Secretary's Advisory Committee on Infant Mortality

Meeting Minutes of April 19-20, 2021

Virtual Meeting via Zoom

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DAY ONE: Monday, April 19, 2021

Welcome, Call to Order & Introductions

Lee Wilson,* Acting Designated Official, SACIM (on behalf of *David de la Cruz, Ph.D., M.P.H.)
***Edward Ehlinger, M.D., M.S.P.H.*, SACIM Acting Chair**
Mr. Lee Wilson called the meeting to order, and Dr. Edward Ehlinger welcomed participants to the virtual meeting. Dr. Ehlinger said that April 19 was Patriot's Day. While Patriot's Day is currently celebrated in remembrance of the first battles of the Revolutionary War, it was previously a day of fasting and public prayer in the New England colonies to avoid calamity, plague, natural disaster, and crop failure. He raised this particular history in light of the tragedies that have profoundly affected Minneapolis in the wake of the George Floyd trial and the killing of Daunte Wright. He suggested that now is an especially important time for the Secretary's Advisory Committee on Infant Mortality (SACIM; or Committee) to act alongside the many efforts currently underway to address the effects of COVID-19 and structural racism at the federal level. Each Committee member then introduced themselves and shared their goals for their work within SACIM.

Review and Approve Minutes, Objectives for the April Meeting

***Edward Ehlinger,* SACIM Acting Chair**
The Committee unanimously passed the motion to approve the Minutes of the January 2021 meeting. The objectives of this meeting were to: 1) review and finalize a letter of introduction to the Health and Human Services (HHS) Secretary (the Secretary); 2) develop draft recommendations for the Secretary related to COVID-19, migrant health, environment, and clinical care and workforce; and 3) review the SACIM Charter, membership process, and bylaws.

Voices from the Community

***Merlin Marrain-Jackson, M.P.H.,* Doula/Certified Lactation Counselor, Syracuse Healthy Start**
***Efua Ansah-Eleazu,* Healthy Start Case Manager/Doula Mentor, Community Health Center of Richmond, Staten Island, NY**
Dr. Ehlinger introduced two women from New York who spoke about their experiences as doulas and the positive impact of their work on both mothers and infants in their communities.

Ms. Efua Ansah-Eleazu shared her story about becoming a doula when she was inspired to give back to her community after a positive experience with her own doula during the birth of her first child. She received support from the Healthy Start Program for her doula training and lactation counselor certification, and she has since supported over 50 women from diverse backgrounds through their pregnancy, birth, and postpartum periods. She has also worked with midwives, OBGYNs, childhood education programs, and breastfeeding education programs to expand doula services. These services extend beyond birth support to provide resources such as childcare, assistance in completing applications for different programs, and education on the postpartum period. She is honored to support these women and has been privileged to see her clients grow stronger and move forward to impact their own communities.

Ms. Merlin Marrain-Jackson provided a unique perspective from her work in the prenatal units in Onondaga County, New York, where she witnessed disparities inside and outside the hospital in the treatment of Black mothers, whose preferences and needs were ignored by hospital staff. This treatment not only distresses mothers and is detrimental to their infants but may also lead to death in some extreme cases. Hospitals that have support groups for Black mothers are often hindered by inadequate childcare, limited access to transportation, and a lack of cultural competency. Her own experience with these disparities inspired her to become a doula. She stressed that these mothers live in conditions that no person would willingly endure, and she asked SACIM to begin addressing the issues of cultural competency, connectivity from the hospital to the home, and ensuring that all mothers are heard and feel supported.

Discussion

The Committee asked both doulas for advice on educating communities on available doula services. Ms. Marrain-Jackson answered that one helpful approach was the Syracuse Community Connections' Lunch and Learn program with doctors and nurses to increase their understanding of the importance and extent of doula services. Ms. Ansah-Eleazu talked about how COVID-19 protocols, while appropriate, can sometimes limit the doula's access to the birth room. This can frustrate any family and especially first-time parents who have worked with their doula during pregnancy and are now unable to receive support in the birth room. The Committee agreed that SACIM should work towards integrating doulas into the health system during the COVID-19 pandemic. Ms. Ansah-Eleazu suggested that hospitals also need to collaborate with doula programs and make better use of technology and social media to promote awareness of their services.

They were also asked to characterize what doula training services looked like in each woman's respective program. Ms. Marrain-Jackson answered that she was trained by Ancient Song, a program that offers four full days of theory-to-practice training, including additional exercises such as book reports and shadowing another doula. Ms. Ansah-Eleazu received a scholarship from Healthy Women, Healthy Futures and was trained by Doulas of North America (DONA), which is internationally recognized. The program consisted of a five-day training, followed by continuous training in topics such as breastfeeding, safe sleep, and professional development.

