front of everyone and kind of reveals the fun gift that Santa gave them that year, so always a fun tradition. A few years ago, my sister and I put together binders that have poems going back through my grandparents and gave them to all of our cousins, so everybody has a copy now.

MS. PETTIFORD: Wonderful. Now, we're going to go to Dorothy, and we may come back to Dorothy. Kristin.

MS. ZYCHERMAN: Hi. I apologize. I'm a little bit under the weather today, but I did not want to miss this meeting, but I might remain off camera for the majority of the meeting, but I am listening and engaged because I look forward to this meeting

every time we have it.

I am Kristen Zycherman from the Centers for Medicare and Medicaid Services and the Division of Quality in Health Outcomes. I lead the Medicaid Maternal and Infant Health Initiative.

And I'm Jewish, so we have a Hanukkah tradition. I have two young children and we pick one night of Hanukkah, it's usually around the seventh night of Hanukkah, and instead of receiving a gift, the kids, when they were younger, they usually picked out a toy and we'd find like a Toys for Tots to donate it to.

Now that they're a little bit older, we let them pick a charitable organization and we make a donation to it, but to try to get them in the spirit of giving and not just receiving, so that's our Hanukkah tradition.

MS. PETTIFORD: Wonderful. What a wonderful tradition. Alicka, we're going to try you again with your sound.

MS. AMPRY-SAMUEL: Hopefully, you can hear me now.

MS. PETTIFORD: We can. Thank you.

MS. AMPRY-SAMUEL: I'm Alicka Ampry-Samuel and I serve as the regional administrator here in Region II, New York and New Jersey. I'm currently in Manhattan, New York. And I don't really have holiday family traditions because my family is kind of unique. We bounce around the world every year. I never know where we're going to end and so for the first time since 1999, we are all in one household together, and so this is a new tradition for

us just being able to enjoy family for the first time in many years, so folks are coming to our home in New York.

MS. PETTIFORD: Well, that'll be nice. Wonderful. And I need to apologize to Gayle because Gayle this is your first meeting as well, so we have another ex-officio member. We've got Gayle Goldin with us, and Gayle is the Division Director for the Women's Bureau within the Department of Labor, so Gayle, why don't you come up and introduce yourself and share your holiday activities.

MS. GOLDIN: Thank you, Belinda. So, it's so nice to meet all of you. I'm the Deputy Director of the Women's Bureau, and we're on the agenda to give a little bit more background about what we do, so I'll wait until that to give you the overview, but I'm happy to be here and share this information with you and join as ex-officio to the Committee.

And I'm also Jewish and don't really have family traditions around holidays, but do have, as we know that the definition of family includes our close friends. I have for probably 17 years or so hosted a New Year's Eve potluck for our friends and some of those in the past couple of years have been outside by a bonfire, but we've managed to pull it off, so that is what we enjoy doing.

MS. PETTIFORD: Thank you so much, and welcome, Gayle. Thank you. Tina?

DR. PATTARA-LAU: Hello, everyone. I'm Tina Pattara-Lau, maternal child health consultant for the Indian Health Services at Headquarters with the Office of Clinical and Preventive Services. I'm an OB/GYN by training. I've been providing care to American Indian and Alaskan Native Communities for the Phoenix area for the last eight years.

Our holiday tradition actually started with our small kids, who really wanted a tree, so they would pick one out around their size, their height, that they could decorate. This was, of course, easier to transport and leave a smaller footprint when we took it to recycle.

But unfortunately, they are getting taller, so this year the tree had to go on top of the car, and we had to navigate that. Thank you and I'm happy to be here today.

MS. PETTIFORD: Thank you, Tina. Thank you for coming and being with us. Alison?

MS. CERNICH: Hi, everyone. I'm Alison Cernich. I'm the Deputy Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development, and excited to join the meeting, as usual.

Our holiday tradition is generally the Christmas tree, but we do ornaments, and we have ornaments for every year. We have ornaments from when I was a kid, dating back to the 1900s, as the kids are saying now, and then up to this year. And we have

ornaments that match things that happened in our lives or the kids' hobbies, and then we also have each year we add something to a nativity scene, so now we have something like, I don't know, 60 characters or something hilarious that we can't even fit anymore. And so, each of our kids when they move out and have their homes, we'll have a whole set of ornaments and a whole set of nativity figures to take them, and I will get rid of large boxes of things.

MS. PETTIFORD: Thank you, Alison. Have I left off any ex-officio members? I was trying to take notes as I was going, but I do want to make sure—apologies, I want to get to Dr. Warren, Michael Warren, if you would come on and say hello.

DR. WARREN: Sure. Good morning, good afternoon, folks. Michael Warren, the Associate Administrator for the Maternal and Child Health Bureau here at HRSA. Excited, as always, to be with you all.

My holiday tradition is similar to what Dr. Cernich just shared, so decorating the tree or tress, plural, has always been a big family affair, and I have accumulated ornaments through the years, so I have some of my, for example, maternal grandmother's ornaments dating back to the forties and collect ornaments when traveling and through various events, so it's always fun this time of year to put those on and sort of reflect back on where those came from and experiences where those ornaments were acquired and think about all those good memories, so excited to be with you all

today.

MS. PETTIFORD: Thank you so much, Michael. Lee, would you come on and share with us?

MR. WILSON: Sure. Good afternoon, folks, and good morning to those in the west. My name is Lee Wilson. I direct the Division of Healthy Start and Perinatal Services.

And for me, one of the longstanding traditions that my family and my people have, I am of Polish origin, and we have a tradition on Christmas Eve, which is called Wigilia, or breaking bread, which is a small square wafer, very similar to, if you're Catholic, a communion toast. And everyone moves around the room and goes to each individual and makes a wish of them that they would like to see fulfilled in the coming year. The person breaks off that piece of bread and then eats it with the idea that that might become real for them in the coming year. And as I have matured as an adult, I find it less intimidating to do and actually a very nice way of opening up and sharing with the people that we spend our holiday with, so that's my tradition. Thank you.

MS. PETTIFORD: Thank you, Lee. I think I omitted, Ada, I see you there. And if I have mispronounced your name, dear, let me go ahead and apologize from the beginning.

DR. DIEKE: That's okay. My name is Ada Dieke. Hi, everyone. I'm standing in for Dr. Charlan Kroelinger and she's

the ex-officio member representing the CDC, the Centers for Disease Control. We're in the Centers for Disease Control in the Division of Reproductive Health. I serve as the health equity lead and am happy to represent our division today.

In terms of Christmas traditions, my family does a lot of different things, so we eat lots of delicious foods, we gather to play games, we look through photo albums of our Nigerian family members and make sure that we get in episodes of Family Feud. Nice to be here with everyone. Thank you.

MS. PETTIFORD: Thank you so much for joining us. And Dorothy, we're going to try you again.

DR. KILNER: This is Deb Kilner. Dorothy Fink is in another meeting and she's running late, so we might want to skip her if you're looking for her to join.

MS. PETTIFORD: Okay, we will come back to her later. And please know that we have two wonderful individuals that are doing tons of work behind the scenes, and I do want them to introduce themselves. You've already heard from Vanessa, so Vanessa, if you will go first; want to share about your holiday traditions.

MS. LEE: Thank you. And it's so good to be with you all. Sarah and I've been saying we're so excited by these holiday traditions, and for me, personally, it's really getting me in the holiday spirit.

We're similar on my dad's side of the family had their tradition of celebrating on Christmas Eve, actually, so every Christmas Eve my whole life--my dad is one of six kids, so it's about 30 of us that all gather. We actually, ironically, order Chinese takeout and just have a lot of Chinese food and play games. When the kids were younger and my cousins were younger, we would sing carols, and it's just fun. And then, at midnight, we were finally allowed to open our gifts, so it's a long and late evening on Christmas Eve.

MS. PETTIFORD: Thank you, Vanessa. And Sarah?

MS. MEYERHOLZ: Hi, everybody. My name is Sarah Meyerholz. I work with Vanessa as the Program Lead for ACIMM and I'm a project officer in MCHB's Division of Healthy Start and Perinatal Services.

If you can't tell by my last name, I'm very German, so we are very German tradition based and tonight is St. Nicholas Eve, so make sure you leave your shoes out. You might get candy if you're good. You'll get coal if you're bad. So, that's our favorite holiday tradition. And Belinda, I will pass it back to you.

MS. PETTIFORD: Thank you, Sarah. And so, thank you everyone for taking the time to introduce yourselves. Now, we're going to go into review and approval of the minutes. The minutes were in the briefing book that came out earlier, so if we can get

a motion from someone to approve the minutes, I would appreciate it.

DR. RAMAS: This is Marie, so moved.

MS. PETTIFORD: Thank you, Marie. Do we have a second?

DR. MENARD: I'll second, Kate.

MS. PETTIFORD: Thank you, Kate. Those in favor of this motion if you will say aye.

(Chorus of ayes)

MS. PETTIFORD: Any opposers likewise?

(No response)

Federal Updates

MS. PETTIFORD: The minutes are approved. Excellent. So, we're going to go on now. We're going to continue on with our agenda. We have several federal updates. We're pleased to have with us today, Dr. Michael Warren, the Associate Administrator for the Maternal Child Health Bureau. He will provide updates.

Shortly after that, we have Alicka Ampry-Samuel. She's the Regional Administrator for Region II, so she's the administrator there in Region II, so she will provide updates for Region II. Then we have Gayle Goldin with us, who will provide us from the Women's Bureau at the Department of Labor. So, we're just going to turn it over. We're going to hold questions until the end because I want to make sure all of them can get through

their presentations, and so I'll turn it over to you, Michael.

DR. WARREN: Thank you, Belinda. It's good to connect with you and provide just a few updates. It has been a busy few months. As you all know, we finish our federal fiscal year at the end of September every year. And as we moved into September of 2023, we made a number of grant awards. At the HRSA level over $90 million in awards went out to communities to support improving maternal health and all of these align with the Administration's blueprint to improve maternal health and eliminate maternal health disparities in this country.

So, just a snapshot of those that came from the Maternal and Child Health Bureau, we expanded the number of states that got state grants for the State Maternal Health Innovation Program. We're now up to 35 states. These funded states, in varying amounts, depending on the birth volume, between one and two million dollars per year, and support those states.

It can be in a State Maternal Health Taskforce to gather available data, including data from maternal mortality review committees and other sources and implement innovative activities in response to that state's particular drivers of maternal morbidity and mortality. So, we're excited to keep expanding the number of states that have those resources.

We awarded 10 new Healthy Start grants. There was specific language in the Fiscal Year '23 budget for us to do

enhancement grants to communities to be able, in particular, to address those drivers of inequities in infant mortality and excess infant deaths, and so we were excited to expand the reach. We're now in 111 communities, and I'll show you a map of that in just a moment.

We launched the first Minority Serving Institution Research Collaborative. This was legislation that started in Momnibus and was passed just part of the most recent budget. We now have 16 individual research centers, many of them are HBCUs or Tribal colleges and universities, and then we have a national coordinating center that is led by Morgan State.

Those institutions are going to be working together to look at community-level solutions to maternal morbidity and mortality and also strategies for addressing disparities.

We made five awards for Integrated Maternal Health Services Program. These are looking at innovative models of care or expanding models that are promising, like pregnancy medical home approach. We expanded our AIM Programs, so for the first time ever we've made AIM State Capacity awards. We made 28 awards to states to be able to provide state specific resources, $200,000 each to be able to spread and scale AIM, so increasing the number of birthing facilities within a particular state that are implementing AIM and supporting Bundle Implementation and Sustainment.

We also expanded our Screening and Treatment for Maternal Mental Health and Substance Use Disorder Program. This is the Maternal Mental Health Tele-Consultation Program that supports primary care providers to be able to access tele-consultation services. We were originally in seven states. We were able to grow that to 12 states with the most recent funding increase from the Congress.

And then, as part of the reauthorization of the Home Visiting Program last year, we awarded a National Workforce Center for Home Visiting and that was $4.5 million and so that is getting started up as well. So, really excited to see the number of new programs that are there, but also expansion of existing programs moving forward.

As you'll see on the next slide, we included the map. I know we're going to hear an update on Healthy Start later. The states that are shaded in blue have an existing Healthy Start site or sites, plural, in some of those states. And then, those yellow dots represent the new additions through the Healthy Start Enhanced awards and those are the ones that we made at the end of September.

We do have a number of funding opportunities that are open. As you'll see on the first slide, the first two are closing very soon, so this is the time when Healthy Start Program recompetes, so the large cohort of 101 grantees or 101 grants

those are up for recompetition. Those applications are due December 15th. And I want to give a shout out to the team who did such an amazing job of developing this latest round of funding opportunity.

They did extensive stakeholder engagement over the last few years to understand what is that communities need to be able to support Healthy Start and to be able to address infant and maternal health outcomes at the community level. We are anxiously awaiting those applications, which will come in, in about another 10 days, and we will be excited to award those in the spring.

We're also recompeting the Healthy Start TA Center, as seen here as the Supporting Healthy Start Performance Project and that application is due at the end of December. Those applications, I should say, and we'll make one award also in the spring.

We also have an open funding opportunity for our newborn screening program, so a couple of years ago we made the move to provide more support to states to be able to address newborn screening systems priorities in those particular states and jurisdictions. This is another round of that funding, and we anticipate making 10 awards up to $500,000 each, depending on the size and birth volume of the state.

So, those are all things that are open. We have a number of things that are forecasted. As you all know, we're still in a

continuing resolution and so all of this is contingent on the final appropriation, but we'll have another round of the State Maternal Health Innovation awards. So, there were some of the cohorts that competed back in 2018 or '19, those are up for re-competition. We anticipate making 12 awards.

Our Supporting Fetal Alcohol Spectrum Disorders Screening and Intervention Program will be recompeting. We anticipate making one award. We will be recompeting our Maternal and Child Health Policy Innovation Program. This is a program that engages organizations that help us reach various constituencies like state legislatures and governors' offices and state public health officials to be able to implement maternal and child health policy innovations.

We will also be recompeting the TA Center for the Maternal Health Innovation Program. That's the Supporting Maternal Health Innovation item you see, and then we will be releasing the funding opportunity for both the base and matching grants for the Home Visiting Program.

You can see the estimated posting dates there. This is subject to those funding opportunities being cleared and, of course, the final appropriation. I will say on that last one, the Maternal and Infant Early Childhood and Visiting Program really excited that with the recent reauthorization by Congress, there was the inclusion of additional funding.

Basically, the program doubles in funding over five years and much of that is in this category of matching grants. This will be the first time that states will have the opportunity to be able to expand and it's a one-to-three federal match. So, for every one dollar that states are able to provide, we will provide three dollars in match. Those can be state funds, those can be local or philanthropic funds, any kind funds. They just can't be other federal funds, but that's a good one to three match, and we're excited about that as an opportunity for states to be able to grow.

Next slide, lastly, just want to remind folks about our National Maternal Mental Health Hotline. We're about a year and a half into the operation of the Hotline. I'm not sure why those bars are showing up across your slide or maybe that's just on my screen, but just as a reminder, the number is 833-TLC-MAMA. The line is available 24/7 via phone or text.

As I mentioned, we're up to about 23,000 calls to date. One of the things in particular I'd like to ask this Committee to do is help us to promote the hotline through your networks, so we've been doing a lot of engagement, for example, with national level hospital associations and large groups that have large catchment areas and members to be able to get the word out.

The QR code that’s here, if you scan that with your phone and to that website, you can actually order promotional

materials, so wallet cards, flyers, magnets, posters, those are free, and we will actually drop ship them to you or to anybody else who asks. So, if you've got the opportunity to distribute those in clinical settings, in community-based organizations. I just heard last week from somebody who was doing a lot of engagement through faith-based organizations.

Whatever your pathway is and the opportunities to disseminate these materials, we would appreciate you doing so and encourage you to do so and happy to support through providing these free materials.

That's it for my update. I'll have the opportunity to talk with you a little bit later, but with that, I will wrap up and pass it along to my colleagues.

MS. PETTIFORD: Thank you so much, Dr. Warren, and we go on now to Alicka to get an update on the Department of Housing and Urban Development.

MS. AMPRY-SAMUEL: Well, good afternoon, everyone. I just want to say quickly, back in June this Committee heard from my colleague, Veronica Helms, during the discussion of social determinates of health focus and the impact of housing on birth outcomes and Veronica's presentation provided an overall briefing about the work we do at HUD with a focus on health, but my representation today provides a specific focus on maternal child health within HUD's Field Policy and Management team, known, as

FPM and our charter initiative called MOTHER, which stands for Maternal Outcomes Through Housing Environments Reimagined and I'll go into detail about that in a moment, but first let me explain why. Why is HUD focused on maternal health?

So, we all know the statistics. The United States is facing a crisis of maternal health. Data shows that the United States maternal mortality rate is more than three times the rate in other countries. On top of that, the rate for Native American and Black women is two and three times higher than that of white women.

So, the chart that you see here compares rates of maternal mortality of the United States and some other countries. So, that first column is the Netherlands, which shows the smallest column is the smallest maternal deaths from pregnancy or birth. The second to last column is the United States. And the very last column, which is the highest column, is Black women in the United States.

So, this is a picture of Tori Bowie, who earned three medals in the Olympics and died due to complications of pregnancy just in April of this year, which has put a very public focus on this issue.

So, these are the stats and there's a national discussion around what we can do to change the numbers and what we should do to change the numbers. But before we even go there, I

just wanted to quickly acknowledge that there's a real need to build trust in many of the communities where HUD works, especially in relation to maternal and infant healthcare.

We are grateful to our technical assistance partner, Homebase, because they have been able to build a foundation with communities we're partnering with, and they've been able to conduct a lot of mother-led assessments and mother-led conversations. And whenever we see a problem or a challenge on issues, experts will come out and they'll conduct research studies, they'll do surveys, and then they will decide what people need. But with our partners in the field, they listen to community and have moved forward again with a mother-led, mother-voice perspective.

So, I just wanted to place trust at the forefront of our work, and we are constantly making sure that we lift up the voices of our residents and the community because many of the women in our target communities have a good reason not to trust government because we have failed them historically, and so I just wanted to mention that upfront.

So, how did this all get started? In June of 2022, the White House blueprint for addressing the maternal health crisis was released with a whole of government strategy clearly outlining the data and crisis of outcomes for Black and Native American mothers with a call to action for federal agencies to partner with

each other around this work.

And the HUD-specific roles that are outlined in the blueprint were, one, connect eligible families receiving housing assistance with access health program. Two, conduct partnership meetings in targeted cities to enhance delivery of outreach, education, and care for HUD clients. And three, educate our grantees who are serving women experiencing homelessness or survivors of Domestic Violence or gender-based violence.

And we took that charge and formed a charter. So, what is a charter, you may ask. It's a team formed by HUD field staff that are geographically dispersed but connected by a common goal or initiative. And so, in this case, improving the outcome for maternal and infant health.

Our team members work across the country on this one initiative, and we were able to do this work because we found TA funding in the budget that was screaming to be used and so that technical assistance can only be used in EnVision Centers which are centralized resource hubs across the country.

So, we started this work within the community and making sure that we were working with women who are most vulnerable but based on policy and, at times the politics, because I'm a political appointee, so we also have to address the politics around these issues.

And so, we started with this maternal health

vulnerability map to target communities with the highest rates of maternal vulnerability. The darker the color the higher the vulnerability score. Then we looked to see which communities also had an EnVision Center and a health partner and started outreach to see if they were even interested in working with us at HUD. And so, by the end of August of last year, our charter team was able to identify six locations to receive the TA with Homebase.

So, who do we work with? Mothers, infants, children in communities of color, with poor maternal and infant health outcomes. What are we doing? Creating action plans to strategically address the community defined gaps from mother-led discussions in maternal and infant health services for HUD assisted housing sites, and I'll say more about that on the next slide.

Where are we? We're in Birmingham, Alabama, Jackson, Mississippi, East Harlem, New York, Tulsa, Oklahoma, Houston, Texas, and St. Louis, Missouri, and we've been working throughout FY '23 and into FY '24. TA is only through the end of this fiscal year, so through September of next year, and we're hopeful that the targeted communities that we've bene identifying with and working with can use their TA to locate grant opportunities or leverage other resources to continue their work and increase capacity around maternal child health.

So, in order to develop individual action plans to

address specific community defined gaps, the work at all sites start with an onsite visit, a listening session with the local moms to hear about their experiences and allowing them to identify what they need. And then, after speaking to the EnVision Center staff and partners, Homebase takes inventory of the community providers to create a picture of the community flow. And the community has responded favorably to our engagement and local residents have been able to have direct impact on community support and in two locations are now standing up, peer-to-peer, mother support groups.

So, in Birmingham, at the Campus of Hope, the organization's located on the property of a public housing authority and operates many of their community activities. So, this partnership provides a lot of engagement with the residents of public housing and specifically relevant, mother and children.

The photos that you see here are from a Domestic Violence Awareness event last month and the mother charter was able to participate. Homebase staff was able to table at the event and they were able to highlight rights of residents protected under VAWA and educating on the connection between domestic violence and maternal mortality rates.

And while Homebase cannot write grants on their behalf, they're able to provide a comprehensive list of funding opportunities, marketing materials, and develop initiatives to

address some community challenges. And in fact, the EnVision Center in Jackson, Mississippi, they requested and received an increase of an existing grant of $400,000 to support a doula program and mother support group.

So, also in Jackson, Mississippi, we have a strong partnership that exists been the EnVision Center and the local health center known as Magnolia Medical Foundation, as well as the Jackson Housing Authority. Our local field office team have been able to provide a lot of support to the health center even offering HUD 101 training and an overview of HUD grants and some education around fair housing and BOWA and this photo was a community baby shower that was held at the center.

So, here's an example of my own region here in New York. Our TA provider participated in the Community Health Fair, soliciting feedback from families in both Spanish and in English, and some of the feedback received spoke to the need for postpartum support, psychological help, parenting education, and the subpopulation specific support services for addicted moms, other primary caretakers, and fathers, and training about rights and antidiscrimination laws, and an action planning session was also held with the staff, highlighting strategies to again increase and diversify funding to ensure ongoing dedicated staff and resources at the center and there was a specific focus on increasing private foundation dollars.

So, aside from the MOTHER Charter specific work, I just wanted to touch on other partnership opportunities or education opportunities. I just briefly highlighted the work that we do within FPM, but our HUD strategic plan talks specifically about integrating healthcare and housing. So, if you're an agency who serves people and you care about equity, I hope that you will consider partnering with us as we serve those who are most underserved. And there's been a lot of discussion about different strategies of engagement and so outside of the MOTHER Charter, we also have our HUD Strong Families Program that falls under our Public and Indian Housing and other that particular program there are educational workshops, webinars, events, so again, I ask for you to reach out to us so that we can figure out a way to work together to support our families.

And this is just a slide of all of the partnership opportunities within HUD, the different program areas that might be of interest to you, and last slide is live links. I think everyone's going to be able to receive this presentation. So, these are links to our HUD field offices, so you can link on the links, figure who's in your area, and figure out ways for us to either continue our partnerships or new collaborations. So, thank you and I look forward to working with you all.

MS. PETTIFORD: Thank you so very much, Alicka. And that connects very well with our workgroup on social drivers of

health, so thank you very much.

Now, we're going to turn it over to Gayle, and I do apologize. I failed to introduce your other two team members, Gayle, so we definitely are excited to have Helen Applewhaite with us and Bonnie Worstell, but turning it over to you, Gayle.

MS. GOLDIN: Thank you, Belinda. And unfortunately, Helen wasn't able to join us today. She got called away, but Bonnie is here. I'm going to talk first a little bit about what we're doing at the Department of Labor from the Women's Bureau's perspective, Bonnie is going to then do an overview of Wage and Hour Division's work, and then I'm just going to wrap it up with little bit of other work about how the Department of Labor interacts with health insurance oversight too, and then we'll be available for any questions following up as well.

But it's so good to be with all of you here today. The Women's Bureau's mission is basically that we work on women's economic security in the labor force. We're the only federal agency mandated by Congress to meet the needs of working women and that means we basically work on anything that interacts with the ability for women to be in high quality jobs, enter the workforce, and address barriers that face them.

We do that in a few different ways. One of the things that we do is stakeholder engagement. We do policy research and data and analysis, and we also have a small grantmaking program.

I'm going to talk for just a brief second about stakeholder engagement as an example of what we do on the many topics we work on.

For instance, this gender-based violence and harassment, we are working across the country to bring people together to have these conversations about what it means to have those experiences at work too and what are some of the solutions or ways people can work together on that. So, it's a variety of different conversations that we have across the country and that is one of the things that we do. Can we go to the next slide?

One of the other things we do is make sure that people know what is available to them across the country for protections. Bonnie is going to provide a little bit more detail about how Wage and Hour Division does enforcement and outreach and engagement, but what we do at Women's Bureau, working closely with our partners at Wage and Hour Division is make sure that people know what rights are there for them on the state level too, so these are the kind of resources that you would find up on the Women's Bureau's website.

We have an interactive map to tell you what state laws are available and protect people against pregnancy discrimination to ensure pregnancy accommodations and workplace breastfeeding rights, and there's a whole host of other products that go along with that map up on our website.

The Nursing Workers Employment Protections we do have a quick factsheet on it, but Bonnie is going to talk about that in just a moment more, but that is available on the Women's Bureau website as well. Next slide.

So, in letting people know about other policies that affect their everyday lives that might make it easier for them to work and care for themselves and care for their loved ones, not only do we let people know about what state laws exist on pregnancy discrimination and accommodations, we also have resources on state paid family and medical leave laws.

