ADVISORY COMMITTEE ON INFANT AND MATERNAL MORTALITY (ACIMM)

Hybrid Meeting

Health Resources and Service Administration Building

5600 Fishers Lane

Rockville, MD 20857

Wednesday, June 26, 2024

9:30 a.m. - 5:00 p.m.

- COMMITTEE MEMBERS -

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Developmental Behavioral Pediatrician
CDC Act Early Ambassador to Oregon
Help Me Grow Physician Champion

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Julia A. Okoro Professor of Black Maternal Health
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Assistant Dean of Diversity, Equity, and Inclusion
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Hannabah Blue, M.S.P.H.
Consultant, John Snow, Inc.

Steven E. Calvin, M.D.
Obstetrician-Gynecologist

Charleta Guillory, M.D., M.P.H., FAAP
Associate Professor of Pediatrics
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Marilyn Kacica, M.D., M.P.H., FAAP
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Scott Lorch, M.D., MSCE
Kristine Sandberg Knisely Professor of Pediatrics
Perelman School of Medicine at The University of Pennsylvania
Vice Chair, Division of Neonatology
The Children’s Hospital of Philadelphia
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M. Kathryn Menard, M.D., M.P.H.
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Joy M. Neyhart, D.O., FAAP
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Belinda D. Pettiford, M.P.H., B.S., B.A. *(Chairperson)*
Women's Health Branch Head
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Jacob C. Warren, Ph.D., M.B.A., CRA
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Division Director

U.S. Department of Labor

P R O C E E D I N G S

Welcome and Call to Order

MS. LEE: Good morning, welcome everyone. This is the Federal Advisory Committee on Infant and Maternal Mortality Meeting. I'm Vanessa Lee. I'm the designated Federal Official for the Committee. I work at HRSA, the Health Resources and Services Administration in the Maternal Child Health Bureau where the Committee is administered.

And before I turn things over to our Chair, I just wanted to welcome our Committee members, our federal ex-officios, our presenters and speakers, and members of the public who may be joining us today. Welcome. Thank you so much for being here. I'm calling the meeting to order, and passing it now to our Chair, Ms. Belinda Pettiford to kick us off.

CHAIR PETTIFORD: Good morning everyone. This is Belinda. I'm so excited to have you all with us here today. I hope your summer has started off well. Apparently, we know it's summer by this temperature we're feeling everywhere, but hopefully you've had a wonderful one also.

We have a very full agenda today and tomorrow, and we also included on the agenda some very specific times for the work groups to meet, so they can begin on moving and drafting their recommendations. I'm also very pleased to share that we have six new appointed members, and two additional ex-officio members, so very excited to have many of them able to join us.

Now, our new appointed members are joining us virtually. We were able to get them in just under the wire, and Vanessa and Sarah and I were able to have some conversations with them this past Monday, so we look forward to seeing them in person at our next meeting, but very excited to have everyone here.

Member Introductions

CHAIR PETTIFORD: So, we're going to move quickly through our agenda, and I want to make sure we have time for some introductions. And I'm looking on the screen cause we've got some here in the room, some virtually, and I want to make sure that everyone gets a chance to introduce themselves.

What I will ask you to do is if you are a member, whether ex officio or appointed, that you give your name, your organizational affiliation, briefly your area of expertise, and then share with us one state in this country that you have not visited yet, but you're interested in going.

I don't need to know why, I just need to know the state, and which one it is that you would like to go to. And so, I will kick us off. Again, I am Belinda Pettiford. I'm your Chair. I'm from North Carolina, with the North Carolina Department of Health and Human Services where I serve as the Section Chief for Women, Infant and Community Wellness.

The state that I have yet to visit is Utah, so that is on my agenda, is to come out to Utah. And now, I'm going to pass it on, and I'm going to start with the virtual people first, who I see on the screen, so Joy, you're popping up first for me.

DR. NEYHART: Good morning. I am Joy Neyhart. I am a

pediatrician who practiced in Juneau, Alaska in a small, independent practice for 22 years, and then I joined Southeast Alaska Regional Health Consortium for two years. I am now doing locum tenens work, and I am currently coming to you from Sidney, Montana, which is far eastern Montana.

We are the only delivering hospital on this side, well, let's see from the highline down, so people from U.S. too that are going to give birth will come down here if the IHS hospital closes, and then Sidney serves the Richland County, and also some of Williston, North Dakota.

I also will be getting a master health program in September, I will probably do less clinical starting then, and more school work. And the state I would love to visit is Michigan. I understand it's beautiful, lots of hills, and Great Lake and then sandy beaches that aren't associated with an Ocean, so I'm interested in that.

And I'm happy to be here with you all today. And one last thing, I am so excited about the new members. They look like a crew of giants, and I'm so excited.

CHAIR PETTIFORD: Thank you so much, Joy. Next, I see on the screen is Jacob.

DR. J. WARREN: Hi everyone. Good morning. I'm Jacob Warren. I'm an Epidemiologist and on faculty at the University of Wyoming. I focus on rural health equity research. I had a career in academic administration, research institutes, I'm also an affiliate of our one rural health institute here at the university.

I just want to echo Joy's welcome to all the new members.

We're really, really excited to have you, very much so. And let's see, one state I haven't visited yet. I grew up in this place in Georgia, even though I live in Wyoming now, so I've never been to Hawaii, and I'd like to go for probably obvious reasons.

CHAIR PETTIFORD: Thanks, Jacob. And here's one of our new members. Hannabah, If you'll come off and introduce yourself?

MS. BLUE: Sure. (Speaking in native language). Hi, everyone, My name is Hannabah Blue. I am Dene or Navajo, originally from New Mexico, where I currently reside. My clan is the Red Cheek People clan, born for Bilagaana, or Anglo. My grandfather's clan is the Tangle People Clan, and my paternal grandparents are also Bilagaana or Anglo. I am honored to be able to join this Committee as a new member.

I live in New Mexico with my spouse and my daughter who turned one year yesterday, which was a huge moment.

MS. LEE: Happy birthday.

MS. BLUE: Thank you. She's wonderful. I'm a Senior Associate at GSI, as well as the Codirector for our Center for Health Equity. My work has been providing training, technical assistants basically supporting the programs that work with our community members through different initiatives around maternal and infant health, around sexual reproductive health, as well - as around other areas that we know are really important to this area. I also just want to share personally, I've had personal experience in my life and in my family and in my community of experiencing some of the issues that we're addressing.

And I just I want to bring that up because often I'm in spaces where I'm sharing the realities of what happens, especially in our tribal communities. I also am--I identify as Two-Spirit or queer, and my spouse is non-binary. And so navigating having a family in that space also has brought up different things.

And so--I thank you so much for the welcome to this committee. I'm so excited to join. I hope that through my expertise, my personal experience, my, and my passion that I'm able to contribute a different perspective as well as insights to make sure that we're trying to reach the solutions that we need, as well as to really just support our people, our families, our communities, and our organizations throughout the country. And so I would love to visit Alaska, actually, Joy, I've never been. And there's just so much amazing people there that from what I hear, the villages, the remoteness, just a different, you know, different atmosphere. So thank you. I'm happy to be here and honored to be invited and enjoy. Thank you.

CHAIR PETTIFORD: Thank you so much, Hannabah. We feel your passion through your introduction, so thank you. Next I see Marie.

DR. RAMAS: Good morning everyone. I am with everyone in spirt—I’m sorry I can't be there in person. I'm a family physician by trade. I have been practicing for over 15 years. I am apart of American Academy of Family Physician Commission of Health of the Public and Sciences. I currently have a background in both delivering babies in both the rural and urban setting as a family physician, and

being a patient myself as a person of African descent and delivering three premature babies, so I have both a public health interest and a personal interest in making sure that we create systems that are equitable, and nurturing to foster our healthier future.

Currently I serve on the Commission of Health of the Public and Sciences for the AAFP, and I also am serving as Chair of our strategic planning group for New Hampshire's largest health endowment as well, and in that have been in creative spaces to address maternal and infant mortality, morbidity within my state on the local spectrum as well.

So, among other things, I am of Haitian descent, so I'm a first generation American, and living in two different cultures, and navigating the healthcare system as a first-generation American is a passion of mine, and making sure that voices that are not typically represented in making policy are represented around spaces like this.

I also have a background in health spending and health business, healthcare systems business, and I think that particularly for our purposes in the group, particularly around health disparities. It is important that we are able to communicate a fiscal return on investment about what we know is a moral and ethical duty for primary care, particularly for those who are birthing.

I'm remiss to say that my pronouns are she, her, hers as well, and I'm looking forward to a generative session the next two days.

CHAIR PETTIFORD. Thank you so much, Marie. Next, we'll go to Marilyn.

DR. KACICA: Good morning everybody.

CHAIR PETTIFORD: She's also one of our new members.

DR. KACICA: Yeah. I'm Marilyn Kacica. I am with the New York State Department of Health. My role is Medical Director there, and I oversee programs for maternal child health, and also the Title V Medical Director. My background is I'm a pediatrician. I have sub-specialties in infectious disease and preventative medicine.

I practiced pediatric infectious disease for about 10 years before transitioning to public health through the preventative medicine residency. I'm also a clinical professor of epidemiology at SUNY Albany School of Public Health. I also, my background is also varied in so far as I've overseen epidemiology, infection control, emergency management, so I'm thrilled to be on this Committee.

I think there's so much good work to be done, and I think this is an amazing group, and I'm honored to be in the room with everyone. And I've always wanted to go to Wyoming, because I'd like to see Yellowstone.

CHAIR PETTIFORD: I think Jack and Mike can work on that. Thank you so much, Marilyn. We're going to now go over to Steve.

DR. CALVIN: Hi. I'm Steve Calvin. I am a Maternal Fetal Medicine Specialist, and I'm spending time half in between Minnesota and Arizona. I had a long career as a practicing, basically OB intensivist physician, and then I spent some time early in my career as a national health service corps physician down in Tucson, Arizona at the El Rio Neighborhood Health Center.

I've spent about a decade working with midwives to try to foster a different kind of system that includes midwifery as a key component, and very recently I've taken on a role as a faculty member

at Banner University Medical Center in Phoenix, which is the College of Medicine, University of Arizona.

So, I just want to welcome Hannabah and the other new members because many of our patients there are from the Navajo Nation, and from White River, Apache, and I have a real passion for trying to figure out how to better provide care for folks that are living in rural communities, but also obviously, a focus too on the cities as well. The state that I have not visited, and would really like to visit is Maine.

CHAIR PETTIFORD: Oh, thank you, Steve. Who do I see on the screen? Oh, you all are moving around. Okay. Let's go with Marya.

DR. ZLATNIK: Hi, good morning. I'm Marya Zlatnik, she, hers, currently speaking to you from unceded Ramaytush Ohlone land. I am a Professor of OB/GYN at the University of California, San Francisco, and a practicing maternal fetal medicine physician there. I am also part of the UCSF Program and Reproductive Health and the Environment, and the Western States Pediatric Environmental Health Specialty Unit.

I am currently on an EPA FACA, the Children's Health Protection Advisory Committee, which is in the Office of Children's Health there. So, I'm very excited to be part of this group, and to be working with so many amazing people. I have never been to New Mexico, and so I would love to visit there. Thank you.

CHAIR PETTIFORD: Wonderful. Thank you so much, Marya. And she also is one of our newer members. I see Scott is also on the screen, and if you'll come in and introduce yourself, one of our newly

appointed members.

DR. LORCH: Hi everybody. My name is Scott Lorch. I'm Professor of Pediatrics in the Division of Neonatology at the Children's Hospital in Philadelphia, and the Perelman School of Medicine at the University of Pennsylvania.

I am a perinatal epidemiologist and health services researcher with kind of an extensive background in health economics, with a lot of our work is on population health systems, and system development to optimize outcomes of pregnant patients, and newborns, particularly around perinatal regionalization, development of protocols and policies to guide hospitals delivering patients and what types of resources should be in place at hospitals that choose to deliver patients.

And a large body of work on the economics of pre-term birth, prematurity, and growing body of work on access to care, both in rural and urban spaces. I'm the Vice Chair of the Division of Neonatology, Director of Clinical research, and direct the CHOP Newborn Research Center, which has over 30 faculty studying a variety of issues surrounding optimizing the care of pregnant patients, and the newborns that are part of that dyad.

The question about where to go actually was a little tricky. I'm originally from Knoxville, Tennessee. I went to school in Chicago, and because you know, pediatrics likes to have conferences everywhere, I've been most everywhere. I actually figured out only five states I haven't been to, so picking of those five states I guess it would be Maine, mostly because it's the closest.

The rest are in the northern Midwest, where we just haven't

with our family, gotten through to the Dakotas, but my wife has thoughts of having our kids see the national parks, which means Acadia would probably be on the radar screen as a closer drive, and to try to get them back to Yellowstone, which was quite a trek when we did it ten years ago.

CHAIR PETTIFORD: Thank you so much, Scott. And now I see Charleta on. She also is one of our newly appointed members.

DR. GUILLORY: Good morning everyone, and I just have to say I'm very excited, and very honored to be part of this group. I am a Professor of Pediatrics in the Division of Neonatology at Baylor College of Medicine in Houston, and I serve as the Director of Neonatal Perinatal Public Health Program here at Texas Children's Hospital.

I have worked as a neonatologist for the last 30 years, and I've had the opportunity to actually experience health disparities in the NICU. As a result of that, I have continued my training, especially in public health. Actually -- I don't know why my camera is doing this -- actually, obtaining a degree in public health.

Because of my interest in the high rate of premature births that are appearing in our NICU, and the high rate of Black infants specifically appearing there. As a result of that, I presently serve on the Academy of Pediatrics Committee on Fetus and Newborn, working with, I think Dr. Eric Eichenwald, who is the Chair of that Committee, Scott.

In addition to that I am the Chapter Chair President of the Texas Pediatric Society of the American Academy of Pediatrics, and I serve presently as the Chair of the Texas Collaborative for Healthy

Mothers and Babies, which is our state perinatal quality collaborative.

I am just excited again, to be here. And my life has been, and my career has been one of working with vulnerable babies, and making sure that they have a voice. The one state I really haven't been in that I would like to visit is Minnesota, and really the reason is because Rachel Harden is there.

I've heard her speak here a couple of times on helping us understand how race plays an important part in the care of neonates, and I have an opportunity to speak with her also in Congress on this matter, and I would love to see the public health work that they are doing in Minnesota there, thank you.

CHAIR PETTIFORD: Thank you, so much, Charleta, and we'll let you and Steve talk about Minnesota later. I'm going to quickly shift to make sure we give the appointed members in the room a chance to introduce themselves also, so Phyllis, if you will go next.

MS. SHARPS: Good morning. I'm Phyllis Sharps. I'm a Professor Emerita of John Hopkins University School of Nursing, and in that former life I led four nurse managed clinics in Baltimore City. My research and practice has always focused on pregnant women and babies, and really looking at Black infant maternal mortality and infant mortality, and issues related to violence against women.

I've had two NIH-funded grants that tested nurse home visit interventions that addressed violence in the home, so I've been to all of the states except for five. When my kids were home I tried to convince everybody we should take a trip to the Midwest and see all the famous parks, and nobody ever liked that idea.

So, I think of the five that are left, I'd like to go start with maybe South Dakota, so I could see Mt. Rushmore.

CHAIR PETTIFORD: How wonderful. Thank you. We're going to go to Kate. I think you all are going to have to share the mic.

DR. MENARD: Great, Good morning everybody. My name is Kate Menard. She asked us to ask where we're from, our roles. I'll try to keep it brief, but I'm a Maternal Fetal Medicine Specialist. I'm based at the University of North Carolina, and have been a professor there since 2006, working closely with Belinda along the way.

My, kind of, I think contributions along the lines for this role and throughout, I was a former President of the Society for Maternal Fetal Medicine, and while I was doing that work is when we were really shifting focus onto from sort of fetal health to maternal health.

And I always had that passion, and we built upon that by working on really through work of HRSA on advancing the need to define perinatal regionalization for the mom, not just about the baby. And I'm looking to recruit a few new members to this work because I continue in that work, and this passion is part of the work that we're doing with this work group too.

The other thing we did at that time was really kind of launched the idea of disseminating safety bundles to the maternity hospitals in the initiation of the AIM program, which HRSA funds, and is now based at ACOG, and I've continued in that work.

My current work includes actually taking an AIM bundle on hypertension that has been implemented broadly in the inpatient setting to the community setting, to clinics, and to really elevate

the importance of understanding the importance of preeclampsia in the postpartum period, and how that can contribute to maternal morbidity and mortality.

So, I am co-chairing the Rural Group that the new members are going to hear about the Rural Workgroup, and I see a couple people that I want to recruit to that. Scott, please join me, please join us. I think Hannabah, another - would be a great contributor, anybody else that is interested it's all-hands-on-deck.

States. I had to look at the map to remember which ones I hadn't been to. Nebraska to New Mexico, Montana. So, I want to go to Montana, Joy, and I'd love to go to New Mexico. I think my -- I can't order them though.

CHAIR PETTIFORD: Thank you, Kate and Sherri?

DR. ALDERMAN: Good morning, my name is Sherri Alderman. I am a Developmental Behavioral Pediatrician, located in Oregon. I'm halftime in Portland, Oregon, and halftime in a very rural area of Oregon, which is quite beautiful from my backyard, a view of Mount St. Helen's, and from my front door, a view of the Columbia River down in the valley.

I came to Oregon after 12 years at University of New Mexico, so I'm delighted for the opportunity to connect with you, Hannabah in that area. I feel like I professionally grew up there. I did my residency there, and then rolled over onto faculty. I am also the American Academy of Pediatrics Early Childhood Champion in Oregon.

And I am one of the Help Me Grow Physician Champions. A special interest of mine, a passion that I have is infant mental health, and I am very thrilled to be a part of this Committee to

always bring the voice of babies to our conversation, and to our thoughts, and to always hold them in mind.

I'm also a co-facilitator with Marie on the Sub-committee Social Determinants of Health, Social Drivers of Health, and I find that work very interesting. And since we are taking this opportunity to recruit Hannabah. It would be fabulous to have you on that Committee as well.

That's right. So I retract that last comment, but I'm saving it for another time. So, I, more recently, I have connected -- a long standing interest of mine is child rights, and the convention on the rights of the child. More recently, I have been connecting with people who are interfacing with the United Nations on climate change, bringing to that conversation, and those advocacy efforts, the interface between climate change and child rights, so it's a pleasure to be here today. Thank you.

My state is Oregon. Oh, that I want to visit? Oh, Okay. You know, it was an interesting exercise because I had not realized until you mentioned that, Belinda, that I've actually been to 49 of the states, and Puerto Rico, and so it took me a while to figure out which one I hadn't been to, and that would be the one that I would want to go to, and that's Delaware.

CHAIR PETTIFORD: Well, thank you so much. As you can see, all of our newly appointed members there is a lot of excitement about you all, so looking forward to seeing you in person. But I want to quickly now move into our ex-officio members, and I want to start with Anne Miller because she's one of our new, new ex-officio members with ACF. I'm going to let Anne introduce herself.

MS. MILLER: Good morning everybody. Anne Miller, the Administration for Children and Families. I serve in the Office of the Assistant Secretary as the Acting Policy Director. I'm very honored to be here with you. We are focused primarily at ACF on how we can collaborate across the many social service programs we administer, which includes Head Start, Refugee Assistant, Child Care and many, many more.

And I'm thrilled to be here, and looking forward. In terms of my state it would be Maine to go to Acadia and camp and hike.

CHAIR PETTIFORD: Wonderful. Several people for Maine. Kristin will be next.

MS. ZYCHERMAN: Hi. I'm Kristin Zycherman from CMS. I'm the Quality Improvement Technical Director for the Division of Quality, and the Lead on the Maternal Infant Health Initiative. And my state would be Maine, both for Acadia and lobster.

CHAIR PETTIFORD: Thank you so much, Kristin. And Allison?

DR. CERNICH: Hi. Good morning everyone. Allison Cernich. I am the Deputy Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development. Our portfolios include both maternal health, as well as infant health, and so that is the reason that I'm here. We also are the lead institute for the Improve Initiative, which is the NIH-wide initiative focused on health disparities for material health and reducing maternal morbidity and mortality.

And I think my state would probably be Alaska because I've never been, and I'd love to go.

CHAIR PETTIFORD: Wonderful. Okay. And I think Deb, we're

also going to let you introduce yourself.

MS. KILDAY: Good morning everyone. Deb Kilday, with the Office of the Assistant Secretary of Health, the Office of Women's Health. I serve as a Senior Advisor leading their material health programs. The leading program would be the Maternal Mortality Morbidity Initiative, which is really focused on data and analytics.

It is an absolute pleasure and privilege to be here, and I am from Georgia. And I've actually been to all 50 states, but I will say I did not spend enough time in Alaska, so I would like to go back.

CHAIR PETTIFORD: Wonderful. Going back virtually to Charlan.

DR. KROELINGER: Hey, good morning everyone. I'm Charlan Kroelinger. I'm a Chief of the Maternal and Infant Health Branch in the Division of Reproductive Health at the CDC, and I oversee the work of maternal mortality review committees, perinatal quality collaboratives, sudden unexpected infant death, and sudden death in the young case registry, and science related to maternal health and chronic disease conditions, including substance use and mental health conditions.

And the state that I would like to visit I think, in alignment with everybody else, a lot of folks on the call is Maine. I know it's a beautiful state, and I haven't been there, and I'd love to just see the landscape and scenery. Thanks so much, Belinda.

CHAIR PETTIFORD: Thank you, Charlan. Apparently, our next meeting will be either in Maine or Alaska. So, Caroline?

MS. DUNN: I would like to commit to attending the next meeting in person, Belinda. So, my name is Caroline Dunn. I am so

excited to join today. I'm the ex-officio from the U.S.D.A., and I worked there in my capacity as a Senior Social Science Analyst specifically working with the special supplemental nutrition program for Women, Infants, and Children, or WIC.

So, the majority of my work focuses on the intersection of food security, nutrition security, and maternal and infant health. I manage our maternal health portfolio, which I am happy to say we just actually awarder a large 5 million dollar grant to the University of North Carolina to research evidence-based interventions in WIC settings to support material health, so very excited about that. I'm excited to be here today.

And if I could visit one state, I actually will go with Belinda, it would be Utah, and I have a conference later this year there, so I'm very excited I will get to check that one off my list.

CHAIR PETTIFORD: You'll have to let me know about the conference in case I need to show up.

MS. DUNN: You're always welcome.

CHAIR PETTIFORD: Okay. And then we have Amanda with us today.

DR. COHN: Good morning everyone. My name is Amanda Cohn. I am a Pediatrician and the Director of the Division of Birth Defects and Infant Disorders of the National Center for Birth Defects and Developmental Disabilities, so really the sister division to Charlan's division.

I oversee programs, such as the surveillance for emerging threats to pregnant persons and infants, as well as our birth defects surveillance and research programs at the CDC, and I am looking

forward to hearing from all of you, and how it informs the work we do on a daily basis.

And the state, I have the privilege of doing many road trips in my life, so I've driven through many states, but I have not been able to drive to Hawaii, so I would love to go to Hawaii.

CHAIR PETTIFORD: Thank you so much. And I think we have Anne Driscoll with us. I don't see you on the screen, but I hear your voice, thank you, Anne.

MS. DRISCOLL: I'm sorry. My camera isn't working. I'm Anne Driscoll. I am demographer at the Division of Vital Statistics at National Center for Health Statistics, where I work on both the birth and infant mortality datasets, and my background is mostly in trend analysis and statistics.

I am actually subbing for my colleague who is out on maternity leave now, who has been at previous meetings, Danielle Elly, so I am tentatively taking notes for her when she gets back. And my state would be I would go along with a few people, New Mexico, just for the wide open, beautiful postcards I've seen from it.

CHAIR PETTIFORD: Wonderful. Thank you so much, Anne. I know we've got -- we're already running behind on schedule, and that's on me to keep us moving, but I do want to take a moment to make sure that Lee can introduce himself, along with Sarah and then Vanessa.

MR. LEE: Good morning folks. My name is Lee Wilson. I direct the Division of Healthy Start and Perinatal Services here in HRSA. Welcome to our space. We're glad to have you all here. And for those of you who are new, it's been a long time bringing you onboard. I thank you for your persistence, and we will reward you

with a trip to Maine or Alaska at some point I guess, no promises.

I have the great pleasure of working closely with our team here, both our staff and the LRG folks who have kindly provided the logistics support here. I have been to almost all 50 states. The two that come to mind that I am missing I'll treat as one, and that would be the Dakotas, because I would like to see them both, so thank you.

CHAIR PETTIFORD: Wonderful, Sarah?

MS. MEYERHOLZ: Hi. Good morning. Sarah Meyerholz here. I'm the Program Lead for ACIMM. Like we said, we work closely with the folks here, and yeah, I'm sure everyone has got an email from me, and lots of communication. Thank you so much for your patience.

And I'm with Lee and Phyllis. I guess we're going on a road trip to the Dakotas.

MS. LEE: And hello again. I'm Vanessa Lee, again Designated Federal Official for the Committee. The other hat I wear in the Division of Health Start and Perinatal Services is a Project Officer for our state maternal health innovation program, and before that I got to know many of you from our infant mortality collaborative that was run by NCHB, so it's such a pleasure to be with you all, and again, just a big welcome, especially to our new members, who as Lee said took years to bring on.

They had applied back in 2021, so if you applied to our recent solicitation, don't worry, we're still reviewing the 2023 call for nominations. This is a different group that came in even before that, so again, welcome. And the state I think I would like to visit, like others have said is Alaska.

CHAIR PETTIFORD: Wonderful. Thank you all. All of our

newly appointed members are able to join us today, except for Ndidiamaka. She was not able to join us, but she will be in touch with us soon, so it was great to be able to speak with her, and she's coming to us from Boston, Massachusetts, so we don't know what state she wants to visit, but not Massachusetts.

Thank you all so very much, and thanks to all of the others that are joining us today, even though you didn't get a chance to introduce yourself, we see you, so thank you for being here.

Overview of Meeting Agenda and Review of Committee Priorities for New Members

CHAIR PETTIFORD: I'm going to quickly move us through the agenda. So, just a quick overview of the agenda. You should have copies nearby. Today we're going to spend time, many of our speakers are connected to one of our three workgroups, so we have a speaker that's connected to the work around pre-conception, interconception care.

We have a speaker that's focused on issues around rural systems issues, as well as one around social determinants of health, or social drivers of health. So, those are kind of the way we structured the agenda to make sure we were connecting it to our workgroups.

Again, we will always have time for public comment, so I think we scheduled a couple of times for public comments, because we've heard from several that would like to make public comments, and we'll always make sure you have time for a few breaks and lunch.

But most importantly, tomorrow we will spend time in the workgroups, so there will be focus time for the workgroups to meet,

for them to really think through what their recommendations are, and at least start drafting them.

Also, if you think about our overall meeting, we do have three very specific objectives today for our meeting today. One is to better understand what federal activities and efforts are happening around the three priority areas that we talked about, which are basically our three workgroups.

One is to learn about best, and promising practices and initiatives that are connected to these priority areas, especially as it works on, or focuses on improving Black, or African American maternal and infant health. And then the last areas to facilitate the discussion between the workgroup meetings and our breakout sessions, to make sure we have time for that dialogue.

As we think through our recommendations, just a quick update on kind of what our timeline is. So, as you know, we are -- this is an election year, so we have to really think about when we're going to get the recommendations to move forward. So, we made a decision that we really wanted to have draft recommendations at this meeting in June.

When we get back together in October we will move those recommendations closer to final. And then by the end of the year, at least by January, we want to have a strong draft report that we could submit to the new Secretary, or maybe the same, you never know, or whoever the Secretary is by March.

So, we really think that we want the Secretary, the next Secretary, to receive the recommendations, so they'll have time to respond, and actually try and move some of the recommendations

forward. So just know that that's what our timeframe is right now.

Again, our three workgroups, some of you have gotten an opportunity to hear a little bit more about the workgroups because through your introductions you were encouraged to join the workgroups. Just know if you are one of our new members, you're going to join as many workgroups as you like, but we do ask you to join one.

If you would just at least join one. And those workgroups typically meet monthly for the most part, but it won't take long I don't think, to get you all up to speed on that, so that you'll have the opportunity to chime in on drafting the recommendations. Any questions thus far? I'm trying to get us back on schedule. Yes, Kate?

