Advisory Committee on Infant and Maternal Mortality

Meeting Minutes of June 26-27, 2024

Hybrid (In-Person and Virtual) Meeting
Rockville, Maryland

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DAY ONE: Wednesday, June 26, 2024

Welcome and Introductions

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

The Designated Federal Official (DFO) called the Advisory Committee on Infant and Maternal Mortality (ACIMM; the Committee) to order and welcomed attendees. The ACIMM Chair announced that the Committee has six newly appointed members and two additional ex-officio members. Committee members then took turns introducing themselves. The Chair then overviewed the meeting agenda and explained that many of the speakers are connected to the three Committee workgroups: Social Drivers of Health, Systems Issues in Rural Health, and Preconception/Interconception Health.

Review and Approve Minutes

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

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

Federal Updates: BHW Investments in Maternal Health

***Elizabeth Kittrie*, Senior Advisor, Bureau of Health Workforce (BHW), Health Resources and Services Administration (HRSA)**

Ms. Elizabeth Kittrie presented the efforts and investments of the Bureau of Health Workforce (BHW) to expand and diversify the maternal health workforce, particularly focusing on rural areas. She highlighted that BHW, a sister bureau to the Maternal and Child Health Bureau within HRSA, aims to strengthen the primary care workforce and connect clinicians to communities in need through over 70 programs. These programs covered the entire career continuum of health professionals, from early outreach to continuing education, and impacted over half a million trainees last year. Ms. Kittrie outlined the Bureau's four main policy levers: supply, distribution, quality, and access. She emphasized the importance of ensuring an adequate and well-distributed workforce trained to work with rural and underserved populations.

Ms. Kittrie also discussed specific programs and initiatives aimed at addressing maternal health workforce shortages. She mentioned the National Health Service Corps and NURSE Corps programs, which place clinicians in high-need areas and provide financial incentives to address maldistribution. She also highlighted efforts to expand nurse-midwifery and medical residency programs, particularly in rural and underserved areas, and the integration of behavioral health into primary care. Ms. Kittrie shared projections indicating significant future shortages of OB/GYNs and family medicine physicians, especially in non-metropolitan areas. Additionally, she discussed maternal care target areas and the impact of scholarship and loan repayment programs in addressing these shortages. Ms. Kittrie concluded by mentioning budget requests for 2025 aimed at further supporting maternal health workforce development.

Discussion

- A Committee member asked about support for Certified Professional Midwives and pathways outside of nursing.
  - Ms. Kittrie responded that most programs are authorized only to support certified nurse midwives. She mentioned the Scholarships for Disadvantaged Students program as an exception, which does fund Certified Professional Midwives. This program will be up for competition again in 2025.
- A Committee member raised concerns about the shift from a master's degree to a doctoral degree in Nursing Practice (DNP) programs potentially discouraging lower-income individuals from entering the field.
  - Ms. Kittrie acknowledged this concern and noted that there are substantive commitments to supporting master's level training. She highlighted the deficit in faculty and clinical placement sites as a significant constraint and mentioned programs providing loan repayment or low-cost loans for those willing to teach.
- A Committee member raised concerns about the impact of the Dobbs decision on OB/GYN residents, and whether they would avoid states that have restrictions on medical practice.
  - Ms. Kittrie confirmed awareness of these trends and noted that BHW programs have agreements allowing training in areas where it is permitted.
- A Committee member from the rural workgroup inquired about legislative authority limitations regarding training doulas.
  - Ms. Kittrie confirmed that legislative authority limits direct support for doulas but noted that some training programs for community health workers include doula training. She suggested further follow-up on this issue.
- A Committee member asked about the sustainability of rural training tracks.
  - Ms. Kittrie explained that HRSA's Federal Office of Rural Health Policy administers the rural residency training program and suggested involving that office in further discussion of its sustainability.
- A Committee member suggested funding for family nurse practitioners who can provide a wide range of services in rural areas.
  - Ms. Kittrie agreed, noting that many BHW programs support family nurse practitioners but explained that they are not always counted in maternal care metrics due to their broad range of services.
- A Committee member asked about the importance of continued funding for both DNP and master's programs.
  - Ms. Kittrie acknowledged the trend in nursing education toward the DNP as the beginning credential and emphasized the importance of continued funding for both educational paths.

Federal Updates: ERASE MM Data Update: Pregnancy-related Deaths Occurring in 2020

***Dave Goodman, Ph.D.* (virtual), Maternal Mortality Prevention Team Lead, Division of Reproductive Health, Centers for Disease Control and Prevention (CDC)**

Dr. Dave Goodman provided an in-depth analysis of the 2020 pregnancy-related deaths using data from two key surveillance systems: the Pregnancy Mortality Surveillance System (PMSS)

and Maternal Mortality Review Committees (MMRCs). He began by outlining the PMSS, initiated by the CDC in 1986, which tracks pregnancy-related mortality ratios (the number of deaths per 100,000 live births). The ratio has remained high and increased significantly from 2019 to 2020, largely due to COVID-19. Dr. Goodman highlighted the disparities in mortality ratios by race, ethnicity, and geographic classifications, noting particularly high impacts on non-Hispanic Black, American Indian or Alaska Native, and Hispanic populations. He underscored the limitations of PMSS in providing detailed clinical information, necessitating the use of MMRC data for a more comprehensive understanding.