As we all know, people need time out of the workforce to care for themselves and to care for their loved ones. That's particularly true in those time periods of pregnancy and caregiving for a new child and so we want to make sure people have those resources available to them about when they need paid leave how to get it if they live in one of the states that has paid leave.

Right now, there are 13 states and the District of Columbia that have paid leave on the books, not all of those are fully implemented at the moment. We just saw new programs coming online this year, so that information is continually updated on the Women's Bureau website about paid leave. On that website, you'll also find information, factsheets, data about who has access to paid leave and who doesn't, factsheets on how you can

use paid leave and what you can use it for, and we're continually updating that information.

So, as I mentioned, part of what we also think about is not only what rights do people need in the workplace in order to do their jobs and care for themselves, we also want to make sure that the jobs women hold are high quality jobs. We hope the jobs that everyone holds are high quality jobs, but particularly focused this year on jobs that are held by women how do we ensure that they are able to care for themselves as well as continue to be part of the care infrastructure of this country.

So, as part of the maternal health blueprint, we did listening sessions this year with doulas to figure out what would improve their job quality in order to ensure that we have a robust, diverse, and growing doula workforce. So, that issue brief is up on our website, and you can learn more about our experiences of talking with doulas across the country. There's also material on the White House blueprint for addressing the maternal health crisis.

And then we have just released, along with Wage and Hour Division, or have worked for the past year, on making sure that we have sample employment agreements for domestic workers. This was part of the President's Executive Order that he released in April, signed in April, about caregiving. And what these sample employment agreements do is enable domestic workers, so people who

work in individual private homes as nannies, home healthcare workers, and house cleaners to be able to negotiate and discuss with their employer what the employment terms should be for them. So, those are up on our website now.

We have a separate domestic workers website and you'll be able to see sample employment agreements that you can download. They're currently now in English. We have plans for them to be in multiple languages over the course of the next few weeks, so please do check back often to see if there are more materials available on the website.

And finally, I mentioned we do research, and we do tons and tons and tons of research, but I thought the one that would be most interesting for this group for us to talk about this today is we've just released data called The Cost of Doing Nothing Update. There was a report in 2015 from the Department of Labor that did an analysis at the time of what it meant that we didn't have family-friendly policies like national paid leave and other investments in families and children in this country.

We have redone that data for 2023, and what we have found is that if we had kept up with the Women's Labor Force participation in Germany and Canada, there would be about five million more women in the labor force right now and that would translate to more than $775 billion in additional economic activity per year. So, when we don't have those investments and

those policies in place, there is an economic cost to our country as well.

We have plenty of other research up on our website and we encourage you to take a look at that. One of our other recent pieces was about older women and caregiving and the impact of the amount of older women who are actually caregiving, and that includes data on older women caregiving for their grandchildren. That might be of particular interest to this group.

So, I'm now going to hand it over to my colleague, Bonnie, who is going to explain more about what Wage and Hour does and what they are enforcing.

MS. WORSTELL: Thanks, Gayle. So, my name is Bonnie Worstell and I'm a policy advisor from the Wage and Hour Division here at the Department of Labor. So, the Wage and Hour Division's mission is to promote and achieve compliance with labor standards to track and enhance the welfare of the nations' workforce.

So, the Wage and Hour Division is responsible for enforcing some of the nation's most foundational federal work protection laws, which includes protections related to the federal minimum wage, overtime, family medical leave, protecting the right for workers to express breastmilk at work, which we'll talk a little bit about, and the prevailing wages for government funded service and construction contracts and more. We enforce a lot of labor standard laws.

So, today we would like to just highlight three critical components of the work that we're doing to protect maternal health in the workplace. So, first, our interagency collaboration on the maternal health series to our work to implement the PUMP Act and our ongoing effort to highlight FMLA and lastly, our enforcement work.

We know that for workers it can be confusing to navigate the web protections enforced by multiple agencies, so in an effort to provide information in a way that workers can understand, we worked with the Women's Bureau and the Equal Employment Opportunities Commission or EEOC to present the protections that workers have in the workplace during pregnancy, through birth, and the after returning to work in just an easy to understand format and so thus, the maternal health series was born and you can see some of the achievements that we've had just on the slide in front of you.

So, the Wage and Hour Division enforces two laws that protect working mothers during pregnancy, birth and bonding, and when returning to work and breastfeeding. So, those include the Providing Maternal Protections for Nursing Mothers Act or PUMP Act and the Family and Medical Leave Act.

So, first, I want to talk a little bit about the PUMP Act, which I'm sure you all are very familiar with, but in short, before the President signed the PUMP Act into law in 2022, roughly

one in four working women of childbearing age or about nine million people who might need this protection didn't have the right to pump at work, so that meant that millions of workers were faced with a choice to either not pump, which we know is a really deeply personal and important choice for a parent to make or to continue pumping and face possible discrimination, harassment, or job loss as a result.

So, the PUMP Act extended coverage of these important worker protections to millions of workers, including teachers, nurses, farm workers, and many more. And since the PUMP Act was signed into law last year, the Wage and Hour Division has really been hard at work to ensure that workers understand their rights and employers understand their responsibilities and the law.

An example of one of the efforts that we've undertaken was that we marked the start of the World Breastfeeding Week and National Breastfeeding Month with a nationwide Day of Action to launch the Power to Pump Initiative, which focusing on educating workers, employers, and stakeholders on workers expanded rights to pump at work under the PUMP Act. So, we release doorhangers and Workers' Rights cards, as you can see on the slide, that workers could hang outside of their designated pumping space at work and the Workers' Rights cards just provide more details on where to file a complaint and find out whether folks are covered under the PUMP Act.

So, this effort included over 300 community-based organizations and nonprofits. Our 54 district offices all participated in distributing those materials and some of those organizations include WIC offices, workers center, breastfeeding coalitions, health clinics, and more. And this outreach effort has just resulted in a lot of new relationships for staff.

Next, the Family Medical Leave Act, which you all, I'm sure, are also familiar with, provides eligibles employees the right to take up to 12 weeks of unpaid job protected leave for specified family and medical reasons with a continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

And healthcare providers can be important allies in helping employees obtain the necessary job protections support FMLA and that includes timely and accurately completing an employee's request for certification. And to celebrate the 30th anniversary of the FMLA, Wage and Hour has just been working to update its resource manuals, release revised plain language factsheets and frequently asked questions and other resources.

And lastly, I just want to talk a little bit about our enforcement. So, when we receive complaints, we really try to prioritize those and work fast because we know that there are very real and serious impacts to a worker's health and ability to nurse if workers are not permitted to pump at work when they need to.

And since the Day of Action, we've received more calls from employers and employees on the PUMP Act. Each of those contacts is another opportunity to effect broader compliance. We also provide technical assistance and active enforcement to educate workers and help employers who want to understand the requirements under the law.

Also, I'll mention that we just signed an MOU in September with the EEOC and we're at the early stages of figuring out how to work with each other regularly on PWFA and PUMP Act, which we know are going to work hand-in-hand. And lastly, we do collaborate with other agencies and organizations, such as the Federal Interagency Breastfeeding Workgroup and HHS's Office of Women's Health, among others. So, with that, I will turn it back to Gayle.

MS. GOLDIN: Thank you. And I just wanted to make sure that everybody knew that the Employee Benefits Security Administration exists in the Department of Labor. You'll see that what they focus on includes the ACA, HIPAA, and COBRA and that within those laws are particular protections for maternal health preventive services that are covered in health insurance. And if you have any questions about that, I wanted to make sure everybody had the resources available to know how to call a benefits advisor at EBSA on the toll-free number or check the EBSA website and they can certainly provide additional details or assistance on that as

well. And that is it for us. Thank you.

MS. PETTIFORD: Thank you all so very much. We appreciate your time. As you can tell, we're running a little bit behind, but we will take a moment for maybe one question; otherwise, if you can just drop your question in the chat, we'll make sure it gets to the right person. So, if anyone has a question now?

(No response)

MS. PETTIFORD: We have a shy group or we're around lunchtime, depending on what part of the country you're in. Okay, we're going to proceed then. Thank you all so very much and we look forward to getting those slides from your presentation.

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

MS. PETTIFORD: So, now we're going to go onto Danielle Ely. Danielle is with us, with the National Center for Health Statistics as part of CDC and she's going to give us an update on this provisional 2022 infant mortality data. Thank you, Danielle.

DR. ELY: Thank you, Melinda, or Belinda. Sorry, I was thinking of my neighbor. So, today I'm going to give a presentation talking about some of the provisional data that we've released since the beginning of November.

My name is Danielle Ely. I am with the Perinatal

Statistics and Research team in the Division of Vital Statistics. So, on November 1st, we released a provisional report using provisional data on the linked infant mortality file and I was the main author on that, with my colleague, Anne Driscoll.

And then a week later, on November 8th, our team was able to release a provisional report for provisional fetal mortality data, and that was written by Elizabeth Gregory, Claudia Valenzuela, and Joyce Martin.

So, some things that I feel like I need to go over quickly, just as a precursor to discussing the fetal mortality report that was released, is the different between live birth and fetal death. So, live birth consists of the complete expulsion or extraction. There has to be evidence of life, which might include breathing, the beating of the heart, pulsation at the umbilical cord, definite movement of voluntary muscles, and it doesn't matter how long the duration of the pregnancy is.

This is in contrast to fetal death where the death must have happened prior to the complete expulsion of the fetus. There cannot be any evidence of life, so no breathing, no beating of the heart, no pulsation of the umbilical cord, no definite movement of voluntary muscles, and it doesn't include induced termination of pregnancies.

Additionally, some important things to note are that heartbeats should be distinguished from transit cardiac

contractions and that respirations need to be distinguished from fleeting respiratory efforts or gasps.

So, now I'll go ahead and start talking about the provisional fetal mortality report. So, this report showed fetal mortality data for 2020 to 2021 and compared that with the 2021 final data to 2022 provisional data. Fetal deaths that were included were those at 20 weeks of gestation or more to U.S. residents and this data was collected through the NVSS.

About 99.1% of fetal deaths that are expected for 2022 were included in the provisional data. Something we found in previous reports is that the provisional fetal data has been relatively consistent with the final data and this report provided information on the total early and late fetal deaths, as well as total fetal mortality by maternal race and Hispanic origin and by maternal state of residence.

Some background, so maternal race is based on maternal self-report on the mother's worksheet and there are five non-Hispanic maternal race and groups, and also a Hispanic group. So, the five non-Hispanic groups are American Indian and Alaska Native, Asian, Black, Native Hawaiian or other Pacific Islander, and white.

So, a couple of definitions also to keep in mind throughout the presentation, so early fetal deaths are those fetal deaths that occur at 20 to 27 weeks gestation. Late fetal deaths

are those occurring at 28 weeks of gestation or more, and fetal mortality rates are the number of fetal deaths at 20 weeks gestation or more per 1,000 live births, plus the number of fetal deaths at 20 weeks of gestation or more.

So, from 2020 to 2021, there weren't significant differences in fetal mortality rates for a total early or late; however, from 2021 final data to 2022 provisional date, there were decreases in the total, early, and late fetal mortality rates. And in fact, the total fetal mortality rate declined five percent in this timeframe.

From 2020 to 2021, and also from 2021 to the provisional 2022 data, there were no significant differences for the rates for American Indian, Alaska Native women, the rates of Asia women, or for the rates of Native Hawaiian and other Pacific Islander. For Black women, fetal mortality rates declined from 2020 to 2021 and although there was a small increase from 2021 to 2022 provisional data, this was not statistically significant.

For white and Hispanic women, there were not significant changes from 2020 to 2021; however, for both of these groups of women there were declines in the overall fetal mortality rate from 2021 to the provisional 2022 data.

These two very small maps show the changes in fetal mortality by state of residence. So, from 2020 to 2021, there were increases in the fetal mortality rate in two states and that

was Pennsylvania and Utah. However, in 2022, rates declined in seven states compared with the rates that were seen in 2021.

So, now I'll go ahead and talk about the provisional infant mortality report that was released. So, this was the first year that we've actually been able to get provisional data and to release any information on this and this is based on the period linked birth and infant death file. We expect it be several months before the final data will even become available, so the linked period birth and infant death data file are based on information from birth and death certificates collected through the National Vital Statistics System and the results that were provided in this report were based on the linked records that were received and processed by the end of July of this year and it represents nearly 100% of the expected linked birth and infant death records for 2022. Of these records, 98.6% of the infant death records were linked to the corresponding birth certificates.

So, our provisional data will differ slightly from some of the final data because it hasn't undergone the more comprehensive data quality checks that are done with the final data and that's really a process that takes a couple months to get through. So, as a result, the infant mortality rates that I'm presenting may be slightly different from those based on final data, but the differences are likely to be very small.

So, the infant mortality rates that shown in this report

are the infant age at death, infant mortality rates by the maternal race and Hispanic origin and maternal age, infant mortality rates by gestational age and the sex of the newborn, by mother's state of residence, and for the 10 leading causes of infant death.

Once again, the maternal race is based on maternal self-report on the mother's worksheet and the same categories that were presented from the fetal mortality report are also presented here, so that's non-Hispanic, American Indian or Alaska Native, Asian, Black, Native Hawaiian or other Pacific Islander, and white, and also Hispanic.

Some infant mortality definitions you want to be sure to know what they are include infant mortality, which is the death occurring before one year of age, the infant mortality rate, which is the number of deaths per 1,000 live births for a majority of the characteristics that are presented in the report. This is per 100,000 for the cause of death statistics because of the small numbers, and age of death. So, neonatal deaths are those that occur before 28 days of age and post neonatal deaths are those occurring between 28 and 364 days of age.

So, from 2021 final data to the 2022 provisional data, the infant mortality rate increased overall about three percent, from 5.44 to 5.60. The rate also increased for both neonatal and post neonatal mortality rates, three percent for neonatal and

about four percent for post neonatal.

Across maternal race and Hispanic origin groups, there were not significant changes between 2021 final data and 2022 provisional data for Asian, Black, Native Hawaiian and other Pacific Islander, and Hispanic women; however, there were significant increases in the infant mortality rate for infants of American Indian and Alaska Native and for white women.

In general, we don't see significant changes by maternal age from year to year, and this is generally true for 2021 to 2022. However, for this year we did see a significant increase in the infant mortality rate for infants of women who were ages 25 to 29.

When looking at the infant mortality rate by gestation age, we do know that there are substantial differences across the different groupings of gestational age. For pre-term infants, those that were born at less than 37 weeks and for early pre-term, so those were born at less than 34 weeks of gestation, there were significant increases in the infant mortality rate from 2021 to the 2022 provisional data.

By infant sex from 2021 to 2022, there were not any significant increases for female infants; however, the mortality rate for male infants did increase significantly from 5.83 to 6.06.

By mother's state of residence, there were four states

that had significant increases from 2021 to 2022 provisional data. Those were Texas, Iowa, Missouri, and Georgia, and there was a significant decrease in the infant mortality rate for Nevada. One of the things I'd like to mention here is that although we are noting these significant changes by state from one year to the next, we do typically see a number of states have increases and decreases by year and sometimes these may or may not be the general contributors to the changes in rates.

And finally, the infant mortality rates by the 10 leading causes of infant death, so for two of the ten leading causes of infant death, there were significant increases from 2021 to the 2022 provisional data and that was for maternal complications of pregnancy, which increased by nine percent and for bacteria sepsis of the newborn, which increased by 14%.

And another point that I wanted to note, even though it was not provided in the infant mortality or the fetal mortality provisional reports, was to give the number for the provisional perinatal mortality rate, which can be calculated by using the data from those two reports.

So, even though there was a significant increase in infant mortality and a significant decrease for fetal mortality, the perinatal mortality rate was statistically similar from 2021 to 2022 and it went from 5.54 to 5.48.

So, I'll just quickly run through the findings of this

again. The fetal mortality rate declined five percent from 2021 to the 2022 provisional data and there were declines observed for early fetal deaths, late fetal deaths, the total fetal deaths, so white Non-Hispanic women, and for Hispanic women and there were declines in seven states and that was Alabama, California, Florida, Maryland, New Jersey, Pennsylvania, and Utah.

For the infant mortality provisional report, it was the first report presenting provisional infant mortality statistics from the period linked file and the release of this allows us to provide more timely information on changes in infant mortality in the U.S. and we do expect the provisional data to be relatively consistent with the final data and we're hoping that will be released in spring of 2024.

And I do want to mention here that one of the reasons that we even went down the road of creating and then reporting on provisional infant mortality data was due to conversations I had in this Committee several years ago at this point, but we were finally able to get this done and get the resources that we could have the file.

The results from the infant mortality indicated that the 2020 provisional infant mortality rate was three percent higher than the rate in 2021 and there were increases in both the neonatal and the post-neonatal mortality rates. Mortality rates also increased significantly for infants of non-Hispanic American

Indian and Alaska Native and white women.

For infants of women ages 25 to 29, infants were born preterm, so less than 37 weeks gestation and early preterm. For male infants in four states there were significant increases in Georgia, Iowa, Missouri, and Texas, but there was that decline in Nevada and there were significant increases for two of the ten leading causes of infant death.

Finally, by combining the information from those two reports, we calculated the provisional prenatal mortality rate and saw that this had a non-significant decline from 2021 to 2022. And that is all I have for today and I'm not sure if we're going to take questions now, Belinda, since we're running a little bit behind, but I did finish in my time still.

MS. PETTIFORD: You did. You did awesome, Danielle. Thank you so much. We will take a moment to see if there's any questions. Yes, Kate.

DR. MENARD: Danielle, thank you for the most current data and for giving us those most recent trends. As you know, one of the things that we, this group, is being charged with doing over next year is particularly looking at the health disparities, particularly for trying to reduce or eliminate the disparities that we see among and the adverse outcomes we see in the Black population.

You showed us those. In the workgroup that I'm going to

be working on is specifically going to be looking at rural health issues and systems to improve rural health and I'm wondering if it's possible or if you could point us to data like this that's specific to the rural health population and the disparities ratios. Is that possible or is that.

DR. ELY: My background is rural sociology. It's what I got my Ph.D. in actually and so my interests and some of my previous reports have focused on rural infant mortality versus metropolitan areas. After this is done, I can go through and find some links for those to send to you. I can't remember, but I believe the most recent data that I did something like this for might've been 2020 or 2021, so I can send what I have out there, if you're interested.

DR. MENARD: That would be wonderful, any trends, and join our workgroup. That'd be great. Thank you. Thank you, Danielle.

MS. PETTIFORD: Thank you, Kate. And we're going to take one final question from ShaRhonda.

MS. THOMPSON: Hello. So, I noticed you highlighted the decrease in Nevada. Do we know if they made any changes as far as the programs that they have or is there a way that we can get some information to compare last year to the year before so we can see what they may have done that could've possibly worked that could be implemented in other places?

DR. ELY: Yes, so that's one of the reasons that I added a little of a disclaimer on that slide because we do see changes from year to year in infant mortality rates by state and some of that is just due to small changes in the number of births or infant deaths can actually make a difference in whether shows up that is statistically significant.

I can speak to whether or not they had any changes in their programs or if they did anything differently. Unfortunately, that's not under our purview. However, I would say that in our previous final reports we could go in and look at to see if maybe Nevada had significant increases from 2020 to 2021 and maybe they were just coming back down from that, but I don't know that off the top of my head, but I can look.

MS. PETTIFORD: Thank you for that question, ShaRhonda and thank you, Danielle. I appreciate and am excited that we have provisional data for the country and we're looking forward, I think you said in the spring, to have the final data with the hopes that we'll see similar data when it comes out. And my final question is do you all plan to release provisional data moving forward when you can?

DR. ELY: Absolutely. The hope is that we would produce this every single year and that it would come out about the same time every year because most years the states send in their data -- well, I should say it's released to our division towards

the end of July after it's been cleaned up and verified a bit by our colleagues in North Carolina. So yes, the goal is to put it out every year and get that more timely data out there for everyone.

MS. PETTIFORD: Thank you so much, Danielle. Great job with your presentation. Now, we're going to switch over to an update on the federal Healthy Start Program, and so Lee Wilson will provide that for us.

Standing Agenda Item: Federal Healthy Start Program

MR. WILSON: Alright, good afternoon, folks. For the record, my name is Lee Wilson. I direct the Division of Healthy Start and Perinatal Services, which includes the Healthy Start Program, as well as our Maternal and Women's Health Activities within the Division and the Bureau of Maternal and Child Health.

So, thank you for the opportunity to give this presentation. I know that we're running a little behind time and so I will be brief in my remarks. Some of them were covered by Dr. Warren earlier and I'll just expand on some of that, but I will be here for the remainder of the two days. And so, if we don't have sufficient time for questions and answers, I'll be available if we want to schedule another time or if somebody wants to bring anything up during the rest of the meeting.

So, as part of our responsibility within the Division,

we provide an update on the Healthy Start Program to the Committee to seek your input, guidance, support, feedback, and direction as we operate and administer the program and its grants to the nation.

We were here about six months ago for the last meeting and a presentation on the activities that the Division had been pursuing around Healthy Start and so I'll build off of that. It does feel a little like the six months have slid by very, very quickly. But then, on the other hand, it feels like there has been so much that has gone on in the last six months that there's quite a lot to report.

You may remember from June that the Division was in the process of reviewing applications for the Healthy Start Enhanced Program, which was a smaller grant competition. We awarded 10 grants. We received some additional funding in 2023, Fiscal Year ‘23, and so we funded that small cohort of grants. At the same time, we were in the process of preparing to re-compete the larger Healthy Start Program, of which we have 101 grants, and the Healthy Start Technical Assistance Cooperative Agreement.

And I'm happy to say that in the last six months we have been able to complete those announcements. Both are on the street for applicants to review and prepare and submit their applications. And as was our goal, we have been able to provide prospective applicants 90 days to be able to complete their

applications. I'll provide some more information in detail about those two competitions in my next slides, but I just wanted to let you know that we have moved on those two significant activities and wanted to say that as we have evolved and have been talking over the years about how we would learn from the existing program and incorporate that, those incremental changes to the program have been reflected year over year in the small competitions that we do.

So, if you're somebody who follows the Healthy Start Program, you will see that the Healthy Start Enhanced Program is a good intro to what the next Healthy Start competition looks like, so there are fewer surprises for the applicants.

So, from the discussions that we had last June, you may remember that we had a very deliberate and active approach to collecting input from our grantees, from our stakeholders, and form the general public through a series of health equity convening, through grantee listening sessions, and through our request for information in the Federal Register.

We collected information about what was working, where there were difficulties with the Healthy Start Program, and where we might be able to make improvements. The engagements were robust. They were sincere and in many ways, they were very helpful.

Before I get to our three major takeaways, let me give

you a little commentary. Having gone through all of these various meetings, first, our grantees, by and large, are pretty direct with us on an ongoing basis. Some might even say they're outspoken or some of them are rather outspoken, which means that much of the information we collected it was useful in that we collected it, recorded it, and logged it, but a lot of the information was stuff that we have heard and have been hearing for quite some time. So, it was nice to get that confirmation and in most cases what we heard was not a significant surprise.

Second, it is very important that I point out that not all of the recommendations we received were in the same direction. What I mean is that some people made recommendations for one thing. Other participants may have made recommendations with opposing opinions on things like data collection, the amount of data that we collect and utilize, whether more money should be given to increase the budgets for existing grantees or whether those dollars should go towards a larger number of grantees or the direction around programmatic areas like how we are handling fatherhood and counting the number of fathers that are participating in the program. So, there was a monolithic response on a lot of the issues.

Our intent in collecting this information, which is, I believe, pretty apparent, is that we would use that input and the data that we collected to improve our NOFO and to assist us in the

drafting process.

Obviously, the info we received was assessed alongside other pieces of input, priority, or confines constraints that we had, such as Congress' advice to us or legislation on things like clinical support being provided for all grantees. It was done alongside priorities that we have that have been stated by the Administration on issues and topics such as equity and social determinants of health and on a number of other factors that we have to deal with internally.

These are the three primary themes that we heard from our grantees when it came to feedback on the current Healthy Start Program and things that they would like to advise us to consider in the shaping of this current competition.

One is a move towards increasing flexibility for the grantees in the design of their program and the numbers of clients that they serve, in the types of services that they provide, and then the reporting that they share with us or are required to give back to us.

Second, is the vital importance of social determinants of health as a central factor in addressing the needs of the individuals that they are serving and providing support to. As an example, it's not only about providing parenting supports to individuals who come in who are pregnant and needing the assistance of the program, but it's supports around safety, it's

supports around housing, it's supports around jobs and nutrition and other things. And the idea that the Healthy Start Program should be working to not only address the individual needs of the individuals in the program but trying to influence the social dynamics that put those individuals in need.

The third area has to do with burden, and this we heard from many, many sources that as grantees, as evaluators, as project directors they would like to remind us that as they're doing their reporting it limits their ability to see more clients, to provide more services, and so as best possible, they would like to remind us to limit the burden that is being placed on them for data collection, for reporting, for follow up with their project officers for developing their non-competing continuation applications.

Again, we took all of these comments and other comments, cataloged them and have used them in a template process for reviewing all of the changes that we were proposing within the Healthy Start Program. We agree with all three of these priority areas and have worked, as best possible, to try to incorporate those three messages into the redesign of the program, into the supports that we're providing through technical assistance, and into the way our project officers are working with our grantees.

This for many of you who have applied for grants is part of one of our face sheets for the application for the NOFO and

this just details a little bit of the basic information about the current Healthy Start grant program, that NOFO that is out on the street. We have approximately $113 million, a little bit more than $113 million that we expect to be available for funding in the 2024 cycle. The cycle is closing. The application deadline is December 15, 2023.

