Secretary's Advisory Committee on Infant Mortality

Meeting Minutes of December 4-5, 2019

In-Person Meeting

Please note that the meeting minutes follow the order of events of the meeting, which differed slightly from the final meeting agenda that was posted to the Committee's website.

Wednesday, December 4, 2019

WELCOME AND INTRODUCTIONS

David S. de la Cruz, Ph.D., M.P.H.
Principal Staff and Designated Federal Official, SACIM
Deputy Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration

Paul E. Jarris, M.D., M.B.A.
SACIM Member

Dr. de la Cruz called the meeting to order. It was noted that Acting Chairperson Dr. Ed Ehlinger was not present due to unforeseen circumstances and that Dr. Paul Jarris would be filling in. Dr. de la Cruz welcomed participants to the meeting and thanked everyone for their continued commitment and support of the Committee's work to advise and guide the Secretary of HHS and the Administrator of HRSA on activities related to Infant Mortality, Women's Health, and Perinatal Health.

Dr. Jarris briefly mentioned his role filling in for Dr. Ehlinger. It was then stressed that how important it is to build a Committee that has multiple types of expertise, perspectives, and create a true dialogue in order to understand the issues.

SETTING THE CONTEXT

Paul E. Jarris, M.D., M.B.A.
SACIM Member

Dr. Jarris presented the PowerPoint created by Dr. Ehlinger and began with an overview of some key events. Since the last meeting, a White House Executive Order regarding advisory committees was executed, the SACIM charter was updated and renewed. An increase in public awareness on social conditions surrounding maternal and infant health has occurred, Dr. Ehlinger conducted one-on-one discussions with SACIM members, and lastly, two new members were added to the Committee.

In June, an Executive Order on "Evaluating and Improving the Utility of Federal Advisory Committees" was implemented asking the administration to look at all current committees in order to evaluate their importance and terminate 20 percent of them. Efforts were made the ensure the continuation of SACIM by stressing its current and historical importance. Dr. Jarris then thanked the HRSA Administrator for understanding the value of the Committee.

At the end of September, the objectives and scope of activities laid out within the SACIM charter were updated to include the focus on life course in order to address disparities in maternal health to prevent maternal mortality and morbidity. The topic of pregnant women is new for SACIM; the additional focus is justified through the impact maternal health has on babies and its effects on future pregnancies. Additionally, SACIM's charter was renewed for another two years, through September 2021. The expansion of SACIM's objectives has been fueled in part by the increased awareness on maternal mortality concerning the maternal and infant health from social conditions. Social determinants of health include structural systematic disadvantages, racial and ethnic differences, and consumer protection relating to regulation of products which can cause infant mortality.

Community Representative
Tonja Honsey
Founder, We Rise MN
Minnesota Prison Doula Project

Ms. Honsey and other community representatives were invited to speak to provide the Committee with a better understanding of the day-to-day perspective from the community level. Ms. Honsey introduced herself as an Ojibwe woman that is working with the Minnesota Prison Doula Project. She benefited from the services of a low-cost doula when she was homeless and pregnant with her youngest child. She elaborated how the doula was the only person celebrating her pregnancy and child which allowed her to feel and understand the sacredness of the pregnancy while dealing with myriad extenuating circumstances. The time with her own doula was her inspiration to begin a career as a doula with the Minnesota Prison Doula Project. Working in seven facilities, the project is funded through grants, foundations, facility contracts, and private donors.

The purpose of the Minnesota Prison Doula Project is to support incarcerated birthing people through pregnancy and birth. Ms. Honsey further explains what an honor and privilege it is to be there for that growing family and the ability to build a safe and sacred space to celebrate new life. There is an average of thirty-six hours that mother and baby are allowed to be together, and the doula is present for the separation visit. This visit is when the social worker comes to either bring the child to a foster home or family member, and is usually the last time the mother would be able to see the baby for at least a month due to the visitor approval process within the facilities. Currently the Minnesota Prison Doula Project, in conjunction with the governor of Minnesota and the Department of Corrections, is working towards ending incarceration for pregnant women so they would be allowed to stay in the community. Ms. Honsey also noted that the organization has been consulting with other states in order to replicate the program there is an additional project under the organization in Alabama, the Alabama Prison Project.

WELCOME FROM HRSA

Thomas Engels
Administrator, HRSA

Mr. Engels summarized the new two-year charter that has been put in place and emphasized its importance for the populations served by HRSA. The work that is being done provides access to culturally competent and high-quality health care within the nation's most vulnerable populations. He elaborated on some of the HRSA programing that has made some significant impacts. For example, over the last year, HRSA-funded health centers served 28 million people. The Ryan White Program served half the population living with HIV and 86 percent of those people served at those centers are now virally suppressed with effectively no risk of transmitting the virus to an HIV-negative partner. HRSA also has almost 15,000 National Health Service Corps and Nurse Corps in underserved areas in the nation in exchange for loan repayment and scholarship. The HRSA-funded Home Visiting Program has provided over 5 million voluntary home visits over the last seven years.

Some accomplishments HRSA has made in relation to serving the maternal and child health populations has been through the Healthy Start program which has been awarded more than $100 million in grants. New funding has also been provided to spark innovation, support maternal health services delivery, and address the high rate of maternal mortality and morbidity through the State Maternal Health Innovations Awards. Funding was also awarded for a national resource center, which provides capacity-building assistance with HRSA's maternal health grantees and other stakeholders in the effort to reduce maternal mortality and morbidity. Additionally, funding was awarded for the Alliance for the Innovation of Maternal Health, or AIM, which supports the development and implementation of non-hospital focused maternal health bundles within community-based organizations and outpatient clinics.

Lastly, HRSA's Federal Office of Rural Health Policy launched the Rural Maternity and Obstetric Management Strategy Program, or RMOMS, and involves world hospitals, health centers, state Medicaid offices, and programing to develop sustainable strategies at world levels.

Committee Questions and Discussion

- Dr. Paul Jarris asked, in Mr. Engels' role of administrator, is there is an ability to coordinate all the HRSA programs in order to work together to multiply its efforts.
    - Mr. Engels has encouraged everyone to reach across and talk to other bureaus within HRSA, to reach across lines in order to understand what the various programs are doing and how they might be able to work together.
- Dr. Lisa Waddell of the March of Dimes inquired about areas with no access to OB or other providers and HRSA's role in the guidance or direction on how to improve access using telehealth and telemedicine.
    - Mr. Engels explained how there is an attempt to expand both. HRSA health centers can offer any OB services. In smaller hospitals, OB services are the first to get cut due to lack of funding or profits and leaves a void.
- Dr. Steve Calvin wondered if there is a midwife scholarship program. He elaborated that there are not enough midwives to work for OB/GYNS and family medicine and asks to keep that on the radar.
    - Mr. Engels briefly described the work of the National Health Service Corps and loan repayment program.
- Dr. Magda Peck asked what the advice would be when looking at health equity issues, such as racial disparities and the underlying upstream causes.
    - Mr. Engles responded that a patient is a patient and to make sure each one is getting the best care possible.
- Dr. Jeanne Corny highlighted the success that California has accomplished in both infant and maternal mortality. There are extremely rural parts of the state, yet it has the lowest maternal mortality and is among the lowest of infant mortality. It may be a good method in order to understand what can be done in the rest of the nation.
    - Mr. Engles responded that California is also looking at the issue of bundles in rural hospitals as they can be quite onerous on the available resources.

INTRODUCTION OF COMMITTEE MEMBERS, EX- OFFICIOS AND OTHER ATTENDEES

Dr. Jarris invited the Committee members, ex-officio members and others to introduce themselves:

<u>Committee Members</u>

Jeanne A. Conry, M.D., Ph.D., President of the Environment Health Leadership Foundation, President Elect for the International Federation of Obstetrician-Gynecologists, past President of the American College of Obstetricians and Gynecologists (ACOG), and a chairperson for ACOG's Women's Preventative Services Initiative.

Steven E. Calvin, M.D., is an Obstetrician-Gynecologist and has started the Minnesota Birth Center alongside midwives. (New member of SACIM attending his first meeting.)

Vijaya K. Hogan, Dr.P.H., M.P.H., currently is the Adjunct Professor of Maternal and Child Health at the University of North Carolina Chapel Hill.

Paul E. Jarris, M.D., M.B.A., Chief Medical Advisor for the The Mitre Corporation, a not-for-profit organization supporting the federal government.