Transitioning to MMRCs, Dr. Goodman explained how these committees offer deeper insights by examining medical records, social service records, autopsy reports, and informant interviews. He presented data from 38 states, showing that in 2020, 47% of pregnancy-related deaths occurred within a week to a year post-pregnancy. Mental health conditions, cardiovascular conditions, infections (notably COVID-19), and hemorrhage were found to be the most frequent underlying causes of death and significant racial and ethnic disparities existed. Dr. Goodman then reviewed the most frequent underlying causes of death by race/ethnicity and emphasized the importance of addressing these through tailored prevention strategies. He concluded with specific data on American Indian or Alaska Native populations, highlighting that 92% of pregnancy-related deaths in this group were preventable. He stressed the need for continuous efforts to address the systemic issues contributing to maternal mortality.

Discussion

- A Committee member asked how the data compared to a recent publication critiquing the quality of pregnancy-related mortality data.
    - Dr. Goodman responded that many have critiqued the publication's inadequacies. He noted that PMSS data shows persistent, unacceptable levels of pregnancy-related mortality, which increased during the pandemic. He emphasized that there are more maternal mortality review committees than ever, providing deeper insights and recommendations for prevention.
- A Committee member inquired about the "checkboxes" or contributors to maternal death , specifically whether the discrimination contributor included systemic racism.
    - Dr. Goodman explained that the discrimination checkbox includes both structural and interpersonal racism. He mentioned that discussions during death reviews focused on immediate circumstances surrounding the death, but also highlighted reports like Illinois', which addressed broader systemic issues.
- A Committee member questioned if PMSS or state committees considered pregnancy diagnoses not related to live births, such as miscarriages or elective terminations.
    - Dr. Goodman acknowledged the standard of using live births as the denominator but mentioned discussions about alternative measures, such as women of reproductive age or reproductive life years. He noted that while these alternatives are being explored, current reporting remains based on per 100,000 live births.
- A Committee member suggested stratifying data on preventability and discrimination to identify intervention points more clearly.
    - Dr. Goodman appreciated the point and mentioned efforts to improve messaging. He described a new approach shared at a recent meeting, categorizing

contributing factors and recommendations by levels (family, provider, community, systems) to better identify where interventions should occur.

Healthy Start Updates

Shannon Williams, M.A. **(virtual), KC Healthy Start Initiative Program Director, Maternal and Child Health Coalition of Greater Kansas City (Nurture KC)**
Benita Baker, M.S. **(virtual), Branch Chief, Division of Healthy Start and Perinatal Services, Maternal and Child Health Bureau (MCHB)**

Ms. Shannon Williams presented on the Kansas City Healthy Start program, which serves Kansas City, Kansas and Kansas City, Missouri. The program, which recently began a new five-year grant cycle, focuses on areas with high infant mortality rates and aims to support 250 pregnant women, 175 parenting women and children combined, and 25 male partners annually. They provide extensive community education, mainly through a collaboration with Promise 1000. The program employs community health workers from similar backgrounds as the families served, offers support to Spanish-speaking clients, and provides doula services, which also act as translation services in hospitals. The program has secured funding for Uber rides for medical and social service appointments and grocery store trips to address transportation barriers. Ms. Williams highlighted the need for more Black and Brown practitioners, free individual therapy, and more explicit program guidelines. She emphasized the necessity for increased funding and greater attention to mental health needs to improve maternal and infant health outcomes.

Ms. Benita Baker presented an update on the federal Healthy Start program and its fiscal year 2024 outcomes. She began by outlining the program's evolution since its inception in 1991, emphasizing its mission to reduce infant mortality rates and disparities in perinatal health outcomes across the U.S. Despite steady declines in the general infant mortality rate over the years, high rates persist among Black, American Indian/Alaskan Native, and Native Hawaiian and Other Pacific Islander infants, highlighting the ongoing importance of the Healthy Start program. Ms. Baker detailed the program's structural changes, such as removing tiered funding levels and introducing the Enhanced Healthy Start Program in FY 23, which focuses on addressing social determinants of health. For FY 24, the program awarded 105 new grants to a diverse array of community-based organizations, county governments, hospitals, and universities, expanding its reach to 115 grantees across 37 states, DC, and Puerto Rico. She emphasized the program's increased flexibility in service delivery, the enhanced focus on social determinants of health, and efforts to reduce the reporting burden on grantees by requiring fewer benchmarks and quarterly data reporting. Additionally, the program now mandates increased consumer engagement and collaboration through community consortiums that address critical community issues to improve maternal and infant health outcomes. These adjustments aim to provide comprehensive support beyond clinical care, tackling the root causes of health disparities and enhancing the program's overall impact on perinatal health.

Accelerate, Upstream, Together to Improve Infant and Maternal Health and Achieve Equity

Ashley Hirai, Ph.D., **Senior Scientist, Office of Epidemiology and Research, Maternal and Child Health Bureau**

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

Dr. Ashley Hirai presented an in-depth analysis of the historical and ongoing challenges in improving infant and maternal health disparities, stressing the importance of a collaborative and preventive approach. Despite significant improvements in overall infant mortality rates, from 100 deaths per 1000 live births in 1915 to 5.6 deaths per 1000 live births in 2022, disparities remain, particularly between Black and White populations. Dr. Hirai highlighted that Black infants face a survival lag of 42 years compared to their White counterparts, reflecting decades of systemic racial oppression and inadequate healthcare policies. Similarly, maternal mortality has declined from 700 deaths per 100,000 live births in 1915 to 6.6 deaths per 100,000 live births in 1987 but has stalled since the mid-1980s, with Black and Indigenous populations experiencing much higher rates. The root causes of these inequities included stress, unhealthy environments, and lack of access to quality care, often stemming from discriminatory policies like residential segregation. Dr. Hirai illustrated the need for systemic changes and emphasized the need for bold recommendations to achieve equity in infant and maternal health.

