Advisory Committee on Infant and Maternal Mortality

Meeting Minutes of March 15-16, 2022

Virtual Meeting via Zoom

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DAY ONE: Tuesday, March 15, 2022

Welcome and Call to Order

***Lee Wilson,* Acting Designated Federal Official, ACIMM**
***Edward Ehlinger, M.D., M.S.P.H.*, ACIMM Acting Chair**

Mr. Lee Wilson called the Advisory Committee on Infant and Maternal Mortality (ACIMM) to order and welcomed participants. Dr. Edward Ehlinger recounted March 15, 1964, when President Lyndon Baines Johnson declared an unconditional war on poverty. Dr. Ehlinger noted that a year later, President Johnson signed the Voting Rights Act to guarantee voting rights for all. Dr. Ehlinger reminded the audience these two events led to major policy changes that positively impacted public health and led to a rapid decline in infant mortality and an unprecedented 10-year trend of reduced racial disparities in infant mortality. He also reflected on new policies that seemed to slow this progress. Dr. Ehlinger reiterated that public policies make a difference.

Dr. Ehlinger reminded the Committee that they do have power to effect change through the policy recommendations they develop for the Health and Human Services (HHS) Secretary. He urged Committee members to use their experiences, perspectives, knowledge, and connections of Committee members to make a difference to the health and wellbeing of mother and infants.

Welcome from the HRSA Administrator

***Carole Johnson,* Administrator, Health Resources and Services Administration (HRSA)**

Ms. Carole Johnson was recently appointed as the new HRSA Administrator. During her presentation, she shared that one of her priorities is to face the critical challenges related to the COVID-19 pandemic and its effects on physical and mental health. Specifically, she noted, there is a priority to focus on the mental health of children, who have experienced great loss—whether from direct grief or losses in learning or connectedness. She highlighted that the critical need to address maternal health issues associated with mental health, specifically to expand access to mental health services through telehealth or within primary care and maternal health providers. She is also committed to ensuring that women's voices are heard as HRSA works to build health care systems, services, and supports. She stated that the disparities between Black and White maternal and infant health outcomes are unacceptable, and there must be a unified response to address and reverse the systemic racism and workforce challenges that underlie these disparities.

She also stated that HRSA is focused on workforce challenges because good policy cannot be effective if the workforce is not supported. She stated that it is critical that the maternal and child health workforce grows and diversifies to ensure that it is reflective of its communities and serves the communities that are in most need. It is also important, Dr. Johnson noted, that the workforce feels supported, cared for, and recognized for the extraordinary contributions they have made throughout the pandemic. She shared that HRSA invests not only in training, but also healthcare workforce mental health and resiliency.

Ms. Johnson concluded by reiterating the importance of the Committee's input and expertise to HRSA as they tackle these challenges. She concluded that these issues are not only her priorities for HRSA, but they are also the priorities of the Secretary and the President.

Comments and Discussion
Dr. Ehlinger said that 2025 will mark the halfway mark of the Healthy People 2030 goals, as well as the 40th anniversary of the Heckler Report, both of which aim to reduce racial disparities. He asked if Ms. Johnson plans to revisit both reports in determining ways forward for HRSA. Ms. Johnson said that it is a good suggestion that she will consider with her colleagues.

Dr. Steve Calvin expressed gratitude for HRSA's commitment to the workforce and said that studies have shown that the current obstetrical workforce is not adequate to care for all of the mothers having babies. He shared that the Strong Start study demonstrated the value of midwifery care integrated within the safety net of physicians and hospitals. However, he noted, there is a scarcity of midwives, and he asked Ms. Johnson to consider this as they address workforce issues. Ms. Johnson replied that HRSA has the same concern and considers midwives and doulas to be a critical part of the maternal and infant health workforce. She hopes the Committee will recommend expanding the model of care and identify best practices in integrating midwives and doulas into the workforce.

Dr. Magda Peck shared that another Committee recommendation in 2013 was greater interagency collaboration. For instance, she stated, there has been an effort to connect the U.S. Department of Housing and Urban Development (HUD) and HHS towards addressing issues critical to women and infants, such as housing security and addiction prevention. She noted that the Committee heard Ms. Tammy Murphy, First Lady of New Jersey, speak about their collaborations to improve quality of and access to care in the state. Dr. Peck asked what partnerships might be essential for addressing the complex issues that impact maternal and infant mortality.

Ms. Johnson shared that First Lady Murphy started with the New Jersey Department of Human Services and expanded her efforts to include the state's Department of Agriculture, the Department of Transportation, and the Department of Housing and Community Development. The effort required a whole-of-government response. She is likewise committed to HRSA building these same types of connections and the Secretary has also charged HRSA, the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH) to tackle these challenges. She noted that it is also important to work with the federal Departments of Agriculture and Transportation to address the social determinants of health that are critical for progress.

Ms. ShaRhonda Thompson brought up the issue of midwives and doulas and stated that most women are comfortable when their doulas look like them. She stated that there are a lot of women of color who are interested in becoming a midwife or doula but do not have the funding needed for training. She asked if there is any effort to make this training accessible. Ms. Johnson answered that HRSA not only supports the Title V Maternal and Child Health Block Grant but also a number of health professional workforce training programs. She shared that HRSA has been working with the President on the provisions of his Build Back Better agenda to transform social services and part of that conversation has included the importance of midwives and doulas. She noted that making this a viable career choice and encouraging people who reflect their communities to provide these services will require resources for training and coordination with the Medicaid program.

Dr. Marie-Elizabeth Ramas shared that it is important not only to create a pipeline for the workforce but also a compensation model that works within community settings. She stated that there needs to be parity for telehealth services and consideration for the social, as well as the informatic, determinants of health to bridge this gap. She said she is also excited about the focus on mental health. She noted that children in both rural and urban areas, especially among the Black, Indigenous, and People of Color (BIPOC) communities, have lost parents as a result of the opioid crisis and COVID-19. She asked about partnerships, such as the Boys and Girls Club or United Way, which are integrated with the community and may help increase access to services.

Ms. Johnson responded that supporting the young children who have lost parents from the opioid epidemic is particularly challenging.
Dr. Ramas spoke about her work developing the New Hampshire health assessment and improvement plan, part of which is to create a geomapping of social resources in communities.
Dr. Charlene Collier talked about the recent Match Day, which is when medical students are matched with a residency program. She shared that a very large number of students were not matched because there were not enough residency spots available. Many of these students, she explained, were BIPOC, first generation students. She noted that there is a shortage of physicians, and it is difficult to see unmatched obstetricians, psychiatrists, or pediatricians particularly from underrepresented communities. She asked what the HHS response will be in addressing this shortage.

Ms. Johnson said that she remembered when the Affordable Care Act passed and allowed the creation of residency slots. Similarly, she shared that the American Rescue Plan provided significant resources for HRSA to expand their Teaching Health Center Graduate Medical Education (THCGME) programs and they have since released solicitations to fund that expansion.