DR. MENARD: Just a reminder for me, Belinda, in terms of the timeline that you described. There are current members, I think, including myself that are on the Committee until March, is that right? So, that will close. We'll package these recommendations with the current Committee, and then a bunch of us, I think.

Approval of Minutes

CHAIR PETTIFORD: Some will be rotating off and some will not. So yeah, so that also times well with the recommendations. Thank you for bringing that up. So, as we go on the agenda, I now want us to move to approval of our minutes from our last meeting. The minutes were in your briefing book, so hopefully you had a chance to at least skim them if you did not read them in full detail.

But at this point in time I will take a motion for you to approve the minutes of our last meeting. Any member can make that motion.

DR. RAMAS: This is Marie, so moved.

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

DR. CALVIN: Steve, second.

CHAIR PETTIFORD: Thank you, Steve, and I think Phyllis's hand shot up just before yours, Steve, so Phyllis is also seconding the motion. Will those in favor of this motion if you'll say, "aye"?

(Chorus of ayes.)

CHAIR PETTIFORD: Thank you. Any opposed likewise?

(No response.)

CHAIR PETTIFORD: Perfect. Then the minutes are approved. Thank you all so very much for getting us back on schedule, just a minute off. Okay. At this point in time we're going to move into some federal updates. We're excited to have with us two of our federal partners joining us. I think they're both virtual today--oh, oh, Elizabeth is here. Oh. Thank you.

Federal Updates

CHAIR PETTIFORD: So, we're going to start, perfect. So, Elizabeth Kittrie is joining us first. She's the Senior Advisor in the Office of the Associate Administrator for the Bureau of Health Workforce here at HRSA, and she is moving around in the room where she can get comfortable, and so, do you want to sit, whichever you're most comfortable. We got you.

MS. KITTRIE: Now I'm good, yes? All right. So, first of all good morning, and you have made me very eager to travel, so feel free to invite me to your Alaska meeting, your Maine meeting, your Dakota meeting, I'll come. All right.

So, first of all it is my pleasure to be here, and to be

able to tell you about our investments in the Bureau of Health Workforce to grow and diversify the maternal health workforce. I know you all are particularly interested in rural, so I will try where I can to sort of touch on some of our rural impacts.

Let me just start with introducing myself. I am Elizabeth Kittrie. I'm the Senior Advisor to the Associate Administrator for the Bureau of Health Workforce. So, if you can go to the next slide. For those of you who might not be familiar with our Bureau, let me just take a moment to tell you about our Bureau.

So, within HRSA, we are a sister Bureau to the Maternal and Child Health Workforce Bureau. We focus on strengthening the primary care workforce, and really connecting clinicians to communities in need.

We run over 70 different programs that are really geared toward the entire continuum of a health professional's career, so that's everything from getting, you know, early outreach, getting students interested in the health workforce, to didactic education and clinical training, to supporting their service in rural and underserved areas, and then of course continuing education.

All told, last year we touched over half a million trainees through our programs. So, if you can go to the next slide. So, just across our 70 programs we have four main policy levers. The first lever is supply, so our goal is always to make sure that the supply of the workforce meets demand, so that we have equilibrium.

And where we have shortages, we will try to ramp up training programs to make sure that we meet that equilibrium. The second lever is around the distribution of the health workforce, so

really one of the challenges in this country is not so much the question of do we have enough workers overall, but it's this question of distribution. Do we have them where we need them?

And in many parts of the country we don't have enough workers. We have maldistributions. The third lever relates to quality of the workforce. We want to make sure that our workforce is not just trained, but really trained to work with rural and underserved populations, and sometimes that's really a different, or an augmented kind of training.

And then the fourth lever relates to access, particularly in rural and underserved settings. Healthcare can occur in a variety of modalities, so we want to make sure that that workforce is comfortable providing care in-person, in telehealth, just in that variety of modalities. You can go to the next slide.

All right. So, so I know one of the questions that I was asked is, so who is the maternal health workforce, and who is it that -- which providers does BHW support? So, we, being a federal agency, we do have to operate under our authorities. We operate under Titles III, VII and VIII, so those are general powers, health professions education and nursing workforce development.

Really, to be honest, there isn't a clean and simple answer because our 70 programs have different eligibilities. But, you know, broadly there are a couple of main buckets.

We support primary care physicians, so by that I mean obstetricians and gynecologists, family medicine physicians that have obstetric specializations, and then as you'll see, we'll talk about we also provide additional training for family medicine, internal

medicine and preventative medicine physicians to help augment their maternal health skills.

With respect to the nursing workforce, we mainly focus on certified nursing midwives, women's health nurse practitioners, and registered nurses that have specializations in labor and delivery.

But we also, I would be remiss if I didn't just talk a little bit about some of the broader perinatal workforce, although we don't have programs specifically focused on these groups, we do have grantees in addiction specialists, behavioral health peer specialists, community health workers, pediatrics sub-specialists like neonatologists, and physicians assistants in women's health that are all focused on the maternal population, so those tend to be like within our programs.

Unlike MCHB, we do not support doulas, and we do not support obstetrical providers who manage OB emergency, so we do not support emergency department teams or paramedics. And I know, like I said, you're interested in some of the rural populations, so again, as I'm going along I'll try to just hit on some of those impacts. If you can go to the next slide.

All right. So, across the 70 programs there are six broad buckets, and that's how I'm going to divide my presentation. The first bucket I'm going to talk to you about are the Health Workforce Analyses, and I did send you background material.

Our Maternal Health Brief, we did a brief in 2022. We are also Congressionally mandated to provide workforce projections. I'm going to talk a little bit about those. The second broad bucket I'm going to talk about are the Maternal Care Target Areas. We were also

congressionally mandated to produce these to help identify the shortage of maternity healthcare professionals.

The third bucket is Scholarships and Loan Repayment Programs. This is really how we use financial incentives to address that maldistribution that I talked about. The fourth kind of bucket I'm going to talk about are Nurse Midwifery Expansion. We do have a real focus right now on growing and diversifying the nurse midwifery profession.

The fifth bucket will be Medical Residencies and Fellowships. When--we talk about quality as one of those levers. We do have a number of programs designed to increase the number and quality of physicians that are prepared to practice obstetrics in rural and underserved areas.

And then finally, just a broader theme for us is Integration of Behavioral Health and SUD, a substance use disorder, into primary care. Again, this is one of these areas where while we don't have a specific focus on maternal health, we do have a number of grantees, and I'll talk a little bit about that there, the focus of that intersection, focusing on perinatal populations.

Okay, so next slide. All right. So, like I said, I sent you the background that we did in 2022 on the enumeration of the maternal health workforce. And that is a great overview of the size, the diversity, the rurality, but I did want to share some of our projections, which we put out every year. These are based on a micro simulation model.

They project out 15 years to 2036, so some of this is new, this is what you don't yet have in the brief, it’s updated. So, the

two projections I wanted to bring to your attention are the projections for OB/GYNs, and also for family physicians. So, I'm just going to start with OB/GYNs.

So, if you look out to the left-hand side, I know there are a lot of numbers. I'm going to walk you through this. You are going to see the total number of physicians that we had. This was in our base year 2021. And what you see basically if you go down to the bottom of this slide, you see there what we are projecting will be the shortage.

So, basically we're saying that in 2036 we project, with all trends being the same, that we will only meet 87 % of the needs, so we'll be at 87 % adequacy, which basically means a 13 % shortfall in OB/GYNs in this country. But like I said, the real issue here is if you look over on the right-hand side, it's really about the distribution.

If you look at metro areas, you'll see that adequacy rises to 91 %, so we only have a 9% shortage in metro areas, but in the non-metro areas it goes down to 54%, so basically we will have a 46% shortage in some of those rural areas. That's what we're projecting.

If you go to the next slide. I also wanted to touch on family medicine physicians because they have an important role in providing maternal case. We did an analysis of the national ambulatory medical care survey, and found that on average family medicine physicians dedicate about 7% of their time to women's health services.

And in rural areas, that actually goes up to about 9.4%. So they're, you know, an important player in this mix. Again, when we

look out to 2036, just go to the left-hand side, right down to the bottom, you will see that we're projecting we will meet only 78% of the demand for family medicine physicians.

And then go over to the right, and you're going to see again that breakout of metro versus non-metro. In the metro areas we will be at 79% adequacy, so just a 21% shortfall, but in those rural areas again, the adequacy is less good. We will be at about a 27% shortfall.

So, those are some real areas of concern for us in the workforce. If you can go to the next slide. So, now I'm going to switch from our projections. You can go actually let me just go back and say for a second that if you go to our website, we have projections for over a hundred occupations, so you can see those breakouts for every single one, midwives versus you name it, we've got them all.

So, now I'm going to talk about MCTAs, or Maternal Care Target Areas. This is another important metric that we have in the public domain. We were Congressionally mandated in 2018 through the Improving Access to Maternity Care Act, to assign MCTA scores to all of our primary care health professional shortage areas. And so, again, we have this all out on the HRSA data website, but one of the key things that I want you to see is that we have determined that there are over 7,000 primary care health professional shortage areas that have maternity care target area scores.

So, what that means is basically there are 112 million Americans, men and women, that are living in maternal care target areas, or about 1 out of every 3 Americans lives in a maternal care

target area. About 70% of those maternal care target areas are in semi-rural or rural parts of the country.

Notably, and you've got this number over here on the right-hand side, 52% of them have scores of 16 and above. That means those are high MCTAs. Those are areas with pretty severe shortages. So, if you just are interested in the criteria what we look at, we measure MCTAs by the number of OB/GYNs and nurse midwives.

We do have provider to population ratio, and then we have a number of other factors. And so, if you go on our sort of on our HRSA data warehouse, you can see all that. It's out on the public domain, but as I'm going to talk about in a moment, what's important is we're using these scores now to assign providers in some of our programs, so that we make sure that they get to those areas of high need. If you can go to the next slide.

All right. So, one of our key programs is the National Health Service Corps. This has been around for about 50 years, and it supports the placement of clinicians in high need areas. We provide them loan repayment and scholarships in exchange for service commitments.

And I know that there are two committee members, Steve Calvin and Marie Elizabeth Ramas, who were scholars or loan re-payers, I'm not sure, but very excited to hear that, and to give back to HRSA and delighted to be able to tell all of you that last year we had over 18,000 clinicians.

We had 18,000 clinicians in the field through the National Service Corps program. There were about 600 of them were maternal health clinicians, so you can see the breakdown. We also had 300

students in school. So, the scholars who are planning to go into maternal health occupations. What am I touching here? Is that me?

I'm good, okay. All right. So, overall about 38%, or a third are in rural areas. A couple of special carveouts that we have this year in '24, we have what's called a student service loan repayment program, so that's for students in their last year of school, and we are offering them a supplement of 40,000 for those that are willing to go into maternity care professions, and work in those high need MCTAs that I pointed out.

The other carveout that we have is we offer a 15 million set aside for clinicians who are willing to serve in Indian health service facilities, tribally operated, 638 health programs, or urban Indian health facility programs. All right, so next slide.

So, National Service Corps is not our only service program. We also have the Nurse Corps program. As the name applies, this program focuses on nurses, and it's -- the program is usually focused on helping to reduce economic barriers for those who want to pursue nursing careers in underserved communities, or in academic nursing.

And again, last year we placed over 3,000 clinicians in the field. I got the numbers here of the maternal health providers, what's special, and I wanted to point out is that we have two set asides. We have 10 million across our programs, 5 million scholarship, 5 million loan repayment for women's health.

So, basically providers will get preference if they want to go into nurse midwifery, advanced practice, registered nurses in women's health, or RNs who specialize in obstetrics and gynecology. Last year about a quarter of these clinicians served in rural areas.

I did want to mention something special also that we're doing in '24. This is new.

And that is we have an expanded applicant eligibility, so persons who are current lactation consultants, or doulas, that want to pursue a nursing education, are now part of the set aside, so that's super exciting for us, and I think also a great tie in with some of the NCH programs.

Okay, so next slide. If you can go to the next slide. All right. So now, I just want to move on to some of our grant programs. So, I had mentioned before that midwifery expansion is an area of focus for us, and there are two programs in particular I want to call to your attention. The advanced nursing education maternity care nursing workforce. We always have these real big names.

And probably a lot of agencies. We just call that one MAT Care. And the other one is the scholarship for disadvantaged students. So let me just start with MAT Care. The purpose of the program is to grow and diversify the maternal and prenatal health nursing workforce.

This program is specifically focused on certified nurse midwives prepared to address and reduce maternal mortality and morbidity in rural, urban, underserved and tribal communities. We currently fund ten programs at accredited midwifery nurse programs, and these programs will provide scholarships, stipends, curriculum enhancement, community-based training.

This is a great example where we have a preference, so you can get preferences if your program substantially benefits rural populations, which means you place your graduates in rural areas. If

you substantially benefit underserved populations, you again, place your graduates in medically underserved communities, or you meet the public health nursing needs in state and local health departments, again based on your graduation rates.

This program is new, so we don't yet have any performance data, but it will run until 2027, and I'm going to talk about this later, but this is one of those programs where we are in the President's budget there was a request for a plus -- to increase this program.

And then, the other program I just wanted to briefly touch on is our scholarships for disadvantaged students. This program is broadly focused on promoting diversity among health professions by providing awards to health professions in nursing schools, and then the schools in turn can give scholarships to students from disadvantaged backgrounds that have demonstrated financial need.

And this is another area where we have a Congressional set side, or an allocation, I'm sorry. And we have a 5 million dollar allocation. We support five midwifery programs, four of them are nursing programs, and one of them is a professional midwifery program.

And just a great little story, just to give you an example of the impact. One of our recipients reported that prior to getting the allocation in their midwifery program, less than a fifth of their students were identified as BIPOC, and after getting the allocation, two-thirds now are of their midwifery students are identified as BIPOC, and many of them are also first generational college students.

So, this is a very powerful program, and it will end in '25, and assuming continuing funding, we hope to recompete the

program, and hope to have this satisfied again. All right. So let me now move from midwifery to medicine. I'm just going to talk a little bit about some of our residency and fellowship programs.

So the first -- if you go to the next slide, the first program I want to call to your attention is the Teaching Health Center Graduate Medical Education Program. This is an incredibly innovative program for those of you that are familiar with GME, or graduate medical education.

It is one of the few ways that the federal government can actually expand available residency programs over the current CMS caps. This program is really important not only for increasing supply of physicians, but that distribution I talked about, research shows that medical residents typically practice within 100 miles of where they trained.

So, if we get residents to train out in the communities, many of them will stay, and our data bears that out. Last year thanks to Congressional Appropriation and ARPA American Rescue Plan Funding, we greatly expanded these programs. We supported 82 teaching health centers programs. Three of them were OB/GYN, 50 of them were family medicine.

We also supported 92 teaching health centers, so these are the planning grantees, the ones on the right-hand side are those that are not yet accredited, but hoping to become accredited. One was OB/GYN, 46 were family medicine. Just to kind of give you the feeling of the scope here on the 82 programs they supported 1,100 residents, of which 700 were OB/GYN family physicians.

So again, this is really helping to bolster that supply,

and that distribution. Okay. Next slide. So, this again, this is a great program. The other program to call to our attention is our Primary Care Training and Enhancement. We have a special program that's focused on community prevention and maternal health. The focus of that program is really a dual track program on increasing the number of primary care physicians trained in one, population health, with a focus on maternal health outcomes. And two, on primary care physicians who provide high quality obstetrical care in rural and underserved areas, so not only a great example of a program that marries public health and primary care, it's also an example of a program where we encourage partnerships with Title V grants, so again, a partnership with MCHB.

It's another great example where we prioritize training in interprofessional settings, so these clinicians are training alongside doulas and midwives. Last year we had 16 million appropriation, and we funded 30 programs, 20 in that clinical track, 10 in the community prevention track.

Again, great rural outcomes. 25% of our participants are from rural backgrounds, 43% trained in rural settings of the 212 sites, 25% of them are in rural areas, and of our graduates, about a quarter are practicing now in rural areas. And I did send this background material, actually go to the next the next slide, sorry.

So, I did want to share, kind of hot off the press, and you all have it in your background material, a supplement that we created. It's in the American Journal of Public Health on improving maternal health outcomes. This was a partnership between us, BHW and our grantees in the primary care training and enhancement program.

And it just got a range of wonderful stories of some of the ways that our grantees are addressing the opioid epidemic, COVID-19 pandemic, maternal care deserts, intimate partner violence, and a couple good examples of rural, so just one that's in there is our South Dakota grantee, where they are using that ECHO model to bring maternal care expertise to Sioux City Falls in South Dakota.

So, definitely encourage you as you're working on the report, look at some of those examples. I mean they're just great stories of best practices, and ways that we've identified that we can really help upscale family medicine practitioners to do obstetrics care, and to do some of that preventive medicine.

So if you can go to the next slide, just the last of the programmatic areas I want to touch on is integrating behavioral health into primary care in light of the new federal strategic plan on improving maternal mental health care. I know this is really kind of hot topic. We also know that a quarter of the preventable maternal health deaths are due to behavioral health and mental health conditions.

So, while we don't yet have any programs that are specifically focused on that niche, we do have programs like that PCTE that I talked about and that MAT care that have grantees that are in the perinatal space. So, the one I did also want to point out is our addiction medicine fellowship program.

This is a program we run for about three years now. It's a program that is focused on training fellows in accredited addiction medicine or addiction psychiatry. We have 41 grantees overall, but five that are focused on perinatal populations. Just a good example

would be our University of Virginia grantee that is helping to expand rural and underserved services in Virginia.

They're doing this by enabling telemedicine for individuals that have high uses of nicotine, or alcohol, or prescription medication, so again, this is another one of those programs that will be hopefully recompeting next year, and we're very excited about it given the need for this care in this area.

All right. So my last slide is, I just wanted to mention our budget request for '25. I did talk earlier about some of the re-competitions, but we also have new funding that we are asking for, in the President's budget, that is focused on maternal health workforce, so I wanted to bring it to your attention. The first is in the area of nursing workforce development, which is a big investment for us.

We're asking for 320 million, with a 20 million dollar increase for two programs in particular, so an additional 10 million in that MAT care program that I talked about that would support ten new awards, and the other is a nurse education practice quality and retention program.

I didn't talk about that, but that would also ask for another 10 million, and that would really focus on registered nurses who are doing labor and delivery, as well as faculty and preceptors. And then, the last program in the maternal health workspace just worth noting is in our behavioral health workforce development line, this is a huge line, just a general line, for behavioral health professionals, it's like a quarter of a billion dollars.

But in the request if we get the full plus up, we are

asking for a portion of it to address family services, particularly maternal behavioral health services, so that's another one that we're very excited about looking to the future. And, I know I have just dumped a lot of information on you, but I'm excited because we really have a lot of investments, and so I'd be happy to take questions.

CHAIR PETTIFORD: Thank you so much, Elizabeth. That was so helpful to hear all of the wonderful work going on there and hands are just flying up. So, I'm going to start with Steve, and then go over to Marya.

DR. CALVIN: Great, thanks. Elizabeth, thanks so much for the presentation. I have a quick question too about midwifery, is there anything on the horizon about certified professional midwives, or the certified midwife pathway that is outside of nursing?

And the reason I ask is because that's a pathway that is probably more likely to bring more -- a more diverse workforce in the midwife world.

MS. KITTRIE: Yeah, no, that is a great question. As I sort of said, we of course, are -- we have to fund that which is within our authorities, and so most of our programs are authorized only to support certified nurse midwives. We just have one program right now, our scholarships for disadvantaged students that does support a grantee who funds certified professional midwives.

So, really we only have that one program. That program will though, will complete, God willing, in '25, so there will be a fresh competition, but your point is great. And I don't know frankly if that's the set of authorities that even MCHB has, but it's sort of outside of ours except for that one program, SCS.

CHAIR PETTIFORD: Thank you. Marya?

DR. ZLATNIK: Hi, thank you. Marya Zlatnik, maternal fetal medicine in San Francisco. I'm wondering about two sort of new trends for workforce, particularly sort of in balance of where people would end up, that I'm wondering if you were anticipating, and whether you're able to sort of support programs that would attract providers to areas.

So, one would be the move in midwifery towards doctors and nursing practice programs, for example, my home program is moving from master's to doctorate, and there's a lot of concern that that is going to discourage people who come from lower income backgrounds.

MS. KITTRIE: Right.

DR. ZLATNIK: To go to rural. So, are you able to sort of promote programs that are sticking with master's level training, rather than moving to DNP? And then the other thing that we've seen in the last couple of years post-Dobbs is OB/GYN residents, or medical students going into OB/GYN residencies, choosing to avoid states that have restrictions on medical practice, and so my, you know, I think a lot of people are predicting that they're going to be some states where even in metro areas there may be fewer of OB/GYNs needed.

MS. KITTRIE: Yeah, so those are both great, great points. I'll take your second one first. We are definitely aware of the trends, and reading from the same, you know, statistics you are about residents, not necessarily choosing programs in states where abortion is banned.

Our programs do have agreements where we can do training in areas where it is allowed, so I mean that's one of the ways that we

are addressing that, but again, I mean very much reading the same reports you are. And your first question was about are we still training those, if I understood, those who have master's levels, those that are not going into the doctorate programs?

DR. ZLATNIK: Yeah. Yeah. I mean, is there a way to sort of boost the masters programs?

MS. KITTRIE: Yeah, so and we do have, we do have pretty substantive commitments like in that nurse corps program that I talked about, and that program is focused really just on the RNs, the APRNs, so that we do have net QR, so I would say yes, we do have several programs that are focused at the master's level, but the other thing we plan on is that, you know, where we see the deficit is also in faculty, so we do also have a number of programs that are providing loan repayment, or low cost loans for those who do get those doctorates who are willing to go on and teach.

Because that's what we're finding is one of the biggest constraints right now, to growing the nurse midwifery workforces. There simply aren't the faculty and the clinical placement sites.

CHAIR PETTIFORD: Thank you so much. Jacob, I see your hand, and then we'll have Phyllis in what will be our last question.

DR. J. WARREN: Thanks Belinda. Thanks for the presentation. I really appreciate it. I co-chair the rural sub-committee with Dr. Menard, and had a couple quick questions for you as we're thinking about recommendations around workforce, we're actually working that space.

MS. KITTRIE: Yeah.

DR. J. WARREN: So you mentioned that I think alluded to

being an authority issue in terms of not having programs for doulas, and I actually hold a BHW grant to train community health workers.

MS. KITTRIE: Yeah.

DR. J. WARREN: And, so we've been looking at how we sort of cross bridge maternal child health training in the community health worker space.

MS. KITTRIE: Right.

DR. J. WARREN: So I don't know if you can comment on if it is an authority limitation that relates to doulas where it might be something we consider making recommendations about. And then, the other question is about rural training tracks.

I've seen that here in Wyoming, and in Georgia, to enhance FMOB practice, but the challenge we run into is that once the RTT funding ends, we're having to close those RTTs, and so I didn't know if you had any thoughts about how we can extend the distance that we're gaining with RTT funding, and confidentiality, but I appreciate it, thank you.

MS. KITTRIE: Yeah. So, on the first one I would have to get back to you. I mean you're absolutely right that some of our community health workers training programs, our participants are also doulas, but I just I know that nowhere in our legislation are we specifically able to train doulas.

They have to be in that sort of broader rubric of community health workers, but that's one I would be happy to sort of to get back to you on. And then the second is on the rural training, and that I believe that is also that's a program that the rural residence is actually one that our sister agency, FORHP, the Federal Office of

Rural Health Policy, they actually run that one, so we would, you know, we would be happy to kind of loop them in, and maybe have them help answer that program.

That's one where we just, we kind of we help support it, but we're not actually the administers of the program.

DR. J. WARREN: Thank you.

CHAIR PETTIFORD: Thank you. And do we have Phyllis in the room, and then I see many other hands that are already gone up. If you'll just put your question in the chat, if you don't, if we don't get to you because we want to make sure we have time for our next presenter as well.

MS. KITTRIE: Yeah, and I'm happy to if you want to send them to Lee, or send them to me. You know, you could send them to me, and we can take some of those and answer them offline, or have extra, other conversations.

CHAIR PETTIFORD: Thank you so much.

MS. KITTRIE: Yeah.

MS. SHARPS: Yes. I wonder if you've ever considered also funding family nurse practitioners? They are much more prevalent, or widespread in some of the rural western parts, and they can do community ambulatory care, women's health, maternity care, and I think that would also help with the workforce issue.

MS. KITTRIE: Yeah.

MS. SHARPS: And I hope that you will continue to fund DNP and master's because the trend in nursing education is many programs are beginning credential is going to be the master's general, and then the advanced practice nurses are going to be at the DNP level, and so

I'm glad to see that funding for those nurses.

MS. KITTRIE: Yeah. And I'm really glad you brought up the family nurse practitioners. We do support them in many of our programs. I didn't highlight then here simply because family nurse practitioners, they provide that range of services that can be sometimes in counting them, because not all of them providing the full scope with respect to maternal care.

That's why we don't always count them in like the metrics here, but certainly in our programs we do almost every one of our programs we support the family nurse practitioners, but thank you for raising that.

CHAIR PETTIFORD: Thank you so very much, Elizabeth. We appreciate your time. If you can hang around a little while we would love that.

MS. KITTRIE: Okay, sure, and I do have a few extra copies of the journal articles for anyone that wants the glossy version.

CHAIR PETTIFORD: Thank you. All right. Thank you so much. We're going to now switch over to our next presenter who is presenting, who is joining us virtually today. We have Dave Goodman with us, with the Maternal Mortality Program. He is the prevention team lead within the Division of Reproductive Health with the Centers for Disease Control and Prevention, and it's good to see you virtually, Dave. Turning it over to you.

MR. GOODMAN: Yeah. Thanks Belinda. I hadn't realized how many old friends I was going to see, at least virtually today, so it's fantastic. You have an amazing Committee. So, good morning everyone. I'm realizing I'm probably going to push right up against time, and so

I'll have a couple of emails that you can send questions to and follow-up if you have them at the end, but also if you put them in the chat I trust Vanessa will pass them along and get your answers.

So today I'm going to share with you information about 2020 pregnancy-related deaths. Next slide. All right. Thank you. So, embedded in this presentation I'm going to provide a review of some key points about the two division of reproductive health pregnancy related mortality surveillance system programs.

One is the pregnant mortality surveillance system or PMSS, and the other is maternal mortality review committees, or MMRCs. And I'm going to start with a quick review of PMSS, and share some info from PMSS data. And then I'll transition to talk about MMRCs, and some of the MMRC data.

So quickly, CDC initiated national surveillance of pregnancy related deaths through PMSS in 1986, to meet a need for more comprehensive and clinically relevant information. And then, that was to fill gaps about the causes of maternal mortality, and then that first year of reporting was 1987.

So, it's been around for a while. And PMSS provides national data that can be used to track proportionate mortality and related mortality ratios, or the number of pregnancy related deaths compared per 100,000 live births. It has national participation and consistent information over that long period of time, and it also includes consistent coding rules applied over those long periods of time, and across the different jurisdictions.

It's been really helpful to tell the story about disparities and pregnancy related mortality. I just want to note that

the leading causes of death from PMSS and maternal mortality review committees are different, and that's really because PMSS does not have sufficient information, even though it has this enhanced approach to vital records data use.

It doesn't have sufficient clinical information to determine pregnancy relatedness among mental health and injury deaths, and so today I'm only going to present the cause of death information from our MMRC data. All right, next slide.

So, the pregnancy-related mortality ratio has generally been flat, although at unacceptably high levels over the past couple of decades. And then, from 2019 to 2020, the pregnancy related mortality ratio significantly increased from 17.6 to 24.9. And PMSS added a cause of death code for COVID-19 in 2020.

And approximately half of that increase, or 55%, had an underlying cause of COVID-19. And on the next two slides I'll be showing graphs of pregnancy related mortality ratios by race, ethnicity and mortality for 2017, 2019, and then next to them 2020 to really help you see the impact of the pandemic on pregnancy mortality. Next.

This graph shows the considerable racial ethnic disparities in pregnancy related mortality in the U.S. for 2017 to 2019 there in the blue. And for 2020 in the gray. And the impact of the pandemic on pregnancy related mortality among non-Hispanic Black, non-Hispanic American Indian or Alaskan Native, and Hispanic persons is particularly notable.