The Committee asked both doulas to describe their views of next steps in doula support, given that COVID-19 has instilled such caution in all areas of health care. Both Ms. Marrain-Jackson and Ms. Ansah-Eleazu emphasized the importance of financial support for doula services, particularly within Medicaid, and the need for the financial support across the entirety of prenatal, pregnancy, and postnatal care. Hospitals also need to create a bridge to community services both by understanding the services available and by promoting those resources. This would create a full circle from clinic to community.

Dr. Ehlinger thanked both women for sharing their experiences on how doula services have helped reduce disparities and improve birth outcomes, particularly in the communities at highest risk for maternal and infant mortality. He acknowledged the challenges to making a living as a doula and reiterated the need to promote doula services through Medicaid and other insurance companies.

Letter to the Secretary

***Edward Ehlinger,* SACIM Acting Chair**

Dr. Ehlinger summarized the draft introductory letter to the new Secretary, which is focused on introducing SACIM, its purpose, and its pledge to work with the Secretary towards advancing health equity. At this time, specific recommendations were not included in order to focus the letter on a brief introduction of SACIM, with the intent to submit specific recommendations in subsequent letters.

Discussion

The Committee suggested adding maternal and infant mortality data to the letter to ensure that the scope of the issue is captured, especially the representation of racial inequity. This will also establish that SACIM recommendations are data-driven, given that the new Secretary has expressed the importance of quality data. Committee members also discussed their concerns about SACIM remaining apolitical, asking if this same approach to introduce SACIM will extend to future Secretaries. There was general consensus that the letter was an appropriate and proactive effort to raise awareness about SACIM and its recent work. Dr. Ehlinger said he would finalize the letter and work with the Health Resources and Services Administration (HRSA) to get it to the Secretary.

SACIM Recommendations

***Edward Ehlinger,* SACIM Acting Chair**

Dr. Ehlinger talked about the development of recommendations to submit to the Secretary. He explained that there has been a lot of activity with the new administration, with rapid implementation of new policies and changes. He stressed it was important that SACIM act quickly and that its recommendations be up-to-date, relevant, and unique to maternal and infant health. He then reviewed the draft recommendations that had been developed based on what SACIM had learned over the last two years in four key topic areas: COVID-19, Migrant and Border Health, Physical Environment, and Workforce and Systems of Care.

The Committee then went into breakout sessions organized by the four topic areas to discuss the recommendations in more depth with the objective to identify what was still relevant, what needed to be changed, and what new recommendations should be made. Dr. Ehlinger asked the Committee to especially consider recommendations related to racial equity. He added that all recommendations should also have supporting data.

SACIM Recommendations Breakout Group Discussion

COVID-19 Group

***Paul Jarris, M.D., Ph.D.,* Facilitator**

The COVID-19 group deliberated on the COVID-19 recommendations from June 2020. The group discussed pregnant women's access to vaccinations, expressing concern about the recent pause on the production of the Johnson & Johnson vaccine. They decided to continue following the CDC's lead on vaccine safety given that the adverse outcome affected only six women of the millions who received it. Some members disagreed about whether the wording of the recommendation would pressure pregnant women who are "low risk" to get vaccinated, although pregnancy itself is considered a high-risk condition. The group also suggested adding lactating

mothers and women planning to become pregnant under the vaccine recommendation and to mirror the CDC's language on the topic. They emphasized inclusion of a phrase such as "promoting access to respectful, quality clinical care" and agreed that expansion of licensed, accredited freestanding birth centers should be included in workforce systems recommendations rather than COVID-19 recommendations. They also recommended that mothers infected with COVID-19 should deliver in hospital settings rather than birth centers.

The group then discussed the issue of vaccinating undocumented immigrant mothers. Some participants felt the recommendation was too vague, as the law does not provide taxpayer health benefits to noncitizens, and some undocumented people may feel uncomfortable or unsafe interacting with the health care system. Others said the recommendation was valid, as SACIM's focus is on best practices for public health rather than on solving logistical challenges. The group agreed that a recommendation to provide this public health service is appropriate for SACIM and that the implementation of any policy is outside of SACIM's scope.

The group moved wording about health insurance coverage from recommendation number three to number four and expanded it to "supporting culturally appropriate, community-based prenatal, postpartum, and newborn care." Importantly, "culturally appropriate" care should include attention to appropriate, specific language for each population. There was deliberation about what this kind of care may look like, especially as it relates to bolstering community efforts to work autonomously while still allowing access to larger agency supports. They debated on the merit of singling out "faith-based" organizations in the recommendation, or to use the broader term "community-based" organizations and possibly listing places of worship as an example. Participants did not find consensus and suggested setting aside this recommendation to discuss again in the future.