Tara S. Lee, Ph.D., currently is the Senior Fellow and Director of Life Sciences at the Charlotte Lozier Institute. She has led research and clinical diagnostics labs at the Medical College of Wisconsin and Children's Hospital of Wisconsin, has extensive training and experience in pathology and pediatric disease, and has worked closely with Milwaukee Medical examiner's Office to understand factors implicated in SIDS. She has a particular interest in prenatal diagnosis and prenatal interventions that

increase survival outcomes for infants diagnosed with birth defects. (New member of SACIM attending her first meeting.)

Janelle F. Palacios, Ph.D., C.N.M., R.N., Nurse Mid-Wife for Kaiser Permanente Oakland Medical Center Labor and Delivery. She is a past President of the Native Research Network, which is the largest organization of American Indian and Alaskan Natives Researchers in Healthcare.

Magda G. Peck, Sc.D., Founder/Principal at MP3 Health Group which focuses on health and equity, particularly on women and children around the country. She is an adjunct Professor of Pediatrics and Public Health at the and University of Nebraska Medical Center where she cofounded the School of Public Health. Additionally, she is the founder and former CEO and current Senior Advisor to City MatCH.

Belinda D. Pettiford, M.P.H., B.S., B.A., is Women's Health Branch Head of the North Carolina Division of Public Health Women's and Children's Health Section.

Paul H. Wise, M.D., M.P.H., is Professor of Pediatrics Health Policy and International Studies at Stanford University and is also co-Director of the March of Dimes Center of Premature Research at Stanford. He was elected to the Federal Court overseeing the treatment of migrant kids in U.S. detention on the border and is responsible for independent evaluation of the situation to mediate improvements with the Department of Homeland Security and the plaintiffs representing the kids.

Ex-Officio Members

RADM Wanda Barfield, M.D., MP.H., Assistant Surgeon General and Director, Division of Reproductive Health for the Centers for Disease Control and Prevention. She is also a clinical neonatologist.

Wendy DeCourcey, Ph.D., is a representative and Social Science Research Analyst, Office of Planning, Research and Evaluation, from the Administration for Children and Families of the Department of Health and Human Services.

Dorothy Fink, M.D., is representative from the Administration for Children and Families of the Department of Health and Human Services. She is the Deputy Assistant Secretary, Women's Health Director, Office of Women's Health, for the U.S. Department of Health and Human Services.

R. Danielle Ely, Ph.D., is the Manager of the linked birth and infant death file for the Division of Vital Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention.

Cheryl S. Broussard, Ph.D., an Epidemiologist, Associate Director for Science, Division of Congenital and Developmental Disorders, National Center of Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention

Committee Staff

Michelle Loh, Management Analyst for the Division of Healthy Start and Perinatal Services, Maternal and Child Health Bureau, Health Resources and Services Administration.
Others who introduced themselves briefly:

Juliann DeStefano, Project Officer for the Division of Healthy Start and Family Services, Health Resources and Services Administration, Maternal and Child Health Bureau

Becky Abbott, Deputy Director of Federal Affairs with the March of Dimes

Caroline Stampfel, Director of Programs at the Association of Maternal and Child Health Programs

Lisa Waddell, Deputy Medical Officer at the March of Dimes International Headquarters

Laura Kavanagh, M.P.P., Deputy Associate Administrator for the Maternal and Child Health, representing Dr. Michael Warren, the Associate Administration for Maternal and Child Health and the Committee's Executive Secretary.

Sarah Foster, Division of Reproductive Health, Centers for Disease Control and Prevention

Theresa Chapple-McGruder, Maternal and Child Health Bureau, Health Resources and Services

Administration

Dawn Levinson, Behavioral Health Lead, Health Resources and Services Administration, Maternal and Child Health Bureau

Vanessa Lee, Division of Healthy Start and Prenatal Services, Health Resources and Services Administration, Maternal and Child Health Bureau

Kimberly Sherman, Health Resources and Services Administration, Maternal and Child Health Bureau

Kacie McLaughlin Division of Healthy Start and Perinatal Services, Health Resources and Services Administration, Maternal and Child Health Bureau

Lee Wilson, Senior Policy Advisor, Maternal and Child Health Bureau

Tiffany Wiggins, M.D., M.P.H., Director of the Division of Healthy Start and Perinatal Services, Maternal and Child Health Bureau and is also an Obstetrician-Gynecologist

REPORT ON ACTING CHAIR'S ONE-ON-ONE INTERVIEWS WITH SACIM, ASSUMPTIONS UNDERLYING THE WORK OF SACIM
Paul E. Jarris, M.D., M.B.A.

SACIM Member

Reviewing Dr. Ehlinger's discussions with the Committee members, Dr. Jarris reported that all members voiced the importance of the Committee and its role to advise the Secretary and the Administration and representative of the Mother and Child Health Bureau. SACIM has the responsibility to be a reliable scientific voice which draws from the vast and diverse expertise, experience, and interests of Committee members to create an inclusive environment for discussion, deliberations, and ultimately the Committee's recommendations. All Committee members feel their potential to make a difference and influence federal policy and programs in maternal and infant health if there is a clear scientific focus. Some of the other concerns and opinions expressed by the members were: MCH is too insular, SACIM should include rural disparities, having more than two meetings per year, and more short-term objectives.

Committee Questions and Discussion

- Dr. Paul Jarris asks the Committee if there are elements missing that are important, that serves the Committee consensus, or anything that should be reinterpreted?
- Dr. Vijaya Hogan stated the need to clarify that multi-sector is broader than health and community services. Further, developing programs to address problems in a reactive way when SACIM needs to set a vision and become wholistic.
- Dr. Wendy DeCourcey believes that over time, the concept of a common direction articulated by thoughtful people that is shared across agencies is developing naturally. However, articulation on how to move forward in perspective to the life course and social determinates of health would be welcome. How do we come up with an action plan?
- Dr. Janelle Palacios references the community representative, Tonja Honsey, and women who are incarcerated. Women who are pregnant while incarcerated are provided a doula, however, to help improve maternal health will be a large social issue as it focuses on the social determinants of health and health equality. How can recommendations be made to improve health once we include social determinants of health and the equity we take? There are adverse childhood experiences that cause things to happen in the same propensity as developing diabetes or other diseases.
    - Dr. Paul Jarris made note that the World Health Organization has criteria for the conditions that are necessary to have health, which may be something to look at. Values, in terms of certain conditions are necessary in an environment when looking at health and a healthy pregnancy, what is the responsibility of our society versus the individuals.
    - Dr. Jeanne Conry appreciated bringing up the World Health Organization, as it is

important for the Committee to tie this into the sustainable development goals.

UPDATES FROM THE MATERNAL AND CHILD HEALTH BUREAU
Laura Kavanagh, M.P.P.
Deputy Associate Administrator for Maternal and Child Health

Health Resources and Services Administration

Ms. Kavanagh informed the Committee that she is going to try to provide context to a number of HRSA programs. After providing an overview, she explained that HRSA houses the Bureau of Primary Health Care, the community health centers across the country, and the Bureau of Health Workforce. Additionally, HRSA houses the Federal Office of Rural Health Policy. HRSA's Mission is to improve health outcomes and address health disparities through access to quality services, a skilled health workforce, and innovative, high-value programs, which calls out health disparities explicitly.

The foundational investments within the Maternal and Child Health Bureau are: Title V Maternal and Child Health Services Block Grant Program; Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV); and the Healthy Start program.

The Title V program is foundational maternal and child health public health support program and is MCHB's largest investment, accounting for about half of the Bureau's budget. This program funding is formula based, which is the percentage of children in poverty within the state. In 2017, the program reached over 56 million people and currently 91 percent of pregnant women, 99 percent of infants, and 55 percent of children are reached through the Title V programs in states and jurisdictions. Historically, the State Title V Block Grant Program has partially or fully supported maternal mortality activities.

The MIECHV Program accounts for about a third of the budget and provides voluntary evidence-based, home-based services, which focuses on at-risk pregnant women and parents of young children. The reach is broad with 150,000 participants in 2018 across 896 U.S. Counties and a total of 930,000 home visits. Lastly, the Healthy Start program which is closely affiliated with SACIM because of its focus on infant and perinatal health, infant and maternal mortality reduction, and elimination of disparities through community-driven efforts. As of April, program is funding 101 grantees in 34 states, the District of Columbia, and Puerto Rico. Additionally, a supplement to the grants has been added this year to focus on providing clinical care providers sites to assist in care coordination to improve maternal health outcomes.

In 2019, MCHB received $38 million to address maternal health issues. Support went to nine states through the State Maternal Health Innovation Awards, the Alliance for Innovation on Maternal Health (AIM) which is funded to ACOG, a new initiative involving community-based bundles, new screenings and treatment for maternal depression and related behavioral disorders, Women's Preventive Services, Bright Futures, and the National Survey of Children's Health.