Pregnancy related mortality ratios were not calculated among non-Hispanic Native Hawaiian and Pacific Islander persons in

2020 because we consider a ratio based on counts fewer than 8 as not being reliable enough for reporting. And I also wanted to note that non-Hispanic multiple race classification was not available for the 2017 to 2019 data.

Next. So, this graph shows the pregnancy related mortality ratios by urban, rural geographic classifications, so those metro counties there on the left, those can be considered urban, and the micropolitan and noncore counties, they're on the right would be considered rural.

The pregnancy-related mortality ratio increased among all urban rural classifications in 2020. And the highest pregnancy mortality ratios persisted among those residing in the most rural classification. And so, the PMSS data is helpful for seeing national patterns in populations disproportionately impacted by pregnancy related mortality.

But information from PMSS is based on vital records, and so it limits the information that can be developed. And so, now I'm going to transition over to sharing information from analysis of data from maternal mortality review committees. So, MMRCs provide a deeper understanding of maternal mortality by identifying the contributors to deaths, and developing and prioritizing recommendations that may reduce future deaths.

While MMRCs also use vital records data, they also use a diversity of other information sources. Medical records, social service records, mental health, autopsy, and in some cases and increasingly informed interviews.

Maternal mortality review committees are multidisciplinary

committees, including representation of diverse expertise. It really helps maximize the use of that broader set of information and data sources they have available in their decision making.

And because of access to that broad data sources, and that broad set of expertise, MMRCs can increase our understanding of both the medical and non-medical contributors to death, and really the specific prevention opportunities within the context of that jurisdiction.

The next... So on this map are the states that contributed maternal mortality review committee data to this analysis of MMRIA data for deaths that occurred in 2020, and MMRIA is the standardized data system developed and hosted by CDC and made available to all maternal mortality review committees.

And so MMRCs in 38 states contributed data on 525 pregnancy related deaths that occurred in 2020 among their residents. Next slide. Start with a review of the timing of pregnancy-related deaths, so 26% occurred during pregnancy, and a similar percent on the day of delivery, or in that first week post-partum.

And 47% of pregnancy related deaths occurred one week to one year after the end of pregnancy. And part of why we highlight that proportion is it's a time when most folks would have left the hospital and be back in their communities, have left that opportunity for quick and intensive care if needed. Next slide please.

The underlying cause of death refers to the disease or injury that initiated the chain of events leading to death, or the circumstances of the accident or violence which produced the fatal injury. And what I have here on this slide is the distinct categories

and codes that are used by MMRCs to code the underlying cause of pregnancy related deaths. And really aside from the mental health and injury codes that are here, it really aligns with the coding system used by PMSS.

The next slide please. These are just the 11 most frequent underlying causes among the pregnancy-related deaths, and so they won't total up to 100%, if folks are doing that math. But if you just focus in on the six most frequent cause for things, it accounts for four out of five pregnancy-related deaths.

So, mental health conditions were the most frequent cause, and these include deaths determined by the review committee to have a manner of suicide, a mechanism of overdose or poisoning that was related to Substance Use Disorder, or other deaths determined by the committee to be related to a mental health condition, such as an anxiety, or bipolar disorder.

Cardiovascular conditions were the second most frequent grouping, and cardiovascular deaths include cardiomyopathy, and then other cardiovascular conditions, excluding hypertensive disorders of pregnancy and cerebrovascular accidents or stroke.

And then infection was the third most frequent. And COVID-19 accounted for just about one in 10 of all pregnancy-related deaths in these data. And then infection was followed by hemorrhage, embolism, and hypertensive disorders of pregnancy. Next slide please.

So, to help identify equitable opportunities for the prevention of pregnancy-related mortality it's important to look at underlying causes of death by race and ethnicity. The next several slides will present cause of death data by race and ethnicity. And

just a few notes. We were not able to provide cause of death distributions among Native Hawaiian and Pacific Islander populations because of small numbers.

And I will present the data for American Indian or Alaska Native pregnancy related deaths separately, because it's based on an alternative approach to classifying race/ethnicity that I'll review with you all. And so, among Hispanic persons the most frequent underlying cause of pregnancy related death was infection, and that's different than in the past where mental health conditions were the most frequent.

COVID-19 accounted for almost the entirety of the infection deaths. And almost a third of pregnancy related deaths among Hispanic persons was COVID infection. The second most frequent cause of death was mental health conditions. Next slide.

Among non-Hispanic Asian persons, amniotic fluid embolism was the most frequent underlying cause of pregnancy related death, followed by embolism. And while these numbers are small, you have to be careful about over interpreting the finding of amniotic fluid embolism being the leading, or second leading cause of pregnancy related death among non-Hispanic Asian persons is a consistent finding, both across PMSS and the MMRC.

Next slide please. Among non-Hispanic Black persons, cardiovascular conditions, including cardiomyopathy were the most frequent underlying cause of death, and this is a consistent and persistent finding in the MMRC data. But COVID-19 accounted for 11% of pregnancy related deaths among non-Hispanic Black persons, so it's about 1 in 10 pregnancy related deaths were COVID.

Next slide. Among non-Hispanic white persons mental health conditions were the most frequent underlying cause of pregnancy related deaths, followed by cardiovascular conditions, and then hemorrhage, and, perhaps notable here relative to what we've seen among Hispanic and non-Hispanic Black persons, is the relatively low proportion of pregnancy related deaths, with an underlying cause of COVID.

Next slide please. This slide shows how maternal mortality review committees document circumstances surrounding a death, so these are the four circumstances currently captured by review committees in MMRIA, that standardized data system. And these circumstances are defined as whether each of them contributed to the death, not just whether that circumstances was present or experienced.

And the next four slides will review each of these four circumstances, and on each you can see an example. Next slide. So, committees determined that obesity was a circumstance, yes or probably, in 32% of pregnancy related deaths. Next slide.

The committees determined that discrimination was a circumstances, yes or probably, among 30% of pregnancy related deaths. Next slide. Committees determined that mental health conditions other than substance use disorder was a circumstance, yes or probably, in 26% of pregnancy related deaths.

Next slide please. And lastly, committees determined that Substance Use Disorder was a circumstance in about 25% of pregnancy related deaths. And as you can imagine, these four circumstances aren't operating independently of each other in analysis that we've done on them, and I don't have here to share, we've seen kind of a lot

of overlap here.

Next slide. A consistent finding with past analyses is that about four out of five pregnancy related deaths were identified by maternal mortality review committees to be preventable. And I think important to acknowledge is that here, preventable means that there was at least some change of the death being averted by one or more reasonable changes the patient, community, provider, facility or systems factors.

Next slide please. So, now I'd like to share data on pregnancy related deaths among American Indian or Alaskan Native persons from the 38-state data. In the presentation of the data we weighed the potential risks of identifying individuals by reporting information based on small numbers, versus the potential benefits of making information available for prevention of pregnancy-related deaths among American Indian, or Alaskan Native communities.

So, the benefit of reporting this data is really providing potentially useful information for a population that we know is proportionately impacted by pregnancy-related deaths, and letting American Indian or Alaskan Native communities determine what information is of use, or not of use in their work to prevent these tragic deaths. Next slide please.

So, I'm going to say something that is maybe stating the obvious, but it's still important to say that methodologic decisions about racial classification impact the size and characteristics of the populations used in analysis. And multiple assessments that have been done have demonstrated the value of expanding the definition of American Indian or Alaskan Native persons, regardless of notation of

Hispanic origin, or other, and multiple race.

And so, what this slide illustrates is the alternative approach classifying pregnancy related deaths that we apply. We began with seven deaths classified as non-Hispanic single race among American Indian or Alaskan Native persons, and then added two more, which had a notation of Hispanic ethnicity.

And finally added three more among American Indian and Alaskan Native deaths with a notation of more than one race, which gave us a total of 12 pregnancy related deaths among American Indian, or Alaskan Native people for analysis. And the next few slides we'll describe these 12 pregnancy related deaths.

Next slide please. Among those with a known underlying cause of death, infection and mental health conditions were the most frequent underlying causes of death, and I think just maybe of note even though it's small numbers, so careful in interpretation, but all three of the infection deaths were COVID-19. Next slide please.

And maternal mortality review committees identified that 92% of pregnancy related deaths among American Indian or Alaskan Native persons were preventable. Next slide.

So, I'll end there. Those are the two emails where you should feel free to email us questions really at any time, but certainly in follow up to today; we have an amazing team of folks who are always eager to share information and answer questions.

CHAIR PETTIFORD: Thank you so very much, Dave. We are going to take a moment now to see if anyone has any questions right now. Am I seeing, Scott, your hand up?

DR. LORCH: Yes. Sorry, let me mute everything.

CHAIR PETTIFORD: Okay.

DR. LORCH: Hi again, how are you doing. And this may be a larger question for a broader day, but do you want to comment on how your data compares to recently published work from folks arguing about data quality for pregnancy-related mortality, and particularly the AJOG paper, and some of that other work that's made breadths.

MR. GOODMAN: I think there's been enough people that have shared their reactions to that publication, and sort of the inadequacies of some of their approach and interpretation. I know NCHS is online, and maybe their best to speak specifically about that paper.

I think taking a step back the PMSS data demonstrates, you know, as I showed on that first slide, pregnancy related mortality has persisted for decades at a level that nobody considers acceptable. And then I think consistent with what has been seen in the NCHS data, we saw increases occur with the pandemic, and we anticipate to see similar trends when we release the 2021 PMSS data in terms of that pregnancy-related mortality ratio increasing again.

And also, widening of disparities. And so, I think the last thing I'll say is excitingly we have more maternal mortality review committees across the U.S. than ever before, and doing consistent things. And having comparable information, and with that more jurisdiction level reports coming out than ever before, so more information available from these committees that really do have the ability to provide deeper information, really calling out contributing factors to deaths, and their recommendations from those multi-disciplinary committees on those opportunities for prevention.

CHAIR PETTIFORD: Thank you, Dave. I see Marya. I know you put a question in the chat, but do you want to come off of mute and ask your question?

DR. ZLATNIK: Sure. I was just wondering when you were looking at the contributors to maternal death check boxes, the discrimination contributor, is that only really sort of you know, interpersonal racism, you know, the example provider ignoring symptoms, as opposed to the bigger systemic racism, you know, environmental injustice, or red lining, or food deserts, or healthcare maternity deserts, historical racism?

Are you able to capture that, which I would think would be in most cases sort of the primary driver, rather than something you know, I mean not that the interpersonal isn't an issue, but…

MR. GOODMAN: Yeah, so we have a set of definitions that I'll share, but to quickly answer, so discrimination is inclusive of all forms of discrimination. It includes structural racism and interpersonal racism. That said, within the conversations and the context of reviewing an individual death, the focus tends to be more on those experiences more immediate to the pregnancy and through circumstances around the death itself.

So, within that timeframe. But that said, what we had seen I think Illinois is a really nice example if you want to look at their maternal mortality report, and have it where they open up their report talking about red lining, and its broader impacts on really health outcomes, but including on maternal mortality, and then go into the specifics of what they saw within their community.

CHAIR PETTIFORD: Thank you. I see Steve, your hand is up

also?

DR. CALVIN: Right. So, thanks for the presentation. It's kind of a larger question too, about I know we refer to the maternal mortality ratio, and using per 100,000 live births. You know, and I know the ability to know how many miscarriages, because we know that's quite common an occurrence from pregnancy in general.

And then you know, elective terminations too. Is there ever anything that you folks at PMSS, or even I guess state maternal mortality review committees look at in just the large picture of just saying a pregnancy diagnosis not related to live birth? I mean I know it's a larger question, you know, it relates to a variety of things, but do you have any comment about that in a surveillance system?

MR. GOODMAN: Yeah. So, it's a great question. It's actually one that we've had a lot of discussions about. I mean the standard is per 100,000 live births, it's the denominator globally, it's the denominator that folks have confidence in that we have the best count of. And so it is the standard, but there are a couple papers, and we've looked at what things might look like if your denominator were to become women of reproductive age.

And so, stepping away to another place where maybe there are other counts, and trying to think about the interpretation, and considerations if you were to take that step. I think there's a couple of other approaches you could take. You could take that women of reproductive age a step further to reproductive life years.

So, I think you're on to something that's on people's minds, and is being explored, but at this time our reporting is based on the per 100,000 live births.

CHAIR PETTIFORD: And then our last question will have Marilyn ask the last question.

DR. KACICA: Thank you so much, and I want to compliment Dave, you and Charlan and your team for the great work you do on this. It's been an iterative process over I know at least a decade, so I commend you on that. Now, one of the things that we've talked about in our committee meetings is the way that preventability and discrimination are rolled up, when underneath there are some categories.

We were thinking that looking at it more stratified might help where the intervention has to happen because I think when they're rolled up, everybody thinks when you put it in the press that it's healthcare, and that's you know, the big offender. And they don't realize the nuances below that.

So, I think as we move forward, we should think about how to portray that data, so that we know where do we need to work. Is it more at the community level? So, I just think that's one way, you know, to make the data clear.

MR. GOODMAN: Yeah. I really appreciate your point, Marilyn. It's something we've been working on with our messaging, and I couldn't share the slides today, but folks who attended our MMRIA user meeting back in April, which is our national convening, you know, representatives from maternal mortality review committees across the U.S., we were able to share some of what we're working on as an approach to that where we show what we call the contributing factor classes.

Which you can think of as sort of what the MMRC has defined

as a theme to this contributing factor by those different levels. And so what you can see is when you look at the contributing factor levels, the contributing factor classes and the levels they're at, it's really describing where is this issue manifesting? Where is this contributing factor making an impact?

So, you'll see like family identified, and you'll see providers identified. More frequently, maybe than systems or community. But when you then look at the recommendations, and the recommendation level, so where is it that the action should actually take place for that prevention, you see a shift.

You see that there's really almost nothing at the family level, or individual level. There's still some at that provider level, but you start to see more coming up in that community in systems level. So yeah, I agree with you. We have more to do. Hopefully, we'll be able to share that way of presenting that data in the near future.

CHAIR PETTIFORD: Thank you so very much, Dave, and we appreciate your time as well as Elizabeth, in providing us some federal updates. We're going to now take a very short break. I said very short, meaning we need to be back here in eight minutes. So, 11:30 we'll see you very close back to 11:30. Thanks everyone.

Healthy Start Updates

CHAIR PETTIFORD: All right. Thank you everyone for returning. I know we went a minute or so over, but we are back from break now. We are happy to have with us next, some updates on Healthy Start. First, we have Shannon Williams with us. She is the Project Director for the Kansas City Healthy Start Program, and that's part of

the greater Kansas City Nurture Kansas City, so we're happy to have Shannon with us today, and she's going to provide us an overview of her program there, so Shannon, turning it over to you. And I think you are muted. Okay.

MS. WILLIAMS: Yes, thank you. Excellent. Hello, and good morning from Kansas City to all of you. Thank you for asking me to highlight our program. We always love an opportunity to be able to talk about the great work that we do here in the metro area.

So, our program, our Kansas City Healthy Start Program is a little special. We are physically located in Kansas City, Missouri, but our program serves both Kansas City, Kansas, and Kansas City, Missouri, so we are by state agency, both our agency as a whole, and our Healthy Start Program. Next slide.

So, we're really excited because we have just started our new five year grant cycle, so with that new grant cycle comes new parameters for our program. So, with the new Healthy Start grant, each year we are charged with serving 250 pregnant women, 175 combined children and parenting women, 25 male involved partners, and for our program here at Healthy Start in Kansas City, we are not aligned with the health department, or with a federally qualified health center, so we only enroll moms when they are pregnant.

And then the only other requirement is that they live in our target zip codes. We serve a total of 12 zip codes, 6 in Kansas City, Kansas, and 6 in Kansas City, Missouri. These zip codes with the highest infant mortality rates are our guidelines. As I mentioned, we are by state program, and something that's really new and we're excited to have this opportunity, the new component with

Healthy Start is that each program has to serve, provide community education to an additional 250 community members.

And these are community members that are not part of the Healthy Start Program. So that in itself builds collaboration. We'll be working with a home visiting collaborative that's here in the Kansas City metro that is called Promise 1000, so it is a group of eight home visiting organizations that see families all over both Kansas City, Kansas, and Kansas City, Missouri, not as restricted to the zip code, but basically counties is how that works.

And so, we'll be able to reach about 250 community members through partnering with Promise 1000. The next slide. So, what we have learned here with our Healthy Start Program is that the community health worker model, I'm sorry, the community health worker model is what works best for the families that we serve, so we in our program here, we have five community health workers that come from similar backgrounds and cultures, as the community that we serve.

We have -- our program is probably about 40% Hispanic Spanish-speaking, and 60% Black African American, so our community health workers, so that staff, as well as our community health nurse are all Spanish-speaking. I'm Spanish speaking, and we also have Spanish-speaking doula support.

Another thing that we learned, we knew that offering doula support to our program participants was going to be huge, but a component that we didn't consider was the fact that our Spanish-speaking doula often, probably more than she doesn't, serves as a translator in the hospital setting, in the birth setting.

So, we were finding that families weren't even able to ask

for water. They didn't know how to access the cafeteria, and so that extra support and translation services have really improved our birth outcomes for our Healthy Start moms.

And we've also learned that you can't just give out a pack and play or a car seat. That's just one thing that eliminating barriers to improving infant mortality, that it requires frequent safe sleep education, so it starts while they're pregnant, continues every time they come in for an encounter, a monthly visit, we are asking about safe sleep, and reiterating the importance of safe sleep education.

And all of our community health workers are also trained as child passenger safety technicians, so they're not just giving the car seats, they're teaching parents how to safely install car seats as well. Next slide. So, we have learned a lot of lessons. I have been part of Kansas City Health Start for almost well, now over 8 and a half years.

And so, one of the things that became very evident right away is that the lack of transportation was a huge barrier for the families that we served. Here in Kansas City, we are not a very public transportation friendly location. You need a car to get around here for whether it's work, or school, medical reasons, so it became a huge barrier.

So, some of the ways that we have worked to alleviate that is that we offer more home visits, so our community health workers are going to our moms. But we also were able to get some funds from a local hospital that we partnered with, and provide transportation, so we're able to have an Uber business account.

So, we offer free transportation not only to and from our appointments, but to medical appointments for both mom, or enrolled children, and then also social service appointments, so WIC, Housing Authority, if they're picking up papers, or they need items to go to the immigration office, we can provide transportation.

And then we also offer up to twice a month, transportation to and from a grocery store as well for our families. The only stipulation is that it all has to be done during our business hours. We also learned really quickly that just because it is offered, that it doesn't mean that our families will participate.

A great example would be our virtual support group, which was something that our families said that they wanted, and this came about during COVID when everything was virtual. On our Spanish speaking-side, very popular, well-attended always, and then on our English-speaking side it's very seldom that we get repeat attendance.

Oftentimes there's only one person showing up, so we are working to figure out how we can make the program more centered around what they want, and what they will actually show up for. And the same thing goes for community events. We were asked to create more, asked by our participants, to create more events that are centered around fathers and bonding opportunities.

So, we had a daddy and daughter beauty day where a local hair salon was going to open up and teach us some basic hair styling tips to dads, and their children. And so, he just had to be aligned with a mom in the Healthy Start Program, and then he could have brought any child with him, and we had one dad registered.

So, even though it's something that they asked for, and it

sounds great, we still have a hard time getting our families actually to show up to these extra beneficial items outside of our initial programming. Next slide.

This one is pretty animated as well, so if you all one to hit one more time. So, in listening to the moms what we know is what they are asking for, are more Black and brown practitioners. They feel comfortable when they're going to someone that has -- looks like them, and has experience and is comfortable with their same culture and backgrounds. Next animation.

We also heard that our moms want individual therapy sessions. Next animation. And our moms love having doula support, so what we have done in addressing these needs, we are getting more Black practitioners is a huge on taking, so we are supporting other agencies that are looking at that work, and how they can do-- start in the high school reaching out, and providing more opportunities to students before they're even at college, making their decisions on what they are going to study.

And we have secured funding, so that with Health Forward here in Missouri, so that we can continue offering doula support free of charge to our moms, and we are very excited. Next animation, that we are able to offer free individual therapy. From a private business we just received a grant for $30,000.00.

So we're waiting for those funds to come in, and we're going to look at our counselors that we use for our virtual support groups, our licensed counselors, and see how we can set several parameters for our moms to get individual therapy, so that's a huge win for us, and we're extremely excited for what this means for our

moms. Next slide.

So, what are recommendations that we have in making the Healthy Start Program better for all involved? Definitely, clearer program guidelines would be extremely beneficial to us here, and nationwide for all the Healthy Start Programs.

You look at our chats with all of the program and project directors, there's still a lot of questions about program delivery, and especially when there are changes and we're scrambling to get those in place, but still have lots of questions about how programs should be delivered.

Also, increased funding for the direct service programs like Healthy Start. This program has been at the same level of funding for the last 10 years, and a decrease from what it was 15 years ago. So, that means that many programs have to find additional funding to offer these much-needed resources, and extra benefits that we offer.

So, without our community and private support, we wouldn't be able to offer those additional services, and you know, with inflation, and the increase in cost of living that would also be great in keeping staff, because we do know the community health model is the best model for program delivery, and we have a fantastic team built, and we really would like to keep them.

And then of course, a greater attention to mental health needs. I think I'm preaching to the choir when I say that mental health issues are the number one, excuse me, preventable cause for maternal mortality, yet the system is still very fragmented, and we need help. We need a federal response, so that we can offer better

care to our moms, and also our dads that are involved in our program.

We're really excited to be able to align with some great initiatives that are here locally. A great one is fathers assisting mothers, so dads are becoming daddy doulas, and learning how they can help support, and you know, eliminate some of that extra stress that moms go through, and ideally, also getting mental health first aid training, just so they can have that extra support for moms. Next slide.

I keep trying to advance it myself, but thank you. That is a very brief overview of our program here at Kansas City Healthy Start, and I'm not sure if you want to go into the next presenter, or if you want to do questions now?

CHAIR PETTIFORD: Thank you so very much Shannon. We're going to hold questions if you could stay for a moment.

MS. WILLIAMS: Sure. I will.

CHAIR PETTIFORD: Thank you. So next, we're fortunate to have with us Benita Baker. Benita is the Branch Chief here in the Division of Healthy Start and Perinatal Services within the Maternal and Child Health Bureau. So, good morning, Benita.

MS. BAKER: Thanks Brenda, thanks Shannon. My name is -- good morning everyone, my name is Benita Baker, Chief of the Healthy Start Branch in the Division of Healthy Start and Perinatal Services. Today, I'm just pleased that you have agreed to attend, be a part of this Committee, so I'm going to provide some updates on the Healthy Start Program, and the outcome of the fiscal year '24 competition. Next slide please.

Okay. I'll start with some background information on the

Healthy Start Program, how it has evolved over the years. Next, I'll give a high-level overview of the FY '24 award recipients, and describe some of the key features of the program this cycle. I'll also talk about some of the changes to the program, and areas of increased emphasis. Next slide please.

So, as most of you know, the overall goals for the Healthy Start program are to reduce infant mortality rates in the U.S. and decrease disparities in infant mortality for perinatal health outcomes. And we do this by developing activities that we would hope help improve the outcomes for the women and children our grantees serve.

Each year approximately 4 million births occur in the U.S., so for the past decade, several decades, the infant mortality rate for the general population has for the most part, steadily decreased. However, we continue to see unacceptably high rates of infant mortality in Black, American Indian, and Alaskan Native infants.

In 2022, the U.S. infant mortality rate increased by 3%. This is the country's first year-to-year increase in about two decades. Today, the highest infant mortality rates continue to be among Black, American Indian, and Alaskan Natives, and Native Hawaiian Pacific Islander infants.

These facts really highlight the critical and continued importance of the Healthy Start Program, and the work of our Healthy Start grantees. Next slide please. So, in many communities across the United States, Healthy Start has come to represent high quality care, supportive resources for people of reproductive age and families.

Since its inception in 1991, Healthy Start worked to improve perinatal outcomes, and reduce racial and ethnic differences in maternal infant health. Originally, the project started with 15 grantees, mostly in urban areas, with infant mortality rates that were at least one and a half, to two and a half times the national average.

The goal was to identify and develop community-based approaches to reduce infant mortality by 50% in those communities. That was a very lofty goal. Those grantees were a demonstration project, and they were allowed to develop their program based on their community needs, and there were not a lot of parameters put on them.

We had grantees who developed programs targeting adolescents, programs targeting substance abuse women. In 1994, seven new sites were added, making a total of 22 Healthy Start Programs nationwide. Over the years based on information from the field, our grantees' feedback, and the previous what was called SACIM Committee recommendations, we changed to developing a set of core services and systems, some parameters for grantees to follow.

These parameters were thought and hoped to help focus the grantees activities in order to help increase the health outcomes. So, in 2001, in addition to that, we added screening for maternal depression, and interconceptional care as part of the core services.

Throughout its early years the program significantly increased community impact through meaningful family engagement, partnerships with Title V, and other local organizations to improve the access to prenatal and other clinical services.

And let me say from its inception until, I guess right around 2014 maybe, the consortium focused on trying to make the

perinatal delivery system in a community more efficient and more accessible to the participants they served. And as you see as I go through this PowerPoint, that it has changed somewhat. That is still the goal, but there are some additional parameters put on the consortium.

So in 2014, five approaches were established, improve women's health, promote quality services, strengthen family's resilience, achieve collective impact, and increase accountability through quality improvement performance monitoring evaluation.

And this was around the time -- it started a little before this when there was an increased focus on data collection, quality improvement for the programs, and performance monitoring. We had to report to Congress our numbers, and so that was the importance for the increased focus on data collection and quality improvement.

Also in 2014, we had -- we developed three levels of funding based on what we saw. There were tiered levels of funding. Level 1, 2 and 3. Each level received a different amount of funds. Each level had a different set of requirements. There were Level 1, which was basically for smaller organizations to build their capacity, to sort of focus on developing their program.

Level 2 were they would have to do complete their program requirements, and some additional requirements like be a part of an infant mortality review, maternal mortality review, and some other requirements. And Level 3's were really supposed to be the pillars in the community, the organization for all things NCH.

They were actually responsible for developing community action networks, or helping other organizations increase their

efficiency around the perinatal development -- perinatal delivery system. What we found was that some of the Level 2's were functioning as a Level 3.

And some of the Level 3's were not quite there because they needed to be more present in their community, and had to develop those relationships. So, we revamped again, and removed those levels, so it's the 2019 to 2024 cohort, those levels were removed.

So, starting in 2019, our cohort had developed to 101 grantees by then, working in 37 states, D.C. and Puerto Rico. In FY '23, we received additional funding. Congress gave us additional funding for a new targeted expansion of Healthy Start, which we called it Enhanced Healthy Start Program Model.

We looked at it as sort of a demonstration. Those grantees, the FY '24 grantees had the same, basically the same requirements as the enhanced, but we used the enhanced to refine the FY '24 requirements. We had 10 of those grantees. Healthy Start enhanced -- there was an increased effort on strategies addressing social determinants of health, both at the individual and community level.

That is also a requirement for the FY '24 grantees. In part, so we brought back the name Community Consortium in lieu of Community Action Network. In the beginning, projects had Community Consortiums, and over the years we found they weren't really functioning as they should. Some were functioning quite well, but others were not functioning as they should.

So, the decision was made that if we changed the name, and sort of the activities to Community Action Network, that that may work

a little better. What we found after, you know, some focus groups and outreach, that we should -- and also, the increased emphasis on social determinants of health, that Community Consortium is more likely to provide the outcomes we need around collaborations in the communities and so forth.

So, in 2024, we awarded 105 grants to communities, bringing the total number of active grants to 115. Next slide please. Over the next few slides I'm going to provide sort of a high level overview of the new awards. Next slide. This map shows the 105 Healthy Start -- where the 105 Healthy Start recipients from the '24 cohort, and also the 10 Healthy Start Enhanced recipients, where they're located.

In total now, we have 115 in 37 states, as I said, Puerto Rico and D.C. This is the largest number we've had in Healthy Start history. We have 83 grantees that successfully recompeted from the last round. And I would say that we have about over half of the original 15 still are grantees.

Next slide please. So, the 22 new Healthy Start awards this grant cycle, they include community-based organizations, county governments, hospitals and universities. If you note that there are a couple of awardees on this list that have aspects besides their state.