The group discussed merging the recommendations regarding telehealth and broadband, as telehealth is not a stand-alone solution but part of a larger system of care. They suggested promoting digital equity to make telehealth services available to those who otherwise lack the means to use it, whether it be via cellular service or broadband. They suggested including language such as a "comprehensive health care and social support system" that would also include transportation needs for pregnant women preparing to deliver. The group agreed that COVID-19 has strained levels of care in rural communities where services have been downgraded, creating tension between best care at the individual level and best care at the community level. It was agreed that the recommendations would also emphasize that COVID-19 had highlighted existing inadequacies of the U.S. health care system, which does not optimally meet the needs of mothers, infants, and women of reproductive age.

The group addressed the recommendation about Medicaid coverage for one year after birth. There was confusion about what this would entail, what restrictions may be put in place, and what "one year after birth" meant in varying contexts (e.g., third trimester miscarriage, second pregnancy within a year). They agreed that the policy must be defined by the Medicaid agency, but SACIM's recommendation should use "end of pregnancy" rather than "delivery" to be more inclusive. They aimed to ensure that the recommendation was as broad as possible and would not be limited only to pregnancy-related services and would include specialist care. Care should also include adequate liability protection for the evolving maternity care team.

The group talked about the challenge of managing data and surveillance systems for pregnancy during the pandemic, especially among underrepresented and disproportionately impacted populations. Finally, they suggested that SACIM recommendations be consistent with the Office of Minority Health COVID-19 Equity Task Force and the American Rescue Plan Act.

Migrant and Border Health Group
***Paul Wise, M.D., M.P.H.*, Facilitator**
The Migrant and Border Health group discussed recommendations related to maternal and infant health in the context of detained migrants, those who have been released into the U.S., and undocumented people. The group established early on that these recommendations should not only address the migrant crisis at the U.S.-Mexico border, but also the problems of those already living in the U.S.

The group agreed to recommend social and mental health services in addition to medical care in the third recommendation. This would address the substantial traumas experienced by migrants who were separated under the Zero Tolerance policy, mistreated in detention centers, or traumatized in their home country. The recommendation would also include community outreach partners to help build trust between migrants and health care workers. There was disagreement about expanding the recommendations from the highest-risk mothers and infants with special health care needs to include mothers and children more generally; the group settled on the former, although they agreed that they should make a strong statement about wellness in general.

The group then deliberated adding COVID-19 specific recommendations, including screening, testing, and vaccination for migrants who enter the U.S. The current policy does not require COVID-19 screening upon entering border facilities, unless the person is symptomatic, which poses concerns in the context of overcrowded shelters. Families released into the U.S. are tested for COVID-19, but a majority of people will be expelled back to their home countries without having been tested. They discussed the availability of vaccinations at these facilities, especially once vaccines are approved for young people. Although vaccines soon may be provided for families in detention centers, vaccination would *not* be required to enter the U.S. The group recommended specifically recognizing the special challenges of vaccine provision in this population.

The group discussed which recommendations truly fall under the umbrella of HHS. They felt that recommendations on international situations causing mass migration, trafficking and exploitation, and assisting unsupported migrants released into the U.S. were outside HHS's jurisdiction. Participants suggested including language in the recommendations to allude to remembering the history of the U.S.'s complicated relationship with all disenfranchised communities, including migrants.

Lastly, the group discussed the issue of non-citizens receiving coverage. While opinions differed among SACIM members, the Committee agreed that they were tasked to recommend what they feel is appropriate for the health and wellbeing of women and infants. Currently, children with special health care needs and third-trimester pregnant women were typically released into the U.S. but rarely received follow-up. Therefore, there was a substantial need in these populations

to receive care. The group suggested adding a strong recommendation to ensure that migrants have access to care without inappropriate barriers, especially related to financially incentivized transfers. They also added language to recommend the reinstatement of Medicaid presumptive eligibility to ensure appropriate access to care. The group emphasized that the Committee's role is to recommend appropriate action for the health and wellbeing of women and children, not to dictate practical activities at the Centers for Medicare and Medicaid Services (CMS), Immigration and Customs Enforcement (ICE), Customs and Border Protection (CBP), and other relevant agencies.

Physical Environment Group
***Jeanne Conry, M.D., Ph.D.*, Facilitator**
The Physical Environment group further discussed and approved all of the current recommendations. There were no objections or comments on the first recommendation, which addressed implementing increased and sustained funding and policies to protect pregnant women and infants from harmful environmental exposures, especially for people of color burdened by cumulative impacts.