Ms. Kavanagh then explained Challenge grants, which are an innovate way to reduce entry requirements in order to support new ideas within the federal government grant program. There are currently two such grants which focus on maternal health. One is MCHB Remote Pregnancy Monitoring Challenge with a focus on remote pregnancy monitoring but also on development of a support system using technology as a support system for women seeking prenatal care. The second is MCHB Opioid Use Disorder Challenge to improve access to quality health care for pregnant women and new mothers struggling with opioid use disorder.

At the last SACIM meeting, Dr. Michael Warren presented a Paradigm for Improving Maternal and Child Health, which has since been developed further. He wanted to develop a paradigm for how to accelerate improvements in maternal and child health and what that would look like. The paradigm is composed of three aspects: accelerate, upstream, and together. The first aspect being the acceleration of the pace relating to innovation and strategic investments. Secondly, upstream is thinking about two-generation approaches and a life course perspective that impacts a person's health trajectory over a lifetime. The third aspect being together – partnerships on all levels through working together and the sharing of ideas, data, and perspectives.

Ms. Kavanagh opened the floor to any questions on MCHB general programs prior to moving on to more detailed specifics per the request of Dr. Ehlinger.

The MCH Title V Block Grant requires 30 percent of the funds to be dedicated towards children with special health needs, 30 percent of funds dedicated to primary and preventative services for children, and no more than 10 percent spent on administration. The broad parameters provides for flexibility in how those funds are spent as long as they meet the requirements. Additionally, the grants legislation requires a conduct of needs assessment every five years with the next one due on July 15, 2020.

Every state and jurisdiction provides a Five-Year Assessment Summary that spans across maternal and child health populations without constraints. It is to include their individual assessment process and the findings from that process. The findings from this assessment the serves as the cornerstone for development of the five-year State Action Plan. Once the assessments are conducted, the information becomes publicly available with extensive detail on the state's programs, financial reports, the population that is being served, and the evidence-based practices being implemented.

The requirements of the Five-Year Assessment Summary Process are:

- An overall goal with an outline of the framework and methodology used to meet that goal.
- Details on the level and extent of stakeholder involvement.
- The use of quantitative and qualitative methods to conduct an assessment of strengths and needs for each health domain.
- The data sources used during the process.
- An interface between the data, the finalization of priorities, and action plan.

The Needs Assessment Summary Findings must include:

- MCH Population needs with a summarization of the population strengths, needs, successes, or challenges.
- Title V Program Capacity with a breakdown of organizational structure, agency capacity, the MCH workforce development and its capacity.
- Various partnerships or collaborations of family engagement and the leadership processed in coordination with other MCHB, federal, state, and local MCH investments.

The National Survey of Children's Health (NSCH) is an annual MCHB funded survey that is conducted by the U.S. Census Bureau. The survey is administered to parents of children between the ages of 0 and 17 years and addresses various health issues, neighborhood factors, and is collected in both English and Spanish.

Ms. Kavanagh finally provided an update on Healthy People for 2020. It is currently in closeout with the data provided to the CDC's National Center for Health Statistics and the end-of-decade estimates are expected to be available in December 2020. Healthy People 2030 is underway with 20 objectives for inclusion in the Maternal, Infant, and Child Health (MICH) Topic Area and three additional developmental objectives identified. The core MICH indicators and new MICH content has been identified with the launch planned in March 2020.

Committee Questions and Discussion

- Ms. Belinda Pettiford inquired about the outcomes being tracked with the MIECHV Program. The program initially was focused on child abuse and neglect but has the focus of the program moved the focus to infant mortality and maternal health or is child abuse and neglect still a focus?
    - Ms. Kavanagh answered that it is dependent on the model but there is an emphasis on including maternal health instead of solely child health.
- Dr. Magda Peck asked if mapping has been done of the U.S. and territories to look at the

distribution of investments MCHB against health outcomes. Additionally, can it be mapped from a local perspective.

  - Ms. Kavanagh informed Dr. Peck that the HRSA Data Warehouse has that capability and the data is better at the state level. A pilot program is being developed on how to map need and investments.

- Dr. Paul Jarris commented that some home-visiting programs aim at the mother, or child, or even multiple people which can be a disadvantage as can be much broader than HRSA's mission.
  - Ms. Kavanagh explained that the legislation requires that HRSA uses the evidence-based strategies that are approved and meet requirements for randomized controlled trials, however the question of how to develop further is something that is being worked on.
- Dr. Magda Peck wondered the ability for the Bureau to see the collective impact or synergy between the private investments at the zonal and local level, and the investments being made by the Bureau and Title V.
  - Ms. Kavanagh elaborated that there is a huge opportunity to look at cross-sectors on a broad scale. There is a public-private partnership which allows the sharing of best practices and the current investments to learn from one another.
- Dr. Paul Jarris asked what the preparations are for addressing the use and abuse of methamphetamines.
  - Ms. Kavanagh admitted that it is not her area of expertise but that it is being looked at in a broader sense
- Dr. Tara Sander Lee asked how many of the NSCH surveys were sent out and what was the determination of where to send them?
  - Ms. Kavanagh stated that it is a household sample and she is unsure of the response rate.
  - Mr. Lee Wilson responded that a series of fact sheets are being done on the survey. Additionally, the Census Bureau is using the survey as a model while attempting to address bias and concerns that have been raised with surveys generally.
- Dr. Magda Peck requested clarification on territories, such as Puerto Rico, and if it is included in the scope of SACIM as it would helpful to know of any immerging issues such as immunization challenges or a measles outbreak.
  - Ms. Kavanagh does not think there are any limitations with territories and jurisdictions.

PREEMIE ACT
Rebecca Abbott

Deputy Director of Federal Affairs for Public Health, March of Dimes

March of Dimes is leading the fight for the health of all moms and babies through research, education, and programs in advocacy. Every November during Prematurity Awareness Month, March of Dimes grades the United States as a whole and each state individually on preterm birth weights in order to bring awareness. Four years in a row the U.S. has received a C grade with preterm births worsening in thirty states between 2017 and 2018. A map containing the grades of each state was presented and demonstrates the significant disparities geographically, which is compounded by racial disparities. There are 50,000 mothers each year that face life-threatening health challenges that have an estimated societal burden of $25.2 billion.

The Prematurity Research Expansion and Education for Mothers who Deliver Infants Early (PREEMIE) Act is the only federal law dedicated exclusively to preventing and treating preterm birth through activities at CDC, HRSA, and SACIM. The PREEMIE Act was first introduced by Congress in 2003 and passed in 2006 with the PREEMIE Reauthorization Act signed into law in December 2018.

The bill authorizes CDC to conduct surveillance and epidemiologic studies on preterm birth along with any

related factors which is reported every two years. At HRSA, it authorizes activities to educate the public and providers on preterm birth with the reauthorization adding high-risk pregnancies to telehealth programs. Additionally, SACIM was established with legislation outlining its responsibilities. Lastly, in 2008, the PREEMIE Act supported the Surgeon General's Conference on Preterm Birth.

The 2018 reauthorization made changes and added to the bill. A new interagency task force led by the Department of Health and Human Services to focus on coordinating federal programs across agencies impacting preterm birth, infant health mortality and maternal health mortality. At the CDC, an increase of focus on social determinants of health in epidemiological studies and the funding for those studies to $2 million each year. HRSA now has an expanded focus on maternal substance use, maternal mental health, and maternal immunization. Lastly, SACIM is to prioritize as areas of focus the issues of health equity and maternal health.

Ms. Abbott went on to outline the following federal efforts being done to improve maternal health

- Extension of Medicaid to one year postpartum
- Support to include bias competency training
- Standardization and improvement of data collection
- Authorization of the AIM grant program
- CDC support for quality collaboratives
- Funding for rural obstetric health CoIIN.

Additionally, three bills are being introduced which focus on maternal health: Maternal Health Quality Improvement Act of 2019, Helping Medicaid Offer Maternity Services (MOMS) Act of 2019, and Lower Health Care Costs Act.