That means that the parent organization resides in one state, but services are provided in another state. For example, Cinq Care is located in D.C., but provides services in Upstate New York. Next slide please.

Also on this slide, Plan A is located in New York, but provides services in Mississippi. This is sort of a new phenomenon

for us, so we're looking forward to see how this design works, and how these awardees can, you know, sort of engage families when the parent organization is in a different state. Next slide please.

These pie charts represent the breakdown of awardees by type. As you see over half of the awardees are community-based organizations. Government is next, and then hospitals and universities, and for-profit is in gray. Next slide please.

As the Committee may recall, in preparation for the FY '23 and FY '24 program development process, we took a robust approach to collecting input from the grantees, the field, and general public on what was working. Where there were difficulties, and areas for improvement. Over the next few slides I'll give a high level overview of the design of the FY '24 Healthy Start Program. Next slide please.

So, through a series of health equity convenings, grantee listening sessions, we put an RFI through the Federal Register, and gathering information from the field, suggestions and feedback, we identified new strategies for the FY '24 Healthy Start Program.

Out of those convenings, several key things emerged. For the grantees, they wanted to increase flexibility to address sort of the diverse challenges and emerging needs, and they wanted enhanced focus on social determinants of health impacting perinatal health.

Not listed on the slide, but of equal importance was the need to reduce grantee burden. These were the major themes, and more specific recommendations obtained from our engagement sessions to guide the development of those two note votes in '23 and '24. Next slide please.

So the two categories of activities that Healthy Start

Programs are now responsible for are directing and enabling services, and the community consortium. In this cycle, grantees are tasked with delivering three primary categories of participant level services, case management and care coordination, group-based health and parenting education, and the provision of clinical services.

Additional health education and promotional activities are infused throughout each service, ensuring that participants are able to access the information they need in a modality and setting that meets their needs. Next slide.

The second focus area for the grantees is the Community Consortium, or what was previously known as the Community Action Network, or CAN. A Community Consortium is a group of diverse representatives across the community working to address pressing issues and needs that may lead to poor perinatal health outcomes.

This term is rooted in the legislation for Healthy Start. The change from CAN to Consortium signals a renewed emphasis on leveraging the Consortium to address the social determinants of health as an upstream approach to improving perinatal health outcomes.

There are three overarching objectives for the Community Consortium, advancing and informing the strategies for direct and enabling services. The Consortium should be appraised and aware of how the organization is going to approach, provide its services, and have the ability to provide input.

They need to develop and implement a plan to address at least one social determinant of health to improve outcomes within the project area, and also participate in technical assistance offerings to maximize Consortium impact. In the past the technical assistance

was provided by the project officer. Over the years we've noticed that several communities have problems bringing their organizations together.

So, we're going to provide intense focused TA for those grantees that need it on the developing their Consortium. Also, there is an increased focus on including people with lived experience on the Consortium. Next slide please.

Next, I'll provide a brief summary of key changes, and areas of increased emphasis in the current cycle. Next slide. So, for direct and enabling services, grantees have the ability, no, the addition of the inclusion of group-based health and parenting education. This enhancement directly responds to feedback calling for increased flexibility for the grantees in their service delivery approach.

We know that Healthy Start Programs have been using group-based health and parenting education as a strategy from the beginning. However, in this cycle grantees are able to count those individuals in group based towards their members served. They have never been able to do that in the past.

I also want to point out that clinical services, as some of you may know, Congress has awarded, for about three years, Congress has awarded us additional funds to hire clinicians in Healthy Start to provide services to pregnant and postpartum women, so that continued in '24, so that's an integral part of the base Healthy Start services currently.

Also in this cycle, the local Healthy Start Program should address of course the broader social determinants of health that

impact maternal infant health outcomes within their community. By integrating social determinants of health, Healthy Start Programs aim to provide comprehensive support that goes beyond clinical care to address the root causes of persistent disparities.

In the past, Healthy Start, while they did focus on some areas of social determinants of health, that was not the big ask. The big ask was look at the clinical care, the delivery system, and try to make that more efficient and accessible. So, that's changed a bit. Let's see.

To give you some examples of sort of the ways in which our grantees have looked at social determinants of health, in the previous, in the FY '23 Healthy Start Enhanced grantees, we have a grantee who that actually partnered with a local housing authority where they allocate housing needs, specifically for Healthy Start participants.

And it's that kind of collaborations that we're looking for from our Healthy Start grantees, and some of the changes that we hope will occur. Next slide please. For the Community Consortium, historically, again, the CANs were primarily focused on bridging gaps to assessing clinical care.

Again, they now have the flexibility for Consortium plans that target critical issues, such as housing, education, and access to health-promoting resources. We recognize that there are challenges in galvanizing and organizing community groups, and again, as I've said, we're going to provide abundant opportunities for technical assistance, even onsite to help the grantees bring their group together.

Family engagement is another -- it's not a change because grantees have always tried to engage the families. The requirement was to engage the families over the course of the five-year cycle. This requirement for '24, the requirement for '24 is that you have to engage 25% of people with lived experience right from the beginning to be on the Consortium.

And again, technical assistance will be provided for how to do that. We have grantees, long-standing grantees, who have done that successfully, so there will be a few cohorts provided by our technical assistance center to help with that mentoring relationship.

Next slide please. And lastly, when we talk about reducing burden for the grantees, data burden is always a big issue with our grantees, how to collect data, what to collect, we're collecting too much. So, we heard them, and we previously had 19 benchmarks grantees had to report on. We have for FY '24 reduced those 19 benchmarks to 10 priority benchmarks that are closely aligned with the purpose and goal of the program, and removed benchmarks that are mostly associated with processes, like completion of the reproductive live plan, which are difficult to objectively capture, also fatherhood involvement.

So, we removed those as benchmarks, and we then capture that information in other ways, like the annual qualitative reporting. We've also given the grantees flexibility in deciding which data collection system they would like to use. Over the last, I guess, three, four years we've have a free data collection system that the grantees could use if they chose.

It's called CAREWare. Our TA center facilitates that. We have some grantees using that, and we gave them the ability to

continue to use that if they so choose, and that using CAREWare would free up some money in their budget that they could use for other activities.

We also had a requirement for an external evaluator. In FY '24 we've given them the flexibility to use an internal evaluator if they so choose. In addition, and lastly, grantees had to report monthly, their data monthly, in what we call HS7D system. We've changed those reporting deadlines to quarterly uploads, so that should reduce some of the reporting burden on our grantees.

We're also looking at our own internal monitoring process, for example, decreasing the amount of grantee documentation requested in preparation for calls with their project officers. So, overall, I think we've changed somewhat in FY '24, but I don't think it's a big a change as -- I don't think it's as big a change from what the grantees had been doing.

We've just given additional flexibility and added a few pieces. So, with that, I will close. Thank you for your time and look forward to answering any of your questions.

CHAIR PETTIFORD: Thank you, Benita, so much. I know we're out of time, but I do want to open it up to see if any of the Committee members have any questions they would like to ask that this point? I did put in the chat, for those of you who are newly appointed, we do serve as the Advisory Committee for the Federal Healthy Start Program, so I wanted to make sure that you have a good overview of the program, and the work that is going on there.

Any questions in the room? I think everybody is trying to get to lunch because they know we've got to get back on time. But

thank you, Shannon, and thank you Benita. We appreciate your time. If we have follow-up questions we'll touch bases with you, so thank you so much.

MS. BAKER: Sure. Thank you.

MS. WILLIAMS: Thank you for having us. Bye Benita.

MS. BAKER: Bye.

CHAIR PETTIFORD: Okay. Thanks everyone. So, now we're going to break for lunch. Lunch is on your own, but the cafeteria is right across the way for those of you who have not been in the building before. And we should be back here, yes, at 1 o'clock, so if you need to bring your lunch in here bring it in here, but we do need to start back at 1:00. Thanks everyone.

Infant and Maternal Health Data Updates

CHAIR PETTIFORD: So, hello everyone. This is Belinda. We are back from lunch, hoping you guys grabbed something. I guess it depends on what part of the country you wanted it to be lunch or not. So, we're going to start back on the agenda. Before we start back, I see another of our Committee members, ShaRhonda Thompson.

ShaRhonda, if you are able to come off of mute, do you want to come off and just say hello and introduce yourself? You're on mute, ShaRhonda, if you think you're off. Okay, ShaRhonda, we'll catch you between another speaker then, thank you. All right.

Now, I'm moving on with our agenda, and our next presentation is on Infant and Maternal Data Updates. I think people have been waiting for this session. I talked to people in the cafeteria that said oh, we're meeting on the updates.

But we're happy to have with us Ashley Hirai with us, from

the Office of Epidemiology and Research at the Maternal and Child Health Bureau, and she's going to be joined by Dr. Michael Warren, the Associate Administrator here at the Bureau. So I'm turning it over to you, Ashley.

MS. HIRAI: Okay. Great, thank you, Belinda, and happy to be with everyone today to share our paradigm around accelerating Upstream together to improve infant and maternal health, and achieve equity. So, our objectives are really to describe infant and maternal mortality in terms of disparities, and Dave Goodman already did that for pregnancy related mortality.

So, we will build on the infant component to understand approximate and root cause contributors, and to highlight programs and partners to achieve improvement.

CHAIR PETTIFORD: I was just going to say, Ashley, can you pause for one second.

MS. HIRAL: Is this better?

CHAIR PETTIFORD: Folks online, can you tell us if you can hear Ashley better please?

(Tech fixing the room audio)

CHAIR PETTIFORD: Give us one moment. We're going to try to adjust the volume.

MS. HIRAI: Okay. So how is this? Is this a little bit better? Okay great, we will continue. So here's our paradigm for improving infant and maternal health. So we want to accelerate the pace of change, and improvement, go upstream to promote prevention in that life course approach, and do this together in collaborative space, including the voices of partners and people we serve.

So, I just wanted to start with a little historical context from over a century ago. So, the Children's Bureau, an early predecessor of the Maternal and Child Health Bureau was formed in 1912 with a special charge to investigate infant mortality at a time when nearly one in 10 infants died before their first birthday.

And it was up to 30% in certain cities. So, in a series of landmark reports and publications, the Children's Bureau highlighted the social roots of infant mortality and various community investigations. So that graphic on the left really highlights a social determinant of health income, and on the right highlights the inextricable links between maternal and infant health, and so you can see -- you might not be able to see actually, the text, but just saying that in 1960 more children died from conditions related to the health and healthcare of the mother, than from bad care, bad feeding, or infectious diseases.

And that really still stands true today. Our language has changed, but we've understood the social underpinnings and importance of maternal and preconception health for a long time. And so, a few years later in 1916, the Children's Bureau released its first report on maternal mortality, again with some familiar themes.

And although our levels of maternal mortality have improved greatly, and that's shown on some subsequent slides, similar patterns were observed then as now, and in that second paragraph what's highlighted, there are some phrases maternal mortality is in great measure preventable. No available figures show a decrease in recent years, and most other high-income countries have better rates.

And so, it is humbling that we still have some of the same

struggles, and that really helps to make the case for why we need to accelerate improvement. So, we have had tremendous improvement in infant mortality over the last century, with declines noted at least every several years since it was first tracked in 1915, and this is shown on the log scale to help see current rates given that exponential rate of decline that has occurred.

So, it's declined by 95%, from 100 per 1,000 in 1915, when an estimated 300,000 infants died annually, to 5.6 per 1,000 in 2022, corresponding to about 20,000 deaths annually, and yet we still have a lot of work to do. Our rates are higher than other peer-income countries, and we have persistent disparities.

So, here we have been able to track Black and white infant mortality for that amount of time as well, and so despite overall program for both groups, the Black/white gap remains, and has actually widened to over two-fold since about 1985. Another way to look at this longstanding inequity is in terms of a survival lag, and this was developed by Dr. Art James, an obstetrician and pediatrician, a former Healthy Start Director in Kalamazoo, Michigan.

He's a frequent collaborator and champion for equity. And so, he has asked how many years does it take the Black population to have to wait to catch up to the white rate? And you can see that here. The 2022 Black infant mortality rate was what the white rate was in 1980, a survival lag of 42 years, and this is a powerful call to action that's only growing with time, as the curve flattens, incremental gains are smaller, and we get closer to zero.

So, if you actually took that arrow back it's smaller. As you go back in time it's widening now, and it will only get wider if

we don't do something bold and innovative. So, taking a look at recent data for all racial and ethnic groups using the linked birth and infant death file that's lagged one year, we see that Black and indigenous populations have the highest rates.

And this is not a coincidence, given that these populations have endured the longest history of racial oppression, violence and trauma, beginning with enslavement, and forcible removal from Native lands. And this -- it kind of struck me with our quality improvement efforts, working on the coins about a decade ago.

They say the system is perfectly designed to get the results it's getting right now, and so we have to change the system. Healthy People sets our national objectives for improving health, and over three decades of tracking for healthy people. Our systems and policies have failed to achieve those targets for Black and indigenous populations, and we have failed to repair and adjust this.

Even if those targets could be met, inequities would persist. white and Asian populations have already surpassed the target, so what we want to do is to maintain continued declines for groups that have already met the objective, while accelerating program for Black and indigenous populations to finally achieve equity, and that's known as targeted, or proportionate universalism, and really that we want to have improvements for everyone while focusing on the groups that have been left behind.

And this makes me think of also a quote from Dr. Wanda Barfield, the Director of the Division of Reproductive Health at CDC, and she has said, you know, "We're not there until we're all there." Similar to infant mortality, we've also had tremendous overall

improvement in maternal mortality.

It's declined by 99% from 700 per 100,000 in 1915, when an estimated 160,000 women died annually, and it was the leading cause of mortality among women of reproductive age, second only to tuberculosis. And it reached a low of 6.6 per 100,000 in 1987. However, the progress has stalled since the mid-'80's, and we have had only observed increases with the exception of COVID, have largely been attributed to changes in measurement ascertainment.

And so, just as the slide that Dave Goodman presented, similar to what we observed over a century ago, we have not seen recent improvement. Although improvements have occurred for both Black and white populations, the relative disparities have also increased, and were lower in the first half of the last century.

Looking at the latest data for all racial and ethnic groups from the National Vital Statistics System, we similarly see that Black and indigenous populations have the highest rates, 2 and a half to 3 times the non-Hispanic white population, who have had the longest historical advantages in this country.

And we're not implying that this is the best group. They're not by far, and they haven't achieved the Healthy People target. We really should be able to do better for everyone, but this is a significant, appropriate, associate political, historical comparison. And here we are using the National Vital Statistics System. It is the official source of maternal morality statistics, and the most timely source, with state identified data, so that's the advantage.

And we'll be able to show some maps, but it does have

significant limitations. It excludes mental health and injury that can only be determined to be in relation to pregnancy through those detailed review committee determinations. And because it's not linked to birth or fetal infant death certificates as PMSS is, the Pregnancy Mortality Surveillance System, it's prone to checkbox errors, so predominantly false positives, and race/ethnicity isn't self-identified, although it should be reported by the family in most cases.

Despite these implementations, the overall patterns of disparities are quite similar to what Dave presented earlier. And in yellow, that total bar shows that we're much farther from the Healthy People Target overall, than we are for infant mortality because we just haven't been moving in the right direction.

And, I would say that mortality is kind of a low bar. Of course we want to for everybody to survive childbearing and that first year of life, and we really want to ensure and restore humanity and joy in the childbearing process. And most outcomes are healthy and positive.

Most is not all, and most is not equal. And so, we really again, want to improve overall outcomes. We want to prevent every infant and maternal death as possible, and really need to address these unacceptable racial disparities and accelerate that improvement. We really should not be here in another century from now, and that is why we're all here in this Committee, and it's really important for you all to make those recommendations, so we can get there faster.

So, infant mortality, what would it take to reach the Healthy People targets and achieve equity? So for both infant and

maternal mortality, you can calculate what it would take to reach the Healthy People targets, and achieve equity in terms of the number of deaths that need to be prevented.

And so here for infant mortality we're pretty close already to that Health People target. We're just .5 per 1,000 away from that, but given the large number of births that still translates to 1,768 infant deaths, so we have to make those policy and system changes that make it possible for that many infants to reach their first birthday, to reach that Healthy People target.

And we can do that for achieving equity. Compared to the white population it would require double that, so we really can't be satisfied with only reaching that Healthy People target. We really have to do more to achieve equity. And we can see what that translates to in terms of the number of babies per day.

And it's not to trivialize the problem, it is hard to prevent these deaths. If it were easy it would already be done, but it really should be achievable, five per day, ten per day. On the maternal side because we're farther from the Healthy People target, it would take more maternal deaths to prevent -- to reach that Health People target than to achieve equity. So, here getting to equity is not enough, and we still need to achieve more overall improvement.

And we can show what this means on a state level as well. We've updated these maps to see where the deaths needed to prevent -- to achieve equity are concentrated, and here we're displacing the Black population as the focus of this Committee, and in darker red states, they have not only high rates and disparities, but also larger numbers of Black births at risk of not reaching their first birthday.

So, those nine states in the darkest shades of red and orange, account for over half of all the deaths that need to be prevented to achieve equity. But ultimately, every state contributes, and we need to achieve equity everywhere, it's just that some states account for a larger share. So if we were able to achieve equity, more progress in those states, we would achieve national progress faster and more quickly.

On the maternal side, most states have at least one annual Black maternal death due to disparity, but there are four that account for a third of all deaths due to disparity: Florida, Georgia, New York and Texas, so these are states that have wide gaps and large numbers of Black moms at risk of experiencing a maternal death.

And again, we need to achieve equity everywhere, but some states account for a larger share of those deaths. And some states like New York have low rates for the white population, where equity may be the major area of focus. Other southern states seem to have high rates across the board, where getting to equity would not be the only goal. We still have a ways to go to reach the Healthy People target for most populations.

Okay. So now I will move into causes and the slide shows approximate causes of infant mortality. Among the official rankable causes of infant mortality, congenital anomalies is the leading cause, but here I have grouped or summarized the individual causes related to prematurity. And when you do that, it is the largest summary cause of infant mortality, accounting for at least a third of all infant deaths.

And this is likely still under-estimated, because some of

those non-specific causes that the majority are to preterm events weren't actually included in this definition, and that's where you see a lot in the other perinatal conditions category in yellow. Similarly, when the codes for sleep related, unexpected infant death (SUIDs) unknown cause and accidental suffocations regulations that are grouped, it accounts for a large share, 17% of all infant deaths.

And then on the right you can see those components of disparities, and so although congenital anomalies are a leading cause overall, they don't account for much of the Black or indigenous population compared to the white population on this graph. We're only showing the causes that account for at least 10% of those deaths due to disparity, and this is really just calculated as those cost specific rate differences, divided by the total difference in infant mortality.

So, disparities are largely driven by prematurity and SUID to varying degrees, depending on the population. For Black population about half of those deaths due to disparity are attributable to pre-term birth. For pregnancy-related mortality overall this is what Dave presented earlier.

We see maternal health condition -- mental health condition, sorry, cardiovascular conditions, infection, hemorrhage and embolism. And infection does include COVID-19, but it was still among the top five leading causes prior to COVID, and that's predominantly sepsis.

The majority of these are deemed preventable. The MMRCs, they are working on being able to calculate rates that would include injury and mental health conditions to be able to calculate those

disparity components and percentages, but for now this just presents those leading causes by race for the Black indigenous populations.

So, this is just listing those that account for 10% or more, so the top three for the Black population are cardiovascular conditions, infection, embolism. Prior to COVID, hemorrhage was in the top three. And for American Indian, Alaskan Native, we see those mental health conditions, hypertensive disorders, are other causes in that top list.

But those numbers are small, and it is hard to be confident in those percentages. So, these are the approximate causes, but what are the root causes? For a lot of these it's stress on healthy environments, lack of access to quality, respectful care. And these upstream, or root causes, are what we need to address to be truly effective and change the system, rather than prevent or mitigate risk.

So inequity in the experience of social determinants like access to quality care, unhealthy environments, limited economic opportunity, have been driven by discriminatory policies and practices, and residential segregation, in particular. So, we have to really think about those opportunities to intervene and impact both social and structural determinants.

And here are some nice illustrations and frameworks of the web of causation, or root cause analysis in the peer reviewed literature, specifically for the Black population, of particular focus, the Committee, and so these are from articles by Dr. Joy Crear-Perry, who is here in the room today, shout out, and Dr. Lori Zephyrin.

They're both female clinicians, scholars, thought leaders,

champions for equity, and they are offering a way to better understand drivers and solutions. So, Dr. Perry's article mentions policies like paid leave, Medicaid expansion extension, doulas, culturally respected care, and Dr. Zephyrin's article employs the five whys in driving further upstream as well, and reasons for unequal access to quality care and other social determinants, including racism in all its forms, and provider bias.

So many cities have pointed to residential segregation as a fundamental cause of disparities. Where you live really does shape your live chances and your opportunities, and here's an example linking the historical practice of redlining with present day infant mortality rates in Cleveland.

So redlining really amounted to government backed home mortgage denial on the basis of race, and disinvestment in non-white neighborhoods. So those areas rated D in pink, red, were predominantly African American neighborhoods, and that's where infant mortality rates are high even now.

And you can look at a lot of health outcomes related to this, including life expectancy, and there are 20 year gaps within the same city, and I like that saying that your zip code matters more than your genetic code. It really does influence opportunity structures.

So, along with steering and racial covenants, restrictive zoning, those were the policies and practices that helped to create and perpetuate segregation and concentrated disadvantage. These maps highlight, of infant and maternal mortality, highlight the patterning at a structure of the state level.

So, we can see that the two outcomes are strongly

correlated. They share common drivers, both a structural and approximate level. For example, pre-term birth, and that's related to those upstream drivers of stress, segregation, hypertension, and perinatal regionalization, and care quality as another example.

So, we really need to think about opportunities to align efforts in the perinatal space through that maternal and infant dyad. And here's another resource of the maternal vulnerability index that may help in going further upstream and identifying dominant social determinants of health deems or needs by state and county, and there was a publication just last year that just kind of showed the dose response associations, with maternal and infant health outcomes, and helping to explain those Black/white gaps.

And now, I will turn it over to Dr. Warren to bring it all together literally and figuratively, and we'll just yeah, you can just begin.

DR. M. WARREN: Thank you, Ashley. Good afternoon everyone. Good morning for colleagues who are west, and I want to extend another welcome to our new members. It's so exciting to see the Committee continue to grow, and bring new and diverse perspectives.

As Ashley has walked you through this paradigm, as we think about improving both maternal and infant health outcomes, the accelerate part is pretty clear. We've got to move more quickly. We don't want to be saying the same things our colleagues were saying 100 years ago. To do that we've got to think upstream.

We know that clinical care is important, and it accounts for about 10 to 20% of our overall health and well-being, and so we've

got to think more broadly about those factors that are influencing health. And the last part of that paradigm is together. We -- none of us -- do this alone, and certainly at HRSA in the Maternal and Child Health Bureau, we do this work in partnership with states and communities, you've heard a little bit about one of our investments this morning, Healthy Start.

We'll spend a little bit of time talking about some of those other investments that we're using to move this work forward. Broadly, in terms of our maternal and infant health programs, we categorize them into three buckets, those that promote access to healthcare services, those that improve the quality of care, and those that strengthen the workforce.

And I'll spend a little bit of time this afternoon just highlighting a few of those for you. Far and away our largest investment is our maternal and child health block grant to states, and I think this is really the biggest lever that we have for improving maternal and child health in this country and it really funds core public health grantee populations across the country.

There is a lot of flexibility associated with the block grant, so states have a few requirements they have to comply with. For example, they have to spend 30% of their funds on primary and preventative care services for children.

They have to spend at least 30% of their block grant on children and youth special healthcare needs, and they can't spend any more than 10 % of their funds on administration. Otherwise, they have a lot of latitude to be able to meet the needs of MCH populations in their states.

And even in some of those broad categories like 30% on primary care for kids, you can imagine that's a very broad description, and states have a lot of flexibility there. So, every five years states do a needs assessment. It is a comprehensive analysis to understand what are the strengths in a particular state.

And I should say when I'm saying state, I'm referring to the states, D.C., the freely associated states and the territories, there are 59 entities across the United States that get those awards. But those entities do comprehensive needs assessments. They identify what strengths they have in their particular jurisdiction.

They also identify the needs and the challenges and the opportunities. They look at that in the context of what legislative requirements they may have in their state, so maybe they have state legislative mandates. They look at what are priorities, current efforts, and they develop an action plan to improve the health and well-being of MCH populations.

So, states are in the middle of doing that right now. Next year, 2025 will be when those next rounds of five year needs assessments are due. Based on the current round, we know in maternal health space 16 of those states have chosen reducing maternal morbidity, and/or maternal mortality, as a state priority.

Six of those have specifically honed in on reducing disparities, and those maternal health outcomes. In the infant health space, 23 of them have listed reducing infant mortalities of priority, 12 have talked about generally improving perinatal or birth outcomes, and 8 have specifically called out reducing disparities in birth and infant outcomes.

That doesn't mean that other states may not be working on those topics as well, but these states that have marked that as a priority have generally an increased focus on those areas. And to give you a sense of how they are doing that, we think about the work of the block grant like a pyramid. This is sort of analogous to Tom Freedman's pyramid that many of you have seen if you think about sort of a public health approach to services.

At the top of that pyramid are direct services, then you have enabling services, and the base of that really where we'd like for the bulk of the effort to be is in the public health services, and systems building area. So, in the direct services space you've got, for example, clinical services.

In the case of the block grant, those may be services provided through local health departments. Direct services like tobacco cessation programs, or breastfeeding hotlines to be able to support individuals. And in the enabling space we've got things like health education from visiting programs, and I'll talk a little bit more about home visiting in a minute, case management, what you've heard about through our Healthy Start Program, and then transport services.

And then in the public health and systems building category you've got population level interventions, like newborn screening programs, hospital engagement on practices around safe sleep, regional perinatal systems of care, partnerships with Medicaid for example, all of those things really working at the systems level to try to have a much broader impact, and also move upstream and address some of the challenges.

In the most recent iteration of the block grant, we have added a number of performance measures that states can choose from. We've got some of those that fall into clinical health systems category, and specifically related to maternal and infant health. Those include things like postpartum visit -- having access to a postpartum visit, but also measuring the quality of that postpartum visit, screening for postpartum depression or anxiety, and receiving risk appropriate perinatal care.

We've got measures related to contraceptive use, breastfeeding, safe sleep, and the newly added measures related to social determinants of health. We have lots of states express interest in work in this area, and they said we need measures to be able to support that, so there are measures related to discrimination and perinatal care, as well as housing and stability in the 12 months leading up to delivery.

One of the things I want to point out with these measures, you maybe can see at the bottom, we are not the primary data source for these measures. So this represents a partnership across the federal government, within the Department of Health and Human Services, to be able to gather data, and make those available for states.

There's a big shift, maybe ten years ago now, with federally available data. In 2015, where it used to be the case. Back when I was a block grant director first I would say send us your data, and we would have to go find the national data on a lot of these statistics, and report it in our application, and find our state data.

HRSA changed that in 2015, and started making available

what's called federally available data. And that's not just to the state block grants. Any of you who have access to that it really is a rich source of information on a variety of maternal and child health indicators, and we have added additional stratification to that even as we're moving forward.

I've mentioned home visiting earlier, this is dollar-wise the second largest item in our budget, in MIECHV. The Maternal Infant and Early Childhood Home Visiting Program; this is voluntary evidence-based home visiting. This first started with the passage of the Affordable Care Act, and states can apply for these funds.

They have the opportunity to design a program of home visiting using a series of evidence-based models, those are models that have been deemed evidence-based by the federal government, and states can then use those dollars from us to be able to implement those models, and this builds on decades of research showing that home visits by a trained home visitor, whether that's a nurse or a social worker, community health worker, peer educator, resulted in improved outcomes for mothers and children.

This is another program that has nationwide reach. You can see on this slide the reach of that program, and yet we know even with the substantial investment that we have in home visiting, we're really only reaching about 15% of eligible families.

And so, there's tremendous opportunities to be able to do more, and we're really excited that when MIECHV was reauthorized in 2022, Congress set us on a path to double the investment in MIECHV over five years, so this has historically been a 400 million dollar program.

By 2027 this will be an 800 million dollar program, so a 400 million dollar increase. One of the things Congress was very clear about is that they really wanted state engagement in this, so of that 400 million dollar increase, 300 million of that is through a new matching grant program.