Grants are due in to grants.gov by 11:59 p.m. This is a computer system, and it is unforgiving. If you miss the 11:59 deadline, you have missed the 11:59 deadline, so one of the things that we remind all applicants coming in is that it's vitally important that they begin their application process early.

And I see I'm using up my time quickly here, so I will move more quickly. We are looking at doing 103 awards. We're looking at approximately $1.1 million per award. This is slightly higher than what grants received last time, although it is also incorporating the clinical support dollars that are included or have been included as a supplement to the program. As I said, it is a five-year program. It will begin on April 1, 2024, and end on March 31, 2029, and the eligibility is quite broad for our program.

One last point that I would like to make is when we put these NOFOs out, we do offer technical assistance to prospective applicants. I do want to call out we have received more than 200 technical assistance requests since we put the notice out about 75

days ago. I really want to congratulate Mia Morrison, Keri Bean, Ardandia Campbell Williams, Melody Watson, and Brandon Wood for their excellent help above and beyond nights, weekends working on technical assistance response to the more 200 requests that we have received.

Just three key areas of change that are being made to the Healthy Start Program or upgrade to the Healthy Start Program is we are broadening -- and this is response to the request for flexibility the ability for grantees for the Healthy Start Program to provide both client management, case management services as well as group-based health and parenting education and those activities will count towards the total number expected for grantees to fulfill their expectations.

We have found from the literature there's evidence that group-based education coupled with case management provides better outcomes. We also believe that it is economical for the grantees to be able to reach individuals through group-based help programs and trainings are more economical than it would be for case management.

We have changed the name from our Community Action Networks, CANS, to Community Consortia. There has been significant attention given to the use of federal funds for lobbying, so we just want to be clear about our intention for these community activities to focus on social determinants of

health and improvements at the community level and less geared towards necessarily lobbying.

And the third is we have worked very diligently to reduce the burden in reporting. The number of performance measures has decreased from 19 to 10 and we're doing what we can to collect as much information as possible from national sources of data and less from the grantees.

Most of you are probably less concerned about this. This is the face sheet for our Healthy Start Technical Assistance Cooperative Agreement that is currently held by the National Institute of Children's Health Quality, NICHQ. The budget for this technical assistance project is $3.5 million. The competition closes on December 29th. The period of performance again is five years and there is an additional supplement in the possibility for funding for additional support of approximately $800,000 to support advancements in group-based health education. We can talk more about that during question and answer at some other time.

I did want to point out that in the TA Cooperative Agreement there is also an expectation that the TA Center have its own Community Consortium to be providing it with input and guidance from stakeholders, including representatives of the community and with lived experience and again to point out that there is this possibility for an enhancement for group-based education.

We've worked, separate from these NOFOs, on many, many other activities around data and evaluation, around our mapping tool and other tools that can be used to help grantees identify need and including working with the General Accountability Office on an evaluation of the Healthy Start Program.

I'll stop there. I'm over. I don't know, Belinda, whether you want to offer questions and answers, but I'm available to do it at another time as well.

Standing Agenda Item: AI/AN Recommendations – Updates and Discussion

MS. PETTIFORD: Thank you so much, Lee. We appreciate you coming, but we're going to hold questions. I want to make sure we can move into our next session. This is another one of those standing agenda items that we have, where we really get an update on Making Amends: Recommended Strategies to Improve the Health and Safety of American Indians and Alaska Native Mothers and Infants.

These are all the recommendations that we moved forward with our last iteration of ACIMM and wanted to make sure we keep them elevated and on our list. We're very fortunate to have with us today, Ed Ehlinger, Dr. Ed Ehlinger. Dr. Ehlinger is the former chair of ACIMM and was instrumental in making sure we had these recommendations moving forward, along with Magda Peck.

So, we were also expecting Janelle Palacios to join us, who also is taking the lead in much of this work. Janelle had

something to come up, so she's not able to be with us here, but she is definitely here always in spirit. So, I'm going to turn it over to Ed to start with the update and move into Magda.

We will have some time at the end because there are a couple of our federal partners that we want to make sure that ex-officio members have a moment to at least share what they're doing to continue to elevate these recommendations. So, Ed, turning it over to you.

DR. EHLINGER: Thank you, Belinda. And it is really an honor to be here and a pleasure to be here and seeing some familiar faces that I wish I could see more often. And I really appreciate the fact that the ex-officios are taking a more visible role. I love seeing some of those presentations from the ex-officio members.

In the time that we've got, I'm going to briefly outline some of the activities that have been going on related to this report. I won't be focusing on what has happened within federal agencies or HRSA or MCHB, but things that I'm aware of outside of the Committee.

Janelle would've been here, but she has a death in the family. She did send a video, so I'm hoping we'll be able to play that, which would really highlight the importance of why this issue needs to continue to be important, particularly why we also need to continue to focus on the data issues.

And then, thirdly, Magda will highlight some of the opportunities and the imperatives that ACIMM has to keep moving this forward.

So, I'll start out with that overview of activities, but I want to highlight the fact that with Rosyln Carter just dying and Jimmy Carter in hospice, the focus has been on peanuts and peanut farmers. And I bring that up because today is the birthday of a famous peanut farmer, George Washington Carver. And he said, “where there is no vision, there is no hope.” And one of the things that I've been impressed with, starting with our meeting at the Shakopee Mdewakanton Sioux and the American Indian Alaska Native Community recognizing that we're paying attention and our report coming out in December, there is a vision that is actually giving hope to people to move this issue forward. So, where there is no vision, there is no hope. And I think that the work that we did as a Committee, I speak as we as a former chair, have really offered a little bit of that vision.

I sent to last night all of the activities that have been going on that I'm aware of. I'm not going to go over each one of those, but just highlight a couple of things, like ASTHO, for example. Since I've got a relationship with ASTHO, I've been able to really get them to focus on them on the report and they've actually put some of their recommendations into their policy statements. And I know Magda has been working with CityMatCH and

was able to get them to really focus some of their annual meeting time to focus on American Indians, Alaska Natives. And I raise this because you are parts of different organizations, and you can work to get either presentations or policy statements in your organizations coming off of what we've been putting together in that Making Amends report.

Also, with the American Public Health Association, the largest public health association in the country, the American Indian, Alaska Native, Native Hawaiian Caucus picked up the report and really liked what they were seeing and actually had a session at this year's annual meeting and plan to do another session at next year's annual meeting which just happens to be in Minneapolis. So, they're really also really focusing on advancing this report.

The three of us, Magda, Janelle, and myself, have done podcasts, have done lectures. We've been really trying to socialize this report as much as we possibly can, so those are our activities, and you can review those on what I sent you last night. But want I want to focus on in a minute or so is what we've learned -- what I've learned from this.

As I've talked to some of my federal colleagues who have gotten the report, they said we got this report, we read the report, and we started to cry because we've never seen a report quite like this. The data came to life because of the stories,

because of the context the data were put into, and people said I normally don't read these reports, but I read this report to the end because it was compelling. It made sense. The data started to make sense, given the context and the stories. So, we need to continue to put data into context. We need to continue to focus on lived experiences. That's why I really appreciate continuing having those community voices and the fact that you're going to be going to St. Louis at your meeting or one of your next meetings to really hear those stories first-hand and listening to those stories and having those community voices.

I also recognize that the recommendations that come out of those lived experiences are actually compelling to people to actually move policies and procedures and programs. But a couple of the things that I have learned that moving these issues forward takes champions. Reports don't move on their own. I'm hoping that there are some champions within federal agencies, certainly within HRSA, MCHB.

Certainly, I will continue to be a champion, but we also need other champions. We need those ex-officios to be champions. We need members of ACIMM to be champions to move this forward because otherwise it will stop, and we can't afford to have it stop because in the 50 years that I've been in public health I have never seen a report like this get as much attention as broadly as it has.

We have an opportunity. We've made an impact on the whole issue of American Indian, Alaska Native birth outcomes. It is getting visibility. We have an opportunity to actually move this agenda and move the needle forward on this and you certainly just saw from the data it continues to be an absolutely important issue to focus on.

And lastly, I've also heard from the American Indian and Alaska Native Community that they would like the people who came to the Shakopee Mdewakanton Sioux meeting would like to continue to be involved. They've developed relationships. They would like to continue to have their voices heard and to be a part of the conversation, so I'm hoping we can do that some place down the road.

Now, Emma, if you can play Janelle's video, that would really be appropriate before we turn it over to Magda. Is it possible to get the video?

MS. KELLY: Yes. I'm just trying to reshare it and make sure it looks good for everyone.

DR. PALACIOS: Good afternoon. I apologize for sharing this recording rather than meeting you all virtually in real time. It is an honor to be here and share some key points over the next few minutes.

I want you to imagine seeing this headline. This is one population's reality in that a report on their maternal and infant

and child outcomes are publicly reported about every 10 to 15 years.

We know very little about American Indian Alaska Native maternal and infant mortality. It is only recently that some states have made an effort to report this population's data and more recent that reports and surveillance systems are using better methods for finding this population in order to report their data combating racial and ethnic misclassification.

The Indian Health Service or IHS, is a federal agency housed within the Department of Health and Human Services and is responsible for providing federal health services to American Indians and Alaska Natives as a treaty right in exchange for tribal nations surrendering land and resources to the federal government.

But this is misleading, because the Indian Health Service is not responsible for all Native people and there are complicated rules even when someone qualifies for Indian Health Service, which may still end in no clinical care.

Please pay attention to this map, because it shows you the twelve Indian Health Service areas or twelve IHS regions. The Indian Health Service Delivery System has publicly posted two comprehensive reports on American Indian maternal, infant and child health. The first comprehensive regional report was published in 2004 covering data from 1999 to 2001. We saw between

1999 to 2001, only eighteen maternal deaths were identified in the Indian Health Service population across all twelve service areas. as seen on the slide.

For the same time period, the infant mortality rate was higher than the national average in eleven of the twelve IHS service areas. Again for the same time period, we also saw that for two-thirds of the IHS areas, Native infants died from SIDS at a rate surpassing the U.S. average. Then ten years later, in 2014, IHS published data from 2007 to 2009.

In a few days, 15 years will have passed since we had our last comprehensive maternal infant data report from IHS. Data from 2007-2009 demonstrated that Native maternal mortality rate was 23.2 per 100,000 live births. Again, this is within a select population of Native people, not all Native people.

In this iteration of the IHS data, IHS sites were not stratified by service area or region. All data was pooled. Therefore, we cannot compare how each of the twelve IHS service sites improved or worsened over time. Likewise, according to IHS data from this time period, the Native infant mortality rate dropped to a rate of 8.3 per 100,000 live births.

This next slide demonstrates a hodgepodge of state maternal mortality data. There are a few key takeaways. One, much of the data is averaged over a few years to find these maternal mortality rates. Two, this data was derived from state reports

published between 2019 to 2023. Three, these newer state reports are getting better at identifying the Native population and have for the most part moved from a restrictive single race to a more inclusive multiple race, pulling Native identities. And number four on the upper right-hand corner you see the rate of 23.2. This was the last known IHS reported Native maternal mortality ratio from 2009.

Please take this data pull from the March of Dimes website, which relies upon data from the National Center for Health Statistics on infant mortality with caution. The data reported by the March of Dimes noted in black does not reflect the true scope of infant mortality on Native people due to a significant data flaw. The National Center for Health Statistics only reports single race categories per racial group. The Native population is a highly mixed population.

In red, you see the state departments of health specific reports on infant mortality which always report higher numbers of Native infant mortality, for these state reports are enacting better strategies for locating Native data. Red arrows indicated a marked increase from previous measures of infant mortality.

Again, I'd like to point out the last known comprehensive report from 2007-2009 from IHS. They found an infant mortality rate of 8.3 which was pooled across all twelve IHS service sites.

This screenshot was swiped from the March of Dimes report on Maternity care deserts, an excellent report everyone should read. The darker the red color, the more severe the maternity care desert.

This is a photo of the U.S. with a few Native reservations noted in purple. You only really see the tribes which hold the largest landmass on this map.

Most of the federally recognized tribal land holdings within the continental U.S., shown in purple, are in the southwest, upper Midwest, and northwestern part of the United States as seen in this green triangle. If we were to overlay the map of Native reservations over the maternity care deserts map, you see the brighter purple red hue is a mixture of severe maternity care deserts and tribal reservation land. Alaska is largely a state with severe range maternity care deserts, which incidentally are where predominantly Native people live.

So what can be done? What are the next steps? Please take a photo of this slide. These are the ongoing questions based upon the Making Amends recommendations that I encourage you all to ask each ACIMM meeting. We are a nation with a disturbing past built on the genocide of one people and enslavement of another. We are a nation of stolen land and resources. We are a land of stolen pasts. We are a nation of stolen futures, through shared federally funded sterilization campaigns affecting both Black and Indigenous

peoples. Our collective pain and trauma have linked us, just as the determination increase we have in finding healing are common ground. We are in this, in body, in spirit, in past and future. We are in this together. One day I hope to see this headline.

Thank you all for your time. Please know that I welcome any questions you might have and can be reached at my email, seen below.

DR. EHLINGER: As always, Janelle makes a powerful statement. Magda?

MS. PECK: So, I had the honor of serving from 2018 to 2022 on the Secretary's Advisory Committee on Infant and Maternal Mortality and had the delight of leading the former Data and Research to Action Workgroup to which Danielle Ely was a strong member. You get to see results today in her provisional data. Thank you, Dr. Ely.

My service included supporting Making Amends co-authors, Dr. Ehlinger and Palacios and the design, writing, and editing of this landmark report, which this Committee approved a year ago and then we submitted it to Secretary Becerra. I want to thank you for welcoming us back as your SACIMM alumni and for keeping American Indian, Alaska Native women, infants, families, and fathers in your ongoing priorities, and as a standing SACIMM agenda item.

A few months ago, at the annual CityMatCH Conference I

was in this windowless foyer in the main ballroom of the Riverside Hilton in New Orleans. Some of you were there. I was approached by a younger colleague, a woman of color passionate about racial equity and eliminating Black/white disparities in infant mortality, the focus of her work.

She came up to me after the lunchtime plenary, which CityMatCH created to highlight SACIM's Making Amends report and it featured outgoing CityMatCH Board Chair Stephanie Grace from Minnesota, Minneapolis, Dr. Ehlinger, Palacios, and myself. My younger colleague was visibly moved to tears after hearing stories and data about maternal and birth outcomes about American Indian/Alaska Native women and infants.

I just didn't know, she said. Where I'm from the numbers are just so small. And in the plenary session, I had lifted up one of the report's quotes from Dr. Donald Warne (Oglala Lakota), who is co-director for the Center for Indigenous Health at Johns Hopkins University. And he said to us in Shakopee, a little over 15 months ago.

So, you can think about where you're from and you might be from a state that is relatively few American Indians, but there's a reason for that. There's policy-based reasons put forth by the federal government that removed people or killed them and that's why we have such small population now.

My younger colleague paused, and she looked up and she

said, “I've never thought about it. I never heard the term data erasure. I didn't know that their small numbers were insignificant by design.” Indigenous moms and babies they just can't be an asterisk anymore and that's how it starts, elevating and catalyzing greater awareness and urgency. It starts with a ripple, not of data, but a ripple of the heart. One by one, each of us, our colleagues, our partners, our neighbors.

As outlined by Dr. Ehlinger and hopefully by others in the rest of this session, you can hear about how ripples are happening at programmatic organizations and systems levels. And the work of our chapter of SACIMM is a passer on to you so that you can continue to make waves with our report, not the one that came before you, but that you own responsibility for now.

So, to go from word to deed, I want to end my part of this today with four concrete suggestions to my colleagues. First of all, read the report. Yes, it's long. It has 59 recommendations, but savor its content. It's a classic. It has stories. It has data not seen before. It has voices never yet before elevated. It can be a powerful primer. And as leaders for the nation's policy setting, you should know it. So, without chagrin, take it off your computer off the shelf, set aside, not just once a year in anticipation of this meeting under this agenda, but know it and commit it to memory so you can never say, I didn't know.

Second, yes, she said take a screenshot of this. You'll have a copy of Dr. Palacios' slides and her recommendations. What is this iterative and iteration of SACIM's question? If you can build a list of questions around strategies and actions that you want to continue to push for, can elevating the IHS issues that have been raised and the 50-year-old ACOG contract that is yet to be evaluated for accountability so we can elevate what works, so that we can look in the social determinants of health work, not only a focus on Black mothers and infants. It can be a both/and. Just change how SACIM does its business.

Will the new expanded SACIM have members who can voice and represent American Indian Alaska Native representations? Will we go to places on Indigenous lands that will have more than just an acknowledgement?

Third, please be pragmatic and action oriented in the work because as SACIMM, you can work with MCHB and all of your partners to translate, yet, 59 recommendations outlined in Appendix C. That maybe you take that Appendix with the help of perhaps a graduate student at MCH's training program so that there's staffing to go along with this that supports the backbone that MCHB provides.

How do you take that table in Appendix C and create a working tool to be able to track and monitor the work of change that has happened so you know we can go from recommendation to

action in your next chapters.

And last, as Dr. Ehlinger said, become a reliable, regular champion for its recommendation. This is not an extracurricular. Find one or two or maybe three of these 59 that you are moved and committee to champion. So, it's not the whole thing, but every piece matters.

In Appendix B, we heard from Rhonda's story. We heard Rhonda's story in Shakopee. It's the very last quote. She challenged us when she told us a story that had happened to her 45, now 46 years ago. She said, So, what has changed in 45 years? Not much. This is from the former Tribal Council Chair for the Confederated Salish and Kootenai Tribes. She said, “keep the focus, make a difference, bring it to the forefront, provide them better care.”

We do lots of reports. We see them come by our email and sit on our desks and read them, but they can be our best tools. This can be a tool for action. It is unprecedented and it can help make change happen. Only though, if you use your powers as members of SACIMM, either appointed or ex-officio, and all of our colleagues that are listening from around the nation, you use your powers to make it so.

An ancient sage in my tribe, Helal once said, “If not us, then who? And if not now, then when?” Thank you for the opportunity to come back and you can count on me and your

colleagues to be partners in making change happen. Back to you, Dr. Ehlinger.

DR. EHLINGER: Thank you, Magda. You know the definition of public health that I use is: public health is a constant redefinition of the unacceptable and having no change happen in 45 years is unacceptable. And it is our job as current members of SACIMM and past members of SACIMM alumni to make that change happen. And as George Washington Carver said, where there's no vision there is no hope. We, collectively, have given a vision using the voices of the Native people themselves. With their leadership we have a vision to move forward. Let's do it. Let's make that change. So, Belinda, let's open it up for questions or any other comments that you might have.

MS. PETTIFORD: Actually, before we go to questions or comments, we have four of our ex-officio members and I want to give them a change to share any of the updates that they're doing that are directly related to this report because I want to make sure they have time, so we're going to start off with Tina with the Indian Health Service. After Tina, we'll go to Karen with the CDC with the birth defects team and onto Ada with the reproductive health part of CDC, and then to Michael Warren with MCHB. So, Tina, we'll start with you.

DR. PATTARA-LAU: Thank you, Belinda. I will try to stay under three minutes but let me know if I talk too fast.

Thank you for the opportunity to share our work at the Indian Health Service today. We appreciate the continued partnership with the Committee and HRSA this year.

I'll start by addressing the first bucket of sustaining and ongoing recommendations specifically addressing our numbers 1 and 16, focused on engaging and centering American Indian, Alaska Native Communities and empowered leaders. So MCH has adopted a model of cultural safety, which means we are working to transform the system to lead by and for the people it serves.

Your intention about lifting up our Indigenous leaders, healers, and community members in our programs and open our didactic sessions with a case study or a story that's based on lived experience.

I currently serve on Arizona's NMOC, in addition to other IHS Tribal and community representatives in other states, such as New Mexico and Montana. In May of this year, we started the IHS Maternal Child Safety Workgroup, which is a multidisciplinary group of IHS and Tribal leaders across areas, specialties, including our colleagues in the emergency department, pediatrics, behavioral health, and pharmacy on disciplines, including midwifes, nursing, and counselors, provide recommendations to leadership and get feedback directly from the field.

Additionally, I want to share with the Committee, as I

did in June, to address recommendation 15, providing adequate and mandated funding to IHS. I'm grateful to report that for the first time in history, IHS just received advanced appropriation for fiscal year 2024 to guarantee healthcare services through an agency that will not stop during the lapse of government appropriations and aligns this with other federal healthcare providers. I also want to thank those who advocated on behalf of IHS, including those on this Committee who continue to do so.

Next, looking at the second bucket of in-progress recommendations, specifically, 15(A) and 15(B) focused on perinatal outcomes and evaluation and assessment of quality of care. And so, currently, is just collaborating with the Office of Quality and our new Office of Clinical Performance and Health Impact to track metrics for the MCH programs that I'll discuss next, and review polices for the field and essentially build dashboards to better track our data, including maternal and infant mortality and outcomes.

And finally, to address recommendations 18 through 27 is addressing the workforce, as well as 28 through 33 approaches to adapting elements on social determinants of health. The vision of MCH Program is healthy pregnancies, healthy babies, and healthy communities because we are mindful the work we do upstream affects outcomes downstream over many generations.

And so, the March of Dimes estimates about 300 in rural

labor and delivery units have closed since 2018, about 70 in the past year in response to these closures and decline in national birth. IHS just developed an obstetrics in the emergency department training, provide sites in maternity deserts for obstetrics care that's not readily available with checklists, quick reference protocols, and training curriculum for safe triage stabilization and transfer of pregnant patients and newborns. I've been fortunate to introduce OB rights to three IHS areas with over 225 providers and staff now participating in hands-on stimulation training. We'll be expanding this to both Billings and Crow in 2024.

The manual is currently undergoing internal review and we hope to share this resource with our federal and community partners to address the growing rural healthcare need.

Next, on development of our IHS STI toolkit, as CDC reported last month, there's been a 32% increase in congenital syphilis cases since 2021, a lack of timely testing and treatment contribute to the majority of these cases, including in American Indian and Alaska Native populations.

And so, in 2022, our CML provided guidance to the field, and we've now published this toolkit recommending universal screening, walk-in testing, bundled treatment at our sites, testing for syphilis at three points in pregnancy and expanding our field screening treatment and options. And the challenge with

this I just did a site visit to rural South Dakota, as always with workforce and resources available, many of our sites are working hard to implement this standard. And again, the challenges remain.

Next, I'll move to our Indian Country ECHO series, which provides support to sites through virtual on demand continuing education consultation in the field. It's important for sites, especially in Central Alaska, which we recently visited as well. The IHS Conference provides services to 39 villages, 12 of which are accessible by road.

And so, we launched this Care and Access for Pregnant People ECHO in collaboration with the Northwest Indian Health Board actually last week in November holding space for Indigenous birthing practices lead by Dorian Day, who as Ojibwe and Ashtanabe, midwife, educator, and activist, which totals for the year reached over 700 participants and we'll continue our curriculum in January with prenatal care outside the paradigm in how to promote a culture of safety and humility and the focus, as always, highlighting the work of Indigenous community programs.

Recently launched our IHS/MCH website this summer, as well as continuing to publish our MCH newsletter, which provides news, resources, and learning opportunities to over 300 participants at IHS tribal and urban sites.

And then our last bucket, just to close with, we're

planning to implement these recommendations. Our Maternity Coordinator Program, we know that American Indian, Alaska Native birthing persons are disproportionately affected by historical trauma, structural racism, and social determinants of health, such as access to transportation, electricity, and running water, as well as some families may start prenatal care at an IHS or tribal facility we're mindful that 75% of American Indian and Alaska Native births occur outside our system and so we will find maternity care coordinators or MCCs provide telehealth and home visit support to pregnant persons before, during, and after pregnancy, increasing access to screening, education, care navigation, continuity of care and so this will be a partnership with our trusted community leaders to extend care beyond the four walls of the clinic or the hospital.

And of course, we'll be tracking our patient pathways to ensure that the transition through prenatal care and postpartum accessibility for our communities.

And then our second pilot project will be an expansion of self-monitoring blood pressure. We'll build on feedback to Logic Quality Improvement Project to study the accuracy in clinical utility in self-monitoring blood pressure. Again, expanding access to care, especially in those rural settings to American Indian and Alaska Native communities.

So, I also wanted to make a comment about Recommendation

17, evaluating the contract between IHS and ACOG and that we have had a consultative relationship with ACOG for 50 years. And ACOG provides the quality benchmarking site visits, some maternity care, and best practices and ongoing training in addition to the site visits.

They sponsor a biannual meeting on Indigenous women's health, which provides an important forum to address common themes and solutions. There is a publication that I did share with Dr. Palacios as well in the Green Journal about the contents of this partnership and I've been again reporting to the Committee that the site visits are confidential to the site and unfortunately cannot be shared publicly.

Thank you for the opportunity to comment today. I'm happy to take any questions.

MS. PETTIFORD: Thank you so much, Tina. We're going to go straight to Karen.

DR. REMLEY: Yes. And I will cede most of my time back because Tina did such a wonderful job of explaining what happens when -- you know, we are part of a team here at CDC, who've identified causes of the incredible increase in congenital syphilis, which is really an increase in syphilis in women of childbearing age, men of childbearing age, and maternal people. People without timely prenatal care or spotty prenatal care.

Also, working closely with FDA to think about testing

that can be point of care testing and making sure that people understand the various ways for people to use different medications. When can we use doxycycline so that we can save medications for pregnant women that are appropriate.