MCHB Updates

***Michael Warren, M.D., Ph.D., FAAP,* Associate Administrator, Maternal and Child Health Bureau (MCHB), HRSA**

Dr. Michael Warren shared highlights of how the Committee's recommendations have been put into action at MCHB. He shared that in 2013 and 2021, the Committee submitted recommendations to the Secretary on strategies for reducing infant mortality and disparities. He stated that MCHB has incorporated those recommendations into program planning and partnerships. Dr. Warren reviewed the Committee's 2013 strategic direction recommendations, which were to:

1. Improve the health of women before, during, and beyond pregnancy
2. Ensure access to a continuum of safe and high-quality patient-centered care
3. Redeploy key evidence-based, highly effective preventive interventions to a new generation of families
4. Increase health equity and reduce disparities by targeting social determinants of health through both investments in high-risk, under-resourced communities and major initiatives to address poverty

5. Invest in adequate data, monitoring, and surveillance systems to measure access, quality, and outcomes
6. Maximize the potential of interagency, public-private, and multidisciplinary collaboration

He stated that the Committee's 2021 recommendations comprised five topic areas:

1. Care Systems and Financing of Care
2. Workforce
3. Environmental Conditions
4. Migrant and Border Health
5. Data and Research for Action

Dr. Warren said that MCHB has implemented these recommendations through program planning and implementation, technical assistance, and legislative responses. For example, he noted, under the recommendation to improve the health of women before, during, and beyond pregnancy, MCHB has supported three preventive programs including the Recommended Uniform Screening Panel (RUSP), which supports newborn screening; Bright Futures, which supports infants, children, and adolescents; and the Women's Preventive Services Initiative (WPSI), which provides guidelines for preventive services that are required to be covered without cost-sharing. He shared that MCHB has also taken a life course approach to mental health, with the Pediatric Mental Health Care Access program, which recently expanded under the American Rescue Plan; the Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program, which is funded in seven states; the Stopbullying.gov website; and the Maternal Mental Health Hotline, which will launch later in 2022. Additionally, he shared that HRSA's Alliance for Innovation on Maternal Health (AIM) develops maternal safety bundles to improve maternal health outcomes.

Dr. Warren stated that HRSA has made a number of investments in support of adolescent health. For instance, the Leadership Education in Adolescent Health (LEAH) provides interdisciplinary training for providers and the Adolescent and Young Adult Health National Capacity Building Program (AYAH-NCBP) builds capacity in states and communities for improving the health of adolescents and young adults. He also shared that the Pregnancy-Related Care Research Network, the Life Course Intervention Research Network, and the AYAH Research Network provide funding to researchers who engage community partners to advance health across the life course.

Dr. Warren then reviewed MCHB activities under the recommendation to provide access to safe, high-quality, and patient-centered care. He said that MCHB's Collaborative Improvement and Innovation Network (CoIIN) used the principles of rapid-cycle quality improvement to reduce infant mortality. MCHB, he noted, also leveraged a relationship with CMS to support state partnerships through the State Title V-Medicaid Interagency Agreement. The MCHB Policy Innovations Program (PIP) engages partners nationally in policies to improve access to quality health care. For instance, one state recently leveraged Medicaid and other funding sources to pay for doula services. He shared that the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) provides voluntary, evidence-based home visiting across a number of states. Congress recently passed the President's 2022 budget and, although the proposed budget included funding for medical home demonstrations, it was not included in the final budget. However, the final budget did include a number of legislative authorizations for future

appropriations, including for pregnancy medical home visits.

Dr. Warren shared MCHB-led activities under the five topic areas that the recommendation for evidence-based prevention activities highlighted. For example, he mentioned MCHB's Healthy Start and the updated WPSI recommendations both promote *breastfeeding*. Dr. Warren shared that WPSI also recommends contraceptive care and counseling, which supports *family planning*. He highlighted The Bright Futures' periodicity schedule, which outlines recommendations for *immunization,* and the Promoting Pediatric Primary Prevention (P4) Challenge, which seeks innovative ways to increase immunization during the pandemic. He also mentioned MCHB's National Action Partnership to Promote Safe Sleep (NAPPS) and the Infant Mortality (IM) CoIIN both support *safe sleep* and the IM CoIIN also included Tobacco Cessation Learning Networks to support *smoking cessation*.

Dr. Warren said that MCHB also ensures it uses an equity lens in all of its activities. MCHB, he explained, has engaged with federal and public partners, such as the March of Dimes' Mother Baby Action Network, to reduce disparities in infant mortality. Dr. Warren shared that MCHB also has an external contract to identify strategies to close the gap in excess infant deaths. Through this initiative, he explained that they have identified three states that account for a quarter of all excess infant deaths.

Dr. Warren reviewed MCHB activities under the recommendation to invest in data monitoring and surveillance. He shared that MCHB's Title V Block Grant program has overhauled its national-level performance and outcome measures. MIECHV has done the same, to ensure that data are being collected consistently across states. MCHB has also supported state and national infrastructure through multiple initiatives including the National Survey of Children's Health; the National Fetal, Infant, and Child Death Review Center; the State Maternal Health Innovation (MHI) Program, and the State Systems Development Initiative.
Dr. Warren reviewed how MCHB promotes the workforce through the Graduate Student Epidemiology Program, which is a paid summer internship to promote diversification in the pipeline of early career professionals, and the CDC Maternal and Child Health Epidemiological Assignee Program, which helps build data capacity across states. He highlighted that MCHB has an emerging partnership with a group of Historically Black Colleges and Universities (HBCUs) to build capacity for a diverse maternal and child workforce and there will be a summit in April for federal partners to advance this work.

Dr. Warren reviewed MCHB activities under the collaboration recommendation. He shared that MCHB has ongoing federal-state partnerships through the Title V MCH Services Block Grants, which is the Bureau's largest lever for supporting states. He also shared that the HRSA Bureau of Health Workforce (BHW) has a number of programs to increase the capacity of the workforce, including the National Health Service Corps and the Nurse Corps Scholarship programs. BHW also has a forthcoming funding announcement for community health workers and is actively targeting maternity care health professionals to identify opportunities for placement. He shared that MCHB is looking to expand doula supplements through Healthy Start and is partnering with the Maternal and Child Health Workforce Development Center at the

University of North Carolina at Chapel Hill to create a series of learning communities to accelerate equity.

Discussion
Dr. Ehlinger asked about the MCHB-CDC partnership and if it can be leveraged further. Dr. Warren said that the CDC Division of Reproductive Health team meet regularly to review activities and discuss opportunities for alignment. Dr. Warren noted that MCHB grantees are often also CDC grantees. He shared that MCHB also works closely with the CDC to coordinate priorities and to avoid duplication.

Approval of Minutes

***Edward Ehlinger, M.D., M.S.P.H.*, ACIMM Acting Chair**
The Committee unanimously passed a motion to approve the Minutes of the December 2021 meeting.

Health of Indigenous Mothers and Infants

***Janelle Palacios, Ph.D., C.N.M., R.N.,* ACIMM Member**
Dr. Ehlinger began the presentation by conveying how the Committee has focused on Indigenous mothers and infants over the last year. He shared that ACIMM planned to have an IHS representative at this meeting but was unable to secure their attendance. Dr. Ehlinger noted that there are plans to hold the next Committee meeting at a tribal reservation in Minnesota, where the Committee will finalize recommendations related to the health of Indigenous mothers and infants. Dr. Ehlinger invited Dr. Janelle Palacio, a representative of the Indigenous community, to share their concerns.

Dr. Palacios expressed disappointment that IHS was not represented at this meeting. She shared that since September 2021, the Committee has heard from several Indigenous maternal and infant health experts speak about the key historical events, federal policies, forced institutionalization, and intergenerational effects that cumulatively led to increased maternal and infant mortality within Indigenous communities and that continue to negatively affect Indigenous people today. For instance, she said that policies to facilitated assimilation of Indigenous children led to Indian children being overrepresented in the foster care system. Dr. Palacios noted that the Indian Relocation Act in the 1950s led to the relocation of Native people from rural areas to cities, which left them struggling and unable to return to their homes. She also pointed out that federally-funded sterilization campaigns targeted Indigenous women in the IHS clinics in which they were meant to be kept safe.