Committee Questions and Discussion

- Dr. Jeanne Conry commended March of Dimes for their work and stated the need to be a spokesperson for prematurity awareness around the United States. Also, there needs to be an awareness of climate change and the impact the climate has on prematurity and maternal and child health.
    - Ms. Abbott explained how the environmental health community currently does not interact with the maternal and child health community regarding policy.
    - Dr. Conry pointed out that the American Academy of Pediatrics has a liaison with ACOG and the two are working collaboratively.
- Dr. Vijaya Hogan inquired about long-term treatments built into the PREEMIE Act considering the life course of babies and the impact on their future babies.
    - Ms. Abbott responded that there was not a current emphasis on life course long-term impacts, but it should be considered for the next reauthorization or through other channels.
    - Additionally, Dr. Hogan asked if the maternity care home demo project has been authorized already. Again, Ms. Abbott answered that it also has not been authorized.
- Dr. David de la Cruz raised concerns about the biannual report due and requested further information.
    - Ms. Abbott informed him that since the taskforce has not been created yet so it is not something that would be asked of the Committee.
    - Dr. Paul Jarris questioned if any related interagency taskforces could provide the report.
    - Ms. Abbott stated that is something to discuss with the Secretary's office.
- Dr. Magda Peck asked where the data come from. Specifically, she asked what connects outside

data in support of the March of Dimes data?

- The data mostly comes from CDC's National Center of Health Statistics. Ms. Abbott emphasized how data are a vital resource as it guides the work and investments being done by the March of Dimes.
- Dr. Lisa Waddell stressed how important and valuable the date is in order to see the whole picture in regions, states, and communities.
- Ms. Belinda Pettiford asked if the PREEMIE Act included funding.
    - Ms. Abbott informed her that authorization bills only authorize funding and the funding has to go through the annual appropriations process.
    - As a follow up, Ms. Pettiford was curious about the new bills not being funded unless there is an additional approval and if funding may not be implemented without taking away funding from somewhere else.
    - Ms. Abbott stated that Ms. Pettiford was correct.
    - Dr. Wanda Barfield made note that the funding for the PREEMIE Act is from existing funding that CDC has under Safe Motherhood.

STRATEGIES FOR IMPROVING MATERNAL HEALTH

Wanda Barfield, M.D., M.P.H.,
RADM, USPHS & Assistant Surgeon General
Director, Division of Reproductive Health
Centers for Disease Control and Prevention

Charlan D. Kroelinger, Ph.D.
Chief, Maternal and Infant Health Branch, Division of Reproductive Health
Centers for Disease Control and Prevention

Dr. Kroelinger provided an overview of the three topics to be discussed: the relationship between maternal and infant outcomes, data on pregnancy-related deaths, and the efforts made to strengthen surveillance through assessment and quality improvements. The maternal and infant health can no longer be looked at separately. Maternal conditions, behaviors, and environments contribute infant health and mortality, including pre-term births.

Women with chronic health conditions such as cardiovascular disease, diabetes, and obesity can cause complications during their pregnancy and beyond. For example, six to nine percent of women develop gestational diabetes which causes the risk of high blood pressure during the pregnancy, the potential need to deliver via cesarean section due to larger babies, and both the mother and baby having a high risk of developing type 2 diabetes later in life. Maternal and infant health outcomes can also be influenced by the environment the mother lives in. These factors include health insurance coverage, access to a healthcare provider, preconception health, housing, and education.

Pregnancy-related deaths are related to or aggravated by the pregnancy or its management and include pregnancy complications, aggravation of unrelated conditions, or a chain of events initiated by the pregnancy. An average of 700 women die during or within one year of the end of a pregnancy in the U.S. each year, and the overall maternal mortality rate has risen since 1999 with no improvement over the last decade.

Data provided by the Pregnancy Mortality Surveillance System (PMSS) has determined that most pregnancy-related deaths occur during pregnancy and has identified the leading cause of death at each stage:

- During pregnancy: Cardiovascular conditions
- During delivery: severe bleeding and amniotic fluid embolism
- During week after delivery: severe bleeding and hypertensive disorders

- Within forty-two days after delivery: infection
- Between forty-three days and one year: cardiomyopathy

Maternal Mortality Review Committees (MMRCs) are comprehensive standardized data systems used to collect complete data on maternal deaths in order to create effective programing which address the factors leading to those deaths. Currently there are forty-one reviews with contacts in the remaining eleven states. Additionally, Maternal Mortality Review Information Application (MMRIA) is being used to create action through common language and standardize recommendations from MMRCs. Currently there are thirty-three jurisdictions using the MMRIA decisions.

Perinatal Quality Collaboratives (PQCs) are state-based initiatives aiming to improve the quality of care by advancing evidence-informed clinical practices and QI principles, addressing gaps within the system, teaching the best practices, and optimize resources. This is implemented through the use of collaborative learning models, rapid-response data, and QI science support with every state having a PQC currently working or in development.

Dr. Kroelinger concluded with a review of Maternal and Neonatal Risk-Appropriate Care with less than half of the states having a policy, or having inconsistencies if a policy does exist. Levels of Care Assessment Tool (LOCATe) was created to implement the standard information and address concerns regarding a large number of areas including hospital equipment, staffing, and transport. Through LOCATe, the CDC has concluded that transport is vital for risk-appropriate care with telemedicine becoming a necessary tool to address health care throughout the nation.

Committee Questions and Discussion

- Dr. Steven Calvin asked how optimistic and realistic it is to use MMRIA and the ability to get data nationally.
    - Dr. Barfield stated that it is going to take time in terms of helping states and jurisdictions change the method of gathering data and providing it to the review committee.
- Dr. Paul Wise asked what gaps are there or what is missing within the system.
    - Dr. Kroelinger responded that one of the big gaps that has been identified is the issue of equity and contribution of partners through reimbursement for services or increasing access to quality care for women.
- Dr. Magda Peck addressed the incorporation of emerging issues. With legal drug use in a growing number of jurisdictions (i.e., with the legalization of cannabis) or the radical shift within the health systems electronic medical records and standardized data systems linking to MRRIA. With emerging issues such as these, the question of how rapidly changing context within the distribution of data is incorporated and addressed.
    - Dr. Kroelinger explained that the states that CDC is currently working with are engaged in MMRIA and are willing to contribute toward how data are examined with the hope of developing guidance and examples to learn from and follow on a national level. When working with emerging issues a good example is the opioid crisis. The MMRC leaders within the states discussed how to address the issue with one method focusing on enhanced review of overdose deaths. Selected states focused on understanding the factors contributing to those deaths. Issues dealing with broad data systems require more thought as the focus is on development and implementation of MMRIA.
    - Dr. Barfield added how remarkable the effort being put in to work with the state with the advantage of having assignees in the field. It is vital to listen to the communities to better understand emerging issues with the benefit of assignees ability to bring attention to those issues. In relation to social factors, Dr. Barfield continued that through the expansion of MMRCs there will be better understanding of those factors.
- Dr. Paul Jarris asked the merit of down streaming unintended consequences in relation to the

LOCATe tool.

  - Dr. Kroelinger responded that there is a benefit of standardizing care, however the cost may be that certain types of care may no longer be available. However, states are addressing this in creative ways through ECHO programs providing telehealth to women in hard-to-reach areas. Our job is to listen and understand their innovations in order to disseminate them to become part of the standard.
  - Dr. Jarris inquired then if that instead of perfection, the reach is the best possible care.
  - The impact of the LOCATe Dr. Kroelinger explained, is not on hospital services, as it is tool intended to discuss what the minimum of care should be.
  - Dr. Barfield explained the potential opportunity to think differently in terms of risk-appropriate care the system of rewards and penalties for how care is provided.

- Ms. Rebecca Abbott requested further explanation on the issue of surveillance and the data challenges around gathering data, the limitations within EHRs, and improvement or expansion on those issues.
  - Dr. Barfield responded that the challenge in severe maternal morbidity, similarly to infant and neonatal experience, has been in terms of severity of illness index and how to incorporate effective measures regardless of intervention to truly understand the issue.
- Dr. Jeanne Conry applauded the CDC for all the work being done and the leadership shown has really made a difference.
- Ms. Janelle Palacios wondered if the CDC has looked into plant-based diets to improve cardiovascular health.
  - Dr. Barfield note that it hasn't been specifically addressed, but there is better understanding of the broader contributions of cardiovascular disease to maternal morbidity and mortality. She cannot answer what specific type of diet or change within the nutritional profile needs to be addressed.

WHAT RECOMMENDATIONS (OLD AND NEW) SHOULD SACIM PROMOTE?
Paul E. Jarris, M.D., M.B.A.
SACIM Member

Dr. Jarris opened the floor to the Committee for discussion. Beginning with guidelines put together by Dr. Ehlinger, the Committee discussed the SACIM Simple Rules:

- Remember every baby and mother
- Center on equity
- Listen to community voices
- Build capacity
- Focus on connections
- Ask powerful questions
- Seize opportunities

Ms. Belinda Pettiford asked in relation to community voices, if the Committee's charter prohibits consumers appointed to the Committee to hear their voices rather than consumers calling in. Additionally, she followed up by asking if someone could be reimbursed for their time or do they have to be appointment members for compensation for their time. Dr. David de la Cruz noted that the logistics contract has funds to reimburse a speaker and expenses incurred. Ms. DeStefano clarified that only two speakers per meeting are allotted in the contract. A discussion was then had on organizations with consumers to reach out to with an invitation to speak at a meeting.