We're working closely with ACOG, with IHS, and everyone else and continuing to look at all these issues, both through our SetNet, which is emerging threats and through MapLink, which is looking at women who've been exposed to opioids, but really the bottom line is we've all dropped the ball in thinking about STIs in our populations and I think syphilis is just one of many. And Tina, thank you for all the leadership and work you're doing in this space.

MS. PETTIFORD: Thank you so much, Karen. And Ada?

DR. DIEKE: Thank you, everyone. And thank you to the presenters before me. CDC continues to engage with Tribal Leaders in Tribal Communities. CDC's Division of Reproductive Health presented on maternal mortality during the 2023 CDC ATSDR Tribal Advisory Committee meeting that was hosted by Oneida Nation on tribal lands.

We asked tribal leaders about maternal mortality prevention in their regions, how best to engage with tribes, and about maternal mortality review committees and MMRC approaches that were best suited for tribal communities. CDC also partnered with the National Indian Health Board, NIHB, and convened the

first national meeting on tribal maternal mortality reviews in an effort to discuss tribally lead MMRCs while also on Tribal lands Santa Ana Pueblo, New Mexico.

CDC expanded funding this year to increase support for this activity. CDC is also excited to announce that we are partnering with the National Institute of Child Health and Human Development, part of the National Institutes of Health, to lead efforts to update and disseminate materials for the Healthy Native Babies Project.

The Healthy Native Babies Project aims to reduce the risks of sleep related deaths among infants in American Indian and Alaska Native Communities. And the update of the Healthy Native Babies Project will engage Tribes, tribal leaders, and tribal organizations in review of current materials and will use this feedback to inform development of new culturally appropriate materials for use by American Indian and Alaska Native populations.

CDC's Hear Her Campaign, which also focuses on personal stories of pregnancy-related complications from American Indian people has garnered over 16.5 million impressions from digital and social media and over 100,000 Hear American Indian and Alaska Native webpage views from November 2022 to September 2023.

Not only has CDC included American Indian and Alaska Native voices and talent in the development and implementation of

the campaign, DRH and the HHS's Office of Minority Health is working with NIHB to fund tribes and tribal-serving organizations to implement the campaign locally to help improve maternal outcomes.

So, that first cohort of grantees have been awarded and NIHB is planning to engage a second cohort of three grantees in early 2024. CDC has additional opportunities that center American Indian and Alaska Native communities in their effort to improve health and wellness in their communities, as well as to support tribal public health infrastructure and links to those programs, such as the Healthy Tribes Program and the Public Health Infrastructure Opportunities will be provided in the chat. Thank you for the opportunity today.

MS. PETTIFORD: Thank you so much, Ada. Michael?

DR. WARREN: Thank you. Just a few updates from us. One of the items, recommendation number 14, related to the reauthorization of the Maternal, Infant, and Early Childhood Home Visiting Program. Congress acted on that and actually doubled the tribal satisfied, increasing that from three percent to six percent. That percentage, in addition to doubling the overall amount of funding increases over time, MIECHV was a $400 million program prior to reauthorization and the amount for the program will increase over the next five years to be an $800 million program total and the tribal satisfied for that, again, will be

doubled to six percent and so exciting.

And we partner with the Administration for Children and Families or ACF to administer the Tribal Home Visiting Program and they've been very busy getting those funding opportunities out to expand evidence-based home visiting.

A second area of work that we've been engaged in this relates around recommendation number 2, involves increased technical assistance and support for maternal and infant mortality and morbidity review activities. At the Maternal and Child Health Bureau, we fund a National Center for Child Death Review and Fetal Infant Mortality Review. That TA Center has hired a dedicated tribal lead to support activities around fatality review, outreach to tribes, national organizations, and the Indian Health Service.

They're also working on a contract to develop learning guides and self-paced modules that will cover essential information for fatality review teams, things they need to know in working with tribes and reviewing fetal, infant, and child deaths of Native American and Alaska Native families.

They also have brought on a liaison who's working to identify national organizations to collaborate with and have done networking, including at the recent CityMatCH Conference to further diversify participation in the prevention review processes.

Lastly, we continue to partner across the federal

government to think about how we disseminate funding opportunities and increase engagement. A couple of very concrete examples we've been working with HRSA's Office of Tribal Affairs with Dr. Pattara-Lau and with ACF's Tribal Home Visiting Program on disseminating funding opportunities or NOFOs.

And also, importantly, for this Committee, the solicitation for member nominations for ACIMM and we've seen an uptick in nominations as a result of this solicitation. So, appreciate these partnerships and look forward to keeping you all updated as we move forward.

MS. PETTIFORD: Thank you so much, Michael, and thank you to everyone. Unfortunately, we do not have time for questions, but we do have a link in the chat if people have questions that we can try to reconvene a smaller group to try to get a response to your questions. I definitely want to thank Ed and Magda, as well as Janelle for sending over her comments.

I think Janelle said it nicely when she reminded us of the shared history of American Indian Alaska Native, as well as African American Black individuals. We all share some history here in this country. And so, if there's opportunities, I think we consider them as we're moving forward with the new recommendations that we're working on within this next year to look at those recommendations, see whether it's overlap, if there are opportunities to reelevate those recommendations. I encourage

the workgroup leads to do this. I do think, again, that there are other opportunities and all of us could look at ways that we can champion this work.

A lot of time and a lot of effort went into releasing the Making Amends Report. And by no means, as Ed stated, do we want it to sit on a shelf. We need all of us to elevate it and to be reminded of why we put it together initially, why did we release this report to the Secretary, and so we will continue to work on this. Thank you all so very much.

Unfortunately, again, apologies. We are out of time, and I know we are up for a 20-minute break and Committee Members, I apologize to you because you're not going to be able to get 20 minutes now because we've got other speakers that are lined up and they need to be other places at different points in time, so we're going to take like a five, six-minute break.

If this is lunchtime where you are or you've never gotten to lunch, please run and grab something. Feel free to stay off of camera for a little while to eat, if that's what you need to do, but we will come back together at 2:38, and that'll put us about eight minutes behind. Thank you all.

(Break)

Community Voices

MS. PETTIFORD: Thank you all so very much for your patience

with that short break. I realize some of you may still be on your break, and we will have another one later on. So, I do apologize for that, but we want to make sure we're giving people the time for their presentations.

And we're very excited to have with us today Rebecca Burger with the RMOMS Program out of the Bootheel Perinatal Health Network in Missouri, along with Heather Pawlik, who's our community voice representative and she's an RMOMS patient with them, so I want to make sure we're giving them sufficient time because we know how much and how important -- we really appreciate their time, but how important it is to make sure we continue to elevate the community voice. Another one of our workgroups around rural health and so having RMOMS Program here with us today is special. So, Rebecca, I'm going to turn it over to you.

Some people are off of video because of technical issues, so please know that we are listening intently whether we are on camera or not, so please do not take that as a sign that we do not appreciate you all being here. So, turning it over to you, Heather.

MS. BURGER: Thanks, Belinda. My name is Rebecca, and I am Assistant Care Coordinator with Bootheel Perinatal Network, which was the RMOMS HRSA grant that is housed within St. Francis Medical Center. I am the one who gets to meet with the lovely moms, so I would love to introduce you to Ms. Heather.

I met her in mid-January this year when she was pregnant with baby Noah. She lives in one of our small towns and has had several previous miscarriages, so when we met at the high-risk OB, we had lots of emotions running, and I was able to hear her story and then connect her to lots of organizations. And throughout her pregnancy and postpartum period, she's provided some valuable feedback that we've continued to share with other mothers and push up to the state level. So, Heather, I will let you take it from here and just share a little bit more about your pregnancy and who you are and Noah and how you and I were able to do what we did. So, I'll turn it over to you, Heather.

MS. PAWLIK: Thank you, Rebecca. My name is Heather Pawlik. I am a mother to a six-and-a-half-month-old little boy. He is currently in the backseat sick right now. We just left the doctor's office.

Rebecca has helped in so many ways. Sorry, I'm pregnant again, hormones. As she mentioned, I have had multiple losses before Noah. It took me 17 years to have him. Sorry.

MS. PETTIFORD: Please do not apologize to this group. Take your time.

MS. PAWLIK: So, Rebecca has given me so many resources. My husband and I have struggled financially recently, and thanks to Rebecca, she sent me to another company that paid our electric bill two months in a row for us just so that we would have heat

and air for our son. I have received so many diapers, I have been in through Building Blocks I was introduced to Whole Kids Outreach. They bring Noah books every month. I get diapers and baby wipes and just everything. Like I never thought that I would be able to get as much help as what I have.

And like I said, you know, Noah is my little miracle baby. I lost four pregnancies prior to him. I have had multiple surgeries. I have multiple medical conditions. I'm a high-risk pregnancy for any time that I'm pregnant. I'm sure that Rebecca will see me again in the next few months. I'm thankful every day for Rebecca and everything that she has done for me and to help me find all the resources that I've needed. Somehow food stamps they somehow got a mix up in their systems and cut my food stamps off one month.

They had it put into their system that we had got like almost $7,000 of income one month, which was definitely not true. And thanks to Rebecca, she sent in to somebody for me. So that a way that they could help me get my food stamps back and get them back quick so I can help get more extra formula because my son's a little pig. But other than that, like I said, Rebecca and the program that she has is just an amazing program.

MS. PETTIFORD: Thank you so much, Heather. We appreciate you sharing with us your experience and the joys and the challenges of your family. We really, really appreciate your

time. So, please hang on a while, if you can, but I understand you have a sick child in the car, if you have to drop off.

MS. PAWLIK: I will actually show you my child, if you would like me to.

MS. PETTIFORD: Of course, if you don't mind sharing.

MS. PAWLIK: And this is Baby Noah.

MS. PETTIFORD: Hi, little Noah. That is too precious and he doesn't feel good. Thank you, Heather. We appreciate that. I'm going to turn it back over to you, Rebecca.

MS. BURGER: Yes, thank you, Heather. Heather is from one of our small towns of Dexter, so where she is located and just like in Bootheel, which you'll hear more about, very rural communities. It's not uncommon for our moms to have to travel an hour one way to seek medical care.

And as she was saying, finances are a struggle, food is a struggle, and all of those things, as everyone here knows, truly impacts the outcomes of our pregnancies. So, I'm getting families connected and letting them share their story openly is a huge thing. I am the blessed one that gets to hear stories with these mommas and be able to make those connections and see these babies grow.

MS. PETTIFORD: Thank you, Rebecca, and thank you, Heather. We'll take a moment now if anyone has any questions. We will hear more about the RMOMS Program that is there and keep in

mind if you think about form our last meeting, our meeting in June, we did have a focus around social determinants of health or those social drivers of health, so being able to focus on the rural nature of our country and how it impacts maternal and infant health. One of the main reasons we wanted to have RMOMS come in and join us today.

Yes, Steve, I see your hand.

DR. CALVIN: Thank you, Rebecca, and thank you, Heather. I hope your son feels better soon. He didn't look very happy right now.

I have a question too. Is the program that you're involved with is -- I've had some connections with SSM Health, is that the hospital system that you're working with?

MS. BURGER: So, the Bootheel Perinatal Network is housed within St. Francis Medical Center. They are one of the hospitals located in Cape Girardeau, Missouri that so graciously stepped up to allow RMOMS to exist. If St. Francis hadn't stepped up to accept this grant, we wouldn't exist.

However, we have a consultant out of SSM that we work with. They partnered with us. They are part of our network to provide some of the level four perinatology services. They also help do some of our education out in Bootheel because it is very rural, so SSM was able to help us do emergency childbirth trainings in our area for our ambulance and firefighters and all

of those things. I do not work under SSM, but they are a part of our network as a consultant.

DR. CALVIN: Sure. And then one quick follow-up question too. So, Heather, was it all OB/GYN physicians or family medicines doctors? Were you able to connect at all with a midwife?

MS. PAWKIL: I spoke with one midwife, and I just chose to go with my regular OB and with the maternal fetal medicine because I felt like that was more safe for me because, like I had mentioned, I do have a lot of medical issues and stuff, and I was currently on blood thinners, which I have to take each pregnancy just to keep my baby safe.

DR. CALVIN: And we're grateful that that all worked out, too. And so Rebecca, is midwifery part of the program you're working with?

MS. PETTIFORD: Steve, can I interrupt briefly because I don't want us to get ahead of ourselves. We do have a whole presentation on RMOMS later today.

DR. CALVIN: Okay, yes. Sorry.

MS. PETTIFORD: No, great questions. I just want to make sure that we realize that this is our conversation around our community voice, but if you look further on in the agenda, we have a pretty full presentation on RMOMS that may answer some of your questions, and I think it might be answered.

DR. CALVIN: Okay.

MS. PETTIFORD: Thank you so very much. You all are welcome. Well, Heather, you're welcome to stay on as long as you want to. I think Rebecca will stay on with us anyway because she'll be coming back, but thanks so much for your time today.

Partnership Panel of National Organizations

MS. PETTIFORD: We're going to go on with our agenda right now because we're going to go up now, and we've got a couple of national partners that we had invited to come. As you recall from previous meetings, we've asked our national partners to come and share what they're doing around improving maternal and infant health in this country. And so today we're fortunate to have with us Ericka Burns. Ericka's the Senior Director of Equity with the National Family Planning and Reproductive Health Association. She will come. And right after Ericka, we'll have Julie Wood.

Dr. Wood is the Senior Vice President of Research Science and Health of Public and she's with the American Academy of Family Physicians, so we'll have then and then I will come back and introduce Deborah Frasier. So, we're going to start with Dr. Ericka Burns.

DR. BURNS: Okay, we'll get started. So, my name is Dr. Ericka Burns. I'm the Senior Director of Health Equity at the National Family Planning and Reproductive Health Association and

I'm going to talk about our membership and our organization and a little bit of concerns and recommendations that we would like to bring forth to you all.

So, a little bit about NFPRHA. We are a nonpartisan, nonprofit membership association. We support the works of family planning providers and administrators throughout the United States, and we'll get into where.

We're also the leading expert in publicly funded family planning and provide subject matter expertise to our members and we also offer members capacity-building support aimed at maximizing effectiveness and sustainability. In my role, in particular, I assist with our members with some of their health equity efforts, especially around family planning.

So, who are our family members, who do we talk to, who do work with every day? Part of our membership, it includes family planning councils, state health departments, Planned Parenthood affiliates, private not-for-profit agencies, FQHCs, or Federally Qualified Heath Centers, city and county health departments, Medicaid, family planning administrators, and so all this is a wide range of folks that we work with and that we're happy to work with to make sure that folks are receiving the care that they need, whether they are the providers directly themselves, whether they're administrating the grant funding, we're all part of a working wheel and so we want to make sure that

all of our members are supported the best way that they can.

Just really quickly around the numbers around our membership, NFPRHA, we have around a thousand members throughout the 50 states, including D.C. Puerto Rico, and Guam. We're really proud of this membership and in total of those members we have various organizations, like I mentioned, and within that network we have about 3,500 health centers and service sites that provide high-quality family planning and preventive services to many millions of low-income, uninsured or underinsured individuals, so we're really proud to support our members in that way.

So, what I want to talk about really in terms of improving infant and maternal outcomes we want to talk about three core things that we're really focusing on. Of course, the Bicillin shortage that's happening, extending Medicaid coverage for postpartum care, and advancing health equity, especially in the family planning space.

So, starting with the shortage, Bicillin is the only recommended treatment for pregnant folks with syphilis and preventing congenital syphilis. We are noticing a rise of syphilis and congenital syphilis, so it's really important that we're talking about prioritizing this medication for this population and the shortage is looking like it's extending into 2024, the end of 2024, so this definitely can be a concern to be on the lookout.

Currently, we're seeing, according to CDC, reported that

in Mississippi alone infant hospitalization of congenital syphilis has spiked by 1,000% from 2016 to 2022, which, of course, is very alarming and this before we're seeing any shortages, so we're talking about access to screening, testing, and treatment. That's really important. And currently, with some of my colleagues, working with our members in North Dakota, who have already started to become affected by this shortage, and so it's happening now and we're going to see an increased surge of syphilis infections and congenital syphilis, which is really concerning because it can affect healthy outcomes of parents and their children.

And of course, we talk about this a lot. We want to extend Medicaid postpartum coverage. We believe firmly that states should be required to extend Medicaid coverage to its beneficiaries 12 months postpartum. We believe that all people should have access to high quality, confidential and affordable health services. That they need to thrive during and after their pregnancy, including prenatal, obstetric, and postpartum care that supports individual autonomy and decision-making. And with that decision-making that also could include conversations around conception access, health coverage, et cetera.

We firmly believe that no one should have to face a loss of health insurance coverage after childbirth, particularly people of low to no income who experience a variety of different barriers to accessing care. And we know that Black and Indigenous

populations they experience two to three times the rates of pregnancy-related deaths of white women in the United States due to implicit and explicit bias of the healthcare providers and service delivery systems.

And so, it's really important that providers, administrators really take in health equity really seriously to make sure that the lives of folks who are especially marginalized are being taken care of and supported in a way that we can reduce those numbers, if not eliminate those numbers, so we can end any health equity gaps.

The work that we're doing here at NFPRHA, so in my role I'm really excited to launch our NFPRHA health equity tool that's in the works right now. We're currently developing various resources and tools, and an assessment tool for family planning providers so they can use to analysis any gaps in services or prepare, evaluate their activities that they intend to promote health equity.

Some of the times when we're talking about the work that we are doing or what we want to do, we're oftentimes like where do we start or what's being done? And so, we want to provide those resources for folks so they can just easily access it at any time and get where they can start or partner with other organizations.

So, the purpose is to support family planning providers as they conduct community needs assessments, program design, data

collection as well, and to seek different partnerships between family planning networks and collaboration with their community. And we separated some of our interventions to support based on community and culturally specific intervention and policy and structural interventions, so how can we get the community involved and how can we change some of our internal policies and even some of our federal policies or state or local so that we can address barriers to care?

And finally, we want to encourage our members to evaluate their organizations' programs, policies, address structural racism, health inequities, and building healthy relationships that build trust between patients and their providers. Oftentimes, many of the gaps in care and some of the barriers to care is the lack of trust that patients may have with their providers due to systemic racism, past experience, and experiences from their community. And so, we want to make sure we're addressing them head on and that we're coming up with clear interventions that engage the community to give them exactly what they want.

And of course, that can change over time, which is fine. We want to make sure that folks are being heard and they have a place in their care and in their autonomy.

And so, that's just a quick overview of what we're doing, what we're working on right now, what we're seeing out in

the field and I'm really excited to launch our health equity tool. Hopefully, our aim is by next spring so that our providers can get the resources that they need to support their programs, support their patients, and their communities at large. Thank you.

MS. PETTIFORD: Thank you so much, Ericka. We'll hold questions to the end, if you don't mind. We're now going to go onto Dr. Wood with American Academy of Family Physicians.

DR. WOOD: Thanks for inviting me here today. I'm here as a family physician and staff at the American Academy of Family Physicians and I'm really glad to be here and hearing the conversation today.

I am representing our over 133,000 family physicians across the country and I will start with my slides. I'll go through the first few pretty quickly because many of them have already been covered about maternal morbidity and mortality and particularly the disparities, but they're very important, as we have heard today.

I do want to share a little bit of a disclaimer and something that's personally important. My background is that I practiced for about half my career, almost 20 years, about half of that was in my rural hometown, so I was born and raised and then went back and practiced until my critical access hospital closed its rural OB unit. So, at that point, that was deal breaker, a very sad, heartbreaking deal breaker for me and I ended up leaving

and going to Kansas City where I am now and then taught in a residency program and helped trained people to go up to rural areas sometimes. Sometimes they stayed urban, but that is my background was in a critical access hospital for several years.

But one of the things that I think is really important for us, and I'll talk about a little bit more in detail, is we know about one in three counties are maternity deserts and two or three of those are rural and family medicine is one of the places where that is filled. We have a lot of family physicians in those counties.

And then we talked quite a bit already about some of the other population issues or concerns, which is obviously grave and very concerning, but one of the things that the AAFP is taking very seriously is how can we mobilize our workforce to help with this, whether the family physician is delivering or not because we do have some baseline training and many of our family physicians are rural areas and other areas that are also disadvantaged.

So, one of the things that we have learned is that we have the ability to influence the outcomes across the lifespan, so that could be prenatal, perinatal, and postpartum periods, and we know that family physicians are trusted members in the communities they serve, and we have strong relationships with families and communities.

I did want to share this slide because I think it has

important data that I hope the Committee can use and consider. Some of this data is not being considered currently because it's not in, for example, the March of Dimes data, but I think it's very important, and it's including where the family physicians are that delivery and that is especially important, I think, in rural areas. And I can get you more of this information.

This is geospatially mapping data from the American Board of Family Medicine. And if you take a look, it's probably a little bit harder seeing detail when it's looking at a slide, but I'm happy to share with the Committee, but this was published a year ago and it shows that family physicians are providing maternity care in 63% of what's designated as maternity care deserts, which would change the flavor of what the deserts are and in 181 counties they're the only maternity care providers.

And I say that not to be divisive or competitive, but inclusive. We would like to be seen as part of the team, work together, look how we can be collaborative, so happy to share more information and look how we can work together. So, I wanted to share some of the things we've worked on already and then some things in more detail. This is not an exhaustive list, but some of the high points.

So, we have been working on supporting the Momnibus Act, as well as the PUMP Act, and then a huge supporter of 12 months Medicaid coverage postpartum. And I also would posit that this an

area were family physicians can be very helpful in that continuum once the 12-month coverage is sustained so we can have continuity of primary care, whether that family physician is delivered or not, and we have several ideas about that.

We're doing research around the role of the family physician and how we can help with outcomes and be a part of that team also. I'm going to talk to you just a little bit about some of our training programs. We've generated more continuing medical education and articles. We have a project called The Everyone Project at AAFP and that's looking at health equity as well as tools or social determinants of health that are integrated throughout our work at AAFP and many organizational partnerships with groups that have been on today and have been discussed already, AIM-CCI, some really important groups that are already here and then we have a new women's health portal and are working on continued partnership.

I want to spend a bit more time on some of our courses that are continuing to make an impact and we want to see how we can better disseminate them to areas that would be helpful or work with your organizations. So, our Basic Life Support in Obstetrics is targeted more to pre-hospital care providers or more entry-level clinicians. And it has just been updated, as well our ALSO, Advanced Life Support in Obstetrics, and it is for the entire pregnancy care team. It is very team oriented. It is skills-

based. It has the didactic proton, some online, some in person, and definitely scenario-based, and we emphasize this very strongly with the Academy. We're very team-based and it's also globally impactful.

That's just from one of the leaders of the ALSO course about why it's been so important for him and his colleagues. This is not new. Many of us heard of the fourth trimester. We've really embraced this at the AAFP, particularly to really mobilize all of our family physicians, not just those that deliver, so we can look across the continuum, concerning preconception, interoception, prenatal, postpartum, and working within the community within public health during that delivery time, especially that year of postpartum.

And part of the reason is because of that involvement with the community, we can really, like I said, mobilize that family physician workforce and this is a more active role that we're taking with mobilizing the family physician. And your committee will recognize Dr. Ramas here. I am hoping that the video will work. I'm going to show you some of the topics in our fourth trimester education that we've been distributing.

Dr. Ramas is one of our speakers and she had a couple of great clips, and I was not thinking of her being on your committee. That was a happy accident, but if the video would work if you could click on it, she had a couple great things to say.

DR. RAMAS: Instead of thinking of postpartum care to be this finite period, expanding it to this fourth trimester concept helps us to bridge that very important life event with life after the event. And who's going to wrap their arms around them? I would submit that it's family doctors.

DR. WOOD: So, here's what we're doing with our comprehensive approach right now is using our training modules. I'll show you the list of those in a minute, as well as the ALSO and BLSO curriculum. We're currently working on an audio series of peers to reach out to our members about how they successfully implemented fourth trimester interventions in their own practices and then working on more funding for dissemination of these interventions so we can reach out to our members.

DR. RAMAS: This patient, she's a working mom, did really well taking care of her now four children after delivery.

And what's interesting is because we had such a good relationship, I was able to share with her after the delivery how important it was for her to monitor her diabetes, monitor her sugar levels, and to make sure that she could maintain a healthy lifestyle to prevent further diabetes.

And what's interesting is come the six-week postpartum phase, she was fine. She had no other results of or sequelae of diabetes as we would expect.

However, six months later, after she stopped

breastfeeding her baby, she started to actually increase in her weight again. And she actually had signs of concern for insulin resistance. She started having changes in her skin color. She had development of more skin tags. And she had regained about 20 pounds at about nine months postpartum.

So at that phase, because she still had time to be with me, I was taking care of the baby and so checking in on her as well.

I was able to get a hemoglobin A1C for her right then and there while her nine-month-old was coming to see me for a well child visit. And at that time, we were able to diagnose her with non-insulin dependent diabetes type two. And that was motivation enough for her to flip the switch on her lifestyle management.

It helped her to realize that there is a connection with her past prenatal care, her past pregnancy experiences, the fact that she was older, she was actually above the age of 40, and with the family history or diabetes, how important it was to maintain her lifestyle. And so, luckily, with that continuity of care, with that fourth trimester insight, we were able to prevent long-stream, downstream, adverse outcomes.

DR. WOOD: All right, thank you, Dr. Ramas. And I just wanted to share the different topics that we have incorporated. These are all delivered by our various members and different experts and it's quite comprehensive. Three's a very targeted

emphasis on health equity and through the lifespan, looking long-term for lifelong health, but also focused on community interventions and particularly looking at mental health, there's some group visit work, as you can see, very classic fourth trimester, but we tried to very intentionally incorporate different types of practices, geographic diversity, and we're very excited about it. Our members are really buying into it, and we think we can help with a variety of teams and be a part of the solution in an action-oriented plan here, so we encourage your involvement as well.