Dr. Michael Warren emphasized the need for accelerating efforts to improve maternal and infant health outcomes by focusing on upstream factors beyond clinical care, which accounted for only 10-20% of overall health and well-being. He outlined the three main strategies of MCHB's programs: promoting access to healthcare services, improving quality of care, and strengthening the workforce. The Maternal and Child Health Block Grant, MCHB's largest investment, supported core public health for maternal and child health populations, with flexibility for states to address specific needs identified through comprehensive needs assessments every 5 years. Dr. Warren highlighted several other programs, including the Maternal Infant and Early Childhood Home Visiting Program, which aimed to expand its reach through increased funding and state engagement, and the Healthy Start program, which had been enhanced to address social determinants of health better. He also discussed the Alliance for Innovation on Maternal Health (AIM) initiative, which implements patient safety bundles in birthing facilities to improve maternity care and outcomes across states. Additionally, he mentioned the national maternal mental health hotline and the maternal and infant health mapping tool, which provides county-level data for program planning. Dr. Warren concluded by emphasizing the importance of collaboration among HRSA-funded programs to maximize impact and foster new partnerships, even without new funding.

Discussion

- A Committee member asked about using data at a very local level, especially concerning Dr. Warren's recommendations, and cited an example of a county in Florida with a higher infant mortality rate than the state average.
    - Dr. Warren mentioned the variation in outcomes within Tennessee where he previously worked and stressed the need to use local data to drive efforts. He suggested using qualitative data from fetal and infant mortality reviews and maternal mortality review committees. Dr. Warren highlighted the maternal and infant health mapping tool as a useful resource for local level data and emphasized the importance of state-level Title V needs assessments to examine outcomes across different areas within a state.

- A Committee member commended the recognition of social determinants of health and focused on the impact of housing on health outcomes. She expressed concern about birthing persons and newborns leaving hospitals without housing and asked about efforts to address this issue.
  - Dr. Warren acknowledged the issue and compared it to ensuring every baby has a car seat before hospital discharge. He suggested a paradigm shift to prioritize housing for newborns and their families, similar to car seat availability.
- A Committee member asked about measurement, specifically the new measures for the Title V block grants and how they are validated. They inquired about measuring the quality of postpartum care, risk-appropriate perinatal care, and discrimination in perinatal care.
  - Dr. Hirai mentioned that states would be able to choose new measures in 2025. She outlined dimensions of quality in postpartum visits, including contraceptive counseling and screenings. She also discussed the challenges of measuring perinatal regionalization and the need for national measures. Dr. Hirai referenced the CDC's LOCATe tool and ongoing efforts to align hospital discharge data with state designation systems. Committee members were invited to contribute ideas on these measurements.
  - Dr. Warren offered to share detailed data sheets for block grant measures, including how they are calculated and data sources.

Rural Health Focus: Federal Rural Health Priorities and Telehealth Activities

***Macarena C. García*, DrPH, M.P.S., M.I.S., Senior Health Scientist, Office of Rural Health, Public Health Infrastructure Center**
***John Pender, Ph.D., M.P.P.* (virtual), Senior Economist, Agricultural Research Service, U.S. Department of Agriculture**
***Chris Proctor* (virtual), Technical Assistance Branch Chief, Telecommunications (Telecom) Program, Rural Utilities Service, U.S. Department of Agriculture**

Dr. Macarena C. Garcia introduced the newly established Office of Rural Health at CDC, emphasizing its goals and strategic direction. The office, operational for just over a year, coordinates across various CDC centers to advance rural public health science. Dr. Garcia discussed key scientific priorities, such as studying rural-urban differences in preventable premature deaths, the prevalence of Alzheimer's disease in rural areas, and developing rural analysis tools. She outlined ongoing projects, including a rural health mapping tool and efforts to leverage CDC surveillance systems for rural health research. The presentation underscored the need for detailed stratification in rural health data to better target interventions and improve health outcomes. Dr. Garcia also mentioned future priorities, including maternal health, broadband connectivity, and mental health in rural areas, inviting collaboration from interested parties.

Dr. John Pender discussed USDA's programs aimed at expanding broadband access in rural areas. He highlighted the significant impact of broadband access on other social determinants such as education, employment, and healthcare, particularly emphasizing its importance during the COVID-19 pandemic. Dr. Pender presented data showing a persistent "digital divide" or disparity between rural and urban areas and among various demographic groups. He detailed

USDA initiatives, including the telecommunications infrastructure loans, rural broadband access loans, community connect grants, broadband initiatives program, and the reconnect program, which collectively is over $75 billion invested by USDA to enhance broadband infrastructure. The programs primarily serve rural areas, benefiting American Indians/Alaska Natives, and predominantly white, non-Hispanic populations, who generally have lower education levels, higher poverty rates, and older age demographics compared to urban counterparts. The presentation underscored the role of these efforts in addressing the digital divide and its implications for health outcomes.

Mr. Chris Proctor provided an overview of the USDA's efforts to improve rural America's economy and quality of life through various programs. He highlighted the roles of the Rural Business Cooperative Service, Rural Housing Service, and Rural Utility Service (RUS), focusing on water, electric, and telecommunication infrastructure. Mr. Proctor emphasized the RUS Telecommunications Program's mission to provide affordable, reliable, high-speed internet to rural areas, outlining funding programs for broadband infrastructure, distance learning, and telemedicine. He detailed the Distance Learning and Telemedicine (DLT) Grant Program, which supports equipment necessary for telemedicine and distance learning, and the ReConnect Program, the flagship broadband deployment initiative investing over $5 billion since 2018 to expand broadband service in rural communities. Mr. Proctor encouraged attendees to utilize USDA's resources and field offices for further assistance and information.