So, this is the first year that we launched matching grant program. It's a one to three match, meaning for every one non-federal dollar that states put forward, we will match that with three federal dollars. There is a lot of flexibility in how states can come up with those non-federal dollars.

It can be state appropriations, state general funds, they can be local, city or county funds, it can be funds from the private sector like philanthropic partners, and there is a lot of interest in the private sector in this space right now. And states can also put together in-kind funds, so we really have tried to make it as easy as possible for states to be able to access these resources, recognizing that the whole goal is to be able to expand home visiting to services, to counties where we're not currently making those available.

You heard a little bit from my colleague, Benita, this morning on the Healthy Start Program. We're really excited to have the largest Healthy Start footprint that we have had in the history of the program. So between FY '24 cohort that was just awarded, and there are ten Healthy Start awardees from 2023, we have 115 Healthy Start projects across the country.

You can see those new sites, the 22 or so new sites that were represented in this most recent cohort, and those are the ones that Benita mentioned to you earlier. We focused very intentionally

in the last year of the previous Healthy Start cycle on listening to our Healthy Start awardees, what was working well, what did we need to continue, what was not working so well, where did we need to think about either taking a different approach, or giving some grantees flexibility.

And the team worked really hard to be able to incorporate those into the next cycle. One of those, as you heard from Benita, is that increased support for being able to address social determinants of health. We hope that the Community Consortia will play a big role in that. We hope that the inclusion, much more deliberate inclusion, of individuals with lived experience, and Healthy Start participants on this Community Consortia, will also make a big difference.

We've also got a footprint for the last few years in this space through a small group of grants in the Healthy Start Program called Catalysts for Infant Health Equity. These were grants that we awarded several years ago, specifically to be able to accelerate our work in communities where not only were there high rates of infant mortality, but persistently high disparities.

And so, these grants were specifically focused on moving upstream, looking at those social and structural drivers, or determinants of health, and in particular, those that are influencing poor perinatal outcomes. One of the areas where we've seen a lot of activity is in the space of housing, and you can see a couple of examples on this slide where folks have really integrated housing work into their Healthy Start projects in their community.

So, a number of programs we talked about that are related to infant health I want to talk just a little bit about, is some of

our investments in the maternal health space. Back a decade or so ago we also launched something called the Alliance for Innovation on Maternal Health, or AIM. These are sometimes referred to as safety bundles, or tool kits that highlight best practices that when replicated should improve not only the quality of care, but outcomes.

Those started with bundles around things like hemorrhage, and preventing unnecessary C-sections, so those have grown over time to include for example, optimizing treatment for people with substance use disorder, or thinking about the optimal transition from labor and delivery to postpartum care, to care back into the community.

AIM is being implemented currently in every one of the states, which is really exciting. About 2,000 birthing facilities across the country, and that number continues to grow. We were really excited last year to be able for the first time in the history of the AIM program to be able to award state capacity grants, and there are 22, 28, somewhere in the 20's, a number of AIM capacity grants that have been awarded to states.

And these are dedicated dollars for states to be able to engage birthing facilities. Maybe those that aren't already participating in AIM, maybe those in a part of the state where birth outcomes are worse, or maybe where there's just a little bit of extra support needed to be able to implement AIM.

States have the flexibility to decide which of the AIM bundles they want to implement. This has been an area of great partnership for us with our colleagues at the CDC, so folks typically don't just implement an AIM bundle on their own. Typically they do that through a perinatal quality collaborative, those are funded by

our colleagues at CDC.

And states have the opportunity to say what are our data telling us about maternal mortality and morbidity, and what are the areas where we need to focus? So, you'll see some examples here of those kinds of state specific focus areas. In Alaska, they focus on managing folks who are presenting with severe hypertension, and we saw an increase in folks who were given timely care.

Georgia focused on hemorrhage and making sure that their facilities were ready. One of the measures they looked at was the presence of hemorrhage carts, which is one of the items that's in that safety bundle. Illinois and New York both focused on substance use disorder, things like making sure that when folks were discharged from that birth admission, that they were discharged and connected with medication for opioid use disorder prior to discharge.

And in the case of New York, they looked at universal screening approaches. So, every state will do this a little bit differently, but really excited to see the progress that is being made across the country. We also know that mental health is an incredibly important, as you've heard, both from our colleagues at CDC this morning, and from Ashley just now.

Mental health is a leading cause of maternal mortality in this country. We have a number of investments within the Bureau. One of the newest in this space is our National Maternal Mental Health Hotline. It was launched on Mother's Day in 2022.

This is a toll-free service that is available 24/7, 365 days a year folks can access via call or text. The number is 833-TLC-MAMA. I know some of you on this Committee have heard about

that before, but we've got some new folks, and until this is not the leading cause of maternal mortality, we're going to keep talking about this and spreading the word.

We have -- this is hot off the press, over 37,000 calls to date received since the launch of the hotline in May of 2022. We are actively working to get the word out about the hotline. The QR code that's shown here, or you can access via our website, will take you to promotional materials. There are posters, there are flyers, there are wallet cards, magnets, all sorts of things that you can get for free. We will even ship them to you for free.

And if you give all of them out, we will ship you some more. We would very much like to get these materials out of warehouses, and into the hands of people who need them, so I would encourage you to think about what opportunities you have to be able to share these important resources.

I want to lastly share just some tools that may be helpful for you in moving this work forward. Ashley shared a variety of maps, and we think it is really important as you think about advancing this work in states and communities, to be able to contextualize the work you're doing to be able to understand what are the unique challenges and opportunities in a particular jurisdiction.

A few years ago, we launched something called the Maternal and Infant Health Mapping Tool. This is publicly available, and gives you access to county level data on a variety of maternal and infant health indicators. You can look at overall outcomes around things like infant mortality, preterm birth rates, low birth for example.

You can look at placement of health resources, so you can

see for example what's the distribution of HRSA funded community health centers. That list of items is growing all the time, and so we continue to evolve the data. For those in the room we're seeing a box on the screen. I don't know if we can make that go away, but we continue to evolve those data over time.

One of the really exciting features of this tool is that folks can also bring in their own data. So, let's say you're a state, or you're a community-based organization, you're planning a project, and you've got data about your particular program, maybe delivery sites or outcomes, you can actually import that into the mapping tool and display that alongside these publicly available data.

Your data only remains visible to you. They don't get ultimately shared with us, but it can be a really useful tool for program planning. This really intense focus on data and local level data is one of the things we have tried to do for example with our Healthy Start Program, and thinking about how do we make sure resources are getting to the communities where the need is the greatest.

Both in terms of those overall health outcomes, but also on communities with disparities. And so, really excited to take a look at where those investments are, and really appreciate the work Ashley and the team did to pull this together. If we go back to those data that she shared with you, about how do we close the gap, those deaths that are due to disparities.

If we look across the country, the counties that have the highest number of deaths due to disparities, 60 counties across the country account for about half of all those deaths. So if we really

want to make a difference, if we want to focus our efforts, we know where those 60 counties are. Each of those counties has 12 or more deaths annually, but at the top of that list you've got places like Cook County in Illinois, where there are over 100 deaths due to disparity annually.

Those are spread across 27 states. What is heartening for me is that all of those sites, all of those 60 counties have at least one key HRSA investment. As we think about community health centers, 100% of those sites have a community health center.

Three-quarters of them have home visiting, about three-quarters also have Healthy Start, and over half of those sites have all three. So, one of the things that we are working on now is thinking about how are we encouraging our HRSA funded investments to work together?

Our HRSA administrator, Carol Johnson, is on a maternal health -- HRSA Enhancing Maternal Health Initiatives Tour. We have 12 states that we're working with, and in each of those states we're bringing grantees together, to talk about the HRSA investments in their state, and what we can do to leverage those investments to do more.

We don't have new dollars, but what we are finding in every state we've been to thus far, is there are people in the room who have HRSA dollars who don't know each other. There are people in the room with HRSA programs that don't know what other HRSA funded programs are doing.

There are people in the room who leave the room with new collaborative partners, with new ideas for engagement moving forward.

And so, even in the absence of new money, there is new activity happening. There is new engagement, and new enthusiasm, and interest.

And so, we are really excited to be able to round out those states as we move through the rest of the year. So, this paradigm, this accelerate upstream together has been something we've been talking about for a few years. We are seeing that start to bear some fruit in terms of the way we are crafting our funding opportunities, and the way we are implementing our programs, and I really appreciate that this is reflected very strongly in the work that you all do.

And so with that, we will pause, and Ashley and I would be happy if we've got time for questions, to answer any that you may have.

CHAIR PETTIFORD: Yes. We do have time, and hands are going up, but Caroline, do you want to come off of mute, and ask your question, and then we'll go to Sherri and Kate.

MS. DUNN: Sure. I'd be happy to, and I will say I think Dr. Warren and others addressed it pretty well, but I was hoping that you guys could talk a little bit more about how the data that you presented could be used in a more hyper-local level when thinking about the recommendations from this.

And Dr. Warren, I know, I will say I've seen you speak on this several times, but just for example one of the counties within Florida has much higher infant mortality rate than the overall state of Florida. So when we see a state with a high infant mortality rate, that can be masked if we disaggregate data. We get better information.

And that can allow us, as public health professionals, to

kind of with better resource intervention that could address the problematic source. And again, you spoke to some of this, but if you have any ideas again, as the Committee is kind of thinking about recommendations about how they might take that into account, I think it would be helpful.

DR. M. WARREN: Yes. Thanks for that question, Caroline. A couple of things come to mind. One is states are doing their Title V needs assessments. This is a perfect time for them to be able to look not only at the state level indicators, but what do outcomes look like across the state.

I think back to my own time in Tennessee for example. The outcomes were very different in Nashville and Memphis and Chattanooga for example, than many of the other counties across the state. And so, it's helpful to be able to think what do we do to localize efforts there.

But even in those three counties that I mentioned, the drivers were very different if we think about poor infant maternal health outcomes. And so, being able to then dive into other data, maybe qualitative data for example, that comes from fetal and infant mortality reviews, or maternal mortality review committees to be able to drive that work.

We want to make sure that all those datapoints are being used for action. The other thing would be again, to point folks to this Maternal and Infant Health Mapping Tool, as they're doing, for example, community health assessments. Think about all of the hospitals across the country that have the community benefit dollars that come to them.

And part of the requirements for continuing to get those benefit dollars are doing community health assessments, and understanding what the needs and challenges are. This could be a very powerful tool there that they could help drive the allocation of resources in those communities.

MS. DUNN: Thanks, I appreciate it.

CHAIR PETTIFORD: Thank you. Sherri?

DR. ALDERMAN: Thank you very much for that powerful data that you've presented to us today, and that you're gathering on a continual basis to inform the decisions that we wish to make to achieve that healthcare goal that we all share. I'd like to circle back. I want to commend you for recognizing social determinants of health as powerful opportunities for improving the health of well-being, and reducing disparities.

And circling back to one in particular that you mentioned, Dr. Warren, housing as such an impactful condition. And providing opportunities for financially supporting housing for the 12 months leading up to delivery. As you know, I am a voice for babies, and what I see in that is a tremendous opportunity for reducing parental, or stress in the pregnant person during the gestational period.

What I also envision immediately is then is that birthing person, and that newborn baby leaves a hospital without housing. And that, I'm sure you would agree, is unacceptable. And I also would imagine that most of those babies were born in hospitals that received federal money.

So, I really I would love to hear any efforts to recognize in a very intentional way, how unacceptable that is, and what we can

do to support housing through that transition to one of the most powerfully impactful events in a pregnant person, the birthing person's life, and that newborn baby.

MR. J. WARREN: Thank you so much, Dr. Alderman. You know, I think that's one of the really powerful roles of this Committee as you think about your recommendation, making power, or authority to be able to think about what are those levers.

If I think about my time in primary care pediatrics practice, we would never discharge a baby home from a newborn nursery without a car seat. Right? That is part of your checklist, and if they don't have one, you connect with social work, and you make sure you get one.

That's not always necessarily easy. You've got to think about where is that supply coming from. That requires staff who are connected to community resources, and know that. And I would wager to say car seats are probably a heck of a lot easier than housing. And yet, a paradigm shift happened at some point where we said not one more child.

And so, thinking about the role of this Committee, is there an opportunity for some sort of, as you all are thinking for some sort of similar elevating of a particular priority?

CHAIR PETTIFORD: Thank you so much, and I do think it connects to the work of your actual workgroups here, with our social drivers of health, so Kate, we'll come to you for our last question, and then we'll just tell you to put your other questions in the chat, and we'll get them answered as soon as possible.

DR. MENARD: Thanks Belinda, for giving me the chance, and

both of you, fabulous. Ashley, in no way could I absorb all of the great stuff, I look forward to reviewing those slides over and over again. But my question has to do with measurement.

Dr. Warren you said, you made the important point that your biggest lever is the block grant, right. And what will drive the way those monies are used locally in well-being measurement. And you listed a number of new measurements. I'd love to hear a little bit more about how those things are actually gleaned, and if you feel like they're gleaned in such a way that believe them reliable, particularly quality of postpartum care, how to measure that, and you know, risk appropriate perinatal care. How do we measure that as just, you know, small babies, or is it true mom-baby.

And then the discrimination in perinatal care. I mean these are really important issues, but how do you measure them?

DR. M. WARREN: Do you want to take this?

MS. HIRAI: Yeah, thank you, Kate. So yeah, these are exciting. Most of those new measures are not like ongoing, they are actually brand new, and states get to choose them next year with their 2025 needs assessment. So, you specifically mentioned postpartum visits, and that comes from PRAMS, and the two dimensions of quality that we have on, in PRAMS are contraceptive counseling, and screening for I think it's yeah, sorry.

Yeah, sorry I'm blanking on that, but so there's two dimensions of quality there. And, perinatal regionalization, that has been a major data gap, and so there could be recommendations again that you have to have a national measure and be able to compare across states.

Right now it's just at the state level they can report it if they have the data. CDC has a locate tool to help track levels of care, and how that aligns with state designation systems. But we have been exploring whether we can use hospital discharge data, and it just didn't seem to align with the American Hospital Association.

There are a lot of anomalies there, and so it's not really capturing the NICU presence as much as we would like. And Scott Lorch, a neonatologist, and Committee member here. I'm sure he has a lot of ideas around that, so I'd love to hear from you all as the experts here.

DR. LORCH: Happy to contribute if there's stuff that we do a lot, or at least I think of a lot in my group. I don't want to speak for everybody else, but happy to help.

DR. M. WARREN: And we can share also, so for each of those block grant measures there's a detailed data sheet that operationalizes those measures. How is the numerator, how is the denominator calculated, the data source, those kinds of things, so we can make that available to the Committee.

The states have that in terms of the guidance that we share with them. And then those federal available data that I mentioned, there's also that kind of a backup documentation, if you will, that goes through all that. So we can make that available to the Committee.

CHAIR PETTIFORD: Thank you both, so much. We appreciate your presentation. I'm trying to think how do we get this presentation out to a broader audience, so that other people can get to hear about it as well, so maybe that's something we can help with

our recommendations, how to make sure people are aware of the need to accelerate the work, but also, you know, the issues of disparities, that we continue to have that conversation about.

Rural Health Focus: Federal Rural Health Priorities and Telehealth Activities

CHAIR PETTIFORD: So, thank you all so much. We need to switch over now. We're running a few minutes behind. Please continue to put your notes in the chat. Next, we're going to go to our Rural Health Workgroup focus area. And so, we're fortunate to have with us Macarena Garcia, who is the Senior Health Scientist, with the Office of Rural Health in the Public Health Infrastructure Center coming to us.

Thank you. Good to see you today. She's in person for those who wonder why I'm looking around the room, because it looks like she's supposed to be here, and then we will move on. But we'll let you introduce yourself further if you like.

MS. GARCIA: Okay. Fantastic. Well, good afternoon everyone. It's a pleasure to be here. This is my first time participating. My name is Macarena Garcia. I work at the Office of Rural Health at CDC. We are a very new office. We've only been around for just over a year. I am a Senior Health Scientist, and I have been working on rural health issues at CDC since 2016, with Diane Hall.

She is not here. This presentation is usually a tri-part type presentation. Our office director, Diane Hall, our health scientist Kevin Matthews, and myself go around making this

presentation really trying to you know, share information about what our office does. A lot of people are not familiar with our office, or don't know that it actually exists.

So, I'm here today just to provide an overview of what our office does. But I will really be focusing on our scientific activities and our scientific priorities. Next slide please. What I will cover today, I'm going to rush through a few slides that I think likely are not incredibly relevant for this audience, but I do want to start off by talking about our office, what our goals are, what are strategic direction is, what our rural scientific resources are at CDC. They tend to be diffuse because we don't have a centralized rural health scientific, let's say, structure. Everything is across all the different centers, and we are coordinating across those centers.

I'll also talk about our public health science priorities, some of the presentations we've given this year, as well as some scientific activities that we're currently taking, or that we're currently working on, some of these are rural-urban differences in preventable premature deaths, that's one of my main pieces of work since 2016 at CDC.

Some work on prevalence of Alzheimer's disease in rural counties, CDC sponsored call for papers on topics related to rural health. We also have some rural analysis tools that are currently being developed, so I'll talk a little bit about those, and also how to leverage CDC surveillance systems to conduct rural health research.

We have over -- well, okay, this was a few years ago 251 surveillance systems, after COVID we easily had more than 300

different surveillance systems that all exist in different centers across CDC. And I'll conclude with our science priorities, and opportunities to collaborate because everything we do at our Office of Rural Health is about collaboration.

We are a small team. We currently only have five people in our office, so all of the work that we do in science is collaborating not only with other centers at CDC, but other federal entities, as well as private sector groups, and institutions of higher learning. Next slide please. Next slide.

While our strategic plan for our office, again I mention that we've only been around for just over one year. However, we have been very active as a diffuse group of members across CDC since 2016. In 2017 we kicked off our rural health MMWR Series. I'm not sure if folks are familiar with that, but that was a call from Dr. Frieden to look at all the rural health activities that were taking place at CDC.

So we were a part of putting that together, and this is really where the idea of having a consolidated Office of Rural Health came from. That was 2017. Our office was actually established in 2023 as we all work for government, we know how long things can take, but we're very excited to have our office.

And really, the purpose of our office is to improve the health of rural communities by advancing the best rural public health science and practices through a coordinated transparent and strategic approach. So, our values are about leadership in CDC, and across the federal government.

We collaborate, like I mentioned that's one of our core strengths. Of course we have scientific curiosity on a whole set of

priorities and scientific areas. We are all about innovation. Again, I know we work with government. Innovation has a completely different connotation in government than it does in the private sector, but we try to be as innovative as possible within, you know, the limitations of our government environment.

And we're also all about empowered decision making. So like I said, we are a small group, but we are nimble, and we can move quickly because we are a small group. Our priorities for this office are to advance engagement with partners and communities. All we do is work with partners and communities.

You can imagine with the top five people, full-time staff members, there's not so much we can do on our own. Number two, we are focused on strengthening rural public health infrastructure and workforce, hence we are in the Public Health Infrastructure Center at CDC.

Number three, advance rural public health science. We have a big focus on rural health science. I'm the lead scientist in our office. So, we have lots of different scientific activities ongoing at all times, some of them we lead, many of them we collaborate on, we advise on.

And number four, of course we want to improve rural public health preparedness, and response capacity. We learned a lot during COVID, and so a lot of those lessons learned we are applying in our preparedness and response work. Next slide please.

What are our principles in our office? Well, we really focus on strengths. What are our strengths as an office, and what are our strengths as CDC? We champion the work of others. We work with a

lot of partners. We're constantly championing the great work of our partners. We disseminate the best practices, and those are of our partners, and those that we generate ourselves.

Of course we collaborate with partners. We examine variability in data, and I'll talk a little bit more about that. And we integrate rural health across CDC programs. For those of you who are familiar with CDC, you know we have approximately 15 centers, offices, they're called CIOs, centers, institutes or offices. Most of them are in Atlanta, some are here in the Washington, D.C. area.

That is a lot of groups to collaborate with. We are organized in a silo fashion, so many of our centers are condition-specific. Our center is a cross cutting center, so our job is to collaborate across all of those other centers, institutes, and offices on rural health issues.

It's a big task for five people, but because we've been doing it for several years, we've really forged a lot of relationships across CDC, and more recently, across the federal government. Next slide.

Now, we have a lot of activities that are ongoing. I'm going to just highlight a few. There's no need to highlight all of them. I think it's just the ones that are relevant here. But I mentioned that we have resources at CDC, and we have a plethora of surveillance systems.

We have some that are available to the public. We have some that are not available to the public, but that we have access to, and there are some that we have access to, but they are restricted because they have restricted variables that even ourselves, we have to

submit proposals to access those restricted variables.

So, we're developing what we call a cookbook, and we're starting with six to seven of those surveillance systems. And what we're going to do is in this cookbook, and this is really for external partners. We're going to highlight each of those public facing surveillance systems, and provide recipes for how to use them to conduct studies that are focused on rural health, right, so that have variables that are rural health variables.

Not all of our surveillance systems actually have urban, rural variables, believe it or not. So, we're going to -- we're working on the cookbook now, we think that will be really, really helpful for our external partners, and like I said, it's public facing. Many of these surveillance systems, we partner with others to help them, you know, go through these recipes, so that they don't have to go at it alone.

These systems are not incredibly intuitive, and they are not easy to access, so we work in partnership with others to basically implement these recipes, and teach and guide you how to do that. Next slide.

We also have a rural health mapping tool. So, this tool has a lot of different variables. It has health outcome variables. It has variables on the leading causes of death. We've integrated prosperity indexes, COVID-19 indicators. This was a really heavy focus during COVID-19, other vaccinations.

This is something that we are now taking over. NORC was managing this for us, but now we're bringing this in house. We're going to revamp it, and we're going to add variables that we think are

really relevant, including the social determinant of health variables.

You can see it's county-level data, so this is a very useful tool. It also has opioid use disorder information and variables. You can overlay several variables as well, so we're really working to make this more robust, and very user friendly. So when it transitions to the CDC it will look different, and we will be, of course, maintaining the data, updating the data. We're even thinking about how to incorporate the county health ranking data, that we all know from the -- I'm blanking on it, but you know what it is.

Yes, okay. So that is a wealth of information, especially on the social determinants of health, so that will be incorporated sometime in the next year. Next slide. Robert Wood Johnson Foundation. I remember now. Okay.

So, additional scientific resources at CDC. We have the PLACES data. I'm not sure if anybody is familiar with that, or has heard about that data. It's local data for better health. It's a really great database. It's managed by ATSDR, which is our sister, I guess, office, you can call it. They do all of our geospatial work. That is their specialty, and what it really does is it provides health data for small areas across the country.

I think this data is not well utilized yet. I think a lot of people don't know about it, but it's a great resource for localized data. Next slide. Of course, we have the NCHS Urban-Rural Classification Scheme for Counties. As you may know, there are lots of different classification schemes for rural, urban categories. We have RUCA Codes, we have OMB, so we for the most part, use the NCHS Urban-Rural Classification Scheme, that has six different categories.

So, you have large central metro, and I have the website here. You can actually see the definition for each of those. But basically these four top, one, two, three, four metro related categories goes from large metro to very small metro. Those usually get combined into just a metro category.

And then your micropolitan and non-core usually are combined into a rural category, so you will often see just two high level categories, which are urban and rural. What we are trying to do in our office is get, you know, to the finer details of rurality, and disaggregate, stratify our data and all the results that we publish into these six different categories.

And I'll be able to show you an example of some of the research that does that, to show you how powerful that disaggregation really is. Next slide. So, I mentioned a call for papers. We are partnering, and we have rural health disparities with this call for papers is focusing on is contemporary solutions for persistent, rural public health challenges.

It's a call for papers for just about any specific health topic related to rural health, so for anyone who is interested, we are collaborating with the journal on this, which is Preventing Chronic Disease, and here's some information. I think final manuscripts are due, so we still have plenty of time, January of 2025.

I believe the QR code, I was told may not have worked, but if you just Google this you will find the call for papers. And again, you know, technology innovation, we're still a little bit behind on that. Next slide.

Now, we'll just talk about some rural health science

publications. This is a really kind of neat story, next slide. And the reason is because since 2017, I mentioned that that was our big push. We called it the MMWR Special Series on Rural Health. The initial publication was launched, it was on the leading causes of death.

I was the lead author, and that launched in January 2017. At the end, December of 2017, we had approximately 13 different MMWRs published, all focusing on some sort of aspect of rural health. That had never happened at CDC before, and that really launched our focus on collaboration and coordination of rural health activities at CDC. Next slide.

So, why do I say this? I say this because before the launch of this series we couldn't really find a lot of publications that highlighted anything happening in rural health in our MMWR series. They were just like, you know, very random. So we wanted to do something very intentional. So, these are all the topics we covered in that year.

So, you can see they are wide-ranging. We had collaborated across at least 8 to 9 centers at CDC, which again not easy to do, but we were able to gain a lot of traction, and so, next slide please. Now, you can see what happened with our publications, right? That these are CDC publications, mostly MMWRs, there were just a few here and there from 2013 to 2016, and 2017 of course we added 13 to what was already being published.

And now, you know, because it's intentional, you can see the increase of our rural health focused publications at CDC. Now, our office was created in 2023. We are hoping that we easily will

reach 100 or more, and increase over time because we have a lot of science priorities, and have built a lot of relationships, so this is you know, folks are familiar with MMWR.

These have a huge reach, you know, they reach media outlets, and so it's -- for us it's something that we really, really want to focus on because you really get the word out. With our 2017 series we were able to be focused, or we were actually featured in the New York Times. We were featured in the Washington Post. We were on NPR.

I mean it was a wide, wide-ranging reach, so we are really proud of that, and we want to continue using that as our vehicle to get the results out. Next slide. Now, we talked about clinical care and public health, and of course there is a distinction. So, I want to share how we think about rural public health science.

So, there's the perspective of medicine, right, that is focused on the individual, and the perspective of the population. So we are a population-focused, I mean we're CDC, so I mean that is, you know, what we should be doing. In our office we really do focus on public service ethic, our emphasis is on prevention, health promotion for the whole community.

We do focus on the local communities because we think that's very important. Not all rural communities are the same, it's not monolithic. So, if you go to a rural community in New Hampshire for instance, it is very different than going to a rural community in Alabama.

So, I want to, you know, really emphasize that we are all about local because we recognize the importance and the uniqueness of

these local areas. Next slide. Now, we also learned from the outliers. Because we do so much research, and we work with SMEs across our agency, we look for outliers, and a lot of research just looks for, you know, kind of the general. We know this is happening, you know, most of the data points to this.

But some of our work, we've been able to see that there are some differences where for instance in this first box here, in region 5, which is the Great Lakes, we do a lot of our research and stratify by HHS region, the rural urban differences and preventable early deaths, nearly disappeared for heart disease and stroke.

I mean that's a great finding, and it's a complete outlier from what we saw from the other regions. So, what does that tell us? We need to look into that. We need to understand why that happened. Did it really happen, or was that some kind of strange outlier in our data, and what is region 5 doing right? If this was true, if this data you know, was validated, what are they doing that's working so well?

So, we really like to focus on those outliers when we see them. And there's a few other examples here. I won't go through them. Next slide. Now, another thing that's pretty important is we are comparing rural areas to urban areas. That's not always appropriate, right, because the resources in urban areas are very different, access to resources are different, so it's not always fair to compare rural areas to urban settings.

But we do that sometimes, when it's appropriate. This is an example of COVID. This is the nonmetro COVID-19 mortality rate, and we saw when they actually surpassed metro rates. Why is that

important? Because all of our assumptions about rural areas were that they were more protected than our urban areas. Why?

They have space, right? They're not all congregating in these small areas. They're not taking metros together. But we actually saw a different story, so it's important to be able to assess, analyze and understand what's happening. However, next slide please, there are times where we want to compare rural-to-rural, right?

Because we want to understand what's happening in our rural communities. Sometimes it doesn't help us to really compare urban and rural for certain conditions because it's a given that in urban areas the, whatever it is, the health outcome, will be better because we have access to resources, et cetera.

Sometimes, and we're doing this more and more, we want to compare rural areas to other rural areas. We want to know why a rural area in Alabama for example, I'm not picking on Alabama, that's just something that comes to mind, and you know, has a completely different health outcome in a certain condition than a rural community in California, right?