And we're just interested in how we can partner with any of you. And that is it. I'm glad to answer any questions at the appropriate time. Thank you.

MS. PETTIFORD: Thank you so much, Dr. Wood. We appreciate you coming.

MS. PETTIFORD: So, before we go into questions, I do want to introduce our next national partner. This is Deborah Frazier with the National Healthy Start Association. Deborah had actually presented with us earlier, some of the work that the National Healthy Start Association was focused on but because of some other issues that have come up and some other changes that's going on with the federal Healthy Start Program at this time, we wanted to give her the opportunity to come back again. So, Deborah, I'll turn it over to you.

MS. FRAZIER: Thank you, Belinda, and thank you, Committee, for the opportunity to be with you today and to offer a few words about the Healthy Start Program. And for those of you who I didn't get a chance to share a little bit about Healthy Start, I want to start with a little bit of history of the Healthy Start Program, not much, and I won't have slides.

So, Healthy Start began in 1991 at the heels of what was an international and national crisis in infant mortality that was inherited by President H.W. Bush, some call Papa Bush, but he inherited this infant mortality crisis and the first thing he did, because he had a campaign promise to invest in America's children, was to appoint a White House Taskforce on Infant Mortality and that Taskforce, which included many in his cabinet and subject matter experts, produced a report, the White House Report on Infant Mortality. And that report started with saying to the President that he should make infant mortality an issue of national urgency. And it also said that the country could not afford either in economic terms or moral terms losing babies and infant mortality, which I think is about where we are right now, and that's a profound statement.

But the Taskforce also had a series of recommendations and some that lead -- and all that lead, actually, to some of the funding that we have right now, but some that was immediate funding for the expansion of Medicaid, the expansion of the Public

Health Workforce, but the creation of this Committee and the creation of the Healthy Start Program.

And why Healthy Start, I'll say to you in a second, but because that report said that the effort, the reality of infant mortality was rooted in community factors. And so, the report said we need a different kind of public health approach, one that is rooted in community, one that is community-driven, one that is community-based, and one that is innovative. And so, that is why Healthy Start was created and it is and continues to be a community-driven, community-based program.

And it was at that time, and still is a pretty big deal. I say it was at that time because it was called a presidential initiative, and the Advisory Committee for Infant Mortality and Healthy Start was celebrated in a Rose Garden ceremony with the President. So, we are, you and I, a big deal.

But what was known then about infant mortality was largely based on clinical factors, but what was not known -- what were the challenges that communities faced to the barriers to getting the prenatal care. What were the systems issues that needed to be addressed, and those are the issues that Healthy Start addressed and addressed successfully since 1991.

So, Healthy Start then did not replace any programs. It didn't duplicate any programs. It was and is what Marybeth, one of the first Healthy Start division directors said, was a gap

filler that was a partner with existing programs. We partnered with Title V and complemented all of those programs and produced a series of reports that informed the Maternal Child Health Bureau and public health about what was going on in communities and continues to do that. And we've grown from those 15 demonstration projects to over 100 programs that exist in city and county and state health departments, community health centers, Tribal Nations, Appalachian communities, and nonprofit organizations across the country in urban and rural settings.

Our programs make a difference across the country. We've improved infant and maternal health. And as you've heard Dr. Warren say and you've heard Lee Wilson report, we've infused fatherhood programs, maternal-clinical interventions and clinicians in our programs and doula services as well.

We've expanded, as I said, from those 15 programs to over 100, and that happened when we realized the success of this community-driven program and the association work with our federal partners and Congress to get authorization for the Healthy Start Program and to continue the expansion of the program.

You heard from Lashelle Stewart, I can't remember, last meeting, meeting before, and I think Lashelle shared with you some of the work that she's doing in Baltimore, and she does that work because Healthy Start programs do what is above and beyond what is in the notice of funding opportunity that Lee talked about the

Healthy Start programs and working on them.

When you work in the Healthy Start community, you know that you're part of that community, you're a trusted member of that community, and trust has been mentioned several times today, and the community relies on you. You can't talk to a mom about making a prenatal visit or an early postpartum visit if she's concerned about whether she has housing, as Alicka talked about, or whether she has a job or her partner or husband has a job. All those issues have to be addressed.

So, what you heard Lashelle talked about in June were all of the things that a Healthy Start Program has to address that is not being measured and reported in the data that you have about infant mortality outcomes, but those are the things that we address in the Healthy Start Program.

I was fortunate to be where you are as a member of ACIMM some years ago, but I am so much more, I think, much more fortunate right now to lead over a hundred Healthy Start programs and project directors who are passionate and innovate in the Healthy Start Program. And I was so fortunate a few months ago to be in Baltimore with the Secretary of Health and the HRSA Administrator and the Vice President's office when they were announcing the Maternal Health Portfolio programs in Maryland.

And they toured the Baltimore Healthy Start. They were able to see a room full of computers that were being used for a

job training program that Baltimore had additional funding to do because they realized Healthy Start Program participants need job training. They were able to hear from Maxine Vance, who's been with that program for over 20 years as their public health nurse, and Maxine's completing her doctorate now, but Maxine said, hey, we got it. We understand moms need to have early prenatal visits, not a prenatal visit a couple months after her birth.

And we understand she's not going to get her early postpartum visit. She's going to take the baby first for that one-month visit. So, we've worked out with our community partners in the Community Health Center, that when she goes with that baby, she's going to get a postpartum visit. That's what Healthy Starts does.

She said we've got a triage process. And the Vice President's office said that's genius. I said, no, that's Healthy Start. That's what we do. We don't duplicate, replicate, we are Healthy Start. We know exactly what our communities need and that's what we deliver.

I think we are an awesome program, and we work in partnership with the divisions to deliver services that complement the other programs under the umbrella of the Maternal Child Health Program.

Where we are now, I think, is at a crucial point and I've mentioned that you are called as you, SACIMM, ACIMM, were

created under the legacy of President H.W. Bush with the sense of urgency to address infant mortality and maternal morbidity and mortality, as we are in Healthy Start, which is why we have the same birthday.

But we find ourselves at a crucial point right now because, we, the Healthy Start appropriations is -- I don't know how mixed up -- but we are not funded in the Healthy Start House Appropriations, but funded in the Senate Appropriates, and will be reconciled in 2024. But we need to have a call to action and determine whether or not this is important enough.

We cannot lose the Healthy Start Program. We cannot lose our sense of urgency around addressing infant and maternal health and infant mortality and maternal morbidity and mortality. Where Healthy Start goes we all go, and so I'm asking and calling for a sense of urgency in exactly the same way that that first taskforce on infant mortality did in 1991. That is my request and call to this ACIMM Committee. Thank you, Madame Chair.

MS. PETTIFORD: Thank you, Deborah. Thank you so much for coming back to share with us the challenges of the federal Healthy Start Program and that the National Healthy Start Association is doing.

So, we're going to open it right now for questions for our three panelists. We had Ericka with Julie as well as Deborah. Does anyone have questions?

(No response)

MS. PETTIFORD: As Deborah just shared, in the House version of the budget, the Health Start Program has been zeroed out. So, as you've heard the information about what is happening with this program and the outcomes just keep that in mind.

I think also in the same House budget, the Title X Program is zeroed out. So, again, as we're elevating the work around maternal and infant health, we need to be aware of what is happening around us. And as we've been asked to do on more than one occasion, to be champions to continue to move this work forward. Any questions?

(No response)

MS. PETTIFORD: Well, if we don't have questions, I definitely want to thank those presenters. Thank you for your time and your expertise in coming to join us today.

Effective Framing and Language for Recommendations

MS. PETTIFORD: At this point, we're going to switch over. We are, again, happy to have with us Julie Sweetland. Dr. Sweetland is with Frameworks Institute. Some of you know that I've been having conversations for quite a while now thinking about what are we doing in this country as we get further and further polarized and what do we really need to do around framing our messages as we're developing our recommendations around maternal and infant

health.

I was fortunate to have a conversation with Julie recently, along with Vanessa and Sarah, for us to talk about, you know, as we're thinking about these recommendations to elevate maternal and infant health, and specifically elevating it with the African American/Black community, are there things that we need to be careful of, are there things that we need to think about so that even though the country may be polarized, that everyone can be excited and know how critical and how important it is for us to improve infant and maternal health in our country. So, at this time, I'm going to turn it over to Julie. The floor is yours, dear.

DR. SWEETLAND: Thank you so much, Belinda, and I also want to express my appreciation to the Committee, not just for giving me the opportunity for sharing some ideas with you today, but for all the important work that you do in vital issues of infant and maternal health and mortality.

Today, I am representing the Frameworks Institute. We're a nonprofit organization focused on ensuring that mission-driven communicators can lead productive public conversations on issues that matter, and we do this primarily through research. We're a group of social scientists, so I happen to be a linguist. We have pollical scientists, anthropologists, sociologists, et cetera, on staff.

That's not your normal setup of a communications-focused organization, but we believe that the issues that we're communicating about in our public conversations deserve as much evidence for the communications part of it as the need for the policy and practice part of social change, so we do that rigorous research and then we share it with NGOs and public sector agencies so they can frame issues more effectively.

And the next slide, I'll just give you a couple of examples. We've been around for almost 25 years and during that time we've enjoyed many partnerships in early childhood and public health and health equity, including research into many health topics that have a major impact on infant and maternal health. So, whether that is helping the field of early childhood move from a narrow focus on child abuse and neglect and vulnerability to a broader focus on brain development, working with the tobacco control movement, federal, state, and local agencies, as well as NGOs to shift emphasis from tobacco being a public health issue to being a social justice issue is really helping to unlock some policy options at every level.

Working with advocates for oral health so they can tell a new story about how oral health is part of overall health and how access to care is a matter of health justice. And in terms of environmental health, moving from a very narrow focus on contaminates to a broader focus on fairness across place and how

place affects health and it's helping advocates for environmental health and environmental justice point to the need for systems and the need to strengthen systems rather than just constantly and consistently pointing out the failures of systems.

So, those are some examples of how the field can reframe its issue, but also examples of research base that open to you all as you start to think through what you want to talk about in terms of recommendations to advance health equity for Black moms and babies.

So, what do I mean by framing? We often hear the term framing thrown around, but what that really mean and specifically what does it mean for those of us who looking to share scientific, evidence-based ideas to inform policy and practice? Framing we can define it simply as choices, making choices about how to present ideas, where to start, what to emphasize, how to explain it, what to leave unsaid.

And the way we frame health topics influences how people think and feel about them and what actions they're willing to take or not take or support or not support. And as frames move through society, they shape issues that the public and policymakers pay attention to, whether or not you're getting a public response to that issue.

And there is no such thing as an unframed communication. We are always making some type of choice about how to present our

ideas. Since we are always framing, I believe we should always be framing strategically and the work that I'm going to try to offer today some evidence about the way people respond to one way of framing an issue or another so that communicators, as you're doing your communications, you can use that data to inform your choices.

So, let me give you a few examples that I think have some relevance to the topic of birth equity and infant and maternal health and then I'll get into some very specific examples of things you might want to try or emphasize in your own communications.

Our next slide I'm going to show you some examples of how framing can open minds to science or close them. The words we choose really can open people up to engaging in an issue or close down dialogue and thinking in that way that Belinda just mentioned. And in our research finds this time and again, I'll show you an example from an experiment we did to measure two different ways of talking about why it might be a good idea for the government to fund and support coaching programs that help families with issues like relationship, discipline, and sorts of things we might talk about as positive parenting behaviors.

So, in this experiment, we asked people about their attitudes towards those programs and explored whether they thought they should be a federal priority. And so, the scale along the vertical line there that you see indicates the level of support

for those programs and the zero line is the control group, people that got no message.

So, when we gave people a message, when we framed these issues in terms of this about effective parenting, giving parents more help to adopt the kind of right behaviors, you can see that lead people to be six percent less supportive of that topic, whereas, when we talked about that same topic in terms of children thriving in terms of child development, that children thrive when parents have the support that they need that lead to a 10 point increase.

And I'm sorry, that line should be at the zero, so it's overall a 16-point swing, right? So, really it can have a pretty major difference just based on what you're emphasizing who the program is for and what the basic statement or problem is.

On the next slide, we can see that word choice matters, so this is an experiment that we did in an initiative to shift healthcare practice so that more family physicians, pediatricians, and family physicians were doing brief, motivational interviewing with adolescents during their wellness visits to do early prevention and perhaps a brief intervention or referral to treatment if young people were using harmful substances.

So, we tested some different ways of framing this. So, the first one was family physicians should screen adolescents for alcohol and drug use. People rejected this idea because they

assumed that screening involved testing of biological samples and that felt like a bit much for your 12-year-olds annual checkup, so that didn't work.

Family physicians should ask adolescents about alcohol and drug use. People rejected that idea. It sounded like an interrogation. They assumed the purpose was kind of catch and punish. And so, the wording that worked was the next one. Family physicians should have a conversation with adolescents about alcohol and drug use.

In this instance, people visualized what the policy change, what the practice change actually was, brief, verbal interventions, and so, they said, yes, that sounds like a good idea. And so, sometimes the words that have a specific meaning for us as experts come with a very set of different associations with folks that aren't close to the issue and so that's a part of framing that we need to pay attention to.

This is an example of how framing can interact with political affiliation. So, as I mentioned before, a few years back we had a project focused on making the case for oral health as a central part of overall health and as a core health equity issue. And I'm sure many of you understand the deep impact that oral health can have on birthing outcomes.

So, it turned out that among people who identified as Democrats support for oral health policy was already pretty high,

but among Republicans, not so much. In fact, there was about a 20-point gap in their support for oral health equity policies. And so that meant in our research we really needed to find strategy that boost support among conservatives.

And in this instance, we decided to experiment with the effects of positive or negative emphasis. So, as you can see there, a negative of loss frame emphasized that if society to fails to act on oral health economic losses and public health problems will follow. So, if we don't do anything, if we fail to act, problems ahead. And the gain frame accentuated the positive. If society takes action to improve oral health, economic gains and public health improvements would follow.

So, in this experiment, people are randomly assigned to receive either a gain message or a loss message and then we asked them their opinion about a range of oral health policies that would help to eliminate health disparities, like including oral health coverage in Medicaid, incentivizing more providers to accept Medicaid, et cetera.

Now, Democrats, as you can see here, really liked gain message, but it did nothing to move -- well, sorry, not as you see here. At a different study, we noticed that Democrats really liked the gain message, but it did nothing to move Republicans.

But what did work was this inaction, was the loss frame. This inaction that leads to losses was particularly effective.

Large, statistically significant increases across multiple communications outcomes that made them more likely to agree that oral health was a collective concern, not just a personal problem. It made them more likely to agree that if we did something it would make a difference, and it boosted their support for equity focused policies. And in fact, the right frame closed the gap between Democrats and Republicans on this issue.

So, that gain or loss frame, we have since found something similar on other issues. Emphasizing the downside of not doing anything has tended to be more persuasive for conservatives who, by definition, are more skeptical that public policy and public programs are the way to address social problems.

So, I don't know that I would go so far as to say that this is a take it to the bank generalizable finding, but I think it's definitely something to keep in mind. And I think that these examples of findings from social science research show that framing is part of the repertoire that we should all be using to advance health equity.

So, as you are thinking about framing your recommendations, there are lots of different choices that you'll make around your tone, around the values that you express or leave implicit, the numbers that you lift up and how you connect those and help people make sense of those through the narrative and the context that you give.

I won't read all of these to you, but just to say that I think of framing as sets of choices, and you're making them as you write the entire report. There's not a frame for the thing. There's lots of adjustments and decisions you're making along the way, but these tiny or smaller characteristics of a message can really lead to big social change.

When we take responsibility and take care with what we say as mission-driven communicators, then that shapes public discourse, it shapes what people hear, and that really matters because even in this time of extreme efforts to polarize and divide, the number one predictor of what people will believe is the number of times they have heard it.

And so, that means we have not just a good reason, but I think an obligation to be out in the public discourse sharing evidence-based ideas about how to promote infant and maternal health. So, if we can be out there in the discourse shaping how people think, that has a real impact on our institutions because one of the things that affects the way the programs or institutions adopt the decisions decisionmakers make really is where public thinking is, so thinking about that is vital.

So, if I had to offer you just three ways to build more productive mindsets on your issues might be to be very attentive to how you are attributing responsibility, emphasizing explanation, and definitely framing toward solutions. So, let me

tell you what I mean by that.

Attribution is the way we explain the causes of behavior, events, or conditions. And social science shows clearly that the attribution, causal attribution has a major effect on how people think about solutions. So, it's about what causes a problem, who or what's affected, and where responsibility for addressing it lies.

Often, we, in an attempt to be very neutral or kind stick to the facts as science communications, we do not attribute responsibility. We leave it out. So, here's an example. In the U.S. too many women are suffering from pregnancy complications that lead to serious injury and death. So, this doesn't say who or what is responsible for the problem or the solution.

In our analysis of this it leaves too much room for fatalism. So, what could be done about it, and people may fill in individual causes. Well, there's too many bad doctors out there or too many women not taking care of their own health. So, if we can fill in the attribution slot with the systemic actor, then that is going to be more effective framing.

So, on the plain side, U.S. is failing to manage pregnancy complications that lead to serious injury and death. So, this chromatically puts the nation as the subject of the sentence, which says somebody's responsible, and it says the systems are responsible. And there's an action we're failing to

manage it, right? It's not just that the women are out there suffering. It's we are failing to do this action. There's an action that the nation is failing to take that we could take, we could manage it. So, this is any one of these choices isn't going to lead to an epiphany, right, among your audiences, but each of the choices adds to a larger frame.

All right, so the next slide it's really important, I think, especially in the discourse that we're in these days to make sure that you're not playing into any sort of individual attribution, anything that's very much blaming women for the problem.

So, here's an example. Every year roughly 3600 babies in the U.S. die suddenly for unknown reasons. Researchers estimate that if expectant moms would just quit smoking, we could prevent 800 of those deaths.

Now, I've gotten feedback in other presentations that this example is just too out there and unrealistic. No one would ever say that, but I took this quote from an article in a major national newspaper that appeared within the last two years, so really making sure we're avoiding those things like if they would just quit smoking, which really places the onus, right, on the parents' individual behaviors.

We can point to the important role, right, of tobacco-free, smoke-free pregnancies in a different way that points to

system. We could make the same point by pointing to systems to say that researchers estimate that if we just connected expecting families to treatment for nicotine dependency, we could prevent 800 infant deaths a year. So, reframing the problem is access to cessation treatment and the solution as connecting expecting families to treatment.

So, this reframe attributes responsibility from making that connection to our shared systems, not to the people experiencing the problem. So, that's an attribution responsibility.

Second, kind of big idea is explanation. I told you there are lots of different choices that framers make, but if I had to pick one framing superpower to make it through the rest of my life with, it would explanation because it can have such a powerful effect.

So, strong, explanatory chains or causal sequences work a lot like this domino run there, right? They clearly lay out what hits what, what affects what, and they have a tight, logical flow, things are spaced like these dominos so that one idea leads right into the next, and there's a lot of causal transition words that help people understand what affects what.

And our research has shown that if you can get a really tight explanation, it can double the level of support for evidence-based policy compared with mere description. So, let me

show you what I mean by that. To really explain how and why things are happening is a pretty big shift from the way public health tends to tell its stories, which is to report out the data on subpopulations and you are focusing the work of the year ahead on a priority population for good reason, but if you're just giving out data on kind of who's, you know, the rates of problems, the problem with that as a communications technique is that it makes it easy for people to think about that particular demographic group in isolation rather than seeing the underlying causes for the problem and the changes we need to make as a society to improve the situation. So, to organize your frame around causal pathways can be a really helpful way to think about that.

So, disparities exist among populations. Or Black women are less likely to receive prenatal treatment during pregnancy. Or higher rates preexisting conditions are one factor in pregnancy complications. These are all true sentences, right, but are they the best frame forward? I would say, no, because there's attribution of responsibility.

It sounds as if the disparities fell from the sky. I don't know why the Black women are less like to receive that treatment or may have more of those preexisting conditions, so the causal pathways may be different for different issues, different topics, and we've found, through our research with the tobacco

control movement, as well as some other health equity topics, that these are kind of good, kind of generic starter causal pathways that you could tailor to your particular data at hand.

So, you could talk about how some groups of Americans are protected from health harms, such as maybe toxic exposures during pregnancies, whereas, others aren't, right? Black women are less likely to be protected and to talk about why. Talk about how discrimination and poverty increase stress and trigger long-term health problems or compound those long-term health problems for some groups.

Pardon me. The unjust and unfair practices causing harm and continuing today, implicit bias being built into systems to shape the experiences of some groups, or how access to care, how some Americans have access to quality, affordable, culturally, linguistically, appropriate healthcare and others don't.

So, if you can think about where you want to tell these stories about the causes at hand and then connect those very tightly to the recommendations you may make to the Secretary or others, we think that will be effective framing.

So, let me show you on the next slide what that might look like at the level of a paragraph. So, here, this is pretty standard, I think, messaging on shining a light on the really intolerable levels of disparities in maternal mortality, so in the U.S. too many women are suffering from pregnancy complications

that lead to serious injury and death. U.S. currently ranks lower than all other developed countries and some women are at more risk than others. Black women being three to four more times likely to die from pregnancy related causes than white women. And then we can look at women in the South, how they have higher rates of death than women in most other parts of the country.

So, here this is a framing that kind of works on the logic that if I just show people how bad it is they will be shocked or shamed, right, into action, right? That they will say this is not acceptable and we have to do something.

As it turns out, that's not the way groups of humans kind of come to decisions on social issues. It's important that people understand why something is happening so that they can see a place to intervene. Just the fact that it's bad won't be enough for people to assume that an uneven situation requires a public response, and we have to do something about it.

People need to just see that not that it's uneven, but that it's uneven and it's unfair, and so you need some ways often that causal pathway is helping show you that injustice, not just the disparity. So, a slight reframe here. So, same sentence, right, or same opening I showed you before, the U.S. is failing to manage pregnancy complications that lead to serious injury and death and then one reason is implicit bias, like all of this, health professionals absorb stereotypes that affect their

decisions and the stereotype of strong Black woman can lead doctors to minimize Black patients concerns and miss opportunities to address problems before they pose a danger. Implicit bias is one reason why Black women are three to four times more likely to die from pregnancy-related causes than women from other groups.

So, I don't mean to suggest that implicit bias is the only reason. That's why this message says it's one reason why, but explaining one reason well is going to be more effective than no explanation and more effective than a list of all the things it could be, right? So, really giving people a sense to understand why so that they can see where the intervention makes sense and why the intervention makes sense. All right, so that final point is to really think about and frame forward to solutions interventions.

It's really important that we talk about collective level solutions that can target those maternal health disparities that are the subject of your report and that we talk about those solutions at a scale that is commensurate with the scale of the problem that we've set forth and that we talk about them in clear ways. Things that aren't only making sense only to us, as experts, but really are easy for the many organizations, national partners, local initiatives that will be picking up this report and looking to it for, you know, they're probably looking to it for the evidence-based and for the direction of policy, but

implicitly, you are modeling how to talk about this issue, right, so the language you use will be repeated and I think that means it's really important that you all set it up in a way where if it's repeated in community it can be understood, right, in community by folks who aren't thinking about this issue all the time.

So, here's an example of three kinds of plain language solution statements. So, this first one used to be, I think, comprehensive approaches to culturally, linguistically appropriate prenatal care, right, which is totally important, and this is written in a different way. When communities offer programs that appeal to different types of expecting mothers, moms get the care they need in the way they need it, and we all get the benefit of healthier pregnancies, birth, babies, and moms.

So, a much more personalized, humanized tone, and saying moms getting the care they need and the way they need it rather than a term-of-art, an expert term about culturally and linguistically appropriate care. I'm not saying you couldn't or shouldn't use that longer term, but it is important to alongside that to use a plain language explanation.

This next one is expanding Medicaid coverage to include oral healthcare. We can require that all types of health insurance treat oral health as part of overall health and build in incentives to accept the plans that lower income people use. So,

that kind of plain language is, I think, an antidote to partisanship. When we are putting things out in very simple, everyday terms, there aren't those trigger words they may have people think, oh, this is about Medicaid. You're not necessarily talking about that, so thinking about some of these things.

The last one, I think, is this around implicit bias, kind of prevention messages, but again, in very plain language. So, I think this is helpful, not only in talking to decision makers, but in making sure that we are, again, remembering that even if our expressed or primary audience is decision makers, an implicit and essential audience is always going to be the public.

Framing can help to shift a policymaker's mindset and the framing can shift that policymaker's mindset so that that one person or one by one they make a different decision, but we also can take a broader view of our role in public discourse and what we can accomplish when we are including the public, inviting the public into the conversation and those public mindsets create pressure on those policymakers to make different situations and we can really move the policymaker mindsets or the decisionmaker mindsets kind of en masse, right?

And so, that is one reason that we do the research the way we do it, but also because we know that the work we have ahead of us can't afford to wait to change each and every mind one at a time. We really need to move things with greater power and pace,

and we believe framing can help us do that.

That's all I have to say for now, but if we've got time -- I don't know. Belinda, are there comments, questions right now or a couple panelists and then we're holding?

MS. PETTIFORD: No, we'll take a moment now to see if anyone has any questions for Julie. I see Marie's hand is up. Yes, Marie.

DR. RAMAS: Thank you, Belinda. Julie, thank you for your presentation today. And I apologize, I have low bandwidth issues, so unable to put my video on.