Discussion

- A Committee member asked Dr. Garcia about data suppression in rural equity research, particularly in maternal and child health. The Committee member highlighted the difficulty in disaggregating data at rural stratifications due to suppression and suggested the possibility of discussing the issue offline.
    - Dr. Garcia acknowledged the challenge and confirmed it is also a significant issue for her office. She mentioned working with CDC’s National Center for Health Statistics to generate aggregated results to address suppression. Dr. Garcia discussed the specific challenge of suppression for data below 10 in rural counties. She highlighted the difficulty with maternal mortality data due to extensive suppression and expressed the need for brainstorming and innovative solutions. Dr. Garcia suggested forming a group or think tank to address these challenges and invited the Committee member to join the group to work on this issue.

Preconception/Interconception Health Focus: Upstream USA

***Emily Eckert*, *M.S.*, Associate Director, Federal Policy, Upstream USA**

Ms. Emily Eckert presented the significant challenges of contraceptive access in the United States and the impact on maternal health. She emphasized that 19 million women of reproductive age live in contraceptive “deserts” - areas where there are insufficient healthcare providers to meet their contraceptive needs. Ms. Eckert underscored the broader implications of this issue on maternal health, noting that contraception not only helps in family planning but also optimizes health before pregnancy, supports healthy birth spacing, and reduces risks of certain reproductive cancers. Furthermore, she highlighted the workforce connection, explaining that restrictions on

abortion services have led to provider shortages, impacting overall contraceptive and maternal healthcare.

Ms. Eckert then detailed Upstream USA's mission and activities, focusing on their efforts to ensure equitable, patient-centered contraceptive care as basic healthcare. They collaborate with clinical practice settings to develop and sustain the necessary infrastructure for providing comprehensive contraceptive services, which includes training healthcare providers on billing, EHR integration, and addressing reproductive coercion. She also discussed Upstream's policy work, advocating for better support and data collection for federally qualified health centers (FQHCs) and developing more comprehensive quality measures for Medicaid. Ms. Eckert highlighted a recent maternal health data set initiative by the Office of the National Coordinator for Health IT, which includes elements for family planning screening and contraceptive counseling aimed at improving EHR systems nationwide.

Discussion

- A Committee member emphasized the importance of using a broad denominator for data measures to capture all potentially pregnant individuals, including those at high risk who might not realize they can get pregnant, such as people extreme ages or with chronic diseases.
- A Committee member asked if vasectomies could be covered by insurance at federally qualified health centers for family planning.
    - Ms. Eckert stated she would need to look into the answer.
    - Another Committee member explained that while tubal ligations are covered, vasectomies are typically not, despite being more cost-effective and less invasive.
- An ex-officio member mentioned NIH had a portfolio of non-condom male contraceptives and questioned if these could be billed under contraception codes for men, suggesting it might vary by state and Medicaid coverage.
- A Committee member raised the importance of data collection and its potential conflict with adolescent confidentiality.
    - Ms. Eckert acknowledged the importance of data privacy and standards, mentioning recent regulatory decisions to strengthen data safeguards, but noted potential future risks depending on administration changes.
- A Committee member echoed the need for inclusion of pregnant individuals in data measures, emphasizing the importance of discussing contraception during pregnancy rather than after childbirth.

Public Comment

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

The DFO opened the floor to individuals who had requested to provide oral public comments. Five individuals had registered, three of which were in attendance in person. No public comments were received in writing.

Tiffany Garner

Ms. Tiffany Garner, a child and health policy advocate with Futures Without Violence, highlighted her organization's work in preventing violence against women and children and

emphasized the critical intersection of maternal health and domestic violence. Ms. Garner stressed that intimate partner violence (IPV) is a significant driver of mortality among pregnant and postpartum women and called for comprehensive, trauma-informed care and support services. She also underscored the need for addressing reproductive coercion, the impact of IPV on children, and the importance of training healthcare providers on evidence-based interventions to support IPV survivors.

Michelle Drew

Dr. Michelle Drew, Executive and Clinical Director of Ubuntu Black Family Wellness Collective, highlighted the dire state of maternal and infant mortality in the U.S., noting that it and Canada are the only developed countries with more OB/GYNs than midwives, resulting in poor maternal outcomes. She emphasized the benefits of midwifery, citing the Netherlands and Sweden's higher midwife-to-birth ratios and lower mortality rates. Dr. Drew attributed historical policies and systemic racism to the decline in midwives, particularly among Black women, and advocated for increased funding for midwifery programs at historically Black and Tribal colleges. She shared her success in achieving low cesarean rates and zero maternal and infant deaths in her practice, demonstrating the effectiveness of midwifery-led care.

Joia Crear-Perry

Dr. Joia Crear-Perry discussed the need to shift the focus on maternal and infant health from a biological basis of race to understanding race as a social and political construct. She emphasized the importance of respectful maternity care, particularly for Black communities, and advocated for an integrated approach to maternal and infant health. Dr. Crear-Perry highlighted the impact of racism on health outcomes and resource allocation, particularly in rural areas, and called for equitable access to broadband and comprehensive reproductive and sexual health policies. She also criticized the oversimplification of improving health outcomes through mere intention and stressed the need to address systemic issues like eugenics, white supremacy, and patriarchy.