And so, when we start understanding those disparities, understanding what the root causes of those disparities are, we can again localize and target our interventions because what's going to work in a rural community in Alabama, may not work in a rural community in California and vice versa. So to us, comparing rural to rural is very, very important. Next slide.

I'm going to highlight now this is my example of showing why stratifying in those finer categories is so important. Next

slide. So, I mentioned that in 2017 the kickoff at MMWR, which was a surveillance summary, those are actually very extensive reports. They're not the weekly reports that we publish that are about 1,600 words.

These tend to be 3,500 words. They're very dense documents, and so this was published very recently. It's an update. This was May 2024. This was an update to the work that we did in 2017 and in 2019. Next slide. So, I just want to mention what this work is in case you, you know, are interested, and want to learn more about it, but we basically estimate the number of premature deaths, and what we call preventable premature deaths, across the five leading causes of death over time.

And what we call a premature death, and it's you know, referred to differently, and defined differently across the literature for us, and our methodology, it's deaths that were outside of the average U.S. life expectancy. What does that mean? Anybody who died under the age of 79 because we're using the life expectancy of 2010, which is the beginning of our study period.

So, when we look at premature deaths, we're just looking at the deaths occurring among persons aged zero, really 1, to 79. And really we're focusing on the middle ages, okay. Next slide please. And so we estimate, it's a very complex estimation for those who want to know more about it, you can go to the paper.

We collaborate with NCHS on this, and if you know, for those of you who are familiar with NCHS, they're very rigorous in their methods, so I could spend about 20 minutes explaining our methodology, and I don't think you want to hear about that today. But

if you're interested, go to the paper, you can read all about it.

But just at a high level, we actually create benchmarks. We call this a benchmark method, and we compare the United States to itself. So basically, we take the best performing states for each condition, which means the states with the lowest mortality rate for a given condition. We average the mortality rate of those three states, and that becomes our benchmark for all other states.

That means for example, and this is a heart disease example, we know that Minnesota, Colorado and Utah have the lowest mortality rates, you know, across the union, and so what we did is we averaged those three, right, and we said if these three states can achieve this mortality rate, we know it can be achieved in the rest of the states in the United States in theory.

So, we used that benchmark to estimate all the deaths that occurred, or were observed beyond that benchmark. I will caveat this. Some researchers have recently done this from Boston University, and they used the best performing OECD states, so European states. Sorry, is that me? Okay, maybe I got too close.

We're good? Okay. So these scientists used OECD, so European, Australian, the best performing of those states. And when you do that what happens is we look terrible, right? So, we don't take that method. You know, we apply methodology where we compare ourselves to ourselves, because our policies are so different than OECD states, and even across states our policies are so different.

So, we believe this is the most fair way to estimate these preventable, premature deaths. Next slide. So, I mentioned that we have those two high level categories. We have the urban and rural

category. And so, this is what you see when we look at preventable deaths.

Obviously, we've already documented that there are much higher in rural counties. We documented that in 2017, and in 2019. And you can see here across the leading causes what that gap is between rural and urban counties, okay? It's different for each of the conditions that are here.

COVID is not on here, we omitted COVID because it's not one of the historical leading causes of death that we're tracking over time. I will say in 2022 it was the fourth leading cause of death. It still continues to be a leading cause of death, just because I think that's important to note here.

But let's go to the next slide. Now, look at what that looks like when we actually stratify the results by those six county categories. I mean we see a very different picture. I mean look at the gap. Of course the gap is so much wider from the most urban, which is the gold, and the most rural, which is the dark purple.

Okay. Look at that across these conditions. I mean that's scary, right? I mean it tells you a much more dire story than the results before because now we see that the counties that are the most rural have very high, very high preventable premature deaths compared to the most urban counties, or in some cases what we call suburban counties, which is number two, that large central metro and medium, and the suburbs.

Look at CLRD. I mean that is such a huge, huge disparity. Now, the next question is what does this look like by gender and race? Well, we have that information. We're working on it now. We hope

that it will be published in the next six months. It looks so different for each race/ethnic group. It is almost mind blowing when you start, you know, further stratifying the data.

But I did want to point this out and show the value of going further than the metro, non-metro categories that we usually see. Because now we can be more targeted, more specific, we can understand, you know, what counties, what county categories are most at risk, and those that are doing great, or much better, and what are they doing, you know, what access to what type of social determinants do they have?

What is their environment that is allowing them to have such better, more improved, or a smaller number of preventable deaths when compared to other county categories. Next slide. Now, for anybody who is interested in learning more, we have an interactive dashboard. This is where innovation comes in. This is off the government server, so it's actually cool, and it's on Tableau Public.

I think, yes, there's the URL there, but you can actually go state by state, hover over the state. You get additional information for your state. If you hover here, you can see the change from 2010 to 2022, you could see it visually, and if you hover over each of these marks you actually see additional information, and you see the trend.

You can select the cause of death, and you can select a county category, and everything updates, and filters, so you can see what that looks like for your state. We think this is an incredibly helpful tool for HHS, regional administrators, for state public health departments, so that they can look at their data. They can maybe look

at their neighbor's data and see, well, wait a minute, why am I doing, you know, why do my indicators look like this, where my neighbors are perhaps so much better?

What are they doing that maybe I should be doing, that I'm not thinking about. So, a really helpful tool for folks who want to dig into the data. Next slide. And I'm going to conclude with our science priorities, right. We can't do it all, we're five people, so we have a set of priorities, and every year we adjust those priorities, next slide.

So, of course we've been working on the leading causes of death since 2016. We're going to continue doing that. I just mentioned that the next iteration is adding gender and race/ethnicity. That has been incredibly powerful, just because I've done it and I see it.

You know, I can't share it right now because it's not ready for publication, but it is so useful to continue adding important variables that are SCS-related, so we can further understand where the disparities are. For women's health specifically, I have worked in -- the last three years, I have engaged with the Office of Women's Health at OASH, and so we're coordinating and collaborating on many scientific projects, on maternal mortality, maternal and child health, obstetric care facility closures.

We're also working with CMS on looking at CMS Medicaid data, and looking at maternal and child health outcomes using that data. Of course, we are looking at racial and ethnic disparities and health outcomes, especially when we're looking at the leading causes of death.

Something that's very important, and I know we're going to talk about this, is broadband connectivity and telehealth. We can't actually successfully implement telehealth unless we have broadband access in our rural communities, which is yet to happen in a very consistent way.

And of course we are focusing on mental and behavioral health, because there is treatment deserts in our rural communities. And another area we're focusing on is aging. I mentioned Alzheimer's. We're doing some work on dementia, so those are our scientific priorities for 2024, going into 2025. Next slide please.

And the great thing about those priorities is that anyone around the room who may be working on those, who may want to integrate a rural health lens into any of those research priorities. You are welcome to contact us, and we collaborate across the federal government, and with private institutions.

So, what we can offer is our rural health expertise, and connection to SMEs across CDC, across NIH, and across OASH. So please, if you're interested in any of those feel free to contact us. You can learn a lot more of what we do on our website, and if you're interested in any of the results that I shared today, feel free to reach out to me. I know my contact information is somewhere there, and I can point you in the right direction, so thank you very much. I think we'll take questions later?

CHAIR PETTIFORD: Yes, if you don't mind, my friend. Thank you so much.

MS. GARCIA: You're welcome.

CHAIR PETTIFORD: We also happen to have with us two

members from the U.S. Department of Agriculture. We have John Pender. He's joining us virtually. He's the Senior Economist with the Agriculture Research Service there at USDA. And after John, we'll have Chris Proctor, who is the Technical Assistance Branch Chief in the same area. So turning it over to you, John.

MR. PENDER: Thank you, and I'm happy to be here at this important event for this Committee. Yes, I'm a Senior Research Economist with the USDA Economic Research Service. The Economic Research Service, our mission is to anticipate trends in emerging issues in agriculture, through the environment in rural America, and we conduct a high-quality research that's intended to inform public and private decision making.

I was asked to participate in this event, and in this meeting to talk about some of the programs that USDA operates to expand broadband access in rural areas. So, first I wanted to -- let's see, there we go. I wanted to give a little context, and we just heard from Macarena that one of the priorities of CDC is to look at broadband access, and its relationship to health, so broadband access has been, you know, argued to be a super determinant of health.

That means that it can affect the many other factors that are social determinants of health, such as access to education, access to, excuse me, employment opportunities, and access to healthcare. These opportunities, and for use of broadband have been increasingly relevant in the context of the COVID-19 pandemic, we've seen how important broadband has been during the pandemic for access to all of those things.

And, the Department of Health and Human Services has made

increasing the proportion of adults with broadband internet as one of the objectives of the Healthy People 2030 initiative. So, there's definitely I think recognition that broadband is important for health, and many of the problems that we see, or some of the problems that we see may be related to, you know, a digital divide that still exists between many areas and many populations in the country.

So, there's a digital divide between rural and tribal areas, and most urban areas, and then between many demographic groups. So, to address the digital divide, the federal government is investing large amounts of funds to reduce that, and for example, just since the beginning of the pandemic, more than 75 billion dollars in new programs have been authorized.

So, I'm going to discuss some of the USDA programs that are intended to increase broadband access in rural areas, and for a few of those programs the areas and populations serve. This is based on a report that was published last October by Economic Research Services, so let's see.

For some reason it's not responding, here we go. So, on the next slide are you able to see the slides? Hopefully, so this is just providing some of the context on the digital divide. The map on this slide show, this is from the Federal Communications Commission's National Broadband Map, and as of last December, it shows the %age of residences that had access to fixed terrestrial broadband service.

And you can see a large gap between the western, much of the western U.S., particularly more rural and tribal areas, and much to the eastern U.S., the more urban areas. So as of that date 19% of households in non-metro areas, and 17% of households in tribal areas,

whether they were metro or non-metro, were lacking access to their availability to fixed terrestrial broadband service compared to only 4% of households in the metro areas that lacked access.

And then, corresponding to -- still having problems advancing my screen. Here we go. Corresponding to the digital divide in broadband availability, there's also a divide in broadband adoption, so the chart on this slide is showing the difference and the percentages of households in metro and non-metro areas that have a subscription to wired, high-speed internet service.

And now, you can see throughout the last 12 years there's been higher subscription rates in the metro, than in the non-metro areas. And that of course that relates likely to the differences in availability that I talked about that also there are differences in the demographic characteristics of the populations and rural areas that can also contribute to lower subscription rates.

It's well established that broadband subscriptions tend to be lower among people that are less educated, people that have lower incomes, and older populations. And rural populations in general tend to be less educated, having lower incomes and being older, so that also contributes to this divide.

So, corresponding to this digital divide and broadband availability, and adoption, there's also a digital divide in the use of telehealth services, so we see that for example, data from the Center for Medicare and Medicaid Services show the, you know, as we know, the dramatic increase in use of telehealth at the beginning of the pandemic, and then a sudden decline after that.

But throughout that entire period non-metro rural areas

lagged the urban areas in terms of use of telehealth services. So, now I'm going to turn to talking about USDA's rural broadband programs, and I think Chris Proctor is on. He's from –- I'm from the research arm of USDA. Chris is from the rural development missionary work.

They're actually implementing these programs, so he may have more to say, but I'll just give a quick overview of it. Since the early 2000s, USDA has operated five programs that have been intended to expand broadband infrastructure availability in rural areas, that's including the telecommunications infrastructure loans program, which was basically a continuation of the old rural telephone loan program established in the 1940's, and that's also supported broadband since the mid-1990's.

There's rural broadband access loans, which was established in the early 2000s. We also have community connect grants, which were established in the early 2000s. More recently, with the American Recovery and Reinvestment Act, established a very large 2 and a half billion dollar program, called the Broadband Initiatives Program, which provided both grants and loans to promote broadband, and all of those loans and grants were provided, and were approved in 2010.

And those projects were all completed by 2015. And then more recently, the ReConnect Program, which was established as a pilot grant and loan program in 2018, is now the largest USDA broadband program, which has had more than 5 billion dollars appropriated since it was established.

So, there's also the distance learning and telemedicine grant program, which Chris may talk about, which is used -- it's not

expanding broadband infrastructure, but used to finance equipment, facilities and software that are needed for distance learning and telemedicine.

So, this slide just shows on the chart the relative sizes in terms of net obligations, the value of net obligations in million dollars, for each of these programs, the five that I mentioned, over the period from fiscal 2009 through 2021. And so, the Broadband Initiative's Program is represented by these red and blue lines over here from 2010.

That was like I said, a one-time program. Then you had large amounts of loans under the telecommunication infrastructure loans, and then the ReConnect Program coming in, starting in 2019 with grants and loans. The broadband loan programs with the Community Connect are much smaller programs.

So, I think I've gotten ahead of myself here. Okay. So in the report that I mentioned that came out last fall, we mapped these -- we had data from the rural utilities service on the project areas that were served by these programs, at least a few of these programs.

And we overlaid that on census data on where populations are and so on, and so we were able to estimate the populations that were served by some of these programs, at least potentially served, you know, for populations living in the project service area.

So, for a portion of the total population of the U.S. 1.3% of the population in 2010 lived in the service areas of the broadband initiative program. That was that one established back in 2009, and then a higher percentage of course in more rural areas, as that

program was intended to serve more rural areas.

And then across race and ethnic groups, the American Indian and Alaskan Natives, they had the highest percentage of their population living in project service areas, but with over 4%. And then whites, and non-Hispanics had higher percent-ages than other race and ethnic groups, and those percentages are all consistent with the rural focus of the program, the populations of those areas tend to be more white and non-Hispanic, or American Indian and Alaskan Native.

Then turning to the ReConnect Program, which is the more recent, large program that I mentioned, you basically see the same pattern, that it's a much smaller -- so far here, we're looking in this report at just the first two rounds of funding of Reconnect, so those were grants and loans that were approved in fiscal 2019 to 2021.

And they reached the population in the areas of those project service areas that were approved was 1.3% of the total U.S. population, so about one-tenth the size of the Broadband Initiative's Program in terms of population served.

But you have the same pattern of more rural areas being, you know, having a higher percentage being served, and then also a higher percentage of American Indian and Alaska Natives, whites and non-Hispanics compared to other race and ethnic groups.

The next slide shows some of the characteristics, so using American community survey data we are able to estimate some of the socioeconomic demographic characteristics of those populations that were served compared to non-served areas. And so, for the Broadband Initiatives Program on the chart on the left, you see that the population outside of the project service areas tended to have higher

education, so the percentage was less than high school, or less education was higher in the Broadband Initiative Program areas.

And the percentage of households in poverty, or people in poverty, and the percentage 65 or older, tended to be higher also in those service areas. For the ReConnect Program it's a similar pattern. We had more data. We had data not only on the populations in approved areas, but also areas that were eligible, and then also areas that had an application, but did not get approval, and we compared them to ineligible areas.

But you see a similar pattern at the areas served either eligible, or served by the ReConnect Program tended to be less educated, in terms of having a higher percentage with, you know, a high school or less education, more higher levels of poverty, and higher levels of the share of the population, age 65 or older.

So, just to summarize, let me get to the last slide. Addressing the digital divide may be important for health outcomes. There are several USDA programs that have sought to address the digital divide. Two of those programs, the relative, the largest programs, the Broadband Initiatives Program and ReConnect, those were the largest ones, and the big projects reached about 10 times as many people as the first two rounds of Reconnect.

Both programs are sort of rural areas to a greater extend, and American Indians, Alaska Natives, whites and non-Hispanics more than other race and ethnic groups, and both programs have served populations that were less educated, or older on average than populations in unserved areas, in the case of BIP or ineligible areas in the case of ReConnect.

So, if you would like more information, most of the information in this presentation is drawn from an ERS research report that came out last October, and then just also for your awareness, given this group's interest, there is a recent report by Kelsey Thomas and others.

It came out in March on the nature of the rural or the mortality deaths, so if you're not aware of that you might be interested in that as well. Thank you.

CHAIR PETTIFORD: Thank you so much, John. We're going to now switch to Chris, if you could hold that we'll get questions at the end.

MR. PROCTOR: Good afternoon everyone. Thank you all for having me. My name is Chris Proctor. I serve as the Technical Assistance Branch Chief at the USDA. We're a utility service telecommunications program. John mentioned we're the side of the USDA house that administers the broadband and telecommunications programs, and so I'll be talking a little bit about that during my presentation.

And I realize we might go over our time, so bear with me. I'll try and get through the slides as quickly as I can, while giving you all the important information that I think you're interested in. Next slide please.

So at USDA Rural Development, our mission is to improve the economy and quality of life in rural America, and we do this through three different agencies, the Rural Business Cooperative Service, which is focused on developing small business in rural communities.

We have the Rural Housing Service, which is focused on providing rural residents with safe and affordable housing, and then

our team, the Rural Utilities Service, which is focused on really three areas, water, electric and telecommunication. Next slide.

So, as I mentioned, RUS has a focus on water, electric and telecommunications. We're really the infrastructure arm of USDA rural development. And I really want to drill down on the telecommunications program, which is our focus within RUS Telecom. And our mission really is to provide all rural Americans with access to affordable, reliable, high-speed internet.

And so, through our various programs we're looking to fund the construction, expansion, and upgrade of broadband infrastructure. And we also have a small program that focuses on increasing access to distance learning and telehealth opportunities. Our focus is solely on rural areas, so those are areas with a population of 20,000 or less.

Our different programs, we get a different flavor of broadband programs. We offer loans under some programs, 100% grants under some programs, and loan grant combinations under different programs. For the most part across our programs, they're open to any entity type, as long as you're not an individual, or a partnership, then you're eligible to apply.

We ask that one organization be the main applicant or awardee, and be responsible for any of the requirements that come alongside of getting an award. And as I said, we exclusively focus on serving rural communities, and tribal communities as well.

So, John actually shared a list of our programs. I won't go through each one, but I will focus on the Distance Learning and Telemedicine Grant Program, particularly on the telemedicine side.

I'll spend a minute talking about the ReConnect Program, since that is our flagship broadband program.

The programs listed following ReConnect, Community Connect, it's our very small broadband grant program. We fund broadband networks that range from 3 to 5 million dollars under that program. For ReConnect, we can go up to 25 or 30 million dollars, so that's for more I would say sophisticated organizations that can deploy an infrastructure project of that scale.

Our Broadband Technical Assistance Program is for communities, or internet service providers that need some planning assistance before they're ready to deploy a broadband network. And then the final two programs, the Infrastructure Loan Program, and the Rural Broadband Program, those are some of our longstanding broadband loan programs.

Across our telecom programs we do have substantially underserved trust areas provisions. We call it SUTA. Essentially if you are a tribal area, then there are certain special conditions that we can provide, so if a tribe were to come in for a loan, we can provide an interest rate as low as 2%. We can waive certain program requirements. We can also provide priority for funding those projects.

So, I think it's important to call that out if there are any folks in the room that work with tribal stakeholders, or if you know of any of them that would be interested in applying for the RUS telecom programs. So, in additional to our distance learning and telemedicine grant program, we call it the DLT Program. I think John mentioned this, but our focus under this program is on equipment.

And equipment that is necessary to deliver telemedicine, or distance learning curriculums. We do typically have a match requirement under this program. 15% cash match, or in-kind match. I mentioned that our programs are typically open to any entity as long as you're not an individual, or a partnership.

I will say DLT is an exception here because we do allow Consortia. We do have a very small portion of this program that can fund broadband infrastructure deployment, but it can only be up to 20% of the grant amount.

I've talked enough about those that are eligible to apply, so I'm going to skip past this slide. I'm also going to skip past distance learning, so I can talk a little bit more about telemedicine. So, the way that we define telemedicine within the RUS Telecom Program, is a telecommunications connection to an end user through the use of eligible equipment, which electronically links medical professionals at separate sites in order to exchange healthcare information and audio/video graphics.

Really the key here is that we're looking at creating that connection between rural residents, and healthcare providers, whether they're in an urban area, or another rural area, as long as we can try and reduce the time needed for travel, and improve access to care that wouldn't otherwise be available in that rural area, that’s the focus of our telemedicine projects.

So, really what we looked for is just ensuring that a rural resident, or a rural residents at the end of the day are benefitting from the telemedicine projects that we're financing. Here we have a few eligible grant purposes. We do look at your application to ensure

that under your project you're looking to acquire, buy, lease, or purpose eligible equipment.

We're also looking at another potential eligible grant purpose, which is acquiring instructional programming that is a capital asset. You can even use grant funds to provide technical assistance and instruction for the equipment, or the software that you're purchasing through the grant.

And that's limited to 10% of the grant amount. Here we have a few more concrete examples of equipment that can be financed under the DLT program. We finance computers, computer software, telemedical devices, audio/visual equipment like speakers, cameras, monitors, inside wiring, and rarely do we do broadband facilities, but we do allow for broadband facility deployment under this program.

We looked to ensure that every line item in the grant is the product, or the prominent purpose of that line item does go towards either distance learning or telemedicine. There are a few ineligible grant purposes I'd like to flag under the program. Grant funds cannot be used for any equipment that is not related to delivering telehealth or distance learning.

We cannot fund electronic medical record systems, salaries, operating expenses, preparation costs, and this is not a construction program, so no construction activities, like purchasing land or buildings. I did mention the matching requirement of 15%. This can be a cash or in-kind match. Typically, we do not allow federal funds to be used as a match.

There are some instances where we will allow it if that federal program statute allows for those funds to be used. As a

match, I think one that comes to mind for me is Appalachian Regional Commission, and some of those smaller federal agencies. Typically, they do allow their funds to be used as a match for another federal program.

If you're interested in learning more about the DLT Program, we've got a great website that has fact sheets, FAQs, application guides. We also have project examples, so you can see every project we funded since 2010. You can read about the type of projects that RUS Telecom has funded.

And next, I just want to talk very briefly about the ReConnect Program, which is our flagship broadband deployment program. Since 2018 we've invested over 5 billion dollars through the ReConnect Program. The various projects that have been funded are in different stages of buildout, but we've made significant investments in high-speed internet through this program.

The purpose of the program is to construct or expand broadband service in rural communities with a population of 20,000 or less. Typically, at least 90% of households must lack access to broadband. That threshold can change year by year, depending on our appropriation from Congress. We have a very flexible different types of funding under this program, so applicants can come in for a direct loan, which is set at a 2% interest rate.

They can come in for a 100% grant. In some cases there's no matching requirement for that grant if they're serving persistent poverty counties, or socially vulnerable communities, or tribal communities. And then we also offer a loan grant combination.

If you are interested in learning more about the ReConnect

Program, we've got a lot of great resources on the ReConnect website. I mentioned FAQs, fact sheets, application guides, webinar recordings, instructional videos. We've really got everything you can ask for on our ReConnect website, under Forms and Resources.

One of the great things about the RUS Telecom Program, and all of rural development, is that we're a field-based agency, so we have over 400 offices across the country, so it doesn't matter if you are in Alaska, or Puerto Rico, or North Dakota, or Ohio. We've got a USDA employee near you that you can connect with.

If you're interested specifically in telecom, we have a general field representative. Our GFR served usually between three and four states, and if you're interested in applying for a program, or learning more about a specific program, I would highly encourage you to reach out to your Telecom GFR, and you could find the GFR for your state using the link that we have here on this slide.

So, I know I went through that really quickly. I'll be happy to share my email if folks have any additional questions, but with that I will turn it back to our moderator.

CHAIR PETTIFORD: Thank you so much, Chris. And we want to thank all of you for your time and the great updates that you provided. We'll take time for one question, and then everyone else you need to put it in the chat, and we'll get Chris and John and Macarena's contact information as well.

The questions are standing between now and break, so I see where we're going. Again, thank you all so very much. Again, we'll drop them in a chat, and get in touch with you if we have questions, so thanks for your time this afternoon. Okay. We are going to

take -- oh, a question did come up.

Obviously, I can't see you, Jacob, so yes?

MR. J. WARREN: Now that you said I was standing between everybody and break, so I thought maybe I shouldn't.

CHAIR PETTIFORD: I know you put your hand down really fast, didn't you.

MR. J. WARREN: I have a question for Macarena, and this might be one that we can connect about offline, and Kate probably knows what I'm about to ask. But as a rural equity researcher, data suppression is like the bane of my existence, and it's just a major factor as we try to look at our outcomes, particularly in maternal and child health because once we start trying to disaggregate at rural stratifications, just the data are always suppressed.

And, I didn't know if your office had given any consideration to how we can have innovative ways of accessing data that is historically suppressed because it affects so much of the work that we do in rural. It might be something that we can connect about offline as well, but it's a major limiting factor for us to be able to really look at racial disparities in rural areas.

MS. GARCIA: Yes. That is actually the bane our existence as well, and we work with NCHS to generate what I would call aggregated results for some of those, so you know suppression starts at anything below 10. And so for rural counties, that's really, really challenging.

So, we are brainstorming at all times about how to deal with that. Of course every data aspect is different. You mentioned maternal mortality, that's like one of our biggest nightmares because

the data suppression is just so, so vast. So again, that's where we work with our DRH colleagues to troubleshoot, think outside of the box. With the MVSS data, it's a little bit better.

We can aggregate a bit, but again when we're looking at county level data, there's so much suppression that it really makes our analysis meaningless many times, so I would love to put together like a think group on this because we are constantly thinking about ways to address this.

So, Jacob, would you like to join our think group? Our think group, think tank, thought leaders on this, you know, we would very much welcome you to do that.

MR. J. WARREN: I would love to, thanks so much.

CHAIR PETTIFORD: Thank you, Jacob, for your question. Okay. We're going to now try to take a five minute break. Our next speaker is already here, so a quick five minute break, and if everyone can come back at 3:07. Thanks.

Preconception/Interconception Health Focus: Upstream USA

CHAIR PETTIFORD: We are back right at that time, see. Okay. We are pleased to have with us Emily Eckert today. She is with Upstream USA. And Emily's conversational updates with us today are connected to the work of our preconception and interconception health workgroup, so turning it over to Emily.

MS. ECKERT: Thank you so much, I'm a little tall, so everyone can hear me right? I'm on one foot, so I'm closer to the microphone. Thanks for having me today. As mentioned, I'm Emily Eckert. I use she/her pronouns. I am the Associate Director of Federal Policy with Upstream USA.

Many thanks to the Committee for all your work, and for the invitation to speak with you all today. I had an opportunity to connect a couple months back with Joy and Phyllis from the Committee, and there seem to be sort of broad interest in Upstream, and what we sort of the primary function of our organization, but also sort of a secondary function of the organization, which is the work that I lead in the federal policy and advocacy space.

So, I'm going to try to talk through both of those things at a high level today, but hopefully, also save some time for questions, and I know we're a little bit behind on time, so I'll try not to talk at you all too, too much. So, I'm going to start at just quickly doing a little bit of a level set on what contraceptive access looks like across the country today, next slide. Yeah you can skip ahead of that one. Here we go, thank you.

So we know this is data from our colleagues at Power to Decide, that roughly 19 million women of reproductive age in the United States today live in what is called a contraceptive desert, and this means that women who -- it references women who live in a county where the number of healthcare providers offering the full range of contraceptive options is not enough to meet the needs of women who are eligible for publicly funded contraception.

For reference, this represents more than one quarter of all women of reproductive age in the United States, and beyond the sort of general figure of 19 million, we also know that just over one million, about 1.2 million women in need of publicly funded family planning services actually live in a county without a single healthcare provider who can offer them the full range of methods.

So as you can see, this is really a major problem, and I want to draw the connection for you all to maternal health as well, so next slide please.

I'm sure this is pretty intuitive for most of the folks in the room, but in the interest of the general members of the public who might be listening in, I'll just talk through this a little bit. So, the Centers for Disease Control and Prevention consider contraception to be one of our nation's ten greatest public health achievements of the 20th century alongside other things, like motor vehicle safety, and fluoridation of drinking water and other policy initiatives.

And the principle reason for this is really because of the health, social and economic benefits of using contraception. At its most basic level, right, contraception can help people determine if and when to build their families. Having access to contraception helps people optimize their health before experiencing pregnancy, and it can also support healthy birth spacing, which we know has better outcomes for both mom and baby.

We also know that contraception can help reduce the risk of certain reproductive cancers, which may have a downstream impact on fertility, and we know that contraception can help individuals achieve their personal goals say around an education career, or economic earnings.

And beyond these sort of what I would consider fundamental connections between contraceptive access and maternal health, there's also a point to be made about the workforce connection.