The group discussed the meaning of the second recommendation around expanding and improving the CDC's Biomonitoring Program on environmental exposures. It was suggested to expand the concept of "environment" to include drugs, alcohol, and tobacco. Although there was a behavioral aspect to these environmental exposures, the recommendation could also cover related areas like living situations, advertisement, and social acceptance of these substances. The group hoped to raise awareness that toxic chemicals may be as much of a concern as alcohol and tobacco use. Ideally, these large biomonitoring databanks would map data that linked environmental contaminants in food, water, and consumer products as well as social stressors such as poverty, food insecurity, and unemployment.

The group also identified lead as an area for policy changes in the fourth recommendation. While measures have been taken to identify and eliminate all sources of lead from water, food, cosmetics, and personal care, the Environmental Protection Agency (EPA) has halted the Safe Lead Program in the last four years. In line with the third recommendation to invest in HHS partnerships with the EPA, the group agreed that efforts to reduce lead exposure were a worthwhile investment and would require consistent, collaborative messaging across CDC, EPA, and HHS.

There was consensus and support for the fifth recommendation for HHS to partner with the Kellogg Foundation and other nonprofits to fund a science-based request for applications that would complement the current Kellogg Racial Equity 2030 goal for an equitable future by 2030. The initiative will invest $90 million to fund bold solutions to drive an equitable future for children, families, and communities.

Finally, the group discussed the sixth recommendation, which focused on infrastructure investments. This would address the inequitable infrastructure that puts disadvantaged communities of color at higher risk of toxic exposures because they are more likely to live near highways, powerplants, airports, and other large industrial areas. Dr. Ehlinger emphasized that this recommendation views infrastructure through an equity lens rather than an economic lens.

It was agreed that the recommendations should be rewritten to specifically address maternal and infant outcomes, rather than the general public, to be more in line with SACIM's work.

Workforce and Systems of Care Group
***Steve Calvin, M.D.,* Facilitator**
The Workforce and Systems of Care group discussed recommendations to improve the diversity of the maternal and infant health care workforce and to expand systems of care to include accredited freestanding birth centers and doula services. Importantly, they pointed out that past care improvement initiatives functionally ended the practice of midwifery, especially among Black communities, and the Committee should remain mindful that recommendations to improve care services are not so rigid as to unintentionally eliminate a service. There was consensus on the recommendation that Secretary and CMS play an active role in facilitating the plan development in improving the section 1115 demonstration waivers to extend postpartum coverage.

The group discussed the third recommendation to collect timely data by race and ethnicity to aid in diversifying the workforce. It was indicated that current information was only as good as the source of data. Participants suggested that data should also be collected to assess the diversity of students admitted to programs, and on how many of those students actually complete the program. Several participants had heard stories that the needs of students of color often go unmet, leaving them unable to finish programs. Dr. Michael Warren (MCHB) said he would put an inquiry into the Bureau of Health Workforce at HRSA for current race and ethnicity data within their programs.

The group then deliberated whether the fourth recommendation, about the Centers for Medicare and Medicaid Services (CMS) encouraging states to continue coverage one year after pregnancy, should mirror the American College of Obstetricians and Gynecologists (ACOG)'s language "following pregnancy", rather than "birth and delivery." Participants agreed the exact definitions would need to be made by policymakers.

Some participants expressed concern about SACIM's recommendation of supporting efforts that increase the availability and capacity of licensed and accredited freestanding birth centers, instead suggesting it become a broader recommendation on the levels of maternal care. Others pointed out that every community is different, and the goal is to increase the availability of options for women to access care. Participants agreed that the overall goal of this recommendation was to increase access to and options for care and suggested including descriptive language specifying birth centers as an option.

The group addressed the recommendation specific to the value of doula services. While all agreed that doulas provide a valuable service and should receive a living wage for their work, some participants were uncomfortable with SACIM specifically recommending doula services, pointing out that doulas play varying roles, and their services lack standardized training and licensure. The group instead suggested recommending that the U.S. Preventative Services Task Force or the Women's Preventative Services Initiative (WPSI) evaluate the impact of doula services.

Finally, the group discussed the recommendations on expanding the integration of certified nurse midwives and the use of telehealth. Participants agreed that certified midwives, nurse midwives, and professional midwives were an evolving field. They wanted to remain mindful of using an equity lens to define and standardize criteria for both doulas and midwives, as past efforts to increase the quality of services provided by these groups drove many Black women from the field. All agreed that telehealth was a valuable tool but was not a substitute for other services. It was suggested to look into expanding support for home visits and funding for the federal Healthy Start program.

Day One Adjourn

Dr. Ehlinger said that the next meeting day would focus on the recommendations from the three SACIM Workgroups' perspectives and adjourned the meeting at 4:00 P.M.

DAY TWO: Tuesday, April 20, 2021

Review and Overview of Day One

***Edward Ehlinger,* SACIM Acting Chair**

Dr. Ehlinger called the meeting to order and spoke about the former Vice President Walter Mondale, whose death occurred on this date. He championed women's and civil rights, environmental justice, and the importance of policy at the state level.