Janelle Palacios (virtual)

Dr. Janelle Palacios, a Salish and Kootenai community member, nurse midwife, and scholar, urged the prioritization of Black, Indigenous, and Native Hawaiian populations, which have the poorest maternal and infant health outcomes. She emphasized the need for lived experiences and federal partners in discussions, highlighted the unique challenges faced by Native communities, such as forced evacuations for childbirth, and called for accurate data on Native maternal and infant health. Dr. Palacios also advocated for improved licensure and certification for diverse birth workers, urgent action against the syphilis crisis in Indian Country, and bold actions to enhance communal well-being and health equity.

Laura Divoky (virtual)

Dr. Laura Divoky, Medical Director of Non-Invasive Cardiology at the Georgia Heart Institute, highlighted the need for consistent antihypertensive therapy guidelines for pregnant women. She emphasized the discrepancies among major health organizations' recommendations related to when to initiate antihypertensive therapy in patients greater than 20 weeks gestation. The American College of Obstetricians and Gynecologists and the Society of Maternal Fetal Medicine suggest initiation at 160/110 mmHg. In comparison, the American College of Cardiology and American Heart Association recommend 140/90 mmHg. This discrepancy has

led to a gap in patient care. Dr. Divoky called for unified guidelines to improve maternal and fetal outcomes, especially in rural and minority populations, and urged the Committee to raise awareness and collaborate to achieve the Healthy People 2030 goals.

AI/AN Recommendations: Updates

***Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair**
***Jessica Perfette, M.P.H.* (virtual), Tribal Liaison, Support to CDR and FIMR Programs, National Center for Fatality Review and Prevention**

The Chair gave the new Committee members an overview of the "Making Amends" report and its recommendations submitted in 2022 to HHS that were focused on improving birth outcomes for American Indian/Alaska Native mothers and infants. The recommendations were categorized into three areas (prioritizing health and safety, improving living conditions, and addressing urgent health challenges) and included 59 specific recommendations, emphasizing federal, state, and local mobilization.

Ms. Jessica Perfette, a Tribal liaison with the National Center for Fatality Review and Prevention, acknowledged the critical support from the Health Resources and Services Administration (HRSA) for the National Center's activities, emphasizing their role in keeping children alive. Ms. Perfette described the National Center's dual focus on programmatic and data aspects of Fatality Review, highlighting the technical assistance they provide to states and sites and comprehensive resources, such as data infographics, webinars, and training modules. It also maintains the National Fatality Review case reporting system, which supports data quality and dissemination through tools like Tableau dashboards.

Ms. Perfette then discussed the National Center's progress on specific recommendations from the "Making Amends" report. As a dedicated Tribal liaison, she had been instrumental in building relationships with Tribes and national organizations, presenting at various Tribal health conferences, and developing learning guides for Fatality Review teams. Ms. Perfette also noted ongoing collaborations with national organizations and participation in events such as the first national conference to enhance equity in Fatality Review programs. She highlighted resources available for American Indian and Alaska Native communities on the National Center's website and provided contact information for further engagement.

Discussion

- A Committee member asked for more details about a storytelling initiative mentioned in response to one of the recommendations.
    - Ms. Perfette explained that they are in the fourth cohort of the storytelling collaborative, in collaboration with Dr. Magda Peck and Dr. Janelle Palacios. The initiative incorporated stories to go beyond data in Fatality Review and emphasized the importance of understanding and acting upon data through personalized stories. Ms. Perfette also announced the kick-off of the fourth cohort in July, which would include Child Death Review for the second year.

Committee Reflections and Open Discussion

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

The Chair invited Committee members to reflect on the presentations and discussions from the day. She also acknowledged a Committee member who had not introduced herself at the start of the day.

- A Committee member highlighted the need to increase the number of midwives in the U.S. to improve infant and maternal mortality rates. They appreciated the new appointed Committee members and federal support.
- A Committee member described the day as "amazing," with a focus on collaboration. They reflected on the specific challenges in Texas related to maternal and infant mortality and emphasized the need for more balanced programs addressing both maternal and infant health. They highlighted the interconnectedness of improving maternal health to benefit infant mortality rates.
- A Committee member acknowledged the extensive efforts in maternal and infant health, and they called for connecting the dots in these initiatives. They questioned what might be missing in current efforts that hinder further improvement.

DAY TWO: Thursday, June 27, 2024

Call to Order and Review of Day One

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

The Chair welcomed Committee members and meeting participants for Day Two and provided a brief overview of the presentations and discussions from Day One. The Chair noted the significant interest in a data session and the concerning news that the House of Representatives' budget had zeroed out funding for the federal Healthy Start program, Title X, and teen pregnancy prevention funds. The Chair emphasized the importance of immediate action, a sentiment echoed by another Committee member, who highlighted the urgency of their work.

Committee Business: Fall Meeting Dates and Agenda Items

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

The DFO overviewed plans for the upcoming October meeting, scheduled for the 16th and 17th. The meeting would take place at HHS headquarters in the Hubert Humphrey Building in Washington, D.C. and would feature a hybrid format to accommodate those unable to attend in person.

The DFO shared that the next time the Committee would convene outside of Rockville was tentatively planned for March 2025, with then a summer meeting would be held at HRSA headquarters in Rockville.