I have a question specifically around framing the concepts of urgency around health equity, particularly for maybe community members that may have less exposure to historically excluded communities and identifying the value of health equity for everyone. That it's important for everyone to make it a priority. How would go about coaching or facilitating that type of viewpoint to shift?

DR. SWEETLAND: That's a great question. And in a moment, I can put a resource in the chat box perhaps that speaks directly to that so you've got a take along with you. So, I think expressing the idea that our communities are better off when every person has the resources they need to be healthy and achieve their best health, I guess, a simple statement like that pulls people in. You're not using a word that kind of already has partisan

associations attached to it. So, a plain language, kind of trigger-free opening statement, I think, is one important part of that.

And then, laying out some of those causal pathways, depending on the communication. If you've got a long report, you can lay out several. If it's a short chat, maybe choose one or two, but helping people see how our environments are promoting health for some and impeding health for others, right? And so, again, you want to get to that sense of not just even, but uneven and unfair.

I think the tone you take with that is going to be important, a sense of I'm inviting you in to solve this problem with me, not you have kind of failed in your obligation to prevent this problem. So, I think that those are some of the key effectiveness factors, really setting that why and how before you get to the what of the disparities data are some of the key tactics.

DR. RAMAS: Thank you.

DR. SWEETLAND: Thank you for your question.

MS. PETTIFORD: And thank you so much, Julie, for joining us today. I've got a feeling we may be back in touch with you at some point in time. I know we've got one article from you, and we may pull a couple of others, but if there's anything you want to drop in the chat that we can share broadly and especially

with the workgroup leads and co-leads that would be very helpful.

DR. SWEETLAND: Yes, I'm pulling it up right now.

Systems Issues in Rural Maternal/Infant Health

MS. PETTIFORD: Thank you so much. At this time, we're going to transition into our next set of presentations. For the next probably about an hour, our focus really will be on systems issues and rural maternal and infant health. This again connects to one of our workgroups around rural health and we're very happy to have with us this afternoon, we have Jeff Strickler, who's actually here in North Carolina with me. He's the Vice President of UNC Hospitals here in North Carolina. We also have Megan Cundari. She's a Senior Director with the American Hospital Association. So, we're going to start with the two of them and then we will continue on, so starting with you, Jeff.

MS. CUNDARI: Actually, Belinda, I'm going to start and then we'll go to Jeff.

MS. PETTIFORD: Thank you. That is fine. Thanks, Megan.

MS. CUNDARI: No worries. Thank you. So, thank you so much for having us this afternoon. We really appreciate it.

So, I'm going to offer more of a national perspective and then we're going to turn to Jeff and he's going to tell you a little bit of what's happening at the local level with his facility. And then at the end of Jeff's presentation, we'll share

some recommendations that will hopefully be helpful to you all as you are doing your advice to the other agencies.

By way of introduction, my name is Megan Cundari. I'm with the American Hospital Association and I'm part of the advocacy team and my focus includes maternal and child health. Jeff Strickler is President of UNC Chatham Hospital in North Carolina, and he's also part of our Maternal and Child Health Committee, so that's part of the reason I know Jeff and know that he has a really great story to share with you this afternoon.

So, I want to just let you know that AHA represents about 5,000 hospitals in the country and we have the full breadth of types of hospitals, so we have small rural hospitals all the way up to big, academic medical centers. We also work with the state hospital associations. Each state has an association, and we try to partner with them to make sure that we're raising up issues that are happening at the federal level.

It's also really important for us to make sure you understand that hospitals do understand the important role that they play in their communities in the lives of their patients and so because they are an anchor in their communities, they don't make the decision to close an OB service line without some pretty serious consideration because I do know that it would really impact the community and the patients they serve.

So, I just want to do a quick overview of rural

hospitals in the United States. They make up about 35% of hospitals in the country. Nearly half of rural hospitals have 25 or fewer beds and just 16% have more than 100 beds, so they're usually pretty small. And we know that half of rural hospitals are usually small, independent hospitals and they are the main access points for their communities.

Some of the challenges they face, which I'm sure you're aware of, is that it could be geographically isolated, patients much travel a great distance to receive care, the population densities are obviously lower in rural areas and, as a consequence, rural hospitals have much lower patient volumes.

In addition to the lower patient volumes rural hospitals treat, patient populations that are usually older, sicker, and poorer, compared to the national average and they often face staffing challenges. Only 10% of physicians in the U.S. practice in rural areas, despite 20% of the U.S. population living in rural areas and 70% the primary health professional shortage areas or HPSAs are located in rural or partially rural areas.

Looking at OB services in rural areas a little bit more closely, we do know that the rural hospitals are delivering about 1 in 10 babies in the U.S. We also know that the number of rural hospitals providing OB services has declined. This is information from a GAO report between 2004 and 2018. We now have more than half of rural counties don't have OB services as of 2018. And we

know that family physicians are doing a lot of the care work in rural areas, which is more common than in urban areas.

So, when we get into understanding the challenge and understanding why OB units are closing, I like to talk about it as these three interrelated topics. So, the first one is volume of services delivered. I mentioned earlier there's a lower population density and rural hospitals do not see as many OB patients, so this means that the staff may not have the opportunity to see enough patients to maintain their skillsets. We also know that when you deliver more babies, you're more prepared and hopefully will have better outcomes for mom and baby because you do this on a regular basis.

The other issue, very interrelated, is workforce. I mentioned earlier workforce challenges in rural areas. We know it's difficult to attract staff to the rural areas. We also know that staff may not want to work in a rural location because they don't have the opportunity to do as much work with their specialized skills and, of course, goes back to the volume issue.

And then the last thing I want to mention is reimbursement. On a national level, 41% of births are reimbursed by the Medicaid program. Keep in mind that Medicaid underpays providers for the cost of the services, and we know that rural hospitals are even more dependent on both the Medicare and Medicaid programs as the primary payers to reimburse them for the

services they provide.

So, if you don't have a mix of patients that includes private insurance reimbursement, they may need to make decisions about whether or not they can continue to provide OB services really based on a pure economic decision-making process.

So, I've outlined some of the challenges that are being faced in rural areas, but I also want you to know that as member association we really do try to lift up those hospitals that are doing great work when it comes to offering maternal services and so we present a series of case studies, we do podcasts, we do webinars on what is happening in the field and how they're ensuring access to maternal services.

This information is available on our website, and we can share this information with the Committee as well. And I'm really proud to be able to present Jeff Strickler with you because he is one of the hospitals that we've been highlighting on our website in terms of the great work they've been doing, so at this point I'm going to turn the presentation over to Jeff and then at the end of the presentation we have some recommendations that we'd like to share with you.

DR. STRICKLER: Good afternoon, everybody. It is a pleasure to be here and talk to you about some of the challenges that we have faced in providing maternity care in a rural environment.

As Megan said, my name is Jeff Strickler. In the introductions, it mentioned that I was the vice president with UNC Health System, but part of my responsibilities is to be President of UNC Chatham Hospital. Chatham Hospital is in Chatham County, which is roughly in the center of the state of North Carolina.

We're a county adjacent to the Raleigh/Durham metropolitan area and we're about 35 plus minutes away from higher levels of care located in Chapel Hill, so we're considered, where we're at, the western part of the county, as a rural environment and we have a rural carveout of Siler City, where we're in and that's the community that we're providing care for.

So, as such, UNC Chatham Hospital is a 25-bed critical access hospital. We have been providing care in this community since the late 1930s. We joined the UNC Healthcare System in 2008. I was one of the founding members of providing this care, and as such, we have all the basic foundational care that we provide to this community, emergency department, diagnostic care, day surgery type programs that we have onsite.

Over 25 years ago, Chatham Hospital, like many community hospitals, was providing maternity care, but over time their providers aged out, retired, and they were unable to recruit and bring those providers and continue that service. So, it's been over 25 years since we were delivering babies at Chatham Hospital.

So, prior to the pandemic, there were a number of

leaders within the UNC Health System that had the thought that could we restart these services at Chatham Hospital and really come with perhaps a unique model for North Carolina that was modeled much like you see in more isolated sites in the Midwest or the western part of the United States for the care providers, with primarily family medicine trained individuals, including those that were trained through a fellowship to provide c-section services.

So, that was the model that we put in place and thanks to the great support of the UNC Health System that provided those initial funds we were able to remodel space in the hospital. And it was a three-million-dollar project to open a five-room maternity suite within the hospital and we actually opened Labor Day of 2020.

Now, opening a new service as we were starting off with a global pandemic is not what one would choose to do, but that was the circumstances that we had. And we had a large team of collaborative partners throughout the county. It wasn't just the Health System support, but we worked very closely with the providers from UNC Family Medicine, we worked very closely with our local FQHC, Piedmont Health Services, which is where our care providers are embedded for the prenatal/postnatal care and they also provide that prenatal and postpartum care in the Chatham County Health Departments, so that is the two organizations that

are primarily seeing the patients that are ultimately going to deliver at Chatham Hospital.

So, this embrace of this model was really an experiment, not just from Chatham Hospital, but from the UNC Health System to try to reverse the trend that Megan had mentioned across the United States. We're seeing the same in North Carolina. There are closures of programs and there are counties that don't provide maternity care.

And similar to with our county, depending upon where a mother and a family may live, they may be anywhere from 35 minutes to an hour away from a site that is going to be providing care for them. So, our mandate was to really experiment with this mode and see if we could come up with a more cost-sustainable model for maternity care that then could be replicated in other areas across North Carolina where UNC may be at and offering services.

And so, that was the approach that we really took with this model, and it was so much more than what we were doing here at the local level, and we were uniquely able to do this because of the support that we had by the Health System and also by our location. You can see us there on the map there. We're roughly in the middle where the blue hospital H is. In the grey it says Chatham, and so we're immediately adjacent to counties that are able to provide the higher level of care and so they were able to support us, and we were able to concentrate on low-risk deliveries

and still have the higher-risks deliveries at those other sites.

So, besides just our geographic location, there were a number of other things that really make us unique, factors where we would be able to be successful in this launch. So, as a critical access hospital, we had a more favorable cost base reimbursement structure. I'd already mentioned the support that the System was providing us. It's not financial support, it's not just the support that our providers actually have, those academic appointments as well, but they are integral in accepting our higher-risk patients. They were also integral in providing training sites for our staff, both the providers as well as the nursing staff that actually oriented to those sites prior to us opening our doors.

I mentioned that UNC Family Medicine is our primary care provider, so this was really leveraging that model and they were already in place at Chatman Hospital. They cover our Emergency Department, they cover our inpatient areas, so it was relatively easy to recruit some other providers with additional experiences to layer in those individuals that were going to provide coverage both vaginal deliveries and then we recruited the individuals that were family medicine trained to provide the c-sections and give us that capability.

We already had OR and anesthesia in place that were primarily offered during the day, so we had all those things in

place. We had the capital that we needed. We really only had to have a process to be able to provide c-section care during the day and then after hours have that on-call response. And as I'd mentioned, we already had an engaged community and university partners have really made it possible.

And then, Chatham County is also one of the fastest growing counties in North Carolina. In essence, we function similar to a bedroom community for the Raleigh/Durham area, so population is continuing to grow and there've been a number of large industries, thanks to some of the recent President Biden acts with the battery plants and such. We've been able to attract some of the electrical vehicle industries into Chatham County, so our population is expected to grow a great deal over the next three to five years.

Even with those good factors in place, we experienced all the other things that Megan had mentioned that those challenges that's causing programs to continue to close. Where most of our feeder patient population is coming through the Health Department or from the FQHC. We certainly see a high level of uninsured or Medicaid patient populations, which is creating challenges for this be a financially substantiable program.

Even despite there's a large number of deliveries, part of our pre-analysis of the viability of this program, we determined there were over 700 babies that are coming from

families that are Chatham County residents and our goal was could we care for roughly 50% of those, but instead, we're only around 150 deliveries a year.

So, much as we mentioned it's difficult to have these systems in place for that low volume and for individuals to maintain their competencies with that and we'll touch upon that again in a later slide.

And then again, I'll expand upon this in the next slide, but we've had many challenges being able to recruit and retain, not just so much providers for us. We've been successful because of the UNC affiliation to attract providers, but our challenge has been on the nursing staff and all the other staff that need to be in place to provide the support for a program such as this.

Now, we're fortunate in the fact that we've been part of the health system and I can't underestimate that support, financial and otherwise, that it's made this possible for us to be able to continue this program for the three years that we've been open, but I do want to highlight and tell me of the story around some of the challenges of the things that we have faced over last three years.

Some of these are natural to providing maternity care in rural environments. Some of this was exacerbated by the pandemic, but staffing was our number one issue. And as I mentioned, even though we had some provider transition, it really wasn't on the

provider side. Our challenge was with nurse staffing, as well as some of the other support staffing as well.

So, during the pandemic I lost 80% of my maternity staff. I essentially completely had to change over the unit staffing. Now, why did those individuals leave? Multiple reasons, some of that was family issues, some of that was pandemic-related, some individuals lost jobs, spouse lost a job and they had to relocate, but much of this was really two factors, individuals taking travel nurse assignments and going elsewhere and leaving the organization and then the second part of this was also individuals wanting to work in their specialty. And as a low volume, particularly at that point in time, we only had a delivery about every couple of days and so individuals having to be onsite to be ready to take care of a patient that would present that was in labor would be used to another purpose throughout the hospital and that was dissatisfying for them.

And just from a financial standpoint, where I think most of us are aware of how the expense of clinical labor has increased throughout the pandemic. It's hard for us to be able to maintain being competitive as the market was accelerating around us and offering higher wages and incentives that were just beyond the reach for a rural, critical access hospital.

And as mentioned, this impacted not just with the nursing staff, but it was support staff as well. Throughout the

hospital, I lost about 50% of my staff through the pandemic at point in time or the other. And using travel staff, for the most part, was just beyond our reach.

We have had some financial support with the system that enabled us to have some travel nurses to stabilize the program for a period of time. We've also had some internal contract type programs which has been very successful for us. We also required because of health-system-related challenges downstream from us also had to do an aesthetician transition during this whole period of time, so it was very challenging from a staffing standpoint.

Now, the good news in that is our unit is back to full strength now and so we've been able to really weather that storm. But as we moved through that, and I think it's important for me to highlight this, I was one resignation away from having to close the program again, us just not being able to provide safe care at that point. And as it was, we had to scale back some of our coverage to Monday through Friday since many of our cases were scheduled inductions, and it created some circumstances where individuals presented with not a lot of prenatal care in labor and either having to deliver in the emergency department or having to be transported to higher-level care.

The second item for us was again how do you really maintain this competency in a low volume environment? Our census, as I mentioned, fluctuated wildly. There were many times we would

be having two deliveries, at one point there were days where we would have none. On average, we would only do one c-section once a month and so it was hard really for those teams to really maintain their skills with that.

Now, we did have relationships with the larger organizations in our system to provide some of that training and some of that ongoing competency, but again, as a smaller employee base, they're needed here for the coverage standpoint, and so it's challenging really to maintain that competency.

And as I mentioned, it's hard to satisfy in the low volume environment. The staff want to care for these patients, what they're trained to do, and if they're not kept active at a certain level, then they seek those environments from other hospitals and both of those issues really then lead to our own financial sustainability challenges as the expenses went up in the program, and it continued to deteriorate the march on the hospital and so it has made it difficult to maintain as we moved through the pandemic.

I do want to highlight one other thing that I think I have gained more appreciation for as I've looked at this from a rural environment. I think most of us are aware of the fact that when it comes to labor and delivery care, you have to have not just your physicians, but your entire team that's able to provide that care at a moment's notice and have to be immediately

available. How that's usually defined, what that really means operationally for those of us providing this care is you have to have that capability to provide a c-section in less than 30 minutes time in an emergent situation.

Most of us that are clinical or not clinical we see the value in that. We understand the importance of that, but for a situation such as with Chatham Hospital, since we already risk stratify most of our patients, the vast majority of our c-sections are either scheduled or they're not in an emergent category, but yet, we have to have all of that standby structure and the resultant expense to be able to provide that care. And being a rural county with larger distances, it forces our providers and anesthesia to have to be in-house and our OR nurses to have to be close to be able to meet the standard of being within the hospital and able to start the c-section within 30 minutes.

It's been a little bit difficult to really see what's the national standard. The numbers change as far as like how many of these cases are truly emergent, but it's probably in the 5-15% range of all the entire infrastructure, the entire program and everything we have in place is built around the ability to provide that care within 30 minutes of time.

So, this is where we move into some of the recommendations that we had. These recommendations are based upon national evidence that's been published in other avenues, but I

think it also very much mirrors our experience as well. So, there's three primary things I want to mention. Of course, first, is making maternal healthcare affordable and accessible, but really highlight for Chatham is the fact that most of our patients were receiving Medicaid, ultimately, and Medicaid reimbursement, not just for the provider, but for the hospital as well. And that funding doesn't really cover all the expense that we have to have from a standby standpoint to be able to provide these services.

The other that I wanted to highlight on this slide with recommendations is often it's put up as how telehealth can play an important rule for rural facilities and that is certainly true. Even in the realm of maternal care, there's opportunities to provide prenatal, postnatal care in a telehealth environment. But as I've learned, it's important to highlight that many rural communities, they don't have access to good, high-speed broadband. It impacts abilities to be able to provide effective telehealth in that environment and also for a program such as ours, which a high percentage of our patients are Latino population that may not be English-speaking. It's another challenge as to why telehealth may not work well for this group.

Before I advance to the next slide, Megan, from an AHA standpoint, anything else you wanted to mention on these recommendations?

MS. CUNDARI: No, you're doing great. Thank you.

DR. STRICKLER: All right, next slide please. For us, again, as I mentioned, workforce is some of the key considerations. So, first bullet there, define various loan repayment programs that really encourage clinicians to practice in an underserved area. And I'll add the caveat with that, and we have some of this with some of our providers, but that is all level of clinical services, so nurses, as I think about our program and those other areas that need to support our maternal program, I think of surgical technologists that are scrubbing in the cases into the OR.

I think of the medical lab technicians that are needed to run the lab tests and to prepare blood products. I think of the respiratory therapist that are needed from a management standpoint. Those are all areas that are difficult for a rural hospital to be able to recruit and to retain and tying it to some of the loan repayment programs to be important.

Using these to expand options for rural residents' programs, this was one of the key reasons for starting our program. We ultimately were expanding our family medicine rural residency program. We were becoming another site for them. There would be three residents these three years that we're cycling through our program.

I imagine you've probably have mentioned in other presentations today that you're much more likely to retain those

individuals to recruit them to practice in a rural environment if they have trained in that rural environment, so that was really the foundation of our effort.

The third bullet there with training and how do we train other individuals to be able to provide maternity-level care because much of our training as clinicians is really to stabilize and to get somebody to higher-level care or help is coming your way if there's a resource from a larger institution, but for an organization such as UNC Chatham there's not additional help coming and so you really have to be able to be trained to provide a pretty high level of definitive care in stabilizing a patient. And in a labor situation, delivering child, stabilizing both mom and baby until you get to a place to where you can transport both mother and baby, and so in our program we brought an advance life support for obstetrics in, so having funding for disseminating that course across the United States for all different levels of care providers it would be important. Much of our program is also based on ongoing simulation. So, with some of the downtime, how do we use that to train providers in the low-volume environment.

And then having access to higher fidelity simulation that is beyond the reach for a rural facility, but it's something that could be supported on more of a regional stay or within a health system perspective. And then, as I mentioned, our program is really using an alternate provider of delivery of this care, so

not your traditional obstetrician, but using physicians that are trained and trained to provide c-sections. So, allowing that based upon their training and the competency, but not necessarily what their individual specialty training is and allowing clinicians to practice at the top of their license, not just for physicians, but for other providers.

A key part of the Chatham program is to use midwives and when you compare the U.S. system to systems across the world a much higher reliance on midwives, and also for us with anesthesia services, so having CRNAs, which are our primary care providers for anesthesia and allowing them to function independently without having to have an anesthesiologist onsite when they're providing this care as well.

We'll just leave you with this one quote. In terms of maternity care, you have to recognize that you're going to be doing obstetrics. If you close your OB unit, you're still going to be doing obstetrics, you're just not going to be able to be capable of handling emergencies.

Now, I will add a couple other things to this quote is that if you close your OB unit, you’re still going to be doing obstetrics but you’re going to be doing it in environments that are really not suited for this for this type of care. It's going to be in your emergency department, it's going to be in the back of an ambulance transporting the individual to the hospital, or as

we've seen prior to us developing our program, it's going to be in the back seat of a car on the highway on the way to care.

So, it's a very important topic and hopefully some lessons can be learned from our experience and perhaps some of these recommendations can be useful. Thank you again for your time and attention and I'm happy to answer any questions that anyone may have for us.

MS. PETTIFORD: Thank you so much, Jeff, as well as Megan. We appreciate your time today, but we're going to continue moving forward with the next presentation. If you'll just drop your question in the chat because we have other presenters that are on a time schedule as well.

So, we're going to now move on to the Federal Office of Rural Health Policy. We have with us today, Kathryn Umali. She's the director of the Community-Based Division in that office, as well as Carey Zhuang, who's the RMOMS Program coordinator in that same division. And Carey, apologies, I'm sure I have messed up your name. So, we're going to turn it over to Kathryn now. While you're bringing them up, Kate, I saw your hand is up, so go ahead and ask your question.

DR. MENARD: Thanks, Belinda, but I don't want to take too much time, but Jeff, I wondered if it's too early to get a sense for the impact this has had on the trainees. I know, as you do, one of the emphasis of this was just to train our family

medicine residents in a rural setting by family medicine physicians rather than the model that's previous and still in place where our family medicine residents are trained by maternal fetal medicine specialists and obstetricians in obstetric units with the idea that might then give them the confidence to then go and practice. Is it too early to assess that and the intentions of the residents that trained in this setting or do they really have the opportunity, given the volume?

DR. STRICKLER: Yes, it's probably a little bit too early. I mean, as you know, in a three-year training program, their first year is totally offsite from Chatham and we're really looking forward to bringing them in, but just like we had a transition in other staff members we had a transition of residents during the pandemic and so it's only now really that we're into year three of the program that we're really starting to see the residents and have them involved in care, so it's really probably too early to evaluate that.

MS. PETTIFORD: Thank you so much. So, now we're going to turn it over to Kathryn, as well as Carey.

MS. UMALI: Yes, hi. Good afternoon, everyone. My name is Kathryn Umali and I'm with the Federal Office of Rural Health Policy here at HRSA, and we'll be talking about today about our Rural Maternity and Obstetrics Management Strategies Program or RMOMS.

I'll be joined today by my colleague here, Carey Zhuang, who will provide a more detailed overview of the RMOMS Program. So, the Federal Office of Rural Health Policy is under Section 711 of the Social Security Act and really our mandate is to provide healthcare access in rural areas. So, with that broad mandate, we are the advising entity to the Secretary on rural health issues. So, that means that we have a program and policy function, and we don't have a counterpart at the department level. We are the direct advising entity to the Secretary.

Our programs comprise of capacity building programs, direct health services programs, and we also have a policy aspect in that we provide recommendations to CMS on regulations that pertain to rural as one of our more policy heavy tasks.

Just like my colleagues have mentioned, these are just some of the rural health issues that are more prominent in rural health issues that we deal with in our office. So, people in rural areas live three fewer years than people in urban areas and really have higher death rates for heart disease and stroke, which are two of the top leading causes of death in rural areas.

Rural women also face higher maternal mortality rates, as Megan mentioned, a study in 2018 revealed that more than half of rural counties lack OB services. Rural residents also face higher rates of tobacco use, physical inactivity, obesity, diabetes, and high blood pressure and really lagging on a lot of

the rural health indicators that we have.

Also, rural populations have challenges accessing mental healthcare and treatment. Also, just like my colleagues have mentioned, rural hospitals are at risk of closing and are facing the possibility of closing, similar to the reasons that were mentioned prior to this presentation, low pay or mix, lack of volume, all those reasons apply here as well.

And also, because of the long distances and the lack of transportation, it really is a challenge to access specialty preventive care and emergent services in that telehealth has been one of the popular modalities of accessing care in these rural communities. And rural populations are also more likely to be uninsured and have fewer affordable health insurance options than urban areas and so I also want to point out the chart book as listed here as one of the references.

If you all need any rural reference statistics data points, this is a good resource to look at. It's categorized by topic areas, by state and region, so I just want to point that out as well.

And I want to focus a little bit on the access of obstetric care. And as I've mentioned before, and my colleagues have mentioned before, not only is there half of the rural economies lack OB service. There are also workforce shortages and the closing of OB service lines, so these are just some of the

studies that we want to highlight and showcasing or highlighting those issues that have been mentioned before.

And in our office, in the Federal Office of Rural Health Policy, not only do we focus on policy, we also focus on community health based programs as we think that it starts on the ground. Scale interventions start on the ground at the community-level, so our office has direct services programs, such as these, and also capacity-building programs.

Just in my division alone, there are about 10 to 12 programs that we administer in any given year and so I won't go through each of them, but if any of you are interested in knowing about any of these programs, please reach out to us, and we'll be happy to discuss it in full detail. We also encourage you all to really look at the video profiles of our grantees that have implemented innovative and really successful projects through these grant programs.

Just to provide context of the RMOMS Program before I kick it off to Carey to provide a more detailed overview of it, as a background, as I mentioned before, the RMOMS Program was really created because of that study in 2018 that revealed that more than half of rural counties lack OB services. And so, our office, in an effort to address that issue, we created this program, the RMOMS Program, and it's really a perfect example of how research translated into a program.