Dr. Magda Peck pointed out the similarities between the SACIM Simple Rules and written recommendations from Kay Johnson in 2013. Dr. Jarris continued to discussions around the 2013

Committee's six strategic directions: care outside of labor and delivery, ensure access to continuum, redeploy key evidence-based preventive interventions, increase health equity and reduce disparities, invest in adequate data, and maximize potential of integration. Dr. Steven Calvin and Dr. Paul Jarris agree on the issue of financing as an addition to equity by ensuring access to a continuum.

Dr. Vijaya Hogan proposed additions to the list such as navigating interagency collaboration and how it filters down from the federal level, addressing different types of narratives and ideologies, policy issues, and a focus on research. Lastly, clarification as the fourth point does not equal the other notating that the language may need to be changed. Dr. Wanda Barfield added that NIH has an Implementation Science Institute which may have opportunities to learn there in terms of the scientific work.

Dr. Wendy DeCourcey made mention of the columns going across six items and feels as if they may already have sub columns. Additionally, she wanted to point out that when discussing cross-agency work and changing narratives across agency work, her office has been trying to change the narrative on equity issues through presentations, discussions, and brainstorming. It has found people who can teach but it seems as if there is no action.

Dr. Paul Wise stresses the need to recognize the most fundamental threat being that we are all living in an aging society. Also, funding levels for the programs we all care about is shrinking relative to other parts of the federal budget.

Dr. Wanda Barfield asks how to adequately invest in data, monitoring, and surveillance systems. Although there are very broad, big-idea recommendations, we seem to look at perinatal data vital statistics when we need to look at all the data. The challenge being in the complexities of it all.

Dr. Tara Sander Lee wanted to follow up on something Dr. Magda Peck mentioned about emerging technologies. It is a serious concern, especially regarding in-utero surgical interventions and the topic of perinatal revolution as there are many emerging technologies. There is an issue not only with accreditation and fellowship, but insurance coverage, and what is deemed as medically necessary.

Ms. Alison Cernich of NIH's NICHD commented how research is incredibly important and given the amount of investment from NIH, there is the ability to track normal pregnancies and birth outcomes, medication use, infection, hemorrhage, and other facts which impact infant health. Funds are contributed to some surveillance and researchers are interacting with those systems. Further, the extent in regard to CPSPR and point-of-care technologies that can be extended are all things NIH does. A pregnancy portal has just been launched on the All of Us Initiative which is NICHD's crowdsourcing research initiative which is part of an ongoing study.

As a follow up, Ms. Belinda Pettiford asked Ms. Alison Cernich if data that's entered into the system is done by race and ethnicity. Ms. Alison Cernich noted that prior to All of Us, research was generally of well-off white women. She continued that they are happy to talk to any community engagement organization that would like to talk about increasing enrollment. Additionally, medications are also tracked during pregnancy and data are collected on ethnicity, education, and other social determinates of health. Dr. Wanda Barfield then went on to acknowledge and thank them for collaboration with PRAMS. She then wondered if they offer anything regarding maternal health that NICHD is trying to think about. The response from Ms. Alison Cernich was that NIH's perspective is to leverage what is known and can be done for other conditions. Focus is on prevention, effective treatment, with a look towards immune factors. Additionally, the biggest limitations is linking moms to babies within the data systems. Dr. Paul Jarris then asked if implementation science is a part of NIH. It is noted by Ms. Alison Cernich that a number of institutions are sponsoring research that is implementation and dissemination based.

Dr. Cheryl Broussard steered the discussion towards the mom-baby linkage and made a comment on how her division at CDC is leading a cross CDC workgroup trying to get pregnancy status added to all data collection systems across the agency. Dr. Wanda Barfield added that there are more collaboration and improvement of perinatal quality efforts happening.

EVALUATION OF THE DAY AND WRAP-UP

David S. de la Cruz, Ph.D., M.P.H.
Principal Staff and Designated Federal Official, SACIM
Deputy Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration

Paul E. Jarris, M.D., M.B.A.
SACIM Member

Dr. Jarris invited participants to provide a one sentence summary of the day's meeting.

Beginning with Dr. Calvin, he stated that he was overloaded but grateful for all the ideas provided. Dr. Sander Lee added that it has been a huge learning experience and she is interested in seeing how everything will work together.

Dr. Hogan, Ms. Abbott, Ms. Stampfel, and Dr. Waddell each expressed their appreciation and excitement towards the progress the is being made.

Dr. Wise made a comment on the remarkable innovations that have happened within the field but there is a need to confront the contradiction of the lack of implementation of those innovations within the field.

Dr. DeCourcey pointed out how the Committee is getting to the problems but a solution or recommendations towards a solution has not been found yet. Then, Dr. Barfield expressed the need to think carefully on how to embrace the needs and health of women in a way that is clear and distinct for the benefit of infants.

Dr. Ely noted how interesting it was to hear about the different programs and organizations in different states. A reflection of possible opportunities may help to direct power within changing systems and what the options are for all or some women.

Mr. Wilson reflected on a comment made within the one-on-one session with Dr. Ehlinger and that the Committee needs to take the time to really set its vision. Building on that, Dr. de la Cruz encourages everyone to not lose momentum and to make sure everyone is doing what they can to make a change.

Ms. Satterfield commented on her excitement for the work the group is doing and can provide any resources she has at her disposal.

Dr. Peck reiterated the importance of Tonja Honsey's work and encourages everyone to draw inspiration from her.

Lastly, Dr. Conry and Ms. Palacios expressed their appreciation to everyone who spoke during the first day and is excited to continue those discussions during the second day.

Dr. David de la Cruz thanked everyone for participating and adjourned the meeting for the day at 5:00 p.m.

Thursday, December 5, 2019

CALL TO ORDER

David S. de la Cruz, Ph.D., M.P.H.
Principal Staff and Designated Federal Official, SACIM
Deputy Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration

Paul E. Jarris, M.D., M.B.A.
SACIM Member

Dr. David de la Cruz called the meeting to order and with Dr. Paul Jarris, welcomed everyone to day two of the meeting. Dr. Jarris mentioned the time of the public comment period and gave an update on Dr. Ehlinger.

REVIEW AND APPROVE MINUTES

Paul E. Jarris, M.D., M.B.A.
SACIM Member

Dr. Jarris then brought the Committee's attention to the minutes from the April 2019 meeting. A motion for their approval was requested and made by Dr. Vijaya Hogan and seconded by Dr. Paul Wise. A vote was held, and the minutes were unanimously approved.

RECAP AND OBSERVATIONS FROM DAY 1

Paul E. Jarris, M.D., M.B.A.
SACIM Member

As a review of the first day of the meeting, Dr. Jarris noted the vast amount of information provided and remarked that it was a successful day. He provided an overview of the content covered during Day One of the meeting:

- SACIM's new Charter (approved September 2019) which lays out the trajectory for the Committee for the coming two years and which now explicitly includes women's health over the life course with the maternal-child dyad and interrelatedness between maternal and child health. Additionally, discussions on health equity and social determinants within disparities.
- HRSA Administrator Tom Engels was welcomed and introduced himself within his new role as the Agency's Administrator.
- Dr. Jarris covered a review of the one-on-one interviews between SACIM members and Dr. Ehlinger which shined a consensus among the Committee on its responsibility and opportunity to focus on implementing actions.
- The Committee heard presentations from:
    - Ms. Laura Kavanagh with the Maternal and Child Health Bureau discussing investments for Home Visiting, Healthy Start, Title V, and new directions in which MCHB is heading.
    - Ms. Rebecca Abbott with the March of Dimes then gave an update on policy and discussed the prematurity report on the increase of preterm births and health disparities nationally.
    - Dr. Charlan Kroelinger with the CDC began with an overview of maternal conditions which impact infants. The CDC's network of Perinatal Quality Collaboratives and national system development tool MMRIA were introduced, both of which will be an available asset to SACIM.
- Lastly, past SACIM recommendations made in 2013 were reviewed in depth.

REVIEW OF MEETING OBJECTIVES

Dr. Jarris reviewed the three meeting objectives outlined by Dr. Ehlinger. The first, identify and utilize immediate opportunities for action to fulfill the charge of the Committee in the next year which was covered in its entirety over the first day and through the task of reviewing the six strategic directions from 2013. The

second is to expand the share of knowledge about opportunities, understanding of issues and ongoing initiatives, and influencing the health and well-being of mothers. This objective began with day one discussions and will be further discussed during the second day. Lastly, the salvaging a framework, strategy, organizational foundation to execute. With the plethora of information that has been provided already and more that is set for today, the third objective may not be fully covered.