The discussion then shifted to potential speakers and topics for the October meeting. Proposed speakers included:

- Dr. Zea Malawa (Abundant Birth Project).
- Dr. Veronica Gillispie-Bell (Louisiana Perinatal Quality Collaborative).
- March of Dimes representatives.
- Dr. Rachel Hardeman (Public Health Institute at University of Minnesota).
- Kimberly Porter (Doula nonprofit in Oregon).
- Frameworks Institute speaker for guidance on crafting impactful policy recommendations.
- Rippel Foundation for futurist concepts in policymaking.
- Experts on trans health in the context of birthing and deliveries.
- Speaker on perinatal periods of risk analysis for localities.

The Committee emphasized the need to craft recommendations that were long-term and sustainable. They highlighted the importance of including voices from communities directly impacted by maternal and infant health issues, particularly Black and African American communities.

Additionally, there was mention of a shared platform for accessing Committee documents and plans by the ACIMM Program Lead to guide Committee members through its use. The new SharePoint team site for ACIMM would soon be accessible to new Committee members, with guidance provided by MCHB staff to ensure a smooth transition.

Workgroup Orientation and Overview

***Belinda D. Pettiford, M.P.H., B.S., B.A.,* ACIMM Chair**
Workgroup Co-Leads

The Chair explained that the three workgroup co-leads would provide a brief orientation to their topic/focus area and share their progress so far.

Social Drivers of Health
The co-leads explained that the focus so far had been on identifying best practices and funding models to address social determinants of health, particularly for Black maternal health. Areas that had been explored included nutrition support and universal home visiting programs. The co-leads highlighted the impact of social drivers like isolation and loneliness on physical and mental health during pregnancy and the perinatal period, emphasizing trauma-informed approaches and the dyadic relationship between infants and caregivers. The workgroup also planned to explore leveraging technology and addressing disparities, such as those faced by individuals with opioid use disorder, in their future recommendations.

Systems Issues in Rural Health
The co-leads shared how their work over the past several months had focused on four key areas in rural health: rural maternal and child health workforce, regionalization of maternal and infant care, rural hospital and labor and delivery unit closures, and telemedicine/telehealth use. They explored the roles of different healthcare providers, midwifery-led birthing centers, policy and payment practices affecting regionalization, and strategies to prevent closures by supporting OB readiness and skills maintenance. They also had discussed the rural emergency hospital model

and the representation of rural areas in maternity care deserts, aiming to build these insights into recommendations.

Preconception/Interconception Health
The co-leads mentioned discussions on a broad range of topics, including reproductive and sexual health frameworks, Medicaid expansion, and the political and social determinants of health affecting access to care. They had heard presentations from various organizations and had explored issues such as reproductive health provider hesitancy, federal restrictions, and the needs of diverse populations. The workgroup also focused on developing culturally appropriate messaging and identifying quality indicators for preconception and interconception care outcomes.

Emerging Issue: Maternal Mental Health

***Dorothy Fink, M.D.*, Deputy Assistant Secretary Women's Health Director Office of Women's Health**
***Nima Sheth, M.D., M.P.H.* (virtual), Associate Administrator for Women's Services, Substance Abuse and Mental Health Services Administration**

Dr. Dorothy Fink highlighted the recent release of a report to Congress and a National Strategy by the Department's Task Force on Maternal Mental Health. She thanked all contributors, including federal and non-federal members, for their collaboration. The report to Congress provided data on maternal mental health conditions, substance use disorders, and pregnancy-related deaths, emphasizing best practices and current federal programs. Dr. Fink also detailed the "Talking Postpartum Depression" campaign, which aimed to destigmatize postpartum depression (PPD) and to increase awareness and access to care. She underscored the importance of the campaign's diverse and inclusive approach, which used lived experiences to reach at-risk populations. Dr. Fink mentioned upcoming pilot projects to assess the campaign's effectiveness and planned initiatives to further address broader maternal mental health issues.

Dr. Nima Sheth highlighted ongoing efforts and strategies aimed at integrating mental health and substance use services into perinatal care. She discussed the administration's commitment to these initiatives, emphasizing the need for universal integration of services across various healthcare settings and community support. Dr. Sheth outlined the strategic pillars within the National Strategy to Improve Maternal Mental Health Care, focusing on infrastructure, accessibility, workforce capacity, data and research, primary prevention, and lived experiences. Each pillar contained specific priorities and recommendations, such as paid family leave, reducing disparities, innovative care models, and expanding workforce training. She also introduced two new programs: a Behavioral Health Technical Assistance Center to support providers, and a Maternal Community-Based Services Program to ensure continuous care for mothers with mental health or substance use conditions. These efforts aimed to enhance the integration, accessibility, and quality of perinatal mental health and substance use services, reinforcing the overall strategy for maternal health improvement.

Discussion

- A Committee member commended the speaker for their work promoting and preventing mental health issues using a dyadic approach. They then asked how the speaker defined dyadic work, particularly in the context of infant mental health and maternal screening.
  - Dr. Sheth explained that dyadic work involves both the parent (typically the mother) and the baby. Interventions should address both parties simultaneously and focus on their relationship. She noted that sometimes separate interventions or providers are necessary, such as a prescriber for the mother, a pediatrician for the baby, and a therapist for the dyad. Dr. Sheth emphasized the importance of non-punitive and non-stigmatizing screening and treatment practices, especially regarding perinatal mental health and substance use. The current scope of their work covered pregnancy and one year postpartum, with plans to expand to three years and to include multi-generational family care.
  - Dr. Fink added that they stay updated with the latest literature on perinatal mental health, for example examining the impact of increased screen time on children with parents who have a mental health disorder. She highlighted the need to think about the spectrum of maternal mental health and its impact on the baby, reiterating their plans to include considerations for the zero to three age range in future developments.