Prior to 2023, the RMOMS Program was authorized under Section 338 of the Public Health Service Act, which really broadly mentions to provide healthcare services in rural areas. Now, it's starting in 2023, RMOMS is authorized under a new statute, which is Section 338-2, the same authorization, just different section, but it outlines more specific elements that is required for this program.

And then now I'll turn it over to Carey, who can provide a more detailed overview of the RMOMS Program.

MS. ZHUANG: Yes, thanks so much, Kathryn. So, as Kathryn mentioned, my name is Carey Zhuang and I'm a program coordinator RMOMS. Given the time constraints and I know that folks are really likely wanting to hear from me what RMOMS presenters after me, I'll keep this moving along and won't be reading everything on the slides.

As you can see on this slide, we've included the purpose in the three RMOMS focus areas in the center below the icon. Each RMOMS awardee receives funding of up to one million dollars per year for four years to fulfill the purpose of RMOMS, which is to improve access to and deliver of maternity and obstetrics care in rural areas, which we all recognize, and as many folks have said before me, is a very much needed thing.

Since 2019, there have been a total of 12 awardees for RMOMS, which more information will be provided in a few slides

from now and is also available on the website. And in case anyone is referring to this presentation later, the RMOMS website link and the RMOMS inbox email address is available here as well for your reference.

Since RMOMS have five overarching goals, we've listed them here for reference. I know there's a lot of text here, so I won't be reading through everything, but in 2023, RMOMS included more a focus on health equity and providing training to bolster the maternal health workforce in rural areas in addition to the other goals and that enhancing access to maternal and obstetric services. If anyone is interested in taking a deeper dive, please refer to the link to the most recent RMOMS notice of funding opportunities that's in this slide at the very bottom.

So, additionally, on this slide, we have a little bit more information about the focus of RMOMS, as well as some highlights. RMOMS is really focused on collaborative partnerships in encouraging the development of rural obstetric networks, as Kathryn mentioned earlier in the authorizations, and also leverage in telehealth and specialty care. And as the RMOMS cooperative agreements provide startup funding, the program emphasizes financial sustainability, which involves working with respected state Medicaid agencies and other payers to sustain this important work after the four-year award period ends.

On the right, we have some early highlights from the

first cohort, showing the impact of RMOMS, including serving nearly 5,000 individuals and supporting over 3,600 deliveries, in addition to implementing several support initiatives to improve access to maternity care and support services in many rural counties across the nation.

Speaking of the areas that RMOMS is impacting, this map shows the states that RMOMS awardees are located in since the program's inception in 2019. As you can see, there's a spread across geography in terms of where the RMOMS awardees are serving their communities, and this slide also includes a legend showing when each awardee's cohort began. More information about the awardees can be found on the RMOMS website.

The last but not least, before I turn it over to one of our RMOMS awardees from Missouri, the Bootheel Perinatal Network, or BPN for short -- social media platforms and our account handle on each platform is @hrsagov. We encourage you to sign up for HRSA's eNews, which is a biweekly email with comprehensive HRSA news and also sign up for HRSA press releases.

As Kathryn and I are representing the Federal Office of Rural Health Policies, the same link on the slide will allow you to sign up for the Federal Office of Rural Health Policy newsletter, which we do encourage you to sign up for, for all things rural, in addition to any other HRSA news that you are interested in.

Finally, please visit our website, www.hrsa.gov for more information about all of our programs. Thank you so much and have a wonderful day.

MS. PETTIFORD: Thank you both so much. We're going to go straight now into having Barb Gleason, who's the project director and Rebecca Burger is coming back with us, who's the System Care Coordinator with the Bootheel Perinatal Network in Missouri and they will share specifically about what is going on with their specific RMOMS program.

MS. GLEASON: Thank you, Belinda, and Committee for inviting us, and thank you, Kathryn, and Carey, for setting us up so well on those slides. I am Barb Gleason. I'm the Project Director for Bootheel Perinatal Network and with me today is Rebecca Burger, our system care coordinator. Many of you may have met her earlier on the presentations with the Community Voice.

We're really excited to be here today and to share the work of Bootheel Perinatal Network. As I move through the slides, you're going to see that a lot of the information is similar to what you've seen earlier, so I'll do my best not to repeat a lot of things.

You'll also see that our slides are jammed packed with information. We've had a lot of growth and a lot of activity happen in our four years and 10 to 15 minutes doesn't give us even just a tip of the iceberg, so we've put a lot of stuff into our

slides.

We've heard a lot about maternal mortality today, different reports, different reviews. I sit on the Plenary Board for Missouri and am honored to sit with individuals that look and review all the cases of the moms that we lose in this state. What we're learning from the reports is that we are mirroring what we're seeing on the national level and our numbers are going in the wrong direction for Missouri.

Maternal health is our number one underlying cause for women who are dying within the first year. We continue to see Black women dying three times more likely than their white counterparts and we've seen an increase of women who are on Medicaid versus women on private insurance dying in our state.

What we know historically is that women who are on Medicaid or public insurance have a whole different set of social and environmental factors that play into the health of their pregnancies and have negative impacts.

Before I move onto the next slide and the work, I want to give a little bit of history on the Bootheel. We're 3,500 square miles of rural small towns and farmland. We cover some of the poorest counties in the state. Statistically, we have -- prenatal care is low, premature births, and low birth weight numbers are higher than the state average and our state ranks seventh when we talk about the Top 10 worst states birthing

outcomes in the nation.

Rebecca's going to be sharing later how BPN's care coordination model is helping to change these numbers. Over 60% of our pregnancies are covered by Medicaid, and we just heard how difficult it is to keep hospitals open when it comes to just Medicaid coverage.

In addition to hospital closures and birthing units closing, we recently had a large impact to our workforce. Tyson Foods closed one of their chicken product plants in Stoddard County and laid off several individuals from Briggs and Stratton, so in one week we saw over 800 jobs disappear in our region and we're just now starting to see the ripple effect of those actions.

Deeply rooted in the principles of collective impact, Bootheel Perinatal Network has worked closely with community partners to implement clinical community care coordination, increase ultrasound and tele-health services in our region, implement a Close Loops resource and referral platform, map social determinants of health to Z codes, and to provide emergency childbirth training where traditionally training was in person. We converted it to virtual with an in-person birthing simulation.

This slide is very busy per presentation guidelines and only gives a small glimpse into how the BPN coordination model bridges clinical care to community wraparound services. As you heard earlier from Heather, the one-on-one time she was able to

spend with Rebecca allowed her to not only get the resources she needed to have a healthy pregnancy, but also created a space of empathy and compassion to feel heard.

When you look at this slide, you'll see that we have an RN working to connect our providers to the client and then also to the community wraparound services. The traits that are important and vital to this individual is compassion, empathy, willingness to learn, critical thinking, problem solving, strong communication skills, and a commitment to be a patient advocate.

When you look at the list of social determinants or social drivers that affect many of our clients are things that we've heard throughout this presentation, ability to obtain adequate prenatal care, many times in our region that is transportation; follow-up appointment visits, that is the same thing, transportation; finding housing; feeling safe at home, and that list goes on and on. So, I will now turn it over to Rebeccas, who'll be sharing more about the work.

MS. BURGER: Thanks, Barb. As I mentioned earlier, my name is Rebecca Burger. I am Assistant Care Coordinator for the Bootheel Perinatal Network. So, what we do with our care coordination, when I came on one of the big things in the Bootheel is, and as I heard earlier in one of the other presentations, words matter. And when I came on, moms were being sent to the care coordinator for resources or help and that is not a welcomed

approach in the Bootheel, so I switched it around to a campaign called “You Matter! Your Voice Matters!” so that the moms could have a place to share their pregnancy and parenting story and make a difference for themselves, as well as their kids, their kids' kids, and so on and so forth.

Not only do they have the opportunity to share their pregnancy and parenting story, but we also complete some screening tools in Edinburgh for mental health and a tool for those social drivers of health. In doing those two things, as well as truly listening to them, it guides us to identify some of those social drivers of health and allows me to inform them and connect them to some of the local blessings, as I like to call it. Again, it's all about word choice, especially in the Bootheel in Missouri, and they don't need resources. Even resources can have a negative feel to our moms, so we like to refer to them as connecting them to blessings in the area.

During our time together, I really focus on building that rapport and that trusting true often take relationships with them to get them open up and maybe sometimes feel a little bit vulnerable because they're telling me some pretty intimate things about their life. The time that I spend with them really, truly is tailored to their needs. Their story guides the length of time that we spend together. It may be 15 minutes, or it may be two hours. It really, truly is dependent upon the need of that

mother.

We have intentional touch points built into our care coordination to help prevent these mothers from slipping through the cracks. As we all know, that happens. We maybe get them into a resource, but life happens. They may have a bad experience and instead of reaching out and trying to find a different resource, they may just shut down altogether. That's what we see. My history comes from being a home visiting nurse myself, and so I witnessed that with some of my own mothers. So, those intentional touch points allow a net for us to capture those families and connect them back to additional blessings.

So, as mentioned earlier, not only is care coordination one of the things that we have done, but we have also increased ultrasound and telehealth opportunities to our moms. Early on with care coordination, prior to my arrival, a mom had been identifying as needing an ultrasound, but couldn't get here. Transportation was an issue, so we were able to, Bootheel Perinatal Network was able to, purchase ultrasound equipment and we've set it up in our Dexter Clinic.

Bootheel Perinatal Network is houses within St. Francis Healthcare System and they have an offset clinic in Dexter, which is a rural area, and so we have ultrasound capabilities now, along with non-stress test capabilities there. And you will see that in the first 14 months of that service being available we were able

to save over 62,000 miles for these moms. And we're collecting this data because not only is that miles on the highway, but that's time on the highway, so less chance of motor vehicle accidents. The dollars saved reverts back to milage, so that is strictly mileage reimbursement, which is potentially saving Medicaid some dollars as well.

That's not counting things like additional childcare, food, extra time off of work, so those dollars saved really are bigger, but the only way that I could truly put a number to it was merely mileage reimbursement.

Lower here you'll see Dr. Wall is our maternal fetal medicine specialist who is housed within St. Francis. She was going to retire, but so graciously agreed to stay on and provide telehealth services. She was one of the region's only in-person MFM services. If she was not here and we could not provide that service, people were going to have to travel to St. Louis or to Tennessee or Arkansas and so we, as BPM, we were able to set her up for telehealth, which started January 1 of this year. And there again, you can see the miles, dollars, and time saved for these mothers with her telehealth clinic, which is continuing to grow. So, that's some pretty awesome savings, both from a Medicaid standpoint, but really for me, from a maternal standpoint because that's a lot of dollars that are lost for our families down here and we can't afford to lose anything else.

No shows were a big concern when care coordination started as well. We had a higher no-show rate for our Bootheel mothers. Imagine that when you have to travel an hour to an hour and a half one way to get to your doctor's appointment and then you're here for a two-hour visit, that's a whole day. So, one of our intentional touch points is prior to arrival of your appointment, which is great, it's an actual conversation with me. It's not an automated system. I'm able to ask them if they have transportation. If they're not, and they're a Medicaid mom, I am able to guide them or even set transportation up for them or guide them or set up mileage reimbursement.

Most of the time the families that I serve don't even know that those two things are available to them through their managed care organization. And we are very excited to say that with that we were able to reduce our no-show rates with our MFM funding by over 50% for our Bootheel families. That is pretty awesome. You can see their highlights there because not everybody do agree to join the network, but those that do have an even higher success and follow through with their prenatal and postpartum appointments.

So, these are some of the birth outcomes that we saw. The most recent ones show that we improved our prenatal care in the first trimester from 70.4 to 75.27, we have now surpassed our state average and we have also surpassed, in a positive way, our

premature births. We now are at a rate of 12.63, so we're right there at the state average. And we still have some work to do with our low birth weight, but we're getting there. We're inching forward. Again, every little bit helps.

So, one of the other things that we did at the start of RMOMS was we talked to our community about what they wanted and what they needed. Both Barb and I have worked in the community for a long time, so one of the things that was identified was the need for an electronic resource and referral platform, a one stop shop to send and receive referrals, so we collaborated with another nonprofit organization and set up and created what we call the Bootheel Resource Network. It is a division, I'm going to say, of the Unite Us referral platform, that it is very community-driven.

The difference between BORN, specifically, and Unite Us is the community leads it. We have a community leader, Rachelle Bennett. Her email address is there. She reaches out to the community organizations first to talk to them about onboarding and you can see that we have over 26 local organizations that have onboarded with us specifically.

So, one of the great things -- there are many great things I could say about the electronic resource and referral platform, but one of the interesting things is the amount of data that you can get. So, this is an interesting slide to me because

it shows the number of clients and cases. You can do what are called internal referrals. So, within my organization I have multiple programs, I can refer internally and use that for tracking myself.

I'm able to see right here that when families have come in for assistance and a referral has been placed in the BORN and let's say they needed the food assistance, they are likely to need a referral for food assistance 4.1 more times, so that is one of our high needs down here. We could dive way even deeper into this slide, but that right there is just kind of high level.

This one the thing I'd like to point out with this one is the real world I live in and referrals I send is not accepted and so this one shows the rejection rate, and it also tells me why they were rejected. Is it because we couldn't contact the client, is it because the services weren't available so that I'm able to see right there that that's a gap, right? So, I could use that information to start looking at other grants. Where are my gaps in the community? So, this is high-level BPN as network data.

Next slide we'll show you specifically me, so I've broken it down even further, and each organization can do that. So, all 26 of the organizations that are onboard with us have this capability and this speaks to that kind of internal referral process, so it can show for me specifically the high needs from the families that I'm seeing is the support, is that individual

and family support. They're likely going to need a referral 3.4 times.

You see the off platform cases there. Just a quick shoutout to that. So, that is because we don't have everybody onboard. For certain reasons, some organizations don't join with us with BORN and that's okay -- hope to get there someday -- but I still have the capability to put in that referral so that for my tracking purposes I can still see that and still utilize that data. Unite US can also use that data to help Unite US and BORN, BPN, identify some of the other organizations maybe that we need to go to, to look at onboarding them.

This is, again, the referrals that I send, another way to pull some data. Beyond data, some of the nice things with this close loops referral system is when I send a referral I can see if it's been accepted fairly quickly. I can see if they've been assigned.

I can also see anybody else that's working on their case if they're within the network, within Unite US. So, if I'm talking to a mom and she's not really sure who all she's working with, sometimes I'm able to get into BORN and I'm able to say, well, I see in here that you are working with X organization, and so and so is your caseworker. Oh, okay, yeah, that's right.

Because when I'm seeing the moms, that's not what's on their mind today. Maybe their mind is where am I going to sleep

tonight, so they're not focusing on and can't give me all of that information and so this close looped system really allows me to identify that and make sure that I'm not referring them somewhere for them to just be turned down again. Because a lot of times these families have been told no several times, and I don't want to be the cause for one more no that I could easily just have not sent because I knew that they've already maybe utilized that service.

I can also send notes between organizations so that me and other organizations know what maybe I'm working on providing for them or what I've assisted her with so that we're not all trying to get the same thing.

MS. PETTIFORD: Well, thank you. I wanted to make sure your slides went away, Rebecca, so I want to make sure that was the end of your slides.

MS. GLEASON: That's what I was going to say, our slides went away. I think we were headed to the end of it and just very grateful for this opportunity to have done RMOMS and how we're continuing that forward with a new grant and we thank everybody who's been in support of us through this.

MS. BURGER: Yes, just real quick, right now the care coordination is just kind of been me, but we are going to be expanding, so we'll have more care coordination opportunities. I think I had a few more slides, but I think that was the end of the

data, so I think it was just questions and our contact information on the slides, if I remember correctly, Emma.

MS. PETTIFORD: Were you good if we don't pull those slides back up, Rebecca? I just want to make sure. I don't want to cut you off by any means.

MS. BURGER: No, it's okay. I am fairly certain that the next slide was just Question & Answers and then the next was contact information, so, no, again that was really it.

MS. PETTIFORD: Wonderful. So, we're all going to get copies of the slides anyway, all of the Committee, so we'll have your contact information. I do want to make sure we have time for Kristen to join us, Kristen Zycherman. I know she wasn't feeling well earlier, but she is CMS and she's bringing up the rear of our focus on rural health this afternoon. So, Kristen, do you feel like speaking, dear?

MS. ZYCHERMAN: Thank you. Can you hear me okay?

MS. PETTIFORD: Yes. Thank you.

MS. ZYCHERMAN: I am thankful for the opportunity to be here to talk about our CMS Birthing-Friendly Hospital designation. Just as a little bit of background to address the United States maternity care crisis and recognizing that it's a key priority for the Biden/Harris Administration, CMS developed a Maternity Care Action Plan that covers these six domains and CMCS, in particular, as Medicaid covers over 40% of births, has activities across all

these areas and we'll have to revisit another time to talk more about the complete action plan. But today, we're going to focus on the announcement from last month that supports our quality pillar, that Birthing-Friendly Hospital designation.

So, the Birthing-Friendly Hospital designation started being displayed on November 8th, so just about a month ago, on CMS's Care Compare online tool, created to identify hospital and health systems that participate both in a statewide or national perinatal quality improvement collaborative program and that implement evidence-based care to improve maternal health. So, there are some links here which will go out in the slides that come out to you, but I will walk through a little bit later in the slides the interactive tool for seeing that displayed.

In August 2022, we established the Birthing-Friendly designation and in October of 2022, CMS posted the first data on the Care Compare website. Future reporting will occur on an annual basis and will include the preceding calendar year. And so, the most recent data for the fall of 2023 reflects measure data spanning January to December of 2022, and this was finalized in the Fiscal Year '23 IPPS, which updates Medicaid fee for service payment rates and policies for both inpatient hospitals and long-term care hospitals.

I will say that initial awarding of the Birthing-Friendly designation to hospitals or health systems we don't

intend for this to be a static designation, so there is the possibility in the future that it will change beyond that first maternal morbidity structural measure, which it is based upon that was finalized in the fiscal year 2022 IPPS rule and first publicly reported in fall 2022 and hospitals have to answer yes to both in order to receive this designation. Those two questions being that the participation of maternal or perinatal quality collaborative and implementation of evidence-based patient safety practices are bundles related to maternal morbidity.

And on December 13, 2022, there was a big convening, some of you may have been there, but it was where we unveiled the logo for the Birthing-Friendly designation and that is what will be posted on Care Compare, as well as the websites of participating health plans to indicate birthing friendly facilities. And just to note that this is the first ever hospital quality designation by HHS that specifically focuses on maternal health.

Along with the designation being displayed on the Care Compare website, CMS also released an interactive map showing birthing friendly hospitals and health systems throughout the U.S. Just as a little background on the hospital Inpatient Quality Reporting Program, or IQR Program, it is one of more than 20 quality and PPB programs that CMS oversees. And through the hospital IQR Program, acute care hospitals must meet certain

eligibility criteria related to factors like geographic location and patient population served.

And in the 2023 reporting year, just over 3,100 eligible hospitals were required to report data to the hospital IQR Program, so there are certain hospitals that aren't required to report into the IQR Program. However, in 2023 approximately 66% of hospitals and health systems reporting received CMS Birthing-Friendly designation.

I will note that if a hospital answered, not applicable, that they do not provide obstetrical services, they would not obviously qualify for Birthing-Friendly designation.

I'm going to quickly walk through the web-based Care Compare tool just so you can get an idea of what that looks like. So, you can search for Birthing-Friendly designation by visiting the CMS Care Compare site pictured on this slide, and on the lefthand side you'll see a menu of providers to compare. You would select hospitals and next you could enter your location, state, city, zip, or you can enter a hospital by name and search for it. And based on the location you entered, you'll be directed to a screen that looks like this and that will include a list of hospitals and a map.

You can filter by distance and other factors, and you'll see on the screen which hospitals and health systems have Birthing-Friendly designation. If a hospital has a designation,

it will have the pink Birthing-Friendly designation icon.

So, if you want more information about the hospital and its designation, you can click on the hospital name. It will pop open a screen with more information about the hospital under the Quality section. You can see client maternal health, and this page will display the following information, the top measure is early elected delivery, and the bottom is the maternal morbidity structural measure.

The Care Compare tool also allows a user to compare more than one hospital at a time, so you can click on the compare button for each hospital you want to compare and a blue bar will appear on the top of your screen and you'll click compare on the upper right-hand button and then you'll be brought to this page, which shows a comparison of the hospitals you selected.

The bubble feature here also displays a clarification that, as I said earlier, that absence of the designation may mean that the hospital does not actually qualify for the designation because it may either not be IQR eligible, meaning that it's not required to report into the IQR system, or it may not provide inpatient labor and delivery services at all.

So, here's a snapshot of the interactive map linked to CMS.gov, which allows users to view, filter, and/or download various datasets. In this case, viewers can be recipients of the Birthing-Friendly designation, as well as other data fields of

interest. And then here's a look at the map by hospital name and similar to the Care Compare tool, users can search by city, state, or zip.

And having clicked on a given geography, here's a look at the individual facilities in that community, in this case Chicago, so it kind of gives you a visual of that. And that is the end of my slides, walking through, but I can tell you that the initial Birthing-Friendly designation was considered to be the start and we were hoping that a lot of our birthing hospitals would pursue that designation and qualify for that designation and want to keep that designation. So, in the future as other measures are perhaps added to that designation to qualify for it, we hope that hospitals will rise to the challenge and continue to work towards better outcomes for their maternal and infant. Thank you.

MS. PETTIFORD: Thank you so much, Kristen. We really appreciate it because I know you did not feel well today, so thank you for hanging there.

I know we have not had a chance to get any questions to come in on our rural health presentation. This has been a wonderful series of presentations, and I'm seeing the activity going on in the chat. If you will just continue to put your notes in the chat and if there's a specific question and you need to speak with someone that did the presentation, we'll do a follow up

afterwards because we are very cognizant that we're running behind on time.

And unfortunately, Committee Members, we're not going to have time for that next break either, so I'm sure no one is surprised, but we do want to take time to hear about the program enhancements for advancing equity and accountability as part of the Title V MCH block grant program. So, Keriann Uesugi -- Keriann, I'm sure I messed up your name, dear. As long as I've known you, I still get your last name wrong.

So, we're asking Keriann if she will come and do her presentation at this time, and we also know that right after that we have Sarah Verbiest queued up to come after her. So, thank you, and turning it over to Keriann.

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

MS. UESAGI: Hi, thanks, Belinda. It's Uesugi. Easy to pronounce, hard to remember based on how it's spelled. But thank you for inviting me here today to share some exciting new enhancements that we proposed for the Title V MCH services block grant program. I'll try not to take the 25 minutes. I think I can do it a little bit faster than that.

So, since our Title V transformation in 2015, we have structured our program guidance for reporting around three core

guiding principles: Delivery of Title V services within a public health services model, data-driven programming and performance accountability, and family partnership.

Our current guidance expires at the end of this year and for our next three-year guidance, we have proposed an additional guiding principle, health equity and assurance that all MCH populations achieve their full health potential to highlight our commitment and strengthen our approach to health equity within Title V.

As part of this, we recognize that our principle on family partnership also needed to expand to include community partnerships. We have further proposed enhancements to our Title V performance measure framework to incorporate this new guiding principle, as well as address emergent priorities for Title V.

I want to start briefly, briefly going over the Title V performance measure framework to level just a little bit. This framework was developed for the Title V transformation in 2015 and has not changed in its iteration of the guidance. It is based on the evaluation logic model. It's a three-tiered system of measures and starting on the right of this figure are the more distal, long-term maternal and child health outcomes that we seek to improve, and these are called our National Outcome Measures or NOMs.

Our National Performance Measures are the short and

medium-term outcomes in the logic model that can be impacted by Title V activities at the state level. Each NPM is associated with one or more national outcome measures. The NPMs are population-based state level measures, just for your understanding for my next few slides.

And then on the left of this figure are the outputs of short-term outcomes of the evidence-based or informed strategies that Title V is implementing. These are called evidence-based to inform strategy measures and they directly measure what Title V is doing. So, given that brief introduction to our framework, I'd love to share proposed changes that will impact the maternal and infant populations particularly.

So, this is a quick overview of our proposed changes to the Title V performance measure framework. We've got a set of measure changes, as well as implementation changes. So, under measure change, we revised both the set of National Outcome Measures and National Performance Measures and we've also created a new standardized measure set for states to select as state performance measures.

On the right-hand side, we have implementation changes to the performance measure framework where we've added two universal National Performance Measures and we've also added the ability for states to select priority populations and I'll go over those in more detail in later slides, but overall, we have not

changed the structure of our performance measure framework in this iteration of the guidance.

So, in terms of the revised set of NOMs, I focused it on those that are particular to the women maternal and the perinatal infant domains. The first was we removed all measures from the National Outcome Measure set that were not true outcome measures. We really wanted to make sure we had a consistent definition of National Outcome Measures such that they're measures of preventable morbidity, mortality, health status, and quality of life.

Secondly, we wanted to address emerging health issues, so we've added mental health status outcome measures for women, children, and adolescents, as well as maintained the mental health status measures that we had for postpartum. We've also added a sub-measure for women's health status, and we've added stillbirth rate as a new National Outcome Measure.

So, briefly, the benefits to these changes for the states is that we've now got a very consistent definition of National Outcome Measures, we're addressing emerging health issues, and we're enhancing the application of the life course approach. A lot of times we had measures that were focused solely on children, but where we've been able to, we've now added a sub-measure for a comparable women's health measure.

Moving onto our NPMs, one of the biggest changes that we

made was sort of overlaying a theory of change to our NPMs by creating measure domains to action. We've now identified NPMs that operate and improve our outcome measures within these domains of action. The first one being improving the clinical health system, the second one being improving health behaviors, and the third is improving social determinants of health.