Voices from the Community

Dr. Ehlinger played a video called HerStory from the Delaware Maternal and Infant Consortium about the rising maternal mortality rates in Delaware. The project raised awareness about the effects of racism and implicit bias on birth outcomes among Black women and promoted strategies such as doula services not only for care but also for advocacy. This disparity also affects infant mortality, as infants born to Black mothers are 2.7 times more likely to die before their first birthday than infants born to White mothers. Dr. Ehlinger said that even though this video was meant to raise awareness about maternal mortality in Delaware, the message is relevant to everyone.

Discussion

Members of the Committee talked about the importance of these messages targeted to specific communities and provide other examples of similar regional efforts. They also compared the HerStory project to the CDC's Hear Her Campaign, which also provided personal stories of unexpected pregnancy- and birth-related complications. These stories were not only important to highlight disparities in health care, but to also celebrate success stories and show women of color that they are not alone. The Committee emphasized that while it is critical to raise awareness about the problem, it is equally critical to find solutions.

Update from the Maternal & Child Health Bureau

***Michael Warren, M.D., M.P.H., F.A.A.P.,* MCHB, HRSA**

Dr. Warren provided an update on Maternal and Child Health Bureau (MCHB) strategic planning, equity work, and COVID-19 responses since the last meeting. MCHB plans to unveil their strategic goals and objectives in May 2021 at the Association of Maternal and Child Health Programs (AMCHP) meeting. The strategic plan was developed from several activities to collect information and feedback, including extensive literature reviews, focus groups, and a public request for information that solicited feedback from thousands of stakeholders. MCHB intends to share the strategic plan later this year and then will move towards its implementation and evaluation.

MCHB has also committed to advancing equity internally. The HRSA Office of Civil Rights, Diversity, and Inclusion Deputy Director had been on detail with MCHB to develop a framework with three areas of focus: the people (learning opportunities for internal staff), the organization (the policies that integrate equity into all aspects of MCHB), and partners (efforts to center on the experiences of women of color and their leadership).

Dr. Warren discussed the "collateral complications" of the COVID-19 pandemic. He talked about the Well-Child Wednesday social media campaign that was aimed to promote routine well-child visits and immunizations that may have been delayed during the early stages of the pandemic. Well-child visits are not only an opportunity for vaccination but are also important to assess needs related to a family's social determinants of health and to connect them to resources.

MCHB also published a new grant opportunity to give communities funding to respond to emerging issues more proactively than reactively. They set aside $1.5 million through the Special Projects of Regional and National Significance (SPRANS) and will announce recipients of these grants later this year. MCHB also held the Program Promoting Pediatric Primary Prevention (P4) Challenge competition to find innovative solutions to childhood obesity, care coordination for children with special needs, remote pregnancy monitoring, and optimized care models for pregnant women and new mothers with opioid use disorder. They are currently selecting the Phase 1 winners.

MCHB received $15 million from the CARES Act to support telehealth activities, which was used to create four awards in maternal health care, state public health systems, family engagement, and pediatric care. The maternal health award was given to University of North Carolina at Chapel Hill and used to support the Maternal Telehealth Access Project, which developed a comprehensive virtual infrastructure to improve access to maternity care, including mental health care. Significant barriers to telehealth included limited access to broadband or low digital literacy. The Maternal Telehealth Access Project developed their action plan to overcome these barriers and reach populations with the greatest needs.

Looking forward, MCHB will be focusing on expanding their COVID-19 response. This includes learning from adult vaccination efforts and applying those lessons to vaccinating pregnant women and adolescents. Many MCHB staff have been deployed to assist with vaccine administration, and MCHB plans to train them on messaging strategies on vaccine access. Community-based programs, such as the Healthy Start program, will also help families access local testing and contact tracing and other public health activities to reduce the spread of

COVID-19. MCHB will also add COVID-19 questions to the National Survey of Children's Health to aid in data surveillance and research.

Dr. Warren finished with a brief summary of HHS and HRSA updates. At the HHS level, new leadership appointments included Secretary Xavier Becerra and Assistant Secretary Dr. Rachel Levine. At the HRSA level, leadership appointments included Diana Espinosa serving as Acting Administrator and Jordan Grossman serving as Chief of Staff. HRSA received $18 billion from the American Rescue Plan and the most up-to-date information on fund distribution will be available on their website. $150 million was added to the Maternal Infant and Early Childhood Home Visiting Program (MIECHV) and $80 million to the Pediatric Mental Health Care Access Program.