Emerging Issue: Infant Mental Health

***Alicia Lieberman, Ph.D.* (virtual), Irving B. Harris Endowed Chair in Infant Mental Health, Professor, UCSF Department of Psychiatry and Behavioral Sciences, UCSF Weill Institute for Neurosciences, Director, Child Trauma Research Program**

Dr. Alicia Lieberman emphasized the urgent need for reparative action due to the United States having the highest incidence of maternal mortality among industrialized nations. Dr. Lieberman highlighted the disproportionate impact on Black birthing people and their babies, underscoring the importance of infant mental health, which she defined as a baby growing and loving well through engaging with parents and caregivers. She cited longitudinal studies showing the benefits of secure attachment in infancy, including better cognitive functioning and emotional regulation in later years. She also discussed the transmission of attachment styles across generations, stressing the need for support systems to break cycles of abuse.

Dr. Lieberman introduced three effective interventions developed by her colleagues in California: Triads, Perinatal Child Parent Psychotherapy, and EMBRACE. Triads focused on trauma inquiry and Adverse Childhood Experiences (ACEs) screening in primary care, promoting healing conversations. Perinatal Child Parent Psychotherapy extended to pregnancy, addressing trauma and its impact on the parent-baby relationship. EMBRACE, specifically for Black birthing parents, incorporated group prenatal care, race-concordant care, and integrated behavioral health. Dr. Lieberman emphasized the necessity of funding training for race-concordant providers and two-generation, trauma-informed treatments, advocating for a holistic approach involving the entire family and community. Her recommendations included making mental health care integral to prenatal care and ensuring all health professionals were trained in trauma-informed care to address and interrupt the intergenerational transmission of trauma effectively.

Discussion

- A Committee member asked Dr. Lieberman about her research on post-traumatic growth, particularly within the maternal context.
    - Dr. Lieberman mentioned ongoing research and emphasized post-traumatic growth as their guiding principle. She also mentioned informing Angela Narayan at the University of Denver about their interest in this area.
- A Committee member inquired about the importance of race concordance among healthcare providers, specifically whether having a race-concordant doula impacts care when the obstetrician is not race-concordant.
    - Dr. Lieberman referred the question to her UCSF colleagues Dr. Jackson and Marquita Mays, noting that the current focus was on implementing and documenting the program's effectiveness. She suggested that more nuanced questions would be addressed over time.
- A Committee member asked about integrating behavioral health into primary prenatal care and how to effectively train mid-career providers in trauma-informed care.
    - Dr. Lieberman emphasized that quick and cheap solutions often lack quality. She advocated for complex, pragmatic, and realistic solutions, highlighting the effectiveness of the learning collaborative model used by SAMHSA. This model involved initial intensive training followed by case-focused presentations and a certification process, which had successfully trained many providers nationwide.

California Department of Public Health: Black Infant Health Program and Perinatal Equity Initiatives

Niambi Lewis, M.S.W. **(virtual), Chief, Perinatal Equity Section, California Department of Public Health**
Franchesca Saulson **(virtual), Program Participant, San Francisco Black Infant Health Program**

Ms. Niambi Lewis presented on health disparities in infant and maternal mortality in her state. She emphasized that while California had lower infant mortality rates compared to national averages, significant racial disparities persisted, particularly affecting Black infants and pregnant women. Ms. Lewis attributed these disparities to structural racism and detailed the state's efforts through the Black Infant Health Program. This program focuses on providing culturally relevant support, reducing stress, increasing social support, and empowering Black women. It includes comprehensive staffing with mental health professionals, public health nurses, and childcare personnel. An evaluation of the program indicated positive outcomes in areas such as emotional support, smoking cessation, food security, and stress management.

Ms. Lewis also discussed the Perinatal Equity Initiative (PEI), highlighting its establishment in 2018 with $8 million annually to address persistent disparities and to expand interventions to support Black women and their partners,. It offered a range of evidence-based strategies, including group prenatal care, fatherhood initiatives, home visiting, preconception care, and community-based doulas implemented through community organizations. PEI required public awareness campaigns, community advisory boards, and utilized the Results Based Accountability Framework for monitoring. Ms. Lewis emphasized the importance of racial concordance in staffing, community involvement, and flexible standards to meet diverse local

needs, ensuring resources eliminated barriers like transportation and childcare. She noted the benefits of community-based service provision.

Ms. Franchesca Saulson, a BIH program participant in San Francisco, expressed gratitude for the opportunity to share her story and emphasized the need for continued efforts to reduce infant and maternal mortality rates. She recounted her personal experience of losing her son at 37 weeks and highlighted the inadequate support she received from the healthcare system. Ms. Saulson noted a historical pattern of loss in her family and pointed out the persistent disparities in the treatment of Black mothers. She stressed the importance of therapy and adequate support for grieving families, advocating for better guidance and resources from hospitals. Ms. Saulson concluded by urging for improved cultural sensitivity and equal treatment in healthcare to significantly lower mortality statistics among Black mothers and infants.

Workgroup Report Out

ACIMM Workgroup Co-Leads

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

Social Determinants of Health/Social Drivers of Health

A co-lead described their discussion on refining home visitation practices, and exploring their definitions, execution, and reimbursement strategies to enhance utilization of the service. They highlighted the need for integrating best practices from various sectors into federally funded projects to ensure they were effectively implemented. Another major focus of the workgroup's discussion was on the criminalization of mental health issues in patient experiences, particularly the biased referrals of Black patients to social services, which impacts maternal bonding and access to care. They also considered the role of social determinants of health screening tools to provide resources for parents facing neonatal complications. The discussion covered how NICU environments could exacerbate social isolation for economically disadvantaged parents. The group agreed on the importance of standardizing progress measurement and discussed workforce incentives and funding mechanisms to support these initiatives, planning to refine these ideas further in upcoming monthly meetings.