She hopes that IHS will be available to respond to these key issues. One of the issues that should be discussed, she stated, is the pros and cons of IHS-funded health care as compared to Compact 638 Tribes. She noted that it is well-established that IHS funding does not meet the needs of the Indigenous populations, especially in maternal and infant health care. She said that it is also challenging to access IHS data in order to conduct research needed to better understand and address these concerns, such as how maternal and infant health care and outcomes may vary

regionally. She shared that an evaluation conducted by the American College of Obstetricians and Gynecologists (ACOG) found that IHS was underfunded and needed to recruit Indigenous people into the health care workforce in order to improve their relationship with tribal communities. She pointed out that ACOG and IHS recently celebrated their 50-year contract partnership, however, as of September 1, 2021, the only ACOG recommendation has been to conduct widespread drug testing among child-bearing Native women.

Dr. Palacios reminded the Committee that in December 2021, CAPT Suzanne England presented data showing that the 2019 IHS average health expenditure per person was approximately $4,000 per person as compared to the 2017 national health expenditure of approximately $9,700 per person. She noted that each of the experts who presented on Indigenous maternal and infant health advocated for increased funding, timely surveillance, and a strengthened Indigenous workforce. Dr. Palacios stated that there is also a need to include members of the Indigenous communities and tribal organization within oversight and advisory boards, such as ACIMM.

Dr. Palacios reiterated that minimal attention has been given to disparities among Indigenous communities. She pointed out that the rate of mortality among childbearing Indigenous women is two to three times higher than White women and Indigenous women continue to be missing or murdered. She stated that Indigenous infants still die at higher rates than most other populations. Indigenous men, women, and children are incarcerated at high rates. And yet, she emphasized, Indigenous people are also not represented in the data. She said that the problems in the Indigenous population are minimized or forgotten. Dr. Palacios urged the Committee to join her in raising these concerns and asking the questions that need answers in order to guide their recommendations.

Discussion

Dr. Ehlinger said that the urgency of the American Indian/Alaska Native (AI/AN) community has been raised for a long time but has not been addressed. He noted that the data for this community are based on small numbers and there is a need to look at this data differently in order to understand the needs of Indigenous mothers and infants. He expressed that there is also urgency within the Committee. He shared that a number of Committee members who represent AI/AN will be moving off the Committee and it is therefore important to develop recommendations at the June 2022 meeting so that the recommendations are made with input from these experts. He asked the Health Equity Workgroup in particular to join the June meeting and help draft the recommendations.

Dr. Collier said that she sits on several committees in which there is no representatives from Indigenous people. She pointed out that the small numbers in Indigenous communities do not reflect a small number of people who are coming into the U.S., but rather the elimination of the population over time. She suggested that HRSA have a specific objective to include representation in the MCHB Title V Block Grants, the Maternal Mortality Review Committees (MMRCs), and any other funding and planning committees.

Dr. Palacios thanked the Committee for their support. She echoed that the small numbers are based on a systematic removal of people and that the challenge in finding innovative ways to capture data is rooted in federal policies that determine who is counted as Indigenous or not. She

is grateful to be in a space in which people recognize the problem, but the awareness needs to be broadened throughout American culture.

Introduction of ACIMM Members

***Edward Ehlinger, M.D., M.S.P.H.*, ACIMM Acting Chair**

Dr. Ehlinger introduced the eight new Committee members and asked them to talk about what brought them into the field of maternal and infant mortality.

Dr. Jacob Warren shared the story of his mother, who was a labor and delivery nurse and experienced a miscarriage at work. He said that his existence was only possible because his mother was at a hospital when she hemorrhaged. He stated that his mother's story highlighted the fragility of the labor and delivery process and the power and privilege that impacts that dynamic. He noted that he is also a member of a marginalized community that is not always visible, which drives his passion for health equity. He shared that he works in maternal and child health in rural communities, which makes him acutely aware of the challenges in small numbers. Often, he said, rural communities are overlooked and the perspective of women and children in rural areas are not shared. He stated that he hopes to raise these voices to ensure that the Committee continues to think about rural communities and the diversity within rural communities that also deserves attention.

Ms. ShaRhonda Thompson shared that she is a 'rainbow baby" (i.e., a baby born after a miscarriage) and that she did not understand what the significance of her successful birth meant to her mother when she was young. She explained that it only became clear what losing a child meant after she had her own children. She has two children who were born more than 13 years apart. She shared that her second child was born prematurely and Healthy Start visited her home to help explain what was happening. Ms. Thompson said that these visits helped her feel less stress about the premature birth, but she realized that many women do not have home visits to explain what is going on with their bodies and babies or how to advocate for themselves. She explained that her experience with Healthy Start and her knowledge of the emotional and physical needs during and after pregnancy drives her passion to help other women advocate for themselves.

Dr. Phyllis Sharps introduced herself and shared that she is a perinatal clinical nurse specialist. She shared that one of her first jobs after nursing school was as an active-duty Army Nurse Corps Officer in the labor and delivery unit, where she observed that African American and Hispanic women were consistently experiencing negative outcomes. She wondered why this could occur in a community in which every woman had access to the same military health care. Dr. Sharps stated that the disparity, however, was even more pronounced when she started working in the civilian sector. Although she intended to become a midwife, she realized that the health of babies is influenced long before their mothers arrive at the hospital. She shifted her focus to community-based practice and began specializing in maternal mental health, substance use, and violence against women. Dr. Sharps has spent the rest of her career focused on testing interventions for violence against women and children. In light of the Committee's discussion about the lack of representation in the workforce and in research and policy, she said that she feels privileged to contribute to the discussion.

Dr. Marie-Elizabeth Ramas shared that she is a first generation Haitian American. She became a family physician because she understood the importance of family as a fundamental structure of society. She has provided maternity and pediatric care in both rural and urban settings, and she has learned how much socioeconomic and racial/ethnic differences matter. As a representative of an under-resourced community, she feels both privilege and immense responsibility to advocate for these communities at multiple levels—from practice to policy. She is passionate about elevating the stories of her patients and communities, as well as her own story as a Black woman who delivered three children in the U.S. One of her goals is to share how metrics and data are important in creating the story that the health and wellness of the nation starts in the womb. She shared her hope to honor her patients and the communities that she serves through her work on the Committee.

Dr. Joy Neyhart shared that she serves as a pediatrician in the Indigenous lands of southeast Alaska, where she has been practicing for more than 21 years. She shared two of her experiences with pregnancy and substance misuse. In one story, she recalled that she was called into the delivery of a baby whose mother had taken heroin just one hour earlier. Dr. Neyhart shared that the baby was healthy, and she had to ensure that mother and baby were not separated and could be in an environment where they would both receive safe care. The other story she shared involved a woman who was not able to overcome her substance misuse but had been able to have input about where her child would be most safely and appropriately reared. Today, Dr. Neyhart explained that this woman's child is five-years-old and doing well. Dr. Neyhart stated that these two experiences represent a fraction of the many stories she has from her practice. She shared that she is motivated by the desire to see improved health care, improved social determinants, and, ultimately, more of these children overcoming their circumstances.

Dr. Kathryn Menard stated that she strongly believes in the power of collaboration. She shared that the most rewarding part of her career has been to work at the intersection of clinical medicine and public health. She said that she is one of six children and was inspired to work in maternal and child health by her mother, who worked a special education teacher as she raised her children. Even as a physician, Dr. Menard noted that she always looked to systems issues as the area by which to make the biggest difference. She explained that this drew her to the field of public health, where she had several opportunities to lead. For instance, she shared that she became the first co-chair for the first CoIIN initiative regionalization. She also served as President for the Society of Maternal Fetal Medicine, where she worked with HRSA to deliver safety bundles. She said that her mother taught her that gifts were given to share, and she has had wonderful experiences that she hopes to share with the Committee.