Dr. Warren talked about Black Maternal Health Week and The Secretary's remarks on the extension of Medicaid benefits in Illinois for postpartum women through the entire first year after delivery. The Rural Maternity and Obstetrics Management Strategies (RMOMS) Program also received new funding and will have increased efforts towards equity.

Discussion
Dr. Warren was asked about MCHB's focus on vaccinating adolescents for COVID-19. He responded that the focus was not solely on COVID-19 vaccinations, but for routine vaccinations because of the recent dramatic decline in pediatric immunizations. Since the COVID-19 vaccine cannot be co-administered with other vaccinations, there is concern that parents will opt for the COVID-19 vaccine over others. MCHB is also tracking research and recommendations that emerge on COVID-19 vaccination for adolescents. Dr. Ehlinger asked if SACIM was a part of the MCH strategic plan, and Dr. Warren confirmed that MCHB will continue its focus on infant mortality. The Committee noted that legislation that leads to measuring outcomes for maternal and infant health, particularly in the areas of health equity and social determinants of health, will benefit everyone.

Pregnancy Risk Assessment Monitoring System (PRAMS) Update

***Wanda Barfield, M.D., M.P.H., FAAP,* Division of Reproductive Health, CDC**
Dr. Wanda Barfield provided a brief update on the recent revision of the Pregnancy Risk Assessment Monitoring System (PRAMS) Survey Questionnaire. PRAMS is a population-based, self-reported surveillance system for maternal behaviors and postpartum experiences. The newest phase of the survey is set to launch in 2023 and will include new topics such as e-cigarettes, marijuana use, and prescription opioids use, as well as topics related to COVID-19 and vaccinations. The Centers for Disease Control and Prevention (CDC) is also working with the Behavioral Risk Factor Surveillance System to include social determinants of health questions.

Discussion
Dr. Barfield was asked whether PRAMS had previously addressed racism as a public health issue. She answered that a series of questions on experiences of racism were included in the Reactions to Racism module in the early 2000s. They would be discussing whether questions about racism should be core questions (i.e., asked of everyone), or standard questions (i.e., selected by each state). Dr. Barfield was also asked if PRAMS includes previous pregnancy

history data or if that comes from the birth certificate data. She answered that there is some opportunity for data linkage about prior pregnancy, but it is limited. The Committee asked about the format of PRAMS, and Dr. Barfield explained that PRAMS has a participation rate of about 90 percent because women are happy to share their pregnancy experiences. The issue is finding the participants, and both mail and phone surveys are challenging. They will be looking at different modes such as a hospital-based mode, which historically has high participation, or an internet-based mode, which has a disadvantage of skewing the population towards well-educated White women and less diversity. They are considering how to ensure sufficient representation so that every demographic will reach a response rate threshold for comparison study. Committee members also asked about the inclusion of fetal intervention data. Dr. Barfield said that PRAMS is not an ideal tool to capture that information because fetal surgery is such a rare event, but it could possibly link information on medical conditions with clinical records in the future.

SACIM Recommendations

***Edward Ehlinger,* SACIM Acting Chair**

Dr. Ehlinger reintroduced the draft recommendations for the Secretary and reviewed the edits he made as a result of the previous day's discussion. The Committee discussed the importance of using sensitive and accurate language to describe vulnerable populations, systemic racism, and social injustice. They determined that the best solution is to consult with specific agencies, such as the Office of Minority Health, to determine the appropriate language.

The Committee suggested an additional recommendation of funding for team-based care under the care system transformation section. They also suggested revising the language related to Healthy Start to describe it as a community-level program rather than a state-level program.

The Committee discussed the workforce section, suggesting that the language be revised to include that resources should be provided to establish, expand, and sustain a diverse public health workforce and that the development of a community workforce should be specifically dedicated to community health workers. Some members felt the term "diversity" is broad and does not necessarily achieve the intended goal. When making recommendations about a diverse workforce, the group felt it was important to ensure the recommendations lead to improved data collection about barriers to representation in the workforce and a system that provides a broader array of providers. The Committee also suggested adding language about a workforce to provide intrapartum care, including family planning. Committee members talked about the term "race-concordant care," which refers to when a patient's race matches their physician's race. The group felt the goal of their recommendations was to not only ensure access to care, but to provide an experience of respectful care and relationship-building.

The Committee also discussed the workforce recommendations specific to doula services. Some members suggested that, rather than a specific focus on doulas, the recommendations could instead focus on ensuring a supportive system of continuous care. This would include doulas and midwives, but not be as prescriptive. Some members commented that it might be a stretch for SACIM to recommend that all women be provided access to doula services, but felt it was reasonable to request that HHS evaluate it as a preventive service and its incorporation into Medicaid.

The Committee talked about how SACIM develops recommendations, acknowledging that there is also a side that focuses on the implementation of the recommendations. The group felt it would be helpful to capture the perspective of insurance agencies, or other professional organizations, to determine if the recommendations represent a practical path towards implementation.