Dr. David de la Cruz reminded the Committee that recommendations not be limited to the Secretary but to HRSA Administration and the MCHB Director. Additionally, Dr. Magda Peck commented with the curiosity to discuss with the room and on the phone in order to gain knowledge from fellow colleagues, Ex-Officio, and other members about what can be done to move the momentum forward in a pragmatic and strategic sense.

Dr. Paul Jarris asked to what extent would the Committee be willing to go through and set a time to discuss some work to try and see what the result would be as there needs to be time to absorb and process the information provided. Secondly, he proposes the Committee formally requests the Secretary, the Administrator, and to the Federal Representatives that we have four meetings a year and three of them face-to-face as some other FACA committees do.

Dr. Wise commented that if the meetings occurring more frequently will not be conducive for serious work it would be more of a hassle. Dr. Calvin and Ms. Pettiford were in agreement with Ms. Pettiford adding the need for clarity on what the commitment is. Dr. Peck, Ms. Palacios and Dr. Sander Lee are all in agreement for increasing the number of yearly meetings. Additionally, agreements are given by Dr. Barfield and Mr. Wilson. Dr. Jarris requested the Committee to express their opinion on the notion of meeting more frequently, not four with three face-to-face but the idea of more meetings followed by all members providing a short opinion.

FETAL & INFANT CHILD DEATH REVIEW

M. Sonsy Fermin, M.S.W., L.C.S.W.
Senior Public Health Analyst, MCHB
Health Resources and Services Administration

Diane Pilkey, R.N., M.P.H.
Senior Nurse Consultant, MCHB
Health Resources and Services Administration

Ms. Fermin provided the four objectives of the presentation: explain HRSA's role in supporting infant fatality reviews; identify how the National Center for Fatality Review and Prevention's partners nationally achieve priorities; distinguish the different approaches of the infant review teams; and, recognize the opportunities provided by the Case Reporting System.

Since 1990, MCHB has been supporting fatality reviews with funding from the Division of Healthy Start and Perinatal Services to create Fetal Infant Mortality Review (FIMR) programs nationally. In 2002, the Division of Child Adolescent and Family Health provided the support for a national center to provide technical assistance and training to Child Death Review (CDR) teams around the country. In 2018, both FIMR and CDR were awarded to the Michigan Public Health Institute.

Ms. Pilkey introduces the National Center for Fatality Review and Prevention (NCFRP) which has the ultimate goal of preventing fetal, infant, child, and adolescent deaths. Fatality review provides the opportunity to identify how systems work together but also to highlight inequities and how people access and are treated by systems. CDR and FIMR review infant deaths but FIMR also reviews fetal deaths and is more health care systems based with a focus on improving maternal and infant care; CDR reviews infants through adolescents and is community based focusing on improving systems.

CDR helps to turn tragedies into lessons learned through a multidisciplinary process to tell the child's story in order to better understand the circumstances and risk factors that contribute to a child's death without focusing on blame. Currently there are over 1,300 teams across the fifty states, D.C., Guam, tribes, and

within the Department of Defense on a voluntary basis and utilize a standardized case reporting form. Team members include physicians, law enforcement officers, educators, amoung many others.

Ms. Fermin introduces FIMR as a warning system that can describe effects of health care systems changes, a method for implementing quality improvement, and to implement needs assessment and quality assurance at the local level. It is a multidisciplinary community team which examines fetal and infant death cases in a comprehensive manner to discover the cause of death and prevent future similar deaths. They are confidential and include a maternal interview to help understand mother and family experiences of inequities within the community and how it impacts maternal outcomes.

FIMR is a two-tier process with a Community Action Team (CAT) and a Case Review Team (CRT). The CRT is responsible for reviewing cases for various contributing factors or trends and develops initial recommendations. CAT works within the community to implement interventions, determine if community needs are changing, and to safeguard system changes.

Ms. Pilkey then provided the components of effective infant death reviews as having a clear purpose, coordinated and comprehensive, inclusive of key partners sharing a vision and commitment to prevention, identifiable risk factors contributing to death, identification of agency practices, policies, and gaps within the system, and provides effective recommendations. Both CDR and FIMR have infrastructure that offers the opportunity to address emerging issues and utilize the Case Reporting System (CRS), a free web-based system for CDR and FIMR teams.

Committee Questions and Discussion

- Ms. Vanessa Lee noticed that not all the states have FIMR programs and questioned the possibility of cross-state support?
    - Ms. Fermin responded that an on-going project is pairing up teams in order to help them become successful as some may be lacking in resources.
- Dr. Wanda Barfield asked what some of the inherent challenges are in particular to fetal deaths. Additionally, it was asked if there is a way to compassionately approach women who have experienced stillbirth to share their stories.
    - Ms. Fermin responded that there is training provided to members within the FIMR team as it is an uncomfortable situation, however it is challenge.
    - Dr. Barfield followed up by commenting on Alaska utilizing PRAM survey data for infant deaths as an addition to the review.
    - Ms. Fermin highlighted the maternal interview done by FIMR. When the mother is not able or willing to, sometimes the grandmother or sister or someone who intimately knows the situation can be interviewed to provide information. Balancing trying to get information as vividly and early on so details are captured is a constant struggle for the FIMR team, that is, how to best achieve an interview is discussed on a monthly basis.
- Ms. Belinda Pettiford commented how different states have numerous teams and asked if some of teams are statewide, but it seems as if it is focused on only certain communities. As a follow-up, she asks if there are other funding options.
    - Ms. Fermin responded that no, she does not know any other funding sources. Additionally, there are larger states with more teams with varying sizes.
    - Ms. Pilkey commented on state versus local teams as it presents a constant challenge. One of the advantages of doing it at the community level with knowledge of the context within the community. What will happen is CDR will be done at the community level and then reviewed at the state level to see if there are bigger issues.
- Dr. Vijaya Hogan inquired about community advisory teams or community action teams wanting more information on the composition of the team and how social contextual data is analyzed.

    - Ms. Fermin explained that the community action team is community leaders or providers such as moms or anyone invested in the community. However, each community is different.
    - Dr. Hogan followed up by asking how social and contextual environmental data is analyzed and to provide an example.
    - Ms. Fermin informed her that role belongs to the community action team. It's difficult to put it as a set rule as each community is different.
- Dr. Jeanne Conry wondered if there are states or regions where FMIR has implemented changes and have seen a reduction in infant mortality.
    - Ms. Fermin explained that she did not have the answer and did not want to misquote but would get the numbers and follow up.
- Dr. Magda Peck commented in relation to MMRIA and FIMR, how are efforts being integrated in order to consolidate results and take action.
    - Dr. Jarris agreed that there needs to be synergy at the data level in a way that initially requires standardization.
    - Mr. Wilson elaborated that there are efforts across agencies to coordinate more data sharing, however it is complicated when organic groups developed at the community level and it is a complicated process to collect the right information on a strict budget.
    - Ms. Pilkey added that bringing CDR and FMIR has happened only within the last few years and work collaboratively together successfully.

PUBLIC COMMENT PERIOD
Caroline Stampfel
Director of Programs, Association for Maternal and Child Health Programs

Ms. Stampfel introduced herself and expressed excitement on the behalf of AMCHP of the inclusion of maternal mortality and morbidity prevention within the SACIM charter. When incorporating maternal mortality and morbidity prevention, the focus on maternal mortality often focuses on keeping the women alive and not improvement to her wellness or health. AMCHP's new strategic plan with the goal entitled Chasing Zero focuses on the health of parent, baby, and family as a triad including the family and community within the concept. The Association is looking to promote women-centered, community-driven, respectful, and equitable care to support thriving by defending programs and policies that reinforce the mom-baby dyad and incorporating the family and community.

WINNOW & PRIORITIZE RECOMMENDATIONS
Paul E. Jarris, M.D., M.B.A.
SACIM Member

Dr. Jarris began by providing instruction to the Committee to go around the room in order to open the floor up to various ideas and discussions.

Dr. Steven Calvin suggested that SACIM recommend that within one year, the Secretary implement and encourages the proven beneficial care model identified by the 2018 results of the CMMI Strong Start Study.

Dr. Tara Sander Lee stated that she is still processing all the information that has been received but what has become noticeable is the need to be standardization and coordination between states. She provided the example of the MMRCs and how each state decides how to process the information and what deaths to included, however with standardization data can become available between organization to benefit survivability of infants.

Dr. Vijaya Hogan recommended SACIM develop the rationale language for health equity in all policies, a case for why health is important to various sectors, and disseminate an effective structure from federal down to local government.