I would say particularly in this landscape we find ourselves in now, you know, freshly two years off of the Supreme

Court's decision to overturn Roe v. Wade, you know, there's such an overlap between the abortion workforce, abortion care workforce, the contraceptive care workforce, and the maternal health workforce, right?

By and large a lot of folks get their contraceptive care from an OB/GYN, and so in states and communities where abortion may be severely limited or restricted, you know, providers are leaving, and that has implications not only for abortion care, but also contraceptive care and maternal healthcare as well. Next slide please.

So, I'll pivot now to talk a little bit about Upstream, and we actually exist to kind of help with some of those workforce issues, right, so we are a nonprofit organization whose mission to ensure that equitable patient centered contraceptive care is basic healthcare.

We essentially exist to just make sure that people have options to do just that, right, plan their families if and when they want to plan them. We were founded about ten years ago. We are a national organization, so I'm here in the D.C. area, but we have staff members really all across the country.

And again, to achieve our mission, to basically make sure that contraceptive care is accessible for folks, the primary way in which we do that is by actually going into clinical practice settings, and helping them develop and sustain the infrastructure that is needed to offer these services.

We work with a broad range of partners. I'll go into some more of our sort of data in a little bit, but we have a unique and special interest in really building up the primary care workforce to

be able to offer contraceptive care, and over the years we've really found that sort of our sweet spot, our partners that we sort of we're a well-oiled machine at this point in terms of delivering our training in our program.

It's with Federally Qualified Health Centers, or FQHCs. The primary ways that we implement our training and technical assistance are through what we call eight core competencies, which are essentially all the tools that you need to be able to offer this high-quality care. So that includes things like training around billing and coding, so that providers know how to be properly reimbursed for the services that they're providing.

It includes a lot of training, and systems work on the EHR integration to make sure that the appropriate fields are being populated in your EHR, and built into your work flow to sort of prompt providers to create the space for contraceptive conversations.

And a foundational piece of the training in TA that I really want to make sure that I highlight is really around you know the history of reproductive coercion in this country, and ways that providers can meaningfully mitigate against any biases or, you know, other assumptions that they might intuitively make about different patients.

So, the overall training program is really built on the frameworks of reproductive justice, and we have a foundations course that every member of a care team that we work with, from the, you know, from the front desk staff scheduling appointments, all the way up to the clinicians right, who might be prescribing, or administering certain methods, go through a foundations course that really talks

about that history, and the harm that it has caused, and how, you know, it's up to them as a care provider to help move away from that. Next slide please.

So, a lot of the core of the work that we do, I kind of mentioned is built around this work flow, so this is just a graphic representation of the components that you need for a basic contraceptive care workflow.

The CDC Office of Population Affairs, the American College of Obstetricians and Gynecologists, all recognize the importance of reproductive need, or contraceptive need screening as a foundational element, so there's a range of screening approaches out in the field, but it's essentially asking a question, right, are you interested in talking about contraception today, something to that effect.

Depending on the answer to that question right, you might move to the next stage of the process, which is more around patient education and counseling, and then you move to, you know, management of contraception, if in fact the patient wants to leave with a method that day, or a prescription, whatever the patient dictates.

Next slide. Another key component of our work is using data for quality improvement, so we have a variety of tools that we use, including a patient survey, which is modeled very closely off of work from Christine Delanor from her colleagues at UCSF around the person-centered contraception counseling measure, which essentially asks patients about the quality of care that they receive, if they felt that they made an independent decision, things like that.

We also look at data in the electronic health record, which is why some of that EHR work is so foundational, so we can help health

centers look at their own data, see how often screenings are taking place, track method provision data, and then we also do a pre- and post-training evaluation survey, that actually looks at the impacts of the programs, or the jumps in knowledge scores, or things like that of the physicians and clinicians that we train.

Next slide. This one is kind of busy, but this is just sort of a visual representation of some of those survey and other data monitoring tools that we use. On the far left you can see, you know, the average knowledge score, pre and post for clinicians and care staff after going through the training.

And then this is an example of one health center's reproductive need screening data from the EHR, that you know, as you can see was 0%, prior to the Upstream training, and then we saw significant increases after they were trained on how to do screening, built it into their EHR, et cetera. Next slide.

So Upstream started as sort of more of a state-based initiative. I know Belinda worked with Upstream when they started work, when we started work in North Carolina several years ago, but to date, or now our approach is really working on sort of nationwide impact, so we're very open to working with healthcare providers that want our training and our support.

To date we've worked with over 130 clinic practice settings across 19 states. We've trained over 4,300 healthcare providers on how to integrate patient centered, high quality patient centered contraceptive care into their practices, and we've partnered or are currently partnering with practices that reach about 700,000 patients of reproductive age, female patients of reproductive age.

Next slide. Okay. There's probably questions about Upstream and our program work, but I'm going to keep us moving, and talk a little bit about some of our policy work, and hopefully generate some ideas for you all, as you look to your next report to the Secretary.

But I'll clarify first that Upstream is really a program-first organization, so all the work that I just went over, I don't do that day to day work with health centers, but the work that I do in the policy arena, is really in service to, or meant to compliment the work that we do with health centers, so you'll probably see some of that reflected in what I go into next. The next slide.

So, I've put a lot on my next two slides. It's hard for me to pick and choose what might be most relevant for you all, but my instruction again from Joy and Phyllis was all of HHS, go broad, just bring us your ideas.

So I put little stars next to the few that I will talk about in more detail, but if there are specific questions about any of the other content across these two slides, I'm looking forward to the Q and A, but also please feel free to connect with me afterwards as well.

So, I want to start with one or two suggestions for the Bureau of Primary Healthcare under HRSA, so Upstream, you know, has a lot of contact with HRSA, right, because of our vested interest in working with FQHCs.

And we are sort of coming off of a really exciting policy change that the Bureau of Primary Healthcare put in place through the uniform data system, which is the annual report that federally

qualified health centers have to submit to HRSA, that captures patients' demographic information, the types of services being provided, et cetera.

And so, beginning in 2024, so the reporting period will be in February of 2025, but all FQHCs that submit data through UDS will be asked to report on the number of patients who are screened annually for their family planning needs.

So, you might be aware that under Section 330, federally qualified health centers are required to provide family planning services, voluntary family planning services. There's really no definition of those services, and we know that sort of the quality and also the sort of scope, in terms of how many methods you might be able to offer really ranges across FQHCs and across the country.

So, we're hopeful that this data, this sort of new prompt and new UDS, how many patients are you screening, will just provide a little bit more insight into the real scope of services that's available at FQHCs, but we know that a lot of FQHCs are going to kind of be starting from zero, right?

They may not be very familiar with the screening approaches that are out there, so such as the self-identified need for contraception and other tools, and so our next task at HRSA, since they have put this data element in UDS is to really provide some support to health centers, so that they can you know really figure out their approach, how to implement screeners.

How to report it into UDS, et cetera. And then sort of related to that I also wanted to highlight that the Bureau of Primary Healthcare Funds, a series, I think there's 14 or so, NTTAPs, National

Training and Technical Assistance Partners, on a variety of topics.

There's one around I believe, you know, HIV. There's one around homeless populations. And by and large those are probably exclusively, they're non-government entities that are sort of recognized as a validated training and technical systems partner for federally qualified health centers. There is not currently one related to family planning, and so you know, Upstream would love to see that created.

That way FQHCs, you know, can sort of have a go-to partner, or a series of partners, folks to go to, to get support on their work on family planning. Next slide, and I'm going to skip over all those other wonderful ideas for you all to consider. CMS, I know Kristin is in the room, she's heard about this ask from me before.

The Centers for Medicare and Medicaid Services, in particular the Centers for Medicaid and Chip Services, did a lot of work on quality measured development testing, and obviously they have core measure sets that Medicaid programs, you know, report into, or report up to.

The measures that currently exist in the Medicaid and Chip core sets are around method use, summarized often as like most or moderately effective method in a LARC method. LARC is a long acting, reversible contraceptive. Those measures, while important, and you know, more useful at sort of the population level, or if you're looking across state Medicaid programs at that level, they aren't particularly useful for quality improvement at the health center level, right because you might see, you know, say you see an uptick in LARC provision at your health center.

What does that really mean if you're not coupling it with a patient experience survey? You don't know did people really want those methods? Do we have a provider on staff who maybe is, you know, coercively offering those methods? The figure itself doesn't really tell you too, too much.

So, Upstream and others in the field are interested in a wider range of quality measures that don't just look at the outcome right, of method use, but things more around maybe screening, or around patient experience. And so, we would love to see CMS put together some sort of initiative where they're bringing states to the table to really test some of these things out, and figure out how they might work, and be reportable at a state Medicaid agency level.

And then lastly, I hope I'm saving times for questions, I want to highlight one policy from the Office of the National Coordinator for Health IT, or ONC, or ONC. I say ONC, which is very live right now, so in the last couple of weeks ONC released a maternal health dataset through the United States Core Data for Interoperability, USCDI+.

It's not core USCDI, but USCDI+ at that basically is a government tool to uplift, or lift up different data elements for EHR vendors to consider including in their products. So, this is a dataset that's mainly focused on maternal health, but appropriately so, includes some various elements, data elements, around contraceptive care as well.

So, that includes two data elements around family planning screening, the self-identified need for contraception, which is one screening tool, and also a pregnancy intention question, which is

another screening tool. And then it also includes a data element around contraceptive counseling.

So, this is very live right now. Public comments are due at the end of July. But that, you know, wouldn't really change the game for what EHR vendors are required to include in their products, but it's sort of a stepping stone to get there. So going from USCDI+ maternal health data set to one day being built into the USCDI core, then all the electronic healthcare vendors across the country would be required to have those data elements in their products.

So, it would make sort of the take training and technical assistance that Upstream does with each individual health center around EHR integration. It would sort of make that easier, right because it would already be built across EHR programs. That's all I decided to highlight for you all. Again, happy to take any questions either about Upstream, or about our policy work, and again, just thank you for the invitation to speak to you today.

CHAIR PETTIFORD: Thank you, Emily. And thank you for your patience with our time. Do we have any questions from anyone? Looking virtually. Anyone in the room?

DR. ZLATNIK: I put a question in the chat, which --

CHAIR PETTIFORD: Okay. Do you want to come up and ask your question?

DR. ZLATNIK: Sure. And maybe it's more of a statement, but for the data measures, I would encourage a really broad denominator to catch potentially, you know, able to get pregnant people since I think some of the highest risk pregnancies are those unintended pregnancies in people who either don't think that they can

get pregnant, or maybe their providers don't realize could get pregnant, so this could include people with bad cardiac disease, or poorly controlled diabetes, that had been told at some point you shouldn't get pregnant.

But what they hear is you can't get pregnant, or that you're not fertile, or people who are, you know, at the extreme ends of the age distribution of pregnancy, or a chronic disease, et cetera. Thank you.

CHAIR PETTIFORD: Thank you for that. Thank you, and Marie, I see your question. Is there a way to have vasectomies covered at federally qualified health centers for family planning? I'm thinking that's not your question.

DR. ZLATNIK: You know I'd honestly have to look into the answer of that question.

CHAIR PETTIFORD: And I was looking at Kristen I think.

DR. RAMAS: Yeah. Just to add some further commentary to that, often times in health centers, so excuse me, tubal ligations are covered, which is an invasive surgical procedure, and that could be covered under family planning in some regards.

But vasectomies typically, to my knowledge, have historically not been covered, and so when we're thinking about reducing barriers to getting longer-term family planning options, I would think that an outpatient procedure that takes 30 minutes, would not only be more cost effective, but would also help on many levels with unwanted pregnancies.

And it would reduce morbidity/mortality, so that's something I think is an area of opportunity, particularly with our

Black and brown populations that if it's not covered, then you know, how can we have that encouraged, so that those who are contributing sperm can also participate with family planning in a proactive way, and you know, leverage being responsible as the counterpart in those relationships.

So, I'd be curious to know if that is something that's covered, or you know, dependent on location because I do think that's an area of opportunity.

CHAIR PETTIFORD: Thank you, Marie. Allison, is your question connected to that, otherwise I'm going to go to Sherri first.

MS. CERNICH: It is actually connected because the other question that comes to mind is for NIH's portfolio we actually have multiple male contraceptives that are not condoms, so they are either pharmaceuticals, gels, long-actings, on demand, and I actually don't know if the code would cover it for -- I don't know actually. The contraception code for a man. So, it's a question.

MS. RAMAS: In my you know, N-of-1, that has historically not been the case.

MS. CERNICH: And that's what I'm wondering, is it that may be another place that as we start getting products in development, that may be something to talk about.

DR. ALDERMAN: Right, and it probably differs state to state on whether the male is eligible for Medicaid coverage in general, not necessarily just under a family planning demonstration.

CHAIR PETTIFORD: Thank you. Sherri?

DR. ALDERMAN: Thank you very much for that very interesting topic of conversation. Looking at data collection, you

know, I recognize the value of that, and how powerful that can be. I also am not a part of the direct conversations, but through my association with the American Academy of Pediatrics, and in my own state, Oregon, it's become a really hot topic in this current climate about adolescent confidentiality.

And so, while data are so important, I think it's also really important to consider the populations that we would be collecting data on, and how that would be handled.

MS. ECKERT : 1,000%, and just for your all's edification too, as part of our advocacy to the Office of National Coordinator around sort of that data piece, right, and what is able to be captured in the electronic health record, the overarching method that we've communicated to them alongside those asks, is around data, privacy, and standards for patient privacy and protection, so you're all probably aware that, maybe two or so months ago, a new final rule was released strengthening some of those data safeguards.

But of course, that was a regulatory decision by the Biden administration. A future administration could potentially do some harmful things, right, depending on what data is actually available, so it's definitely top of mind for us. Thank you for raising that.

CHAIR PETTIFORD: Thank you, and our last question, Kristen?

MS. ZYCHERMAN: I just wanted to echo what was said before about the denominator and excluded population because like for example, PCCC excludes pregnant people, and like that's when we should be talking to people about their contraception, not when they're like throwing a baby on their chest. It should be during pregnancy, what

are you going to use after pregnancy. So, I think that's an important consideration.

CHAIR PETTIFORD: Thank you so much. I appreciate you being here, Emily.

MS. ECKERT: Thanks.

Public Comment

CHAIR PETTIFORD: Now, we're going to switch into our public comment period, so I'm turning it over to Vanessa.

MS. LEE: Thank you, and just for the new members, at every Committee meeting we do hold space for public comments. People, members of the public can request to submit comments to the Committee in writing, or orally during their registration process.

If they miss that, they can always send an email to our email box, that's sacim@hrsa.gov. We do have five people who did register to provide oral comments, three who have joined us in person. We're so excited to see you here, so we're going to call you in order of the request received.

And then we have two overflow people that want to make comments that we're going to take at 4:15, so we've talked with the Chair, and just want to allow enough time. So, we're going to start with Tiffany Garner from Futures Without Violence, and we've allowed up to three minutes for each public commenter.

Thank you, Tiffany, and while she's making her way to the mic, I did want to register, remind the Committee we did not receive any public comment in writing, but if we did they would go in your briefing book, or we'd give it to you if it came in late after the briefing book was published. And this is being recorded, thank you.

It's the whole meeting, so this is again public comments for the record that will go on our website as part of the recording and transcript.

MS. GARNER: I'm ready, okay. Wonderful, and good afternoon everyone. It's great to be with you all today, and I will make sure I'm hitting some highlights from our public comments, I'll probably submit the written portion, to make sure everything is covered, so just a few things.

First of all, my name is Tiffany Garner. I work with Futures Without Violence, and I serve as the Child and Health Policy Advocate. And we're grateful just being a part of Futures, we're grateful for the opportunity to provide these public comments for the Committee here.

We are a national nonprofit that has worked for more than 35 years to prevent violence against women and children in the United States. We do a lot of education around the elimination of domestic violence, sexual assault, child abuse, and human trafficking through education and prevention campaigns, as well as TTA, training technical assistance, to lots of institutions, colleges, universities.

Court systems, we do a lot of training around Judges, and we also do a lot of promising policy work at the state and federal level. We have worked for many years to improve maternal health, addressing the intersection of maternal health and domestic and sexual violence, including the alarming rates of homicide involving pregnant and postpartum women within this country.

We're home to the National Health Resource Center on Domestic Violence for more than two decades, and we have supported

healthcare professionals, domestic and sexual violence experts, survivors and policy makers as they work to improve healthcare systems responsible to domestic violence and sexual assault.

We appreciate, as I mentioned, this opportunity that you all are working to enhance Black maternal health, improving rural health access, and preconception and interconception health. A couple things I just wanted to highlight for you all today is as I've mentioned, our work around domestic violence.

We are seeing firsthand the importance of addressing intimate partner violence when it comes to a lot of the statistics, and a lot of the work, because we do see it is a driver of mortality in pregnant, postpartum women and infants. And we call attention to this, because it's oftentimes a barrier for a lot of our survivors, and their families to seek care.

Intimate partner violence is abuse or aggression that occurs in romantic relationships, and can include physical violence, sexual violence, stalking, financial abuse, psychological aggressions, and other forms of coercive behaviors. In addition to offering some strong support for comprehensive services that we would definitely lift up to our healthcare providers, we suggest more attention needs to be given to address this intersection of intimate partner violence, and prenatal and postpartum support.

I will submit in the record some of the stats, but just to highlight a couple here for you all. Pregnant people are more likely to be murdered during pregnancy, and immediately in postpartum than they are to die from a lot of other disorders, physical disorders that we were discussing today.

We just know that it's missing in some of the research, the role that intimate partner violence is playing. And also, pregnancies associated with significantly higher homicide in the Black population, and among girls and younger women 10 to ages 24.

We also would like to just call attention also to address the role of reproductive coercion, and how it poses a critical concern within relationships, especially since the Advisory Committee is considering preconception and interconception health. Reproductive coercion is associated with both unintended pregnancy, and undesired pregnancies, violence, limits people's ability to optimize their health overall, and their reproductive and sexual help uniquely.

And it is a form of abuse that includes using threats to promote pregnancy, and active manipulation of condoms and hormonal contraception, to promote pregnancy such as breaking condoms on purpose, flushing birth control pills down the toilet, et cetera.

This can occur in both IPV relationships where there's physical, and sexual IPV, if absent or present. We would also like to call briefly, I know my time limit is coming, but I want to also just lift up the intersection of intimate partner violence, racism, and mortality among birthing people.

It is one of the least explored, and under-resourced topics, approximately 45% of Black women experience physical violence, sexual violence, and stalking from an intimate partner, which is significantly higher than the national average of intimate partner violence experienced by women of all races.

This ongoing maternal health crisis, which again, disproportionately impacts Black women, requires sustainable funding,

policies and resources, and support for Black birthing survivors. A couple recommendations I would like to submit to you all is we definitely want to lift up the important role of quality care.

From our perspective, that looks like care for pregnant and postpartum individuals, which is holistic trauma-informed, culturally sensitive approach to improving health, wellness and safety for the adult and the child involved. It should be affordable and accessible.

We also would love you all to look at addressing the health needs of children exposed to violence, infants and children exposed to intimate partner violence can experience a range of problems that persist into adulthood. These risks could occur and interact with structural factors, such as housing instability, food insecurity, poverty and other childhood adverse experiences.

We also recommend and suggest us look into the role of training healthcare providers on evidence-based interventions to address intimate partner violence, such as CUEES model which stands, the acronym is confidentiality, universal education and empowerment and support, which is a model that is used by many healthcare providers to provide warm referrals, and assessing safety, when it comes to interacting with intimate partner violence, so that they can disclose within a comforting environment and seek a resource by a domestic violence advocate, to continue to further their safety, and address their resources and needs.

And then lastly, you just lift up the importance of partnerships and warm referrals as I've mentioned, how important it is for healthcare providers to already engage with advocates in the community who can further assist patients, who are experiencing

intimate partner violence, and care for their child because infant mental health is an important thing for us too as we know that a lot of our young babies are born into relationships where there is intense violence.

And as we know, as they're forming, brain development, all those factors, play into how well that child will turn out. So anyway, I just want to say again, thank you for the opportunity. We definitely look forward to hopefully doing some more work with you all, and sharing some information about what we can do.

As Futures to support, you all need to examine this important conversation, important topic, so thank you so much.

MS. LEE: Thank you. Thank you so much, Tiffany. The next public commenter that registered was Michelle Drew, Ubuntu Black Family Wellness Collective, I apologize if I mispronounced that.

DR. DREW: Good afternoon. As she just stated, thank you very much. My name is Michelle Drew. My pronouns are she/her. I am the Executive and Clinical Director of an elegant little demonstration project and community-based organization called Ubuntu Black Family Wellness Collective.

We are located in Delaware, and specifically what Ubuntu is, is a community-based safety net and easy access reproductive health clinic, where we provide the full range of all reproductive health services, primarily in the zip code and the census tract that has the highest rates of maternal and infant mortality throughout the state.

And I'll also disclose that I am the Chair of the Caucus of Black Midwives for the American College of Nurse Midwives. So, I'm

really thankful to be able to have been here today, and hear what's happening, you know, first person with the workplace.

And this may already be well known information, but to put it into context, that the United States and Canada are the only two countries in the world, the developed countries, where there are more OB/GYNs than midwives, and they're the only two countries where midwives are not considered the primary caregiver of people capable of pregnancy, not only during their pregnancies, but before, during and after.

And they are the two developed countries with the highest rates of infant and maternal mortality. So, the system isn't working. So, as we're thinking about how to replicate it, and how to fix the workforce, things that's really an important figure to put into context.

You know, by contrast, the country that has the lowest ratio of midwives per 1,000 live births in Europe is the Netherlands, and that rate is 25. Australia, Sweden, and basically every other wealthy nation it's above that, and in Australia, and Sweden specifically, it's almost 70 per midwife.

And that also translates into, you know, changes in your maternal mortality/morbidity because we do know that two of the most contributory factors to maternal mortality and morbidity right, and us not dying shouldn't be the ceiling.

It shouldn't even be the sub-basement. We should be able to thrive, but Cesarian sections lead to bleeding, bleeding leads to hemorrhage, surgery has a risk of infection. And so, when you consider hemorrhage and infection, and complications of anemia, and

just how important hemoglobin is to the body.

You know, if we can reduce our Cesarian rate, we can also reduce the maternal mortality and morbidity rate. Currently, the Cesarian rate in the United States is 32%, significantly three times higher than what the World Health Organization considers to be an acceptable rate of around 10. We know at less than 10% C-section rate, we start to see higher rates of fetal demises.

And as you see Cesarian rates above 15%, you start to see higher rates of maternal mortality and morbidity. And, of course none of this can be talked about in the United States, without actually just being historical, and looking at how the impact of policy has impacted that.

So, 100 years ago there were 100,000 midwives in the United States, 90% of them would have been Black women, another 9% would have been ethnic immigrants. Only about 1% would be of, you know, English descent, or somebody who was more of a middle class white background, right.

Most of those people were people who served their communities, and they served their communities in a cultural perspective. Two things that led to that was the Flexner Report, and the Sheppard-Towner Act. The Flexner Report looked at the quality of medicine, and- has formed what we have today as the medical model that we use today.

And one of the impacts from Flexner's Report was that it eliminated five of the seven existing medical schools, or medical colleges that served African Americans. And why that's important to midwives is because those were often places where they went to learn

and train.

At the same time, the Sheppard-Towner Act, which was supposed to be a project to improve infant survival rates, looked at midwives, and gave basically midwives the blame for being responsible for things like the fact that penicillin didn't exist, because it must be midwives that these women are dying of infection.

It must be the midwife's fault that she's bleeding to death, not the fact that she's protein energy malnourished, and suffering from iron deficiency and anemia before she ever began pregnant. And this is really important when we think about now, the changes that were happening where we see in the United States right now that number one, we've always had a concentration of African Americans in areas that we would call rural, and also those southern states.

So, when we looked at those maps and saw those states with the highest rates of maternal mortality, and then that maternal morbidity, you also see that those are some of the states, Texas, Alabama, Mississippi, Louisiana, with some of the highest rates of African Americans, and what we're also seeing now, which is really interesting in our country, is that there is actually a migration out of the north and the east.

Some of those places were two generations ago. Our families went as part of the north great migration, there were a lot of Black folks that were moving south. So, if we're moving into a maternity desert, and places with total abortion bans, our risks for surviving pregnancy are going to go significantly down, and our changes of having major complications go up.

So, how can we do something about this? As you're looking at funding, especially health profession's programs. I'm going to be biased, midwives, right, if you need a population of like 25 per 1,000 live births, today we have around 15,000 and you need 150,000, and yes, that does intentionally mean that we're going to probably need less of OB/GYNs.

Because if you had OB/GYNs who are surgeons, not attending the bedside in vaginal births, they could do it, and the things that they need to be doing, like managing endometrial cancer, and doing hysterectomies, and doing care that people in those rural areas cannot get because there's not a qualified OB/GYN around, or if there is, they're often occupied attending vaginal births.

Prioritize some of those programs instead of just giving money to existing programs, think of giving some of that money, or concentrating those by finding ways to support the development of midwifery programs at historically Black colleges and universities and tribal colleges.

There already exist several tribal colleges, and many of the when you think of the tradition of what HBCUs did in training teachers and nurses, there are already existing programs that offer graduate level nursing degrees. Help them to develop, and incentivize it to a certain extent, by offering the support financially to help develop and grow a midwifery program until it becomes sustainable.

Prioritize programs that are willing to maintain the standard of the masters of science in nursing for entry level, versus DMP. It seems hypocritical since I have one. However, I didn't need one to become a nurse midwife. I completed my masters of science as a

nurse midwife and family nurse practitioner at Vanderbilt, and practiced for more than two decades before I ever went back to get my DMP, and my DMP was specifically focused around my community-based qualitative research.

If we add the DMP, and say that is the terminal degree for advanced practice nurses, we are going to do one of two things. We're going to acknowledge that we're taking a workforce that is already not diverse. The midwifery profession right now only about 6 to 7% identify as people of color.

And in the years, just in the 10 years that I've actually tracked, we've gone from 39 programs across the United States to now 46 accredited certified nurse midwifery programs. All of them are at predominantly white institutions, and of those, there are only four program directors, three who are Black, and one is Latinx, and none that is Asian, Pacific Islander, and none that are Native American.

So, we have to look at when we're choosing organizations to fund, how do they demonstrate their commitment to anti-racism, and truly diversifying the workforce, and one good judgment of that is by doing a simple survey of what does their faculty look like? What does the leadership look like? Because if they don't want us as colleagues, they probably don't want us as patients, and they're not going to do us well.

Look at graduation rates as well. If it's a 60%, you know, diversity, you know, of 65 BIPOC cohort, tell me how many of those 65% actually ever graduate and pass the boards? And looking at things that actually focus on not only that, but the FMP. One of the problems that things that sort of go up the back of my neck, and other

people's when we hear like preconception, interconception, is that it's focusing on simply like one part of my, you know, as my journey as a human being, but I'm still going to be here my whole life, so if we can't focus on our health, and maintaining our health, we don't have to worry about, you know, the relative risk of being pregnant.

And it goes into the form of oh my gosh, in that case we need to contracept everyone. Everyone's pregnancy intention is not the same, and also just acknowledging that you could give me all the contraception in the world, however, if I'm still undereducated, and working a low wage job in a rural area, does it matter?

You know, so when I hear people say that you know, they have proof that contraception can decrease poverty, then why are there, you know, then why are there so many infertile Black women that I know, you know. Because if they've never conceived, they should be able to get out of poverty.

Your biggest concerns about poverty are you know, where you are born, what level of education, what level of wealth your family is born into, and what are your opportunities to do that, and you know, so whether I have zero children, or five children, or 10 children, if I don't have an opportunity to thrive economically and a place built on social, economic, and environmental justice, the chances that I'm going to thrive ever is very low.

So, I want to thank you for your time, and share that with you that we know these principles work, and in our last year that we're about to come to a close of July 1 in the fiscal year, I've had 72 births so far, and one patient who is due, you know on the 2nd. So if she delivers in the next couple of days, she'll be 73.

But not only this year, but for the last four years of this program, and in my entire career, I have had zero maternal deaths, zero infant deaths. Every baby that I've ever cut has lived to its 1st birthday, 5th birthday and beyond. And you know, only a 6% C-section rate for my clients, despite the fact that we didn't, you know, like cause any harm by not having the C-section.