Committee members discussed the language around establishing Maternal and Infant Mortality Review Committees in every state and the challenge of establishing a committee in a state that did not have access to the resources needed to access and manage records that were necessary for the reviews. Dr. Pettiford agreed to develop specific language to revise this recommendation.

The Committee reviewed the recommendations for environmental contributions to maternal and infant health. Members requested adding language about evidence of the effects of environmental hazards and to specify how environmental exposure disproportionately affects Black and Hispanic women.

Dr. Ehlinger stated that because the list of recommendations was already comprehensive, they did not include recommendations that impact the economy, such as tax credits, or recommendations that address the full range of reproductive health services. Both topics have an impact on maternal and infant health but require a longer conversation. Dr. Ehlinger reiterated that Committee members can opt out of recommendations if there is not unanimity, as long as the recommendations represent a majority.

Workgroup Breakout Session Reports

Report from the Health Equity Workgroup

***Belinda Pettiford, M.P.H., B.S., B.A.*, Co-Chair**

The Health Equity Workgroup reviewed the draft recommendations and discussed the need for consistent language and for definitions in terms such as "vulnerable populations." They also discussed the impact of COVID-19 on limits of the number and type of support people allowed in the birth room. Workgroup members said that this policy was different across states and is a sensitive balance in the need for birth support and the need to reduce potential exposure to COVID-19. It would be helpful to have CDC guidance on safe and proper labor, delivery, and postpartum care during the pandemic. The Workgroup agreed that the goal should be to have at least one support person in the room, and possibly a doula in addition to the one support person.

The Workgroup talked about the need for race and ethnicity data and challenges that can arise when asking people to provide that information. They suggested that sensitivity training is needed to help overcome these challenges, for instance by providing scripts to help frame the question in a way that provides context. They also talked about including language in the introduction of the recommendations to call out the disparities among Black and Indigenous communities and the need for race concordance across the workforce.

In discussing the recommendation for Medicaid to provide coverage for 12 months postpartum, the Workgroup discussed whether the language should be one year after "delivery" or "end of pregnancy." Some members suggested that "end of pregnancy" would provide care for those who have a miscarriage or other adverse outcome. Others suggested "at least 12 months

postpartum." They agreed that the language is important because there can be different interpretations and suggested that the recommendation represent a broad definition to allow for expansive implementation. If Medicaid implements the recommendation, the states will need to be made aware of what it covers.

The Workgroup then discussed the recommendation on care systems, including telehealth, for prenatal care. They suggested adding "group prenatal care" and expanding the recommendation about broadband to also include other access such as by telephone. There are disparities in access to broadband, and telehealth is meant to increase access to care. There should not be a divide among those who can afford access to broadband. They also discussed the need for affordable, adequate transportation, especially in rural areas and in the event of emergency or need for specialty care. Not everything can be managed with telehealth, and transportation is part of increasing access.

Members of the Workgroup suggested changing the language in workforce recommendations to "increase capacity" rather than "expand the use" of a racially and ethnically diverse workforce. Increased capacity would allow midwives, for instance, to practice within the full extent of their training, and in all states and facilities. The Workgroup also discussed mentioning the closure of rural hospitals and the lack of obstetricians in rural communities. The closures affect all levels of care. They suggested a recommendation to increase the workforce within rural areas due to hospital closures and obstetric unit closures, with specific mechanisms to recruit and retain providers—ideally a diverse workforce. Members suggested that the recommendation include specific providers to include community health workers, doulas, and midwives.

The Workgroup briefly discussed how Infant and Maternal Mortality Review Committees are almost all maternal and the need for clarification about how deaths are reviewed.

Report from Data, Research, & Action Workgroup
***Magda Peck, Sc.D.*, Chair (absent); *Edward Ehlinger,* SACIM Acting Chair**
The Data, Research, & Action Workgroup agreed that the list of recommendations for data and information was comprehensive and that the focus now should be on prioritization. They talked about how much data is being collected, but there is no funding provided to utilize the data. Often committees focused on data surveillance will talk about funding efforts to include new data, but funding for data analyses was cut decades ago and has never returned to where it should be. They suggested that a recommendation be added to increase funding to utilize available data.

The Workgroup discussed how to prioritize the recommendations and considered pulling data recommendations into a separate section. Members suggested that data-specific recommendations could be highlighted in an appendix. Dr. Ehlinger said that the letter of recommendations to the Secretary should be concise, but that the details can be covered in a more comprehensive report that accompanied the letter.