Discussion

- The Chair attended this workgroup breakout session and noted there was discussion about screening and housing. They emphasized the importance of cultural sensitivity when doing home visits, recognizing that not everyone was comfortable with them. They also highlighted the need to focus on Black and African American maternal and infant health specifically, when narrowing the recommendations.
    - The workgroup co-lead agreed and added the necessity of asynchronous modalities for service delivery. They also noted that in-person visits may not be convenient for all patients. They mentioned examples of apps that allowed self-screening, which increased screenings among Black and brown individuals in neonatal settings.

Systems Issues in Rural Health

A co-lead summarized the various themes and recommendations that had been discussed, focusing on enhancing the rural maternal and child health (MCH) workforce by improving training, employability, and billability for roles like bedside nurses, Family Medicine OBs, doulas, and community health workers (CHWs). They also emphasized expanding the midwifery workforce and supporting midwives to practice and bill comprehensively. Regarding regionalized and risk-appropriate care, the group was looking at new payment structures and policy reforms to encourage provider collaboration across state lines. They also discussed stabilizing rural labor and delivery units to prevent hospital closures, exploring telehealth to improve access to maternal and child health services in rural areas, and addressing the challenges posed by state-based licensure for cross-state telehealth services.

Discussion

- A Committee member highlighted the importance of credentialing for family physicians in providing maternity and neonatal care.
    - The co-lead acknowledged the oversight and made an assurance that recommendations would include protecting, recognizing, and compensating the scope of family physicians, doulas, and CHWs.
- A Committee member inquired about the scope of midwifery being discussed, specifically whether it included all types of midwives or was limited to certain certifications.
    - The co-lead responded that the discussion had been broad and that narrowing it down may occur later due to state-specific licensure challenges.
- A Committee member suggested sharing criteria for narrowing each workgroup's recommendations, including feasibility, actionability, and levers within HHS.

Preconception/Interconception Health

A co-lead reported that their workgroup breakout session reviewed previous discussions, including a conceptual framework for their recommendations. They aimed to categorize their recommendations into immediate and long-term goals, focusing on training, workforce diversity, and the inclusion of various healthcare providers such as doulas, midwives, nurse practitioners, and community health workers. Their primary recommendation was to eliminate barriers to accessing preconception care and resources, while considering social determinants. They proposed a holistic life course approach to reproductive health, defining critical elements for reproductive health visits and plans. The group emphasized the importance of increasing BIPOC representation in all levels of healthcare, suggested integrating metrics and quality indicators into existing programs, and advocated for a comprehensive, culturally appropriate education campaign on reproductive health across the lifespan, addressing literacy and digital access issues.

Discussion

- A Committee member mentioned that the social determinants of health group had a similar discussion on preconception health and suggested the need for the two workgroups to follow up with each other.
- The Chair noted that workforce diversity seemed to be an overarching issue in all three workgroups, and wondered if it could be recommended in a way that was not confined to a single workgroup topic area.

The co-lead emphasized that workforce diversity included not only ethnic and racial diversity but also diversity in the types of providers delivering care. The Chair agreed.

Next Steps & Assignments

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

The Chair thanked the workgroups for their efforts. The SDOH workgroup co-leads mentioned that they were planning to move to monthly meetings like the other two workgroups rather than every other month. The Chair noted that monthly workgroup meetings would continue until the full Committee meeting in October and stressed the importance of refining the recommendations to make them manageable and time bound.

She mentioned scheduling one-on-one calls with workgroup co-leads in August to follow up on progress and said that she would set up one-on-one meetings with the six new appointed members in July to discuss work group participation.

A Committee member raised the issue of overlapping themes in recommendations, suggesting a preamble to address foundational concepts. The Chair agreed, highlighting the importance of workforce diversity and proposed discussions in August to identify overarching themes along with narrowing recommendations.

Meeting Evaluation and Closing Observations

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

The Chair asked Committee members to share their thoughts and observations from the past two days, which included:

- The importance of creating lasting, actionable, bold recommendations extending beyond the Committee's tenure.
- Appreciation for the new Committee members who had joined, bringing fresh perspectives and energy to the conversations.
- Gratitude for the diversity of experience and skill sets brought by the new and existing Committee members.
- A focus on collaboration and emphasis on the need for boldness and innovation to address persistent issues in Black infant mortality.
- The need for boldness and a shift towards a more inclusive approach to address persistent problems differently.
- Appreciation for the passion and importance conveyed by the workgroups and their discussions.
- The need to be unencumbered by old ways of thinking to make effective changes.
- The impactful story shared by Ms. Francesca Saulson and the importance of listening to those with lived experiences.

- The frequent mention of infant mental health and dyadic work was heartwarming and inspirational.

Wrap-Up and Considerations

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

The Chair expressed gratitude to everyone for their time and energy, particularly appreciating the contributions of the new Committee members who provided valuable input and feedback. She acknowledged the two days of dedicated efforts towards improving Black maternal and infant health, emphasizing the need for continued work and innovative approaches to achieve better results. She thanked everyone for their commitment and noted that follow-up emails would be sent in the coming week.

Adjourn

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

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