And the second change is, as I just mentioned, we've added new measures to our NPM measure sets to cover social determinants of health and other emerging issues around mental health, reproductive health, and lastly, we've taken some existing national performance measures and moved them to our new standardized measure set. We particularly moved the ones that were less frequently selected to this new measure set.

One change, if you're familiar with what we had originally proposed back in the spring, we retained the preventive dental visit NPM as an NPM. So, the benefits to these changes came from a lot of conversation that we had with our state partners to really begin addressing, not just downstream targets, but also those upstream social determinants of health factors that are associated with MCH outcomes.

We'd also heard from our state partners that there had been too much emphasis on clinical care, so now our NPMs have a more balanced approach with the different domains of actions and there's less emphasis solely on clinical care. We also are

adjusting emerging health issues and we've increased the options available to states. We went from 15 NPMs and now we have 20.

So, I'm just going to show you, for the sake of time, our changes to the women maternal population domain measures and the perinatal infant. So, I've color coded the measures so you can see which measures belong to which of the measure domains. The ones in gold or orange are the clinical health systems domain measures, the grey is the health behavior measures, and the red is the social determinants of health measures.

We have pretty much all new measures for this domain, except for the preventive dental visit. We've added postpartum visits, and this is a two-part measure that captures both access and quality of the postpartum visit; postpartum mental health screening, preventive dental visits, so those are three clinical health systems measures.

Our health behavior, which can also be considered somewhat of a clinical health system measure as well, is postpartum contraception use. And our two social determinants of health measures are discrimination during prenatal care, particularly racial ethnic discrimination and housing instability in the 12 months prior to delivery shorthanded to pregnancy.

All of our measures come from PRAMS and many of them will be new to the PRAMS Phase IX questionnaire.

So, for perinatal infant health, there were actually

less changes for this domain. We've retained the clinical health system's measure, which is risk appropriate perinatal care. One improvement that we've made on this measure is before we did not have a federally available data source to prepopulate data for this measure, but we anticipate that beginning this year that we'll have data from HCUP that will allow us to provide federally available data for risk appropriate perinatal care.

Breastfeeding and safe sleep remain two health behavior MPMs, but we have made some changes to breastfeeding. We've switched up the data sources. We're now using the birth certificate data for breastfeeding initiation and we're using the National Survey of Children's Health for exclusive breastfeeding, which is Part B of this measure, and this is really intended to provide more timing estimates for breastfeeding, as well as stratified data for breastfeeding at the state level, which was not available before.

And the two social determinants of health measures are the same ones that are applicable to women and maternal health, that housing instability and perinatal care discrimination because they have impacts and are associated with infant health outcomes as well.

And, as I mentioned, we have a new standardized measure set. All states have the ability to create state performance measures to address any of their priority needs that did not align

with our national performance measures. They still have that option. We have just added some standardized measures to help states with sometimes less capacity to create their own SBM. They'll now be able to select these measures as an SPM and have all that prepopulated data that they've been able to have with the national performance measures up until now, so they can still create their own state performance measures.

Right now, this measure set consists of all of our former and National Outcome Measures and National Performance Measures that would operate as Performance Measures. So, the key benefit to this new measure set is reducing the burden on some states to create their own SPMs and it allows states to continue working on previous MPM measures that are no longer designated as MPMs and allows them to continue working on them, as needed, with all the available data.

And I'm highlighting, these are all of our standardized measures, but the ones in red are the ones particular to the two population domains of interest, early entry to prenatal care, which was an outcome measure, but really acts as more of a performance measure. Drinking during pregnancy, we've revised it with the new changes in PRAMS questionnaire to be able to capture any drinking during pregnancy, as well as any binge drinking during pregnancy, so even that's a big improvement on that measure. And it also captures the form NPMs, well woman visit,

low-risk cesarean deliveries and smoking during pregnancy.

So, those are all of our measure changes and now I can briefly touch on our two implementation changes. In the past, since the transformation, states have had full flexibility in selecting a minimum of five national performance measures to include in its state action plan, but now in order to accelerate progress on priority areas at the national level, we are requiring the reporting of two universal NPMs by all 59 states and jurisdictions.

And the selection of our two universal NPMs is really based on our legislatively defined purpose for Title V, which is to provide and to assure mothers and children have access to quality maternal and child health services, so therefore, our focus for these measures was on access and quality of primary preventive care.

Of interest to this committee, the first universal measure is postpartum visit. And as I mentioned before, it has two components. We're not just focusing on access and we're not just focusing on quality. The focus is on both of those components. So, this is intended to address the maternal health crisis and drive a permit around maternal mortality, knowing that more than half of pregnancy-associated deaths occur after seven days postpartum.

I won't go into the medical home, but that is our second

universal NPM, which is intended to drive improvement in the system of care for all children. What this will look like is states must still report a minimum of five NPMs, but that includes the two universal NPMs and they still need at least one NPM in each population domain.

A second improvement that really goes along with our addition of our new health equity guiding principle is the opportunity to select priority populations for their NPMs. So, currently, states are only reporting state level total estimates for their NPMs. We've provided stratified data for various demographic stratifies as part of their FAD resource document that they've had available to them since the transformation, but now we're going to be able to use all that stratified data for them to select a priority population for any of the NPMs that they've selected.

They're also going to be able to have prepopulated data for their annual reporting and they're going to able to set annual objectives. What this will look like is a state will select an NPM and then they can select any one of our available demographic stratifies, such as urban/rural geography or race/ethnicity or income level and then be able to pick a target sub-group and designate that as a priority population for their MPM and report on their progress for that priority population in their annual reporting.

All the other stratified data for all the other MPMs and NOMs will still be available for state use and so none of that is changing. So, this really benefits and supports the states' capacity to address health equity.

Just briefly, our implementation plan, we have not received final OMB approval. We anticipate that any day now for our new guidance. So, we have told states that we expect full implementation to take place over the next two years with most of the changes happening in the needs assessment year, which is 2025.

For this upcoming reporting year, which is application year 2025, the universal measures will be incorporated or need to be incorporated into those state action plans, but there is no other requirement for them to change their other MPMs or their state action plan for this last year of their cycle.

We will provide federally available data for the current measures, as well as the new measure in April 2024 to support their annual reporting, as well as their 2025 needs assessment work and working with our Georgetown partners at the Evidence Center, we plan to have MCH accelerators, which are evidence-based strategy briefs completed by May 2024 to support states in their needs assessments and state action plan development for the next cycle.

I know this is a lot of information. I want to point you to some of the resources that I shared with you beforehand. I

provided our technical assistance resource document that has all of the detail sheets for our new measures. It's also linked to, in the draft guidance, which you can request. I can point you to Appendices B and C. That's where all the pertinent information is, if you'd like to learn more.

And that's it for me, and I saw that there was a question, so I'm asking.

MS. PETTIFORD: There's one question in the Chat, Keriann.

MS. UESAGI: Okay. Is there a web resource? No, and thankfully, I'm getting support from our colleague and friend, Ashley Hirai. We're working on data validation and collaboration with CDC and expect to include her in that work, so we'll be in touch with more information.

MS. PETTIFORD: Well, thank you, Keriann. We appreciate you coming and sharing, giving us an update on the performance measure with the Maternal Child Health block grant. Any others have any questions, please drop them in the chat and we can always reach Keriann.

Preconception, Interconception, and Postpartum Health

MS. PETTIFORD: Now, we're going to go onto our next presentation. As stated earlier, we've had a focus on rural health and the amazing work that's going on around the country.

Our other workgroup is focused on preconception, interconception, and a little on the postpartum side. So, we've asked Sarah Verbiest from the University of North Carolina in Greensboro -- in Greensboro, in Chapel Hill. You can tell I have my other alma mater on my brain, Sarah, University of North Carolina in Chapel Hill to come and join us this afternoon, late early evening for some of us. So, Sarah, turning it over to you.

MS. VERBIEST: Thank you so much, Belinda. Is my audio okay, loud enough?

MS. PETTIFORD: It is.

MS. VERBIEST: Okay, great.

MS. PETTIFORD: You're good.

MS. VERBIEST: Well, I want to say thank you for the invitation. I was messaging Keriann before, I have never before in my career ever presented to this group before, so it's truly an honor and I'm really excited that you all are talking about this topic.

I also wanted to thank the co-authors of the paper that was sent to you on preconception history. I really just want to name Lindsey Yates and Alise Neely and Shamika Timberland, as I thank our future faces and leaders in preconception health, and also just want to acknowledge Suzanne Woodward, Erin McClain, Kathryn Bryant, and also Belinda and Vanessa, as being people that have been in this work a long time.

So, in preparing for this, I had some quest questions from the team and so I'm going to respond to some of those as we go. When we think about the definition and inclusion around preconception health, I would say that the definition has really shifted over time from a really narrow focus on pre-pregnancy healthcare to a very broad frame that is focusing more on equity-centered wellness.

So, I shift from the early focus on reducing risk before pregnancy to this bigger vision of what is it for people to thrive and really live healthy, happy lives in their full potential. Reproductive justice, equity, and life corners are continuing to be key frameworks for this and the tension, this comes up a lot and I don't have an answer for it. I'm just naming it as a tension between being fully expansive in this work to include people without a uterus and well as thinking about the vast needs and diversity of people with uteruses who then also physically bear the consequences of pregnancy.

So, I think should resources time be without limits, we would certainly want to be engaging with everybody of reproductive age in this work, but there are many tensions in this space.

When it comes to messaging, we've been doing a lot of thinking about this and have really shifted from the preconception health and healthcare initiative to really focusing on Show Your Love. So, Show Your Love was an initial campaign that was launched

by the CDC in 2013 and it has really tested well, been of evergreen concept, but what we added was a tag line and we extensively focused test to this and what people really wanted was to hear that your health matters, your health is important.

Another strategy that we've taken in communicating about preconception health is to, first and foremost, focus the majority of the time and message on just the health benefit to that person as a person and then having a place that if people are thinking of pregnancy, they could click or read for additional information. And so, in this way we're not centering that we only would be providing this information because they might become pregnant, but we are still providing pregnancy preconception specific related information.

We've also incorporated information where it comes to justice. So, for example, if we're telling people, gosh, you should reduce your stress and sleep better. We have to acknowledge that for some people they may not live in a place where they can control their sleep environment. They might live by a train, they might be couch surfing, and so it is a justice issue. For example, sleep is a justice issue.

So, we have also been thinking about how do we pair resources and information on some of these other justice issues that are just a different way of kind of acknowledging that you can give people a list of 10 things to do to be healthy, but what

we have to do is be providing a lot more comprehensive information around how to actually lean into some those changes.

And you all are the choir, but we really have to keep our eye on working upstream. We know way back from the perinatal periods of risk day that the data showed that we really need to be working in maternal health. We find the same from our fetal and infant mortality reviews, from our MMRCs. I have now taken over. Cheryl Robbins has given me the listserv that goes out every month and so now I'm also reviewing and there are hundreds of research studies published every month, which I whittled down to about 30 to send out, so there's a lot of research, and then a book, so we have the evidence that says working prior to pregnancy is important and effective.

It's just moving that science into implementation, right? And I would say that as we're thinking about maternal health. I've just been in a maternal health meeting all day in D.C., and really a lot of the work, as we think about preconception, interconception is really just expanding what we already know is important to do in maternal health, so access to respectful healthcare, being heard and believed, access to behavioral healthcare really important, not to forget disordered eating, anxiety, trauma. Social determinants of health is still really important. Relationship care, thinking about interpersonal violence and self-advocacy skills is really important, substance

use services, including cannabis, which is a topic that comes up a lot, and alcohol consumption. Access to reproductive health services, and I listed everything on this slide because the full continuum is important.

And again, we see the impacts of structural and historic racism and bias that start early in life and carry through pregnancy and infancy and onward. And so, I'll just offer I really think we really need a life course approach and I think this starts with our adolescent population that we serve in MCH, thinking about menstrual care, menstrual justice, period justice, moving into that fertility and support around pregnancy consideration, preconception, and then all the way to perimenopause support and menopause care.

I was talking with folks that do research in perimenopause and menopause, and really, if you think about it, across the life course people with uteruses are not getting any anticipatory guidance about important things that happen to them. Research is lacking, care transitions and coordination are lacking across the life course and so I just challenge how might we consider the arch of the experience of having a uterus and hormones and all the social constructs that come with that.

So, I'm just going to jump through a couple of slides really quickly. We had resources from the Collaborative for Innovation Improvement on Infant Mortality. You know I had this

project for years, Vanessa, and I still cannot remember what COIIM stands for, but we were able to do some great work and I'm just going to share a couple of key findings with you from that work.

So, one, we did a national panel survey. We had over 2,000 participants and it was interesting. These are folks of reproductive age. Something that really surprised us from that quick research, quick survey, was that 56 precent of the people we surveyed had one or more chronic conditions and we left the definition of chronic condition as a condition that you manage every day and the majority of those folks had not received any counseling about their reproductive health.

We also heard that the majority of people thought it was important to talk with their provider about reproductive goals. Some of those felt this was only important in the context of planning a pregnancy, but actually very few people didn't think that having a conversation about reproductive goals didn't matter. And we found that one in four women in that survey did not know that health prior to pregnancy was important.

We also found that people want health education right from their provider during a visit and they want access to have someone to talk to with their questions and follow-up information. A lot of times we hear, well, people just want videos and videos are important, but there's really no substitute for having conversations with providers.

I just thought it was interesting the types of topics that people wanted more information about and really stress, depression, anxiety really popped as being near the top and also dealing with weight and feelings about weight really emerged as being an issue that people wanted to talk about or felt was really important in that space.

And then I apologize that the font is kind of small on this slide. It's small for me too. Some of the key things that we also learned is that partnering with clinics is really worth the investment and that it takes time in a relationship for community and clinic and public health and clinic partnerships to happen, but when they happen, they're really valuable.

This will probably not come as a surprise to the folks on this call, but we also found that preventive care is important, but it is not a priority in a clinic that has a lot of other stressors and it's not that people don't care, but honestly, sick care does seem to continually take precedent over preventive care.

We saw that clinics that partnered with community groups like Healthy Start have a major advantage in providing comprehensive wellness care. They tend to have the trust of the community, which it's just a beautiful thing in some of the clinics like Magnolia Clinic where that's happened in Florida. And also, we just have to continually talk about how white supremacy and whiteness functions and be prepared to challenge

that and be open to change.

And I just wanted to make sure that you all had access to the last national convening that we had in 2021 was virtual. We recorded all the sessions. They were all graphically narrated. They were amazing and beautiful voices in that space, and I just would encourage you to actually go back and listen to those conversations. I'm just providing a summary of those today.

We did put this visual together and I believe that was in the article that you also reviewed where we really summarized all of that drawing and all of those conversations to say really, really what matters in preconception health. And so, again, you'll notice we're not using the word preconception health at all and we're talking about equity-centered wellness, thinking about shifting care and shifting a culture for change.

I think many things on here are things that we've been saying across all of our spheres of maternal and infant health, about co-creation, how we provide information in health education really matters, that we need coordinated clinical care, but we really wanted to highlight that words really matters and how we say it really matters to people and then data really matters, and I wanted to circle this. When we think about what national data do, we routinely review that help us understand the state of care for people reproductive age in our country.

Where can we go to really understand how are people in

their thirties doing, what are their health concerns, what are their challenges, and then, particularly having that data in context of their lives? And so, if I had wish list, being able to really, I think, keep an eye on what's going on with those trends is really important because I can tell you as we're starting to see excess deaths or increasing deaths for folks in this age category, we're going to see that also transfer into maternal and infant death as well. So again, another argument for getting upstream, but I think we need more investment in data in that space as well.

So, as our HRSA funding was ending with the COIIN, our team thought, okay, we're not seeing any other resources out there for training and technical assistance on preconception health. What should we do? And so, we really thought about, well, where would we want to focus work in an area that had a strong link to maternal mortality and morbidity and also where an investment in preconception health and reproductive wellness would have a significant return on investment. So, we started really focusing on folks with chronic conditions.

And so, we were able to get funding from PCORI, the Patient Centered Outcomes Research Institute and we were in community with a whole group of women who identified as having one or more chronic conditions, being Black or Native American, and being of unreproductive age and this is really, really rich work

and the folks in this space, again, had a variety of chronic conditions from MS to Sickle Cell, Lupus, endometriosis, PCOS, anxiety. And we spent a lot of time really listening to them in terms of their journey in seeking and receiving reproductive care and I wanted to share the findings with you because I have to say it's possible. I was starting to feel a little sad and jaded about preconception health going into this study and really listening to these women's voices really reminded me again that this an equity and reproductive justice issue.

So, they talked about this need for self-reliance, that they felt they had to be in charge of their own information. They had to advocate for themselves, do their own research on their condition and what it would mean if they got pregnant. They didn't feel seen or heard. They didn't believe that they could trust the healthcare system. They had had lot of fear and guilt and even shame about asking questions and advocating for themselves and they experience a lot of negative mental health effects.

It was really stressful to have chronic conditions and experience discrimination in healthcare and feeling like they had to take charge of their own healthcare. And I think if we think of this happening outside of pregnancy, it helps us understand what is happening and where we're seeing inequities during pregnancy, right?

We also saw that there was a lot of racism and provider bias that emerged and, in some cases, perhaps providers were thinking they were being protective of their patients because becoming pregnant or having a baby might have bene risky for them, but women internalized that as you don't want any more Black and Brown babies in this world. You don't want me to have a baby.

And we saw also discrimination based on weight that was something that really emerged and was interesting and important to think about, and also age, although honestly, you could be either too young and you were brushed off or you were too old and fussed at that you didn't get care when you were younger. So, really it didn't really matter. There is no age where women could win.

We also saw a lot of delays in condition identification and treatment. Women felt sick, they were experiencing infertility, miscarriage, infant anomalies, infant still birth and death. It was really heavy, and they weren't getting the information they needed.

One woman said she didn't actually get treated for her conditions or even know what her conditions were until she was pregnant and saw a maternal fetal medicine specialist. And also care is caring. People want to know the truth and they want it delivered with hope.

So, we also listened to a lot of strategies for change. And I'm just going through these quickly because I know this is

just starting your conversation, and again, these are things that we're hearing in other spaces around comprehensive care clinics, care coordination, and care quarterbacks for folks. Insurance doesn't cover needed tests and treatments for folks that aren't pregnant. We already talked about educational materials. Trust is so important. We've talked about that.

We need to be training providers and clinicians to talk about infertility, miscarriage, and infant loss in the context of chronic conditions. It's a very tender conversation that needs to be done exquisitely well and also clinicians need to know that conversations about reproductive goals are essential to care and they're not extra.

I really love this visual that emerged from some work that was funded by the W. K. Kellogg Foundation. That was also what funded our work in chronic conditions to move out and think about systems. And again, these are some of the strategies I'm going to mention in the next slide, but I wanted to highlight the top, the language that people wanted us to use in preconception space is reproductive sovereignty, abundance, flourishing, agency, and connected. And we also acknowledge that there's a lot of collective responsibility in dismantling a lot of ism’s, including fat phobia, homophobia, and transphobia.

We also were able to do a really big national system mapping conversation with W. K. Kellogg funding. Here are some of

the strategies that emerged, which I won't dive into all of them here, but I think that some things to highlight, such as providers, policy folks, and payers agree that we need to continue to explore so innovative models of providing care and reimbursement for care outside of pregnancy.

And that we, again, get better sex and gender desegregated data across all data systems and also trying to breakdown some of the siloed funding structures and mandates. One would think that the MCHers would work well with your chronic disease departments and folks, and honestly, that's not really happening, and the funding streams and other things actually create a system whereby a lot of people that could and should be working together are not.

We did an entire series of issues on this topic with some really fabulous writers and lots of strategies and those are all available open source for you to read and dive into later on. And so, I would challenge you as you're thinking about this topic are there some other groups that we would want to focus on? Because doing preconception health for all people we're talking three to four decades of a person's life. It's a huge audience. It's a huge country. Are there some areas that we might -- again, we've been intentionally focused in on, I think, in thinking about maternal and child health are we looking at youth in the carceral system and foster care or dealing with substance use. Are there

some young adults that we can provide additional care, focus attention and resources to, and then are there periods of time, as we think about transitioning young adults from their pediatrician to adult care or as they fall off their parents' insurance as my child did this year, and how do we use those as some teachable moments for them to begin to build their own autonomy for their care. Also, yay thank you, North Carolina, passed Medicaid expansion December 1, got a lot of young adults on care, which is great.

In wrapping up, I'm just going to offer you some thoughts about preconception health looking forward. So, some suggested strategies are supporting quality preventive care and mental healthcare services across the life course. As we are seeing this wonderful influx and interest in maternal health right now where there are just so many resources out there, can we be creative and innovative and think about stretching those resources across the continuum a little bit more outside of just pregnancy and birth and postpartum.

We need to talk about preconception health in a way that says you matter for you as a person, the gifts that you bring to this world, you matter whether or not you want to become pregnant, which is tricky for those of us in MCH, I know.

We need to really be having these conversations. We need to provide respectful trauma, informed, and helpful care.

And yes, inclusion matters of folks across however they identify by gender and however they express themselves in all of their identities.

When I think about what federal initiatives are underway, we have Women's Preventive Services Initiative, which is still happening. We have our NPM I is changing, and I am thrilled about the postpartum changes. I think they're great, but I'm also sad because not having the well woman visit as a national performance measure really -- I don't know. We all know that resources follow what those NPMs are, so I think it’s something, that's a big change and what does that mean for us as MCH and Title V?

Federal Healthy Start programs their focus has varied over time. I think we could still do more with Title X preconception guidelines. I was going to complain a little bit about research, but I think that NIH just announced a whole new round of funding, so good for them. And then, as I mentioned before, we are seeing Medicaid expansion. How have we leaned into that, how are looking at who is getting access to care. I just think there's a really, really rich body of work that we could be doing in that space as well.

And so, I'm just leaving you with some questions for which I don't have any answers in the next slide and I just wonder is there a national will to support equitable wellness for people

who are not pregnant. And if it's not something totally that we, as a maternal and child health field do, how do we generate and push other people to lean into that space with us. How might we expand, as I mentioned, this big investment in maternal health, how might we do more to track national trends in women's health. And I just want to say, in particular, in having conversations around what is the bigger impact of the Dobbs decision, we're not going to see that necessarily in our maternal mortality data. We're going to see it in other data sources that we should start tracking. And how do we manage challenges to women's autonomy in decision-making about their body, which are just making all of this work so much more difficult.

And then, finally, a few other questions for you. I guess this will go to your committee. So, I would say that programmatic and intervention research funding is needed. What is written into grant opportunities really matters, what about a training NCA center for women's preventive care and services. I think that there's lots that can be done to improve access to primary care visits, which was the focus of our COIIM work. Could that cascade below, there's lots of points of intervention.

And I put my email there. And I just wanted to again remind you we have two websites that are still running. The next one is our resources for consumers which is Show Your Love Today. And then, finally, we are still keeping Before and Beyond.org

alive as well. We are actually funding those through our personal development dollars of my team, but I am holding out hope that we will continue to put energy in working upstream for real primary prevention to improve outcomes for moms and babies and people. So, with that, Belinda, I'll turn it back to you.

MS. PETTIFORD: Thank you so very much, Sarah. I know you're trying to get to the airport, so if you have questions for Sarah, if you want to drop them in the Chat, and we can hold onto them and we can get back in touch with Sarah in the next day or so to get some responses, I'd appreciate it.

You all should give yourselves a hand, and thank you, Sarah. You all should give yourselves a hand because you all have truly been troopers today. I want to thank everyone for all of their presentations, but also I especially want to thank the Committee members for being so diligent in letting me skip over your breaks and just keep us moving because I was just texting with Sarah and Vanessa that I think we were a little overzealous when we were working on the agenda, but it is so much amazing work going on around the country and we're just trying to figure out how do we share it, how do we have this information so that we can move it forward in our workgroup work. So, I know it's 6:00, 6:01, so we are getting ready to wrap up.

Just a couple of reminders for tomorrow morning. It'll be morning somewhere. Tomorrow, 12 noon Eastern time tomorrow, we

will start off with workgroups. So, we have three workgroups. If you have not joined one of these workgroups, please plan to do so. You will get the email information in the morning that lets you know how to join the specific workgroups. If you've not already received it, all three workgroups will be meeting simultaneously. So, they will be meeting from 12:00 until 1:30 tomorrow.

This will be an opportunity to start the dialogue on some of the recommendations, but specifically to think through the information that we've been able to hear from our presentations today, as well as our meeting in June. So, we have a workgroup, as you know, on rural health and systems issues that Kate Menard is chairing it or leading it right now.

We have a workgroup on preconception, interconception reproductive health. And Phyllis and Joy are leading that work for us. And we have a workgroup on social determinants of health or social drivers of health and happy to have Sherri and Marie to lead that work. Please, please plan to come and join one of those sessions.

After the workgroups, we're asking the workgroup leads to please keep a check on your email because during the workgroups you will have notetakers, so you don't have to worry about that. The notetakers will be able to pass the information back onto you so that you'll be prepared for the report outs. So, I just want to make sure everybody has that information. So, does anyone have

any questions, comments, concerns before we adjourn for today?

(No response)

MS. PETTIFORD: It looks like everyone is ready to move onto to the next part of their day. Thank you all so very much. Have a wonderful rest of your day, evening, depending what part of the country you're in, and we look forward to seeing everyone tomorrow. Take care everyone.

(Whereupon, the meeting was adjourned)