Dr. Paul Wise recommended three principles to focus on with the hope being the three principles will provide strategy and structure moving forward over the next year. First, a focus on equity due to parallels in the decline of infant mortality rates over time, suggesting differences that cannot be resolved with maternal or infant health. Second, a need to focus on fundamental discontinuities of grave consequence. Lastly, a focus on taking risks with new strategies to take advantage of new opportunities. The hope being the three principles will provide strategy and structure moving forward over the next year.

Dr. Jarris responded with the notion of the centrality of the mother-baby dyad and its importance in all policies. Ms. Belinda Pettiford responded with the need to address health inequity in all policies in order for improvements to be seen as well as more of a family conversation including access to care for all family members. Additionally, in support of Dr. Hogan's recommendation, noting how the dialogue needs to change and the need to provide examples of that language. Adding to that, Dr. Wanda Barfield expressed the need for practical examples and a strategic way to address disparities in health equity.

Dr. Magda Peck commented on the need for expansion of public sector coverage of doulas, community health workers, and women-centered forms of care. However, although there is an interface for it, she expressed concern on how it will be funded.

Dr. Jeanne Conry focused on two pointed issues: learning from findings across all demographics and sustainable development goals. She also emphasized the need for universal access to health care.

Another recommendation presented by Dr. Calvin is to require each state Medicaid Director guarantee Strong Start compatible care to mothers within two years.

An idea presented by Dr. Sander Lee is the need for a standardization of data that are being collected in order to have clear understanding of what infant mortality means by including information specifying the analytics involved and at what stage loss occurs.

Dr. Hogan advocated for the reconsideration how infant and maternal mortality rates are measured. It is suggested to monitor some programs or interventions on a year-by-year basis and others across a ten-year span.

Dr. Wise expressed the need to bridge recommendations with antagonisms in order to address and improve upon issues. This needs to be done between pregnancy-related issues and women's health prior to pregnancy as well as with social determinates of health. Another example provided by Dr. Jarris is between nine-month prenatal care for mothers and babies compared to longer life stage with the recognition of other determinations effecting the baby. He also stressed the need to have an equity goal within infant mortality as the prior recommendation was generalized. Additionally, Ms. Pettiford believes there should be a review of programs and prior lessons learned, for example from the original Health State program, in order to address social determinates of health.

One of SACIM's primary strategies, suggested by Dr. Peck, is a focus on women's health with a lens on equity. It is suggested to expand that lens to women's health from the ACA and community services which allow for systems of care outside clinical settings to define and fund community preventative services. Building on that, Dr. Calvin added the need to focus on FQHC's rural health systems and non-hospital community providers such as doula services. Dedicated NIH funds for research was recommended by Dr. Sander Lee. Additionally, Dr. Jarris made suggestions on the preservation and enhancement of rural maternal care. Lastly, Ms. Pettiford cautioned the notion of an equity lens as being something different versus what is already being done.

An increase of access to reproductive choice family planning including intendedness of pregnancy and pregnancy spacing is a strategy presented by Dr. Peck. The inclusion of reproductive health, reproductive justice, and reproductive access regarding family planning is needed within women's health. Specific recommendations given by Dr. Calvin are to require reimbursement from Medicaid and Medicaid-managed care organizations for providers comparable to Strong Start. Dr. Sander Lee notes the need to understand community issues regarding the choice of abortions with an increased access to reproductive choices. This will help reduce induced abortions therefore decreasing infant mortality. Additionally, Dr. Conry stated that access to abortion and contraception are basic human rights and elements to women's health. Ms. Danielle

Ely pointed out that abortions are not incorporated within the infant mortality rate.

Dr. Hogan suggested the same focus used on rural areas be used on southern states in order to tackle structural issues and create a blueprint for other areas with high mortality rate.

Dr. Peck then addressed the need for a data strategy to integrate and bring to scale effective views of that data in order to address maternal health and infant mortality.

Again, Dr. Conry addressed the need for universal health care as preventative or surgical care contributes to maternal and infant health outcomes.

Dr. Calvin stressed the need for Medicaid-bundled payment pilots for the entire episode of care for mother and newborn which would address doula services, community care, and neonatal care. Further, to advance care, a commitment to engage with interested public, private, and government entities is needed.

Dr. Wise made note of dropping fertility rates in the United States, how it fits in with mortality rates, and the concerns surrounding childbearing and demographic shifts. Dr. Conry pointed out environmental factors playing a role in the decrease of fertility and its impact on health. Adding to the topic of fertility rates, Dr. Calvin addressed the need to focus recommendations on populations that are having more children. An increase of in-vitro federalization and the significance it has on reproductive medicine was mentioned by Dr. Sander Lee.

Finally, Dr. Jarris concluded the session by addressing the need to prioritize the recommendations provided with some having potential for immediate action and others focusing on long-term results. Dr. Peck suggested looking for cross-cutting themes in an effort to sort the issues and recommendations. Then identify further the immediate priorities or opportunities. Dr. Jarris suggested actionable criteria being six and twelve months.

TRANSFORMING MATERNAL HEALTH CARE IN AMERICA'S MATERNO-TOXIC ZONES

Jennie Joseph
Executive Director, Commonsense Childbirth

Ms. Joseph began by providing a quick overview of the 2018 HRSA Maternal Mortality Summit and the solutions identified to decrease maternal mortality and morbidity rates:

- **Access** to patient-centered, comprehensive care before, during, and after pregnancy.
- **Safety** protocols in birthing facilities.
- **Workforce** distribution to provide care before, during, and after pregnancy.
- **Life course model** of care for women before, during, and after pregnancy.
- **Data** improvement within national surveillance and surveys.
- **Review Committee** consistency.
- **Partnerships** between multiple summit participants

Examples of women who chose health care outside of the main system were given. This includes but is not limited to midwifery, doulas, lactation support, and childbirth education. These services have the ability to integrate and collaborate within interdisciplinary support for the various methods of providing health care for those women.

Coined by Ms. Joseph, materno-toxicity is defined as the environmental impact and social determinants which impact a mother. This includes poor neighborhoods, neighborhood violence, lack of resources, as well as structural inequity. Serena Williams was used as an example because, although she is an affluent black woman, black women are three to four times more likely to die from pregnancy or childbirth-related causes. The distinction is stressed between social determinants of health and materno-toxicity of neighborhoods and the materno-toxicity or Pop Up Toxicity that follows black women, indigenous women, and other marginalized people in the United States.

The Birthplace Lab has found that one in six women experience mistreatment during childbirth with the top four types being:

- Being shouted at or scolded.

- Refusal or ignoring requests for help.
- Physical privacy violations.
- Threatening to withhold treatment or forcing unwanted treatment.

A model of care was established entitled The JJ Way which creates a culture and environment that supports all pregnant women in order to make a difference in the health, gestational age, birth weight, and breastfeeding rate. Ms. Joseph has been providing low birth weight specific care utilizing the JJ Way with support from additional providers, paraprofessionals, per supporters, and volunteers. One-hundred women enrolled in a study using the JJ Way in order to eliminate racial disparity resulted in 95 percent of babies averaging seven pounds seven ounces and 95 percent of women delivering at 39 weeks. This model of care model is built on four pillars: access, connection, knowledge, and empowerment.

Black women are more inclined to have low birth weight premature infants due to physiological impacts as well as underlying materno-toxicity with the variable not being the black women but the black women's experience. In order to address this, providers in entry level positions from outside communities can be used. They are trained quickly in a cost-effective manner and enables them to serve their own communities upon their return. This creates community-based, community-owned, and community-led health care providers.

Committee Questions and Discussion

- Dr. Steven Calvin asked what the thoughts are on how Strong Start or the JJ Way can be implemented on a global scale.
    - Ms. Joseph responded that there needs to be consideration to where women chose to be safe and to create a smooth transition from community-based prenatal care, delivery, and community based postpartum care using our physician, midwife, and paraprofessional extenders in order to become incorporated within the main health care system. Further, create a collaboration between her obstetric providers, licensed professionals, and hospitals to create a simple delivery method.
- Dr. Magda Peck requested more information on finances and the policy surrounding this strategy.
    - Ms. Joseph clarified that she is a Florida Medicaid provider and is able to bill for prenatal and postpartum care. There are some grants, however they are not dependent on that money. There are areas that could be beneficial to bill for doula and educational services, but Medicaid does not reimburse for it. The Beacon Policy would allow a billing period of the first twelve months postpartum. Policy then would be an important way to address and create streams of funding.
    - Dr. Peck followed up by asking about the interface between Ms. Joseph's model and what is under the Affordable Care Act.
    - Ms. Joseph stated that there is no interface and it is reliant on policy
- In conclusion, Ms. Joseph mentioned that policy plays a part in funding, training, support, and reimbursement for the paraprofessionals.