They discussed data related to migrant health. Dr. Ehlinger had aligned SACIM recommendations on migrant health with ACOG guidance. Workgroup members suggested that this topic could become complicated because this population typically did not want their health data aggregated. The group agreed that SACIM recommendations would have to take this into

consideration. It was noted by members that there were immigration advocacy groups who were also making recommendations, some of which were specific to HHS. The group felt SACIM recommendations should be specific to maternal and infant health, particularly addressing children with special needs and the lack of a referral network to continue care for those who were released.

Report from Quality and Access Workgroup
***Steve Calvin, M.D.*, Chair**
The Quality and Access Workgroup discussed the benefits of doula and midwifery services. Ms. Lily Bastian, a doula, spoke about the benefits of a continuous presence of support and the need for doula and midwifery services to become part of the care team. They talked about how midwifery care was common in other countries, and, in some cases, midwives were mandated to be present during birth.

The Workgroup was concerned about being prescriptive with its recommendations. Some noted it was important to require outcome data to better understand what works well and when, rather than the Committee prescribing a list of people required to be part of the care team.

The Workgroup asked how doula services are generally provided. Ms. Bastian said that doulas were most often hired independently, although there were some hospitals that provided doula training. There were nonprofits that provided doulas for mothers who could not otherwise afford the service. The Workgroup talked about the challenges in mandating payment and standardizing care because doula and midwife support could be complex, and the fields were evolving.

The Workgroup explored how to give rural and suburban communities better access to neonatal care. One option was to mobilize neonatal nurse practitioners to hospitals in need. Neonatal nurse practitioners have a skillset that can bridge this gap in care, but the bar to become certified had been raised over the past few years. Members asked for the HRSA Bureau of Health Workforce to share its data on the number of neonatal hospital beds, neonatologists, and neonatal nurse practitioners. They suggested changing to a care model that required paying for it, such as with Strong Start and midwife services.

Some members talked about race congruent care, with a concern that it might cause further division. Some pointed out that in reality, a team of providers would care for the mother and infant, and so it could be difficult to track outcomes with multiple people providing care.

The Workgroup discussed the current status of rehabilitation programs for mothers struggling with substance use, as most had been put on hold during the pandemic. The Substance Abuse and Mental Health Services Administration (SAMHSA) oversees these programs, and the group felt that there should be increased activity towards those operations and advancing the field in the future.

Next Steps in Preparing Recommendations

***Edward Ehlinger,* SACIM Acting Chair**
Dr. Jeanne Conry announced that World Patient Safety Day will take place on September 17th. The focus of this day in 2021 will center around maternal and newborn health safety.

Dr. Ehlinger said that the letter of recommendations is currently eight pages long and needs to be consolidated. One approach towards consolidation would be to create a document with all of the recommendations with supporting evidence and a separate document with a small subset of recommendations to highlight for the Secretary. The Committee agreed that a letter summarizing some of the major topic areas and a separate comprehensive report is a good approach. Dr. Ehlinger suggested that the Committee prioritize the recommendations by the potential impact, practicality, and unique focus to SACIM. He would be reaching out to the Workgroup Chairs and any other Committee member interested in prioritizing the recommendations. He shared that he aims to have a draft finalized prior to the June 2021 meeting, so the Committee could have a final discussion and vote at that meeting.

Public Comment

***Lee Wilson,* Acting Designated Official, SACIM**
Mr. Wilson said that they received one written public comment, which is in the briefing materials. There were no oral public comments.

SACIM Organizational Issues

***Edward Ehlinger,* SACIM Acting Chair**
***Lee Wilson,* Acting Designated Official, SACIM**
The new Bylaws had been reviewed by MCHB and were currently at the HRSA Office of the Administrator for their review. MCHB expected to have approval relatively soon. MCHB planned to begin working on renewing the Committee's Charter shortly after this meeting. The process needs to be completed before the end of the period of operation in the current Charter, which is September 30, 2021. Dr. Ehlinger asked members to share with MCHB any feedback on the Charter and talked about the importance of ex-officio members. He asked the Committee and MCHB to consider members who could provide expertise particularly on the social and environmental issues that were emerging. A member noted that the Charter should state "pregnant women" before "infants" when talking about both (i.e., "pregnant women and infants" rather than "infants and pregnant women").

Mr. Wilson briefly discussed new member nominations, which were currently under review. In this review process, he explained that they hoped to achieve both diverse representation and an orderly transition of Committee members through the staggering of appointments. He shared that Committee member nominations moved through different levels of the agency and then were vetted through the Office of the White House Liaison. This was to ensure that the administrative requirements of the Federal Advisory Committee Act were met. The Chair position was similarly nominated and chosen based on different factors such as leadership skills.

Adjourn

Each Committee member shared their thoughts on the meeting. There was consensus that two half-days were preferred over two full days.

Dr. Ehlinger adjourned the meeting at 3:48pm.