Dr. Charlene Collier shared that her mother was also a special education teacher. She explained that she had always wanted to become a doctor and a large influencer of that came from her experience growing up in a segregated community in New Jersey in the 1990s. Although the community was over 50 percent White, she stated that her public high school was over 90 percent Black and Latino. Throughout her childhood, teen pregnancy was an obvious problem in her community, and she realized that the underlying issues were grounded in social inequities. She became a physician so that she could address the social challenges that lead to health inequities. Dr. Collier explained that when she learned about Black maternal and infant mortality disparities, she immediately knew that the inequity was not driven by biology but by social

inequities, injustice, and racism. She recognized that medicine would not be the tool needed to undo these inequities. She shared that after attending Brown University, which had a partnership with Tougaloo College, an HBCU in Jackson, Mississippi, she began working with the Mississippi State Department of Health, where she was able to integrate her experience in medicine and public health. Dr. Collier believes that social inequities and racism are the root of these problems and there is a need to break down the siloes to solve them. She is also a mother of two boys and had suffered a severe obstetric hemorrhage. She brings these experiences to her work in perinatal quality improvement, ensuring that mothers receive quality care.

Dr. Sherri Alderman shared that she graduated from medical school when she was 42-years-old, and she is grateful for the convoluted path that led her to medicine. Her family roots began in New Mexico, as far back as the 1600s. As the first generation of her family to graduate from high school, she said that she carries the lived experiences of how a social culture can affect public health. She was living in other countries and working on various public health initiatives when she began a focus on children and pregnant women. From there, she was motivated to move back to the U.S. to pursue medicine so that she could work towards health equity for children. She shared that she is grateful to bring her experiences to the Committee and is excited to continue her pursuit for health equity.

Race Concordant Care

Belinda Pettiford, M.P.H. **(Moderator)**
Ms. Pettiford spoke on behalf of the Health Equity Workgroup to present their recommendations for race concordant care. She shared that in September 2021, the Committee heard a presentation from Ms. Patrician Loftman and Dr. William McDade on race concordant care strategies for reducing disparities in maternal and infant health. Race concordant care, she stated, is connected to the Committee's larger recommendation to ensure a diverse workforce. She explained that it is based on relationship-building that impacts access to and utilization of services and it ensures that communities have options for providers of choice. She pointed out that race concordant care is not segregation but rather provides options to individuals so that they feel comfortable in their care setting.

Patricia Loftman CNM, LM, M.S., FACNM**, Chair, BILPOC Committee, New York Midwives**
Ms. Loftman became a midwife in 1984 in Harlem, New York, at a time in which the crack epidemic was hitting the U.S. She shared that they began to provide services to the primarily Black women in central Harlem who were experiencing chemical dependency and realized that the women needed a supportive environment to feel trust and safety. At the end of her 10 years in this work, Ms. Loftman stated that she understood the value of race concordant care and she has focused on it for the remainder of her career. From a policy standpoint, she said, race concordant care is critical for positively impacting maternal mortality and morbidity.

Ms. Loftman said that women are seldom given the opportunity to share their perinatal experiences. She pointed out that however, the National Survey of the Experiences of Care During and After Pregnancy and Childbirth in the U.S., a national multiracial and multiethnic effort from the Birth Place Lab in British Columbia, documented experiences after pregnancy and childbirth in the U.S. She explained that the 2,700 women who were interviewed came from

all 50 states, with the majority from New York, California, Washington, and Texas. Approximately 66 percent of women identified as White, 15 percent Black, 10 percent Hispanic, 5 percent Asian, and 3 percent Indigenous. Most had completed post-secondary education and one-third reported family annual income of less than $50,000. The majority were between ages 20 and 39 when they gave birth.

Across participants, 71 percent received prenatal care from midwives, 26 percent from obstetricians, and 2 percent from family physicians. She noted that fewer Black women received prenatal care from midwives than White women. Half the participants gave birth in their homes or at a freestanding birth center and the other half in a hospital. Fewer Black women had a planned community birth than White women. More Black women had a Cesarean birth than White women. Ms. Loftman highlighted that, since the COVID-19 pandemic, the number of Black women who had an out-of-hospital birth dramatically increased and their experiences have generally been very positive.

Ms. Loftman reviewed factors women identified as important during maternity and newborn care. These factors included having a trusting relationship with their care provider or who was a good match for what they valued, not being separated from their baby at birth, having enough time to ask questions and to discuss options for care, having support people of choice present at labor and birth, knowing which provider will provide care during birth, and having an option to choose a birthing place.

She shared that Black women were less likely to access midwifery care, experience continuity of care, or have the provider who cared from them prenatally at the birth. Black women also reported the lowest scores for autonomy and decision-making and had the least access to models of care that supported decision-making. Although 95 percent of Black women indicated that it was important to have enough time to ask questions or discuss options for care, they were the most likely to have very short prenatal appointments.

She also shared that 46 percent of Black, 25 percent of Indigenous, 25 percent of Latina, 13 percent of Asian, and 9 percent of White women indicated that finding a midwife or doctor who shared their heritage, race, ethnic, or cultural background was important to them. However, 69 percent of Black, 49 percent of Latina, and 4 percent of White women reported having difficulty locating a midwife or doctor who shared the heritage, race, or cultural background.

Ms. Loftman said that the more than 90 percent of women who planned an out-of-hospital community birth did so very deliberately. She explained that they indicated that they wanted control over their birth experience; a comfortable and peaceful environment; fewer intervention options; safety and confidence in their body; and avoidance of disturbance during labor, a Cesarean section, separation from their baby, and hospital policies and procedures.

She said that women of color predominantly reported mistreatment from health care providers. She shared that twice as many Hispanic and Indigenous women were shouted at or scolded than White women. Black, Indigenous, Latina, and Asian women, she pointed out, were twice as likely to report that their health care provider ignored, refused, or failed to provide a timely response to their request for help than White women. She highlighted that Black women were

twice as likely as White women to report that their care providers performed procedures against their will or were not consulted. She noted that care in community settings and by midwives was associated with greater respect, privacy, and dignity. However, Ms. Loftman explained, women of color reported lower over rates of respect, privacy, and dignity than White women.

Ms. Loftman shared data on the midwifery workforce. Approximately 13,500 midwives in the U.S., of which 90 percent are White women and 10 percent are Black, Latinx, Asian, or Indigenous. Therefore, the ability for women to interface with a midwife of color is remote. Within midwifery education programs, most of the program directors and faculty are White and most midwifery students are also White.

Ms. Loftman summarized that Black, Indigenous, Latinx, and People of Color (BILPOC) reported that the perinatal care system does not provide them with access to care by their provider of choice, which would be a midwife or doctor who shares their heritage, race, ethnic, or cultural background and with whom they can develop a trusting relationship and a good match for what they value and want in their pregnancy and birth care.

Discussion
Dr. Conry said that this message of a need for respectful care has also been shared by the White Ribbon Alliance, which highlights many of the focus areas that the Committee has discussed.

Dr. Calvin thanked Ms. Loftman for pointing out that the pandemic resulted in BILPOC women looking for alternatives because the pandemic made a bad situation even worse.

Dr. Colleen Malloy pointed out that less than half of women said that they preferred a provider from a specific race or ethnicity but the majority of women indicated that it was more important to have a provider who agreed with their ideas for pregnancy and birth. She asked if there were other data that supported the idea that women preferred a specific heritage or race. Ms. Loftman answered that she obtained the data from the researchers, who would have the specific survey questions that were asked.

Ms. Pettiford reviewed the three recommendations that the Health Equity Workgroup developed for the Secretary. These were:

1. The Secretary should encourage and support the licensure and federal recognition of Certified Professional Midwives and Certified Midwives who graduate from accredited midwifery education programs in all 50 states, territories, and D.C.
2. Federal grant applications for health care professions (i.e., medical, midwifery education programs) must include accountability metrics in the applications to monitor efforts to improve diversity of the workforce that reflects the diversity of the population being served.
3. Develop and implement an external evaluation report on the "lifespan" training (e.g., recruitment through initial employment) for Black, Brown, and Indigenous students in the medical, midwifery, and health fields that support maternal/child health to develop and/or identify best practice guidelines for training institutions.

Dr. Collier noted that only 10 percent of Certified Nurse Midwives (CNMs) were women of

color and asked if there is evidence of more diversity among Certified Professional Midwives (CPMs) or Certified Midwives (CMs). Ms. Loftman answered that the organization that represents a CPM is the National Association of Certified Professional Midwives, and their data is not readily available. She pointed out that CPMs who come from accredited midwifery education programs are limited to the state in which they can practice.

Dr. Collier explained that the recommendation would benefit the community as a whole to improve maternal and infant health but may not specifically solve the diversity issue. She noted that the training programs might not be accessible to communities of color. She stated that for example, in Mississippi, midwives are challenged to find clinical hours or places to practice. Regardless, she believes the recommendation is important to the mission. Ms. Loftman said Mississippi used to have a midwifery education program that no longer in operation. She stated that there are many issues for students of color that extend beyond their education program, clinical sites, and faculty preceptors.

Dr. J. Warren said that Georgia has a very limited scope of practice, as do other southern states, which may be a challenge as an entry point. He noted that states that could contribute the most to diversity may have more restrictive scopes of practice. Ms. Loftman said that the absence of a universal policy regarding jurisdiction over midwifery is a barrier Ms. Pettiford added that the Health Equity Workgroup discussed the challenge of CNMs not being able to practice under their full authority.

Dr. Conry said the Committee needs to look at the International Confederation of Midwives (ICM), which provides minimum education and training requirements for midwives in all countries. She explained that the distinctions between CNMs, CPMs, and CMs can be confusing to patients who do not understand the levels of training and requirements needed. She stated that a midwife in Bangladesh will have met higher requirements than a midwife in the U.S. She reiterated that ICM standards should be consulted for these recommendations.
Dr. Menard asked why there was a focus on the midwives when there were opportunities to broaden the doula workforce and increase the use of community health workers. Ms. Pettiford answered that recommendations specific to community health workers and doula services have already moved forward to the Secretary. Ms. Loftman said that her presentation was meant to center and contextualize the voices of midwives.

Dr. Collier asked if any HBCUs were associated with midwifery programs. Ms. Loftman answered that there was one in the 1980s but there are none currently associated with midwifery education. She noted that it may be time to assess if there is renewed interest.

Ms. Pettiford asked the Committee to discuss Recommendation 2, which is not specific to midwives but spans all health care professions.
Dr. Peck suggested that the recommendation should be more specific to define what is meant by "health care professions." If the intent is to assess the constellation of all health care providers, she said, this recommendation is an opportunity to define what that means because it could include mental health care providers or dentistry. She advised that that recommendations should be as clear as possible so that the Secretary and HRSA can act in alignment with the development of a diverse workforce. Additionally, the accountability metrics should include both

process measures, which encompass strategies and actions, and *impact measures*, which define the outcomes aligned to strategies and actions. Ms. Pettiford said that the Health Equity Workgroup used a few examples of health care professions in the draft so that the Committee could understand the intent of the recommendation. She added that the intent of the recommendation was to include both process and outcome measures and that there will be opportunities to clarify the language.

Dr. Ehlinger reminded the Committee that their previous set of recommendations included a recommendation to expand and strengthen the public health workforce dedicated to women's and children's health through policy, financing, and commitment to community-based providers that are culturally and linguistically reflective of the community. This current recommendation, he explained, builds on the previous recommendation and provides specific guidance for the Secretary. He shared that he would also like to contextualize these recommendations through a letter to the Secretary to indicate that these recommendations are a follow-up and that there will be forthcoming related recommendations specific to AI/AN communities.

Dr. Collier suggested that the recommendation specific to federal grant applications includes resources, best practices, and accountability metrics so that applicants have the tools needed to develop their grant applications. Ms. Pettiford agreed with this suggestion and said that MCHB does a good job including such resources and tools within notices of funding.

Ms. Pettiford asked the Committee to discuss Recommendation 3.
Dr. J. Warren asked how an evaluation of resources and best practices would be conducted. Ms. Loftman suggested that a request would need to be made by an external body to identify resources and best practices, which could ultimately become a step(s) in the accreditation process. It is difficult for educational programs to evaluate themselves; therefore, an external body might be best suited to provide information and resources on ways to improve outcomes for BILPOC students.

Dr. Peck asked for more information on lifespan training. She explained that she knows that lifespan begins prior to recruitment, employment, and retention—particularly for BILPOC students in predominantly White institutions. She asked for clarification on the development of the pipeline prior to recruitment and efforts beyond initial employment through the first five years of practice. Ms. Loftman said that midwifery education programs are extremely rigorous and that there is concern that potential students may not realize the rigor required to complete the program. She explained that this can result in a high rate of attrition. Dr. Peck agreed that the application process should reflect the rigor required for success to help support retention and asked about the financial cost of the programs. Ms. Loftman answered that students are admitted with the understanding that they will complete the program and, if they did not, the financial burden would be significant.
Dr. Ramas said that accountability metrics are not only important for improving diversity but also for sustaining diversity. She suggested specifying the need to sustain student success.

Dr Ehlinger suggested that the Committee review these recommendations in context with the July 2021 report of recommendations to the Secretary and frame them as a follow-up. He stated that the Health Equity Workgroup will revise the recommendations and the Committee can

review them in the June 2022 meeting. Ms. Pettiford asked the Committee to provide their feedback by April 4.

Review of Committee's Work and Updates from Committee Members on ACIMM Issues

***Edward Ehlinger, M.D., M.S.P.H.*, ACIMM Acting Chair**

Dr. Ehlinger asked the Committee to provide a brief update to new members on the Committee's recent activities. He asked Dr. Calvin to start by providing an update on what has been learned from the COVID-19 pandemic. Dr. Calvin said that the COVID-19 pandemic uncovered a number of challenges, such as mothers being unaccompanied during labor and delivery. He shared that a significant amount of data have been gathered about the effects of COVID-19 on pregnant women, including a number of articles about maternal morbidity and mortality related to COVID-19. For instance, he said, COVID-19 is related to an increased risk for hypertension and preeclampsia and a slight increase in stillbirth rates. He shared that the CDC Division of Vital Statistics Health-E reports have indicated an increased maternal mortality rate in the U.S., some of which is related to COVID-19. He noted that the rate of maternal mortality related to COVID-19 among non-Hispanic Black women has been at least three times higher than in White women. He shared that there are also specific outcomes related to asymptomatic COVID-19 during pregnancy. He stated that the Committee contributed to the CDC recommendation to obtain a COVID-19 vaccination during pregnancy.

Dr. Peck added that the pandemic provided an opportunity for better disaggregation of data by race and ethnicity, which resulted in a strengthening of data and surveillance systems and elevated the issue of racial equity. She noted that the pandemic provided an opportunity to illustrate how dire the data were in racial disparities.

Dr. Conry said that the global perspective of COVID-19 has also helped. She stated there has been a registry of births from around the world and the ability to combine and share that data has been very helpful.

Dr. Ehlinger said that the COVID-19 pandemic also highlighted that everything is connected. He noted its impacted housing, transportation, economic development—all of which impact populations of color and affect the health of mothers and infants.

Dr. Ehlinger asked Dr. Conry to provide an update on activities related to the impact of environmental contaminants on health and the World Patient Safety Day that was recognized on September 17, 2021. Dr. Conry said that the September 2021 World Patient Safety Day was focused on safe and respectful care. She talked about presentations on environmental contaminants from the June 2021 meeting and Committee discussions that spanned the effects of climate change, environmental exposures, and endocrine disrupters that impact maternal health in the U.S. She shared that the Committee also heard about a review article that showed a significant association between heat, ozone, fire particulate matter, and pregnancy outcomes, which tends to disproportionately impact Black and Latino populations. She noted that a recent report showed a disproportionate risk of negative environmental impacts among underserved communities related to preterm delivery and low birth weights. She shared that the Committee also learned about the impact of lead on infant's and children's health.

Dr. Ehlinger asked Dr. Peck to review activities related to housing issues. Dr. Peck highlighted the Committee's ability to work with federal agencies outside of HHS, such as HUD. She said that the Committee heard presentations on the connection between housing insecurity and adverse outcomes in mother and infants that was been exacerbated by the pandemic. She noted that there has been a new focus on evictions as a sentinel event for pregnant and postpartum women. She said that the Committee has an opportunity to strengthen interagency relationships to develop specific recommendations that can augment programs, such as Healthy Start, or shape research funds, such as with NIH. She stated that partnerships can also facilitate better data sharing and surveillance systems, which lead to better and more specific research.

Ms. Thompson asked if the Committee has previously addressed transportation as an issue for maternal and child health. Dr. Ehlinger said that the topic has been introduced but has not yet been a focus area. He encouraged new Committee members to move their areas of interest forward in discussions.

Mr. Wilson added that ACIMM staff makes every attempt to use inclusive language in its minutes and reports and asked Committee members to share any concerns about the language being used so that it can be corrected.

Dr. Ehlinger closed the first day of the Committee meeting by sharing with the new members his vision for changing the narrative about mothers and babies to include a holistic view of the social, environmental, cultural, and societal issues that impact maternal and infant health.

DAY TWO: Wednesday, March 16, 2022

Introduction of ACIMM Members

***Edward Ehlinger, M.D., M.S.P.H.*, ACIMM Acting Chair**

Dr. Ehlinger highlighted that March 16 was the birthday of the nation's fourth President, James Madison, who was foundational in the creation of the Constitution and the Bill of Rights. He shared that President Madison had stated that popular government (i.e., made up of the people) without popular information or the means to acquire it is a prologue to a farce, a tragedy, or both. Dr. Ehlinger suggested that this statement reflects the need to acquire data about all people who live in all communities within the nation so that good policy can be developed with the understanding of the needs and issues of the people. Dr. Ehlinger then invited the Committee members who have served for the last few years to share what brought them into the field of maternal and infant mortality.

Ms. Belinda Pettiford shared that she has worked in public health for more than 30 years, all of which have been spent focused on maternal and child health. She said that her passion for the field comes from being in the room with her great-niece as she was having her first child and from her mother's history of delivering a daughter (Ms. Pettiford's older sister) prematurely in 1954 in a rural hospital in North Carolina. Her mother experienced a great deal of fear and stress and did not experience the important bonding time during the first six weeks. She later experienced the trauma of a miscarriage. Ms. Pettiford noted that these experiences would have been more challenging had there not been a support system. She knew that the system could be better, and this motivated her to focus on maternal and child health.

Dr. Magda Peck shared a story related to her professional development during her time as a research assistant in Boston. She said that one of her jobs was to calculate the infant mortality rate and trends for Boston, and she was alarmed by the disparities she found. One morning, the school hosted a presentation from former U.S. Surgeon General Julius B. Richmond, a child health policy expert who had founded Head Start and the Healthy People reports. After the presentation, Dr. Peck asked him why the infant mortality rate for Black infants in Boston was three times higher than in White infants. He replied that there are three essential components of social policy: knowledge from data and research, social strategies (i.e., programs and policies) based on evidence, and political will. His response has been a powerful motivator that continues to drive Dr. Peck today. She quoted one of her favorite sayings, "She who asks the questions is more powerful than she who has the data." She said that asking powerful questions brings the data and the evidence-based programs and policies needed to influence political will.

Dr. Janelle Palacios shared that her mother was a teen mother, like her own mother before. Before the age of 10, Dr. Palacios lived in six different places on the reservation and also experienced homelessness. From an early age, she and many of her family and friends felt the need to escape their circumstances. Escape typically came in the form of alcohol use or sometimes violence. One of Dr. Palacios' friends had become pregnant through a rape. Dr. Palacios accompanied her to IHS prenatal visits and delivery. Dr. Palacios said that she began to consider why there was such a need to escape. She recognized that these escapist behaviors—behavior stereotypes of Native Americans--were external to being Native American. She was fortunate that the high school she attended had a six-week pipeline program at the University of North Dakota, which helped motivate native students interested in health sciences program. After attending that program, she went to nursing school and, later, midwifery school. She shared that she served as co-President of the Native Research Network and began to present on the significance of the Native American history towards understanding context in health. An IHS representative nominated her to serve on the Committee. She is grateful to have benefitted from the wisdom and mentorship of the other Committee members.

Dr. Tara Sander Lee shared that, as long as she can remember, she felt a calling to become a scientist to understand what causes disease. She said that her career led her to work in a children's hospital setting, where she extended her interest to pediatric disease. In her work with pediatric surgeons and pathologists, she saw firsthand both the advances in technology that have helped babies survive but also the times in which babies do not survive. Her research has focused on understanding what causes childhood disease and why some infants do not survive. One specific area of her research is congenital heart disease, which is one of the leading causes of infant mortality. She works to educate and advance ethical advancements in health care to help mothers and babies with life-saving fetal interventions. She sees herself as an advocate for accurate, timely information to help families make the best decisions possible. Dr. Sanders Lee explained that her motivation for maternal and child health also comes from personal experience. She experienced a complicated pregnancy that resulted in an emergency Cesarean section. She also noted that her mother experienced an unplanned teenage pregnancy, and it resulted in adoption. Recently, she shared that her sister-in-law died from COVID-19. She urged members to connect through their shared interest.

Dr. Edward Ehlinger shared a story of living in Green Bay, Wisconsin and going to his first

Green Bay Packer game, where he saw Bobby Mann, the only African American on the team. He said that he asked his parents why he never saw Bobby Mann around in the community. He was told that Bobby Mann was not allowed to live in the town and could only come into Green Bay during football season. He shared that he was also told that the reason he didn't see his American Indian cousins was because they did not feel welcome in the town. Dr. Ehlinger stated that his parents told him to use his privilege and education to change the way things were. Ten years later, Dr. Ehlinger saw another Green Bay Packer game. This time half the team was African American. This, he thought, represented progress. However, his high school football coach said that it was not enough and gave Dr. Ehlinger a book by Michael Harrington called *The Other America* (the same book that inspired Presidents John F. Kennedy and Lyndon B. Johnsons' War on Poverty). This book inspired him to attend medical school at a time in which the War on Poverty was building community health centers. He explained that he realized that there were two paths to health—medicine and public health. He shared that he tried to integrate these paths in his subsequent work at the Minneapolis Department of Health, where he recognized the significance of community development and social determinants of health. He stated that he continues to bring this balance to the Committee.

Dr. Jeanne Conry shared that she began her career as an environmental researcher, teaching community ecology at the University of Colorado. She explained that she decided to change careers and attend medical school. Soon after, she became pregnant with her first child, which led to her interest in obstetrics and gynecology. Later in her career, she was asked to represent University of California, Davis at American College of Obstetricians and Gynecologists She shared that she continued to be involved with ACOG when she joined Kaiser Permanente, where she introduced a concept of collaborative practice that focuses on primary prevention. Given the fact that half of all pregnancies are unplanned, she became interested in preconception health and the need to improve the health and wellbeing of women at all times. She was serving as the Chair of the California ACOG when she received a call from a state legislator, who asked her about the safety of lead in lipstick. She realized that ACOG had no guidance related to environmental factors. Through this, she led a team to include environmental issues in their recommendations. When she retired from Kaiser Permanente, she became President of the International Federation of Gynecology and Obstetrics (FIGO), where she remains passionate about environmental influences on maternal health and well-woman health care.

Dr. Steven Calvin shared that he attended medical school at Washington University at St. Louis where he received a National Health Services Corps scholarship, which is administered by HRSA. He completed his payback program at the Del Rio neighborhood of Tucson, Arizona. He said it was a wonderful experience working with almost exclusively Spanish-speaking patients and patients from the Papago Tribe. He shared that subsequently, he completed a maternal fetal medicine fellowship in Tucson before returning to Missouri, where he worked with high-risk obstetrics in Minnesota for 20 years. During this time, he gained an appreciation for the work midwives do, however, he needed to transition out of high-risk obstetric and the rigorous schedule it demanded. He is currently a family medicine physician working with midwives at a Minnesota birth center that handles approximately 400 births per year. In collaboration with hospital partners, he and they contribute to a database called the Perinatal Data Registry (PDR). In addition to his practice, Dr. Calvin is interested in payment reform. Half of the mothers in the U.S. are recipients of public health insurance programs, but health care spending is not

necessarily going towards high-value care. He stated that there are models of care that do work, and he is grateful that there are new community representatives in the Committee that can contribute to this discussion. He said that his work is dedicated to his 11 grandchildren and to the mothers attending the birth center in Minneapolis. He noted that the center is one mile from where George Floyd was murdered in 2020. He also noted that there are significant disparities that must be addressed; Black mothers deserve better.

Dr. Colleen Malloy spoke about her great grandmother, who was an immigrant from Ireland and died during childbirth. She noted how far the field has come and the amount of work yet to do. As a neonatologist, she sees herself as a fierce defender of babies and the unborn, who are voiceless and completely reliant on their families. Although most births are successful, she finds it rewarding to help families in the small percentage of births that have challenges. She noted that an important part of her role is to provide a graceful, respectful process for those who lose their babies. Even families who experience a genetic birth defect and may not expect their child to outlast their diagnosis need support for their grieving process. Dr. Malloy said that she aims to maintain a focus on infants because, as the voiceless, they truly need an advocate that puts them first.

Impact of Violence on Infant and Maternal Mortality

***Jacquelyn Campbell, PhD, MSN, RN, FAAN,* Professor and the Anna D. Wolf Chair at the Johns Hopkins University School of Nursing**

Dr. Jacqueline Campbell began by acknowledging the original owners of the lands, the historical trauma they have been subjected to, and the missing and murdered Indigenous Women.
She shared that the Missing and Murdered Indigenous Women (MMIW) USA project published a report that highlighted three murdered women who were pregnant and an unknown number of pregnant women who are still missing.

Dr. Campbell provided context to the issue of violence related to pregnancy. She noted that the social determinants of health that impact Black and Indigenous women include historical trauma, structural and individual experiences of racism, structures that deny access to wealth, adverse childhood experiences (ACEs), and gender-based violence. She explained that pregnancy-associated deaths include causes unrelated to pregnancy such as trauma, homicide, suicide, and drug overdose.

She highlighted findings from a review of research on maternal mortality among AI/AN women. Dr. Campbell stated that the review reported disproportionately low rates of homicide and suicide among AI/AN women, which may result from missing data and the use of "other" as a race/ethnicity category. She noted that other studies showed that approximately five percent of women murdered by an intimate partner were pregnant. She also noted that between eight and 25 percent of women who die during pregnancy or postpartum were murdered. She shared that approximately half of these women were murdered by their intimate partners. Pregnant Black women had a disproportionately high rate of homicide. Dr. Campbell suggested that pregnant Indigenous women were also likely to be disproportionately affected but the data to support this is missing. She noted that one of the challenges in capturing data is the inconsistent use of the pregnancy checkbox on death certificates, especially among homicide, suicide, and substance use disorder deaths.

Dr. Campbell pointed out that homicide is the second leading cause of maternal mortality, with firearms as the most common method. She shared another study comparing homicide deaths with other causes of maternal mortality, which found that when open cases were excluded, the number of pregnancy-associated homicides by intimate partners increased from half to approximately 65 percent of cases. Dr. Campbell noted that although all of these women were receiving prenatal care, risk of intimate partner violence was not identified.

She pointed out that intimate partner violence is a significant risk factor for suicide and suicidality. It is the number one risk factor for suicide among Black women, with suicide representing up to 20 percent of postpartum deaths. Yet, protocols for postpartum depression do not include guidance for intimate partner violence. She noted that few studies have been conducted on substance use disorder deaths in pregnancy. These few studies have shown an increase in pregnancy-associated mortality due to substance use and, importantly, a significant association between intimate partner violence and substance use disorder.

Dr. Campbell shared a study using National Violent Death Reporting System (NVDRS) data showing more homicide and suicide pregnancy-related deaths per 100,000 live births than pregnancy-related deaths from hemorrhage, eclampsia, or amniotic fluid embolism. She explained that this study was able to capture data for both Black and Native American women, which showed that they were both disproportionately affected by pregnancy-related homicide or suicide.

She said that there are different periods of abuse – different periods of pregnancy when intimate partner violence occurs. Abuse during pregnancy is the period in which prevalence is currently captured, however, there are other periods of associated risk, including the 12 months prior to pregnancy, abuse around the time of pregnancy (i.e., before or during pregnancy), abuse during the first year of pregnancy, and abuse during the postpartum period. She stated that these distinctions are important because Pregnancy Risk Assessment Monitoring System (PRAMS) data show a higher prevalence of abuse before pregnancy than during pregnancy, lower prevalence during pregnancy, and an increase in risk during the postpartum period. Although pregnancy has been commonly considered a risk factor for homicide, the period during pregnancy may itself be protective. She noted that other studies show that physical abuse may lessen during pregnancy, but emotional abuse may continue or increase.

She also shared that there is an overlap between physical, sexual, and emotional abuse that can create cumulative negative effects on physical health. She explained that these negative outcomes are further exacerbated when a woman has a history of ACEs. Dr. Campbell pointed out that these cumulative effects impact the health of both mother and baby.

Dr. Campbell summarized that women should be routinely screened for abuse during the pregnancy as well as for any history of abuse prior to pregnancy. She stated the importance of considering how a woman may respond to screening questions. She said that providing context questions, making eye contact, ensuring that the partner is not in the room, and assuring confidentiality can help women feel more comfortable. Dr. Campbell noted that women who talk about abuse with their care provider are four times more likely to use an intervention and more

than twice as likely to exit the abusive relationship. She shared that several interventions are available. Futures Without Violence provides helpful resources for talking about abuse with women. She also noted that interventions such as the Domestic Violence Enhanced Home Visitation (DOVE) program has been shown to reduce negative outcomes, and the MyPlan mobile app can help women make safe decisions. She stated that there is a need to develop programs for fathers that address healthy relationships, the impact of trauma, and provide tools to becoming nonviolent.

***Maeve Wallace, PhD, MPH,* Assistant Professor, Department of Social, Behavioral, and Population Sciences; Associate Director, Mary Amelia Center for Women's Health Equity Research, Tulane University School of Public Health and Tropical Medicine**
Dr. Maeve Wallace presented data from 2018 to 2019 showing homicide as a leading cause of death during pregnancy and the postpartum period, with higher rates than maternal mortality related to hemorrhage, hypertensive disorders, and sepsis or other infections. Although homicide is known to be leading cause of death during pregnancy, national-level data were not available until 2018. She shared that the CDC estimates of maternal mortality do not include homicide or other violent causes of death, limiting the ability to capture the scope of the problem.

She said that pregnancy itself increases the risk of homicide; in other words, women who are pregnant or postpartum are more likely to die by homicide than non-pregnant women of reproductive age. Dr. Wallace explained that this increased risk varies by geography, age, and race/ethnicity, with adolescent and Black individuals at a consistently higher risk of homicide during pregnancy/postpartum than their non-pregnant/postpartum counterparts. Dr. Wallace shared a study showing a significantly higher rate of homicide in pregnant/postpartum Black women than non-pregnant/postpartum Black women, but no such difference among White women. She showed that when these data were stratified by age, pregnant/postpartum adolescents were six times more likely to suffer homicide as compared to other ages. She explained that at the intersection of race and age, both White and Black pregnant/postpartum adolescents are two times more likely to experience homicide as compared to their non-pregnant/postpartum counterparts.

Dr. Wallace shared unpublished 2020 data showing a substantial increase in pregnancy-related homicide relative to the two prior years. She pointed out that homicide across the general population increased overall in 2020, but not to the degree that it increased among pregnant women. The patterns of race and age were similar to previous years, with younger and Black pregnant women experiencing the highest rates of homicide.

She noted that inequities in the number unplanned pregnancies can result in increased stress and conflict, leading to a higher risk of intimate partner violence. She explained that interpersonal, systemic, and structural levels of racism are associated with higher rates of unplanned pregnancy and create barriers to the timely and respectful prenatal care needed for a woman to feel comfortable disclosing experiences of violence.

Most pregnancy-related homicides are committed by an intimate partner and most involve a firearm. She suggested that the number of pregnancy-related homicides committed by intimate partners is likely an underestimate, because it is challenging to obtain pregnancy status in

homicide victims who are in early stages of pregnancy or who are incorrectly identified as not being postpartum. She shared that the 2020 data indicate a surge in firearm violence in general and an 80 percent increase in the use of firearms in pregnancy-related homicides. She noted that abusers who own a firearm tend to inflict the most severe violence and having a gun in the home is a key factor in the escalation of nonfatal spousal abuse to homicide.

Dr. Wallace provided suggestions for reducing these trends. She said it is important that efforts to accurately identify and address pregnancy-related homicide are afforded the same rigor as for other causes of maternal mortality. She noted that the Office on Women's Health (OWH) recently funded several states in an initiative to reduce violent maternal deaths. She stated that the establishment of violent maternal death review committees that parallel other maternal mortality committees could help generate recommendations for interventions for intimate partner violence at multiple levels.

Additionally, Dr. Wallace said that some of the upstream factors involved in maternal mortality are also involved with pregnancy-related homicides. Addressing these upstream factors would produce a cascade of benefits to reduce all maternal deaths. She stated that policy-level interventions are key to ensuring equitable distribution of resources and reducing the racism and social inequalities related to pregnancy-related homicides. She shared that interventions within health systems, such as universal screening, pre- and postnatal care visits, and coordination between emergency departments and obstetric care settings, can offer more immediate opportunities to identify and support women experiencing violence. She pointed out that state-level firearm and domestic violence laws have been associated with substantial reductions in pregnancy-related homicides. Finally, she noted that given that pregnancy itself is a risk factor for homicide, the ability for a woman to have control over pregnancy decisions may also decrease this risk.

***Heather Burner, RN, BSN,* Executive Director, National Safe Haven Alliance; Director, Arizona Safe Baby Haven Foundation; Director, NSHAC Crisis Pregnancy Safety & Prevention**

Ms. Heather Burner shared her experience as a pediatric emergency room nurse that led her to focus on crisis pregnancies and the abandonment of infants. She is now the Executive Director of the National Safe Haven Alliance, which is a nonprofit that provides safe alternatives for women and parents towards the prevention of harm or death of infants through resources and Safe Haven providers.

She explained that these laws allow a parent to anonymously relinquish an unharmed baby to a Safe Haven provider without fear of prosecution She reviewed how Safe Haven laws provide safe options for parents who are unwilling or unable to care for their infants.. Each state, she explained, has a different Safe Haven law. Hospitals are an approved Safe Haven location for every state. She shared that other Safe Haven providers include firefighters, emergency medical services personnel, law enforcement officers, emergency department staff, church staff, adoption agency staff, county health department staff, and child welfare agencies. She noted that since 1999, 4,524 infants have been relinquished to a Safe Haven and 1,610 infants have been abandoned illegally, most of whom were found deceased.

Ms. Burner said that the National Safe Haven Alliance manages a provider-staffed crisis hotline to provide emergency referrals, facilitate safe relinquishment, connect parents and providers to community resources, assist parents with direct support, and provide comprehensive training and guidance for Safe Haven providers. She explained that the hotline is utilized by the Department of Health and/or Department of Child Abuse and Family Services in lieu of the child abuse hotline, which has been found to be a frightening option for parents.

She said that the crisis hotline uses a communication model that identifies the reasons the individual feels they cannot parent the infant, provides direct assistance for immediate needs, develops a safe plan for both the parent and infant, and provides placement options for children outside of the Save Haven age limit. Often, the reason a parent is seeking crisis support is because, not the child, but other aspects of their life is in crisis-- abuse, assault, trafficking, homelessness, substance abuse, or mental health issues. She explained that different crises impact the types of resources and support that are provided. Support may include resources to help the individual continue to parent the child, temporary placement, adoption resources, or, as a last resort, a Safe Haven provider and location.

Ms. Burner said that Safe Haven laws were put into place 20 years ago and most states do not provide funding for education and awareness. She talked about the need to increase public awareness of Safe Haven resources, training for Safe Haven providers, a contract to make the crisis line a national resource, a national registry for state reporting of relinquishment and abandonment, and funding for a contract or a staff position to develop training tools and to provide oversight for the hotline.

Discussion

Dr. Ramas said that this issue is particularly important in light of increased domestic violence during the pandemic. She asked if the resources have been translated to other languages and if resources for non-binary individuals, who are at high risk for intimate partner violence, have been addressed. Dr. Campbell answered that some of the resources have been translated in Spanish. She also noted that there are efforts for developing resources and interventions specific for the transgender population but not yet for non-binary individuals.

Dr. J. Warren asked if there had been any discussion about aligning violent maternal mortality reviews with child fatality reviews. Dr. Wallace answered that she is not aware of any discussions but there are challenges in terms of what is included in different reviews. She noted that a reorganization of terminology might be needed to help address these challenges.

Dr. Peck talked about the overlap of maternal intimate partner violence and child abuse and asked