SETTING THE CONTEXT: Community Representatives Continued
LaTia Davis
Parent Educator, Delta Health Alliance

Ms. Davis introduced herself as a parent educator based in Leland, Mississippi who is working with prenatal women as early as possible in their pregnancy in order to track them and serve them throughout their pregnancy. Due to the rural area, a lot of women are not attending doctor's appointments due to the lack of affordable health care and health insurance.

Once a participant is in the program, Ms. Davis experienced gestational diabetes and severe preeclampsia leading to a premature birth at 28 weeks. She believes that if she had prior knowledge and health care access, many of her health problems could have been prevented or minimalized the dangers.

The women in this geographic area experience very poor with limited access to resources. Through home visits, parent educators like Ms. Davis are able to provide resources wherever the mothers feel the most comfortable. Some of the services provided include: housing assistance; supplies once the baby is born including diapers, wipes, and Pack and Play; Delta Dads to help involve the dads; group connections once a month to get the moms out talking about their pregnancy.

Committee Questions and Discussion

- Dr. Steven Calvin asked if she is supported within the medical community.
    - Ms. Davis responded that she does feel supported. She is a part of the Delta Breastfeeding Coalition and works closely with pediatricians at the Greenwood Leflore Hospital.
- Dr. Magda Peck asks about her family and if her children are well.
    - Ms. Davis informs her that her son is one year old and that she and her family are doing great.
- Dr. Vijaya Hogan asks about the transition from being a pregnant person in Mississippi to becoming a parent educator.
    - Ms. Davis enthused how supportive her paraprofessional educator was and that she is her mentor now. The transition was very smooth. As a parent, she knew what was needed as it was what she needed at that time and has been in the mother's shoes.

Diana Jolles
DNP Clinical Faculty, Frontier Nursing University

Ms. Jolles introduced herself and stated her focus is on the results of the Strong Start for Mothers and Newborns impact analysis. Although there has been over $43 million of funding for the program, the impact analysis was released over a year ago with almost no efforts since then. Currently, there isn't an ability to move a model to scale that you see with Medicare outcomes that come through CMMI. In order to do so, there needs to be improvement of access to appropriate levels of care at appropriate times for all families, an emphasis on appropriate primary preventions, and preserving physician workforce.

In support of Ms. LaTia Davis, for childbearing women, we know that community health workers achieve five times the results regarding infant feeding practices than a nurse midwife does. There is a need to understand who can impact social determinates and break down barriers. It is state-level barriers with each state needing legislative changes for a nurse midwife to practice, for a birth center to open and receive reimbursement.

The idea of this analysis was to test different, innovative models: birth center, community health workers, medical home, and group prenatal care. The primary outcomes were to reduce preterm birth rates, low birthweight, and decrease the cost of care. Birth centers in this instance is not where a person gives birth but where they receive their prenatal care through the whole episode of care. It is an integrated care system with a blended health care workforce that includes nurse midwives, registered midwives, nurses, doulas, physicians, and many other team members.

Strong Start is the most robust data analysis that has ever been done on the topic in the history of midwifery in the United States. Not only was there lower preterm births in all the primary outcomes, there was higher quality metrics, lower cesarean section rate, impact of life course health, and higher breastfeeding rates across all race categories. Controlled studies were done where Medicaid beneficiaries were matched to non-Strong Start beneficiaries. There was a $2,000 saving through the first year of life. However, payments need to be looked at for quality and value of the metrics.

Committee Questions and Discussion

- Dr. Paul Wise asked why there has been pushback for Strong Start.
- Ms. Jolles responded that she is unaware of any pushback but there is overt inaction.

Dr. Magda Peck inquired about the preparation of the workforce and relationship with academic or other institutions.

- Ms. Jolles answered that there are 60,000 OB/GYNs in the United States and 12,000 more midwives. At Frontier Nursing University a third of the midwifery workforce is graduating with about 300 midwives per year. The model is to work with high-functioning, high-quality labor and delivery nurses in rural communities and united with the variation and types of midwives servicing the county.
- Dr. Peck followed up by asking in the context of HRSA, what are the current investments being made to the maternal and child health workforce and what is needed to extend that workforce.
- Ms. Jolles was unable to answer that question at the immediate moment.

WHAT ADDITIONAL INFORMATION IS NEEDED FOR THE NEXT MEETING

Belinda D. Pettiford, M.P.H.
SACIM Member

Ms. Pettiford opened the floor to discuss what the focus or vision will be for the current iteration of SACIM.

Dr. Vijaya Hogan stressed the importance of visioning. The fundamental crux being the issue of equity, how it will lead transformation and changes in outcomes. Building on that, Dr. Magda Peck stressed the importance of framework proposing a three-tiered structure: equity, maternal health, and data. An extension to address and bridge concerns was brought up by Dr. Paul Wise.

Furthermore, Dr. Wise wondered if there are strong enough feelings regarding financing mechanisms, specifically Medicaid and CMS, to move in that direction. He suggested an informational action step to better understand CMS and include them as part of the conversation. Mr. Lee Wilson asked what the timeline is to receive a response from CMS. Within a month or two was Dr. Wise's response, in order to receive fact sheets or a memo on what they are doing.

Additionally, Dr. Peck asked if there should be an activation of working groups to address specific challenges to engage other SACIM members and partners in the field. For example, the focus around financial access maximizes the resources through CMS could be assigned to a working group. She suggested three different groups: equity, advancing access and quality of care to bridge social determinants of health, and more accessible data and research. Ms. Pettiford concluded from Dr. Peck's suggestion, that the three working groups will work to formalize recommendations based on their focus.

NEXT STEPS & ASSIGNMENTS
Belinda D. Pettiford, M.P.H.
SACIM Member

Ms. Pettiford and the Committee members discussed and assigned members to each of the three working groups:

- Equity: Dr. Ed Ehlinger, Dr. Vijaya Hogan, Ms. Belinda Pettiford, Ms. Janelle Palacios
- Access and Quality of Care: Dr. Paul Wise, Dr. Tara Sander Lee, Dr. Steven Calvin, Ms. Janelle Palacios, Dr. Colleen Malloy
- Data and Research: Dr. Magda Peck, Dr. Paul Wise, Dr. Paul Jarris, Dr. Jeanne Conry

Dr. Hogan highlighted that there has been an actionable recommendation draft, questions or a list of requests for additional information, and potential presenters for the next meeting. Dr. Peck requested that the recommendation be a priority as well as ask non-Committee members to work within the groups.

Ms. Pettiford stated that all the workgroups need to take the list recommendations previously made at the meeting and ask if it applies to your workgroup. Also, within the workgroups, they can prioritize different lists.

MEETING EVALUATION & CLOSING OBSERVATIONS

David S. de la Cruz, Ph.D., M.P.H.
Principal Staff and Designated Federal Official, SACIM
Deputy Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration

Belinda D. Pettiford, M.P.H.
SACIM Member

Ms. Pettiford opened to floor to Committee members to share any observations or make any comments regarding the meeting.

Dr. Peck expressed her gratitude to Dr. Jarris, Ms. Pettiford, and Dr. Ehlinger and appreciation of the Committee's willingness to follow her structural suggestions. Additionally, in reference to Strong Start, it's a reminder of how you get from research and data to action. Afterwards, Ms. Janelle Palacios notes that she is looking forward to working together on the upcoming recommendations.

Dr. Calvin and Dr. Sander Lee are both grateful to be a part of SACIM and stated what a pleasure it has been to meet everyone. Dr. Sander Lee continued that her only request would be to receive a bit of information prior to the meeting as a new member in order to be fully prepared.

Dr. Hogan looks forward to the progress that is being made. Additionally, Dr. Wise is looking forward to the progress that the working groups will make. Then, Dr. Ely offered support in terms of data and Dr. Wendy DeCourcey appreciates being a part of the Committee.

Mr. Wilson is encouraged by what he is hearing during the meeting and by the discourse as it sparks discussion and propels the Committee forward. Lastly, Ms. Pettiford expressed that the presenters for the meeting were wonderful.

MEETING ADJOURN

David S. de la Cruz, Ph.D., M.P.H.
Principal Staff and Designated Federal Official, SACIM
Deputy Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration

Dr. de la Cruz concluded the meeting by reviewing that, per the Committee's charter, the next meeting will be by webinar and the Committee will continue to have two meetings per year. He thanked everyone for participating and adjourned the meeting at 5:00 p.m. on December 5.