So, you know, we can thrive. We can thrive, not just survive. Thank you.

MS. LEE: Thank you, Dr. Drew, and you've got a lot of hearts that were floating up. Our last speaker, because I looked online. I don't think we have the two that were going to give comments virtually. Dr. Joia Crear-Perry from the National Birth Equity Collaborative, you're our final commenter, and then we'll take, as I mentioned, the two at 4:15.

DR. CREAR-PERRY: Okay, you all. I still haven't gotten use to calling this ACIMM. I still want to say SACIM, from having Deborah drag me here, as you know, she's been telling me what to do since elementary school. All right. So, we're going to talk a little bit about biology vs. culture. So, this is kind of the framework of the work that we get to do.

So, as an OB/GYN who trained in the deep south, what I consider confederate medicine, I learned Mongoloid, Caucasoid, Negroid, right, so I was taught the biological phases of race. We know that race is a social, political, and I would also say spiritual, like an energetic construct, right?

And so, as we move away from all you brilliant people here, move away from the scientific basis of race, to understanding that

it's a social, political and spiritual event, then how do we as a group collectively give recommendations to the Secretary of Health acknowledging that we are unlearning, this bad belief in biology of race, and really investing in the root cause of the racism, classism, and gender oppression.

So one of the ways to do that is to do respectful maternity care. I can send you all the links to this afterwards, it's a WHO construct, the White Ribbon Alliance started it. At NBEC we did some work with Black birthing people, with AHRQ, with A-1, with a whole bunch of groups around respectful maternity care.

So, I do think instead of birthing friendly, which we can have a long conversation about baby, friendly, and how that went that we need to talk about respectful maternity care for Black maternity communities. For perinatal mental health, really moving away from separating out infants versus mamas.

I used to be in a lot of conversations where we talk about maternal mental health and infant mental health, and what does perinatal mental health look like? What does it look like to address the needs of the unit because this pitting is how we get to choice, and how we get to disinvestment, so really investing in the collective unit of mom plus baby.

Because if mom and baby are well, then baby will be well. And then last, not last, I have a few more. So, I loved seeing Dave from CDC, and thinking about how the MMRCs and the PQCs, and this combination of what happened with AIM work that we used to do all the time with ACOG, this continued here at HRSA.

How do we ensure that the Secretary of this organization,

or that whatever we submit, whatever you all submit, honors that there's a whole collection of both AIM, PQC, MMRC, that has been doing work, and it's time for us to take a step back and see where they need to be next, so how we recommend how they would work together before going forward.

The rural hospitals usually close first in Black neighborhoods. The Rural Hospital Association used to say this to us all the time, so racism also impacts rurality, so we definitely need the data breaking it down by race in rural communities, because if you don't catch the hospitals that are closing, you won't be able to predict where to put your resources next.

Broadband. Back in 2009, when the BIP was put out, I was actually brought up here to speak to the FTC about the need for broadband because Barack Obama had given how many millions of dollars to Louisiana, and my Governor, Bobby Jindal said no.

So, readdressing and looking at how racism also impacts these kinds of decisions. Bobby Jindal did not want to invest in having broadband brought to rural communities because in his mind, and in the mind of the community members who were there in Louisiana at the time, that would bring information to poor Black communities.

At the time that's what Bobby would talk about, right? That we are not going to have these free things going to these communities. So, how do we reimagine broadband going to everybody. How do we take a moment and a breath and say okay? We all deserve, not just grants, and I know there's loans for broadband, free access to information because when we segregate information, we segregate our ability to thrive together.

And then the last two preconception and interconception. So, we spent a lot of time talking about conception versus pregnancy, and I love Kate Johnson. Kate and I have had this debate for the last 15 years. And the truth is it was really important to be able to talk about conception because we were only focusing on pregnancy.

So, it was a great political strategy at the time for people to come together and say well, what happens if there was actually pre-care conception? But when you just focus on these words instead of reproductive and sexual well-being at all times, then you still create policies focused on pregnancy.

So, this idea that we intend, if we just intended better we would do better does not show up in any dataset, does not work for any outcome. I intend to run a marathon, I should have run today, but I'm required to actually exercise at some point.

So, this idea if we could just get them to intend better, the babies will be bigger, the moms will be healthy, and all things will work out, even Guttmacher has let that idea go. So it's time for us to evolve our understanding of how reproductive and sexual health and well-being work, and it requires us to be really honest about the history of eugenics, white supremacy, patriarchy, and religious fundamentalism in the United States of America.

And so, and -- they're not going to fix -- that's it.

MS. LEE: Thank you so much. Thank you to all of our public, members of the public who wanted to give comments. Again, I think as the Committee is growing, we will be sure to have longer periods for public comments, but really appreciate those who came, especially in person, to share their thoughts with the Committee.

We will take our final two at 4:15, and so I'm going to turn it back now to Belinda for the next session.

AI/AN Recommendations: Updates

CHAIR PETTIFORD: Thank you, Vanessa, and we are going to go on into our next session -- this is specifically for our newer members, because we want to make sure you have a little background information on the last set of recommendations.

And the last set of recommendations were around working with a focus on American Indian and Alaska Natives. I think we have some slides going up sometime soon. So, as the slides are coming up, just a little bit of background on the last group of recommendations.

In 2021, members -- the next slide, thanks. That's just yeah, in 2021, the members of ACIMM at that time, which chose to focus on factors affecting birth outcomes among indigenous infants and mothers. And really spent nearly a year really looking at such topics as incarceration, SEID and SUID.

We looked at violence among American Indian, Alaska Native people. We even focused on murdered and missing indigenous women and girls. We looked at workforce issues. We looked at training and a host of things. This was really the first time that the Committee had come back with a report, and made recommendations that it intentionally focused on this specific population of American Indian and Alaskan Natives.

And wanted to make sure that we were prioritizing women, infants and families, during that time. The next slide. During that time we also, if you look at those recommendations, and they are out on the website. So, if you look at those recommendations, there were

a total of 59 recommendations. Yes, we wanted to focus on this, and we worked very -- making sure we got all of our thoughts on paper, for 59 recommendations.

But this is the report we sent to the Secretary. If you really look at the report more broadly though, it really falls into three specific categories. One is around making the health and safety of American Indians, Alaska Native mothers and infants a priority for action, is really making sure that, you know, we've been working with a population of individuals that we're leaving behind.

So, making sure that their issues are being elevated. We also, as a second category, was improve the living conditions of this population, specifically the mothers and infants, and ensure universal access to high quality healthcare. This was critical to our recommendations. And then last, but not least, address urgent and immediately health challenges that disproportionately affect American Indian and Alaska Native women before, during and after pregnancy. Next slide.

If you look at the three categories you can see here the number of recommendations in each of those categories, so you could see which areas of the 59 recommendations for the focus is coming from. Here's the first one, making the health and safety of mothers and infants a priority.

The sub-recommendations here you can see the three of them. The one that come out moved to the top was around mobilize federal, state and local agencies and funding to data and visibility and erasure. This is where you saw more recommendations under this category. The next slide please.

As you look at the second one, around improving the living conditions of American Indian, Alaskan Native mothers and infants, and ensure universal access, that is high quality care, most of those recommendations fell under expand and diversify the workforce, making sure that people saw themselves in the workforce.

And then the last one, the next slide please, was around addressing the urgent and immediate challenges. And here you could see, you know, it pretty much spread throughout, but our leading one was around expand violence surveillance and universal screening. And it's very specific recommendations here.

But I would encourage you to read those recommendations, and that full report. I think there's one more slide. And making sure that, you know, because as this final report we make sure that as a Federal Advisory Committee meetings that our focus on specific issues of communities to be held in those communities.

So, we really wanted to make sure that we were elevating the issues of indigenous women and infants, but also making sure as we move forward with these recommendations, that wherever there were committees, wherever there were entities talking about this topic area that we have people with lived experience who were from these indigenous populations at the table.

And I think, is there another slide? No, that was this slide. And so, adding to that again, I do encourage you to read the full report. Yes, all 59 recommendations, because I think it gives you a good background of what brought us to where we are today.

But at this time I want to also turn it over to Jessica Perfette with the National Center. Jessica, I see you on. Do you

want to provide any updates? She with the National Center for Child Fatality Review and Prevention. Thanks Jessica.

MS. PERFETTE: Yeah, thank you. Hello. My name is Jessica Perfette, and I am a citizens of the Cherokee Tribe of Northeast Alabama, and a Tribal Liaison with the National Center for Fatality Review and Prevention, or the National Center. It is an honor to be here today and discuss responses from the National Center on select recommendations of the making amends report, and the work that CDR and FIMR teams do.

I want to thank the ACIMM Committee for all their work on this report. Next slide. The work we do here at the National Center would not be possible without our key funding partner, the Health Resources and Services Administration, who funds and supports the important work that we do.

We are so thankful for our relationship with HRSA, and strides that we continue to make with their support for keeping children alive. Next slide. The National Center is a program of the Michigan Public Health Institute, and has been the recipient of the cooperative agreement for the national CDR technical assistance center since 2002.

In 2015, MPHI was also awarded the cooperative agreement to serve as the national resource for FIMR. These are separate cooperative agreements, but they do function as one program. The funding that National Center receives from HRSA serves as the foundation for most of the CDR and FIMR activities across the nation.

The National Center's charge is to support all aspects of fatality review. The work in fatality review is typically divided

into two buckets, the programmatic and data. The staff at the National Center, such as myself, provide expertise, technical assistance on topics ranging from creating partnerships, to improving data quality, writing recommendations, and promoting well-being within team members.

The staff also provides consultation and training to individual states and sites, as well as comprehensive resources, which I'll show a few later at the end of this presentation, for the field that come in the form of data quick looks, commonly called infographics, webinars, written materials, newsletters, and listservs, training modules, and next, also a 10 part death scene investigation learning series.

Additionally, the National Center provides real time guidance to the fatality review field on navigating emerging issues and public health crisis, such as the COVID-19 pandemic, -weather- related disasters, or the opioid pandemic. -

T-he National Fatality Review Case Reporting System is a core pillar in which the National Center's activities are built around. In addition to the technical assistance- I already described, additional services for the case reporting system, includes an extensive data dictionary, help desk services, support analyzing data, and services to states to improve data quality.

The National Cener also provides fatality review data to external partners through a data dissemination process, and newly released tableau dashboards, which I'll get into in one of the recommendations here in a minute. Through quarterly connection with local and state fatality review teams, the National Center can stay

connected to the needs in the field.

The National Center serves as a conduit for passing information from federal and national partners to fatality review teams and vice-versa. Next slide please.

So, let's jump into the recommendations from the National Center. I want to begin with the first recommendation that is up on the top of each of these next slides. It is recommendation A #2, which is found on page 26 of the report. So, let's dive into this first recommendation A.2.a.

The National Center has hired a dedicated Tribal Liaison, myself, a Senior Project Coordinator, and Tribal Liaison to work with the Center since July of 2023. As a tribal member, I have made significant strides in building relationships in the short amount of time that I've been here with the National Center. Almost a year coming up on.

This includes connecting with tribes, national organization, and Indian Health Service. I've also been invited to present on tribal lands, such as the 4 Corners Without Boarder Conference in Navajo Nation in Utah, and the National Tribal Health Conference in the Great Plans Region in South Dakota.

The National Center sub-contracts with subject matter expert Dr. Janelle Palacios, who is a prior member of ACIMM, to develop learning guides and self-based modules covering essential information that fatality review teams need to know in working with tribes, and reviewing fetal, infant and child deaths of Native American families. Next slide please.

Recommendation A.2.b, the National Center has released a

capacity funding building opportunity in September of 2023, approximately 1 million dollars to local, state and tribal teams. Topics range from starting, or reinvigorating a CDR or FIMR team, improving data quality and access to data sources, and inclusion of parental and family interviews.

Although tribal applications were not received, some freely associated territories did apply. There is additional funding available if tribal applications are received. The Center is continuing with a story telling collaborative, with Magda Peck and Dr. Janelle Palacios as the primary faculty.

By incorporating strategic storytelling into fatality review, the influence and impact of racial inequities on health incomes across generations maybe better heard, understood, elevated, and acted upon. Cohort four of the storytelling collaborative is currently wrapping up for 2024, which includes CDR for the first time.

Additionally, self-paced modules on storytelling will be created and available on the National Center's webpage. Next slide please. Recommendation A.2.c, the National Center continues to promote the use of the national fatality review case reporting system for all FIMR and CDR teams, including those with tribal affiliations.

To date, all but two states are using the system for CDR, and of the 26 states with FIMR, 20 are now using the system for data entry. The National Center has created a number of resources within the national case reporting system, including standardized reports, Data Explorer, which is modeled after CDC WONDER, and a variety of download options.

The National Center has created a comprehensive Tableau

dashboard environment for CDR teams, which expanded to FIMR this year in 2024. There is an ability to identify our AI/AN children who have died across all the dashboards. These data are vital for prevention. Next slide please.

Recommendation A.2.d, the National Center's Tribal Liaison has worked to identify national organizations to collaborate with, including the National Healthy Start Association, National Indian Health Board, and Indian Health Service, and networked with tribal organizations, such as at CityMatCH, the National Tribal Health Conference, and AMCHP, most recently.

Quarterly calls are held with staff supporting MMRCs, Maternal Mortality Review Committees, and the CDC's Sudden Unexpected Infant Death, or SUID, and the Sudden Death in the Young, SDY Case Registry to coordinate technical assistance and leverage lessons learned.

The National Center serves as the data coordinating center for the CDC, SUID and SDY registry. The CDC has invited the tribal liaison, myself, to present July 30th, coming up on a National SUID prevention call with a focus on AI/AN expertise. The National Center recently hosted the first national conference to collaborate across fatality review programs to enhance equity and fatality reviews, also called EEFR in June of this year, 2024.

Some of the fatality review programs included were Maternal Mortality Review Committee programs, suicide, domestic violence, FIMR, CDR, and overdose fatality review, and so many others. Next slide please.

The final thing I want to highlight is a set of resources

that are available from the National Center on our website specific to our American Indian and Alaskan Native communities. Next slide.

And then I put a QR code up here as well that will take you to our resources available on our website at ncfrp.org and my contact information as well. I do want to thank you for the invitation to speak with you today, next slide. And here is all of our contact information for the National Center. Thank you.

CHAIR PETTIFORD: Thank you so much, Jessica. We'll take a moment if anyone has any questions for Jessica. Yes, Hannabah?

MS. BLUE: Thank you, Jessica, for the presentation, your work. You mentioned as response to one of the recommendations a story-telling initiative that will be on your website. Can you share a little bit more about that?

MS. PERFETTE: Yes. So, we're a cohort for the Story-Telling Collaborative. It's in collaboration with Dr. Janelle Palacios, our primary faculty. And it really is incorporating stories, and going beyond data and fatality review. We feel in support that it is better to understand the story and data when it's elevated and acted upon when you're hearing a personalized story.

So, we are about to kick off the cohort. We're starting in July of this year, which now will incorporate CDR for the second year.

CHAIR PETTIFORD: Thank you so much. No other questions? Thank you so much, Jessica, for joining us today. And now, we're going to switch back because we have a few more public comments, so I'm turning it right back to Vanessa.

MS. LEE: Thank you, Belinda, and thank you Committee members for your patience, and to our speakers, public commenters for

their patience and flexibility. So we have two more people who did register to provide oral comments, Dr. Janelle Palacios, and then following here will be Dr. Laura Divoky. Janelle, I'll pass it to you.

DR. PALACIOS: Thank you. It's great to be here. Good afternoon. It's my pleasure to join you all during public comment. I see a number of colleagues and friends. I'm Janelle Palacios, -- and I'm a prior ACIMM member, and was Co-Chair along with Belinda Pettiford on the Health Equity Workgroup.

I'm speaking to you first and foremost as a community member with lived experience as a child bearing Native woman in our nation. A nurse midwife for 15 years, preparing for childbearing families. And as a scholar with content expertise on Native maternal child health.

My comments are largely to challenge the Committee to grow. First, move the MC agenda forward among those most affected at an accelerated pace. As my colleague, and dear friend, Dr. Art James, has called for. Black, indigenous, and Native Hawaiian maternal and child health rotate in first, second, and third place for poorest outcomes.

My challenge to you is to ensure speakers, people with lived experience and federal partners, are invited to each meeting to speak on these issues. And that continues addressing the common needs of these populations, but also the differential needs for the communities.

Case in point, go to Alaska. Witness how care is provided, and hear from families affected by forced evacuation from villages in

order to wait out a birth, even a normal birth, for weeks, two months, isolated from family, children, partners and community support.

Second, read that 2022 ACIMM making amends report. The 59 recommendations we put together was just scratching the surface. Many more were not included. Third, demand and advocate for Native maternal child health data. Unfortunately, we cannot rely on Indian Health Service for data, or intervention.

We do not know the true rate of maternal infant death among natives for a number of reasons, including misclassified race, not counting us correctly, inaccurate charting and reporting, and most disheartening lack of accountability. Your recommendations are powerful, and can change the landscape of MCH, such as an example the CDC and the National Center for Fatality Review and Prevention, what Jessica just shared, how they calculated their Native sample, which grew between 30 to 90 % based on recommendations and guidance from ACIMM.

Fourth, press the Secretary to advocate for an evaluation of Indian Health Service, specifically related to maternal child health since 2009 because it was since 2009 that we have had comprehensive published data on maternal child health outcomes from Indian Health Service. That was 15 years ago.

Fifth, consider the harm created when limiting birth worker diversity, or in placing restrictions on licensure and certification for doulas and other birth workers. If licensure and certification will be imposed, programs should be created for community members to access the training necessary, and funding necessary to pay for licensure and certification.

We need to keep these birth workers in the communities they want to serve, not disenfranchise them. Sixth, press for action in response to the Syphilis crisis happening in Indian Country by the Secretary. Please read Pro-Publica author, Erna Juster's writings of the Syphilis crisis and Native communities.

The rate of Syphilis has risen in our country, but has wreaked havoc in Native communities, with congenital Syphilis increasing 40-fold over the past five years. Clinicians, leaders and community members of the Great Plains, and throughout Indian Country, have requested that Secretary Becerra declare a state of emergency to release funding, and resources to combat Syphilis.

Request true partnership in any movement and evaluation on this crisis. Remember, you all have power. Seventh, take bold action for common well-being and thriving. Do not fear standing outside of your discipline, or future career goals because the best action to take is an unpopular one.

Challenge our nation in being better, and believe it can be. In Salish, the way that we term ourselves, the way that we call ourselves Salish, it means one fire. And I truly believe that we have to be one fire, one nation in order to make these efforts move forward, and we can do that. I believe we can. Thank you.

MS. LEE: Thank you so much, Janelle. Always good to see you. Again, we appreciate your flexibility and your comments. I'm going to move next to our final public commenter, Dr. Divoky, and she's with the Georgia Heart Institute.

DR. DIVOKY: Good afternoon, and thank you for the opportunity to speak with you today. My name is Dr. Laura Divoky,

M.D., MPH, FACC, the Medical Director of Noninvasive Cardiology, and Director of the Women's Heart Center for Georgia Heart Institute at Northeast Georgia Medical Center. -

I am the cardiologist who is the principle investigator for our health organization that receive the U.S. Department of Health and Human Services State and Maternal Health Innovation and Data Capacity Program Grant, to aid in reducing maternal mortality in the State of Georgia.

Where cardiac conditions are the leading cause of death with worse outcomes in the rural and minority populations. Maternal cardiac conditions are also a focus of the Georgia Perinatal Quality Collaborative, also known as GAP QC. Through our investigation over the past 18 months, we have identified a discrepancy in the guideline recommendations on antihypertensive therapy for patients greater than 20 weeks- gestation, that has led to a gap in patient care.

Currently, the American College of Obstetricians and Gynecologists, and the Society of Maternal Fetal Medicine, recommend initiation of therapy in patients with severe range blood pressure of 160 over 110. While the American College of Cardiology, and the American Heart Association provide support for tighter blood pressure control of 140 over 90.

Additionally, the World Health Organization, European Society of Cardiology, and the National Institute for Health and Care Excellence, have different recommendations. Recent studies on chronic hypertension and pregnancy show that a decrease on the development of severe hypertension improves maternal and perinatal outcomes, and reduces the number of unplanned and early deliveries.

Collaboration and consistency among professional organizations for updated guidelines, recommendations, needs to be incorporated into the national public health agenda. We would like to call to action this Committee to raise awareness to close the GAP BP for pregnant women, especially those in rural areas and minorities.

Close the GAP BP to increase the survival rate of women who are dying from preventable cardiac conditions. Close the GAP BP to increase the fetal survival rate, so they are not born prematurely due to an emergency C-section secondary to uncontrolled blood pressure. -

Close the GAP BP to reach the Healthy People 2030 goals to prevent pregnancy complications, maternal deaths, and improve women's health before, during and after pregnancy, as well as reducing preterm births and fetal death rate. Close the GAP BP by forming a Committee to rewrite multi-disciplinary guidelines, so that regardless of what provider a woman is seeing, they are receiving the same chance to have a healthy pregnancy and infant. Thank you.

MS. LEE: Thank you so much, Dr. Divoky, and I just want to do my due diligence and say we did look for Rhonda Smith Branch and Jackie Long online, I just want to doublecheck that they have not come through, but they had also requested to make public comments, but we did not find them in the Zoom.

I think that concludes. - I'll- turn it back over to Belinda.

CHAIR PETTIFORD: Thank you everyone, and again, thanks to all for your public comments. They are appreciated, and views carefully by our Committee, so thank you all. We're going to go back to our agenda now, and still try to get you out of here by 5 o'clock,

so I'm not still talk while you all are gone.

Committee Reflections/Open Discussion

CHAIR PETTIFORD: Okay. At this point I really just want to open it up for discussion for the Commission, which includes the ex-officio members, around what your thoughts have been for today. You know, we've had a full agenda. You know, we've been able to pull in some discussions around just looking at the data, which is always important.

We view ourself as being data driven, and looking at the evidence, or at least the promising practices or strategies that can move our work forward. So we've had some time today to look at the data, but we've also heard from work related to many of our workgroups. And so, I just want to open it up at this time for any reflections, any thoughts that anyone has.

This would include our members that are virtual. And if you are virtual, if you could come on camera if possible, that would be great. If you cannot, I understand it. But we can see if you're on camera. And speaking of one of our members, ShaRhonda, I know you joined earlier, so ShaRhonda, if you are able to come off of being muted, would you like to introduce yourself? Thanks, ShaRhonda.

MS. THOMPSON: Sure. I'm having a technical problem trying to unmute myself.

CHAIR PETTIFORD: No problem. You could go on and introduce yourself to everybody.

MS. THOMPSON: Hello. Hold on, let me turn the camera on as well.

CHAIR PETTIFORD: Ms. ShaRhonda hosted us for last meeting

when we were in St. Louis, Missouri.

MS. THOMPSON: All right. Can you all see me? There I am.

CHAIR PETTIFORD: Yes.

MS. THOMPSON: Okay.

CHAIR PETTIFORD: Thank you.

MS. THOMPSON: Hello. My name is ShaRhonda Thompson. I am a community member and I have been, oh many, it's been over 12 years now. In a little it will be 12, that infant maternal mortality has been something -- a cause of mine to eradicate the inequity and the birth outcomes is something that just it needs to end.

But yeah, we're trying to be the voice of the community to the best of my ability, based on not only my experiences, but the life events and stories that I've had, that I've heard from others.

CHAIR PETTIFORD: Thank you, ShaRhonda. I appreciate it. Look, it got real quiet on me all at once trying to leave, I know. Okay. That's what you all are trying to do. Anybody want to share one word that helps them think about how today has gone? Just one word? Not a whole sentence, just a word? Yes, Joy, one word? You are muted.

DR. NEYHART: Sorry about that. Do I have to be limited to one word?

CHAIR PETTIFORD: Since you raised your hand first, I'll let you give a couple words, Joy.

DR. NEYHART: Well, wow is one word. Lots of amazing information. One thing that struck me, especially toward the end of the day was the talk, and I'm not going to remember who it was, but

one of the midwife talks about how, you know, Canada and the United States, we have not very good infant and maternal mortality, terrible infant and maternal mortality.

And our midwife ratio is low, and ten years ago when I did this research for my local hospital in Juneau, Alaska, it was the same, and so a lot of work to do to increase the numbers of midwives in our country, and that one thing will improve infant and maternal mortality for sure.

Again, I am really amazed, and I feel I'm among giants with these new appointees, so thank you to the federal support for getting these people on the Committee.

CHAIR PETTIFORD: Thanks, Joy. And actually that quote was coming from Michelle Drew. She made that quote during her public comment period, so thank you. I see a couple of words coming up in the chat. Hannabah is appreciative. I see ShaRhonda, hopeful. Anyone else? Yes, Charleta?

DR. GUILLORY: Today was just amazing. I've been going through and listening to the vast amount of knowledge, and the vast amount of data that was presented today. So, the first word that comes to mind is collaboration. How do we bring all of these things together?

The second thing I wanted to say, being from Texas, by the way I noticed no one said they wanted to visit Texas earlier.

CHAIR PETTIFORD: People have been there before, so we're going to go.

DR. GUILLORY: Anyway, 10% of all deliveries, mother maternal deliveries and babies in terms of being born, so I can't help

but think individually of the problems that we have with both maternal mortality and the high rate of infant mortality.

So, I'm taking all this information and seeing how we can actually make a difference. And one thing that stuck with me is someone talked about both maternal mortality and infant mortality and showed how the two really work together as a dyad. So, I'm sitting here thinking about we tend to do a lot of maternal programs.

And I can see the slide now. We have a lot more maternal programs than we have for infant programs, and I always felt that as a neonatologist, that had to be brought up. But in actuality, as you -- when they brought up that particular comment, as you really improve maternal mortality, you're really improving infant mortality as well.

So, those are the things that came to mind today, and I just am thankful and appreciative.

CHAIR PETTIFORD: Thank you, Charleta, and we'll come visit you in Texas at some point, okay, if that will make you feel better.

DR. GUILLORY: Not when it's hot, but any other time.

CHAIR PETTIFORD: Thank you. Anyone else, Marilyn?

DR. KACICA: You know, I have to agree. I think it was pretty amazing the amount of material, and activity that is going on around both maternal and infant health. And then it makes me wonder with all the investment and people working, what are we missing that we're not improving more. What is it that we need to do to connect the dots in all these efforts in order to see some real progress?

CHAIR PETTIFORD: Excellent question, Marilyn, and you keep that file because we're going to think about it tonight, okay? Anyone else? I want to look at the chat and see if anyone dropped it in the

chat. Okay. I'm not going to try to pull anymore out of you. I can tell that the energy level is going down.

Overnight Considerations

CHAIR PETTIFORD: So, thank you all so very much. I will ask for you all tonight just to consider, you don't need to write it down anywhere, but especially for our newer members, think about which work group you want to join. Tomorrow we will have time for the workgroups to meet separately.

They will each be in their own room. Some people will be virtual. Some people will be in the room, but think about which workgroup you want to join, so you'll be prepared to go to that workgroup tomorrow. Again, you can join more than one, but tomorrow you can only probably get to one meeting, so I know several had made a pitch for, but I'm sure all three workgroups will make their own pitch given the opportunity.

And you'll actually hear a little bit more about it in the morning, so you will be able to ask them some questions in the morning. But for everyone else, think about it, and you know, what other things that should be considered there. I also think we need to keep in mind I think it was Ashley that reminded us you know again, when we're thinking about -- it might not have been Ashley, I think it was Ashley.

But either one, somebody reminded us again when we're thinking about improving infant and maternal health, you know, it's not just the clinical things. It's not just -- it's part of the work. It might have been Michael that said it. I think 20% is attributed to clinical issues, so how are we dealing with the other 80%?

Because I think we tend to go to sometimes our low-hanging fruit, the things that we're comfortable with, things that we have more information on, but how do we think outside of the box and really be bold. Let's think through really what else needs to be done as for developing our recommendations. Okay.

If you have no other questions, and no one is putting anything else in the chat, then I will adjourn this meeting until in the morning at 9:30. You've got 26 minutes back on your schedule today for all that running around. Thanks everyone. And those in the room have a wonderful evening. Thanks.

(Whereupon at 4:34 p.m., the ACIMM June 26-27, 2024 meeting was adjourned until June 27, 2024 at 9:30 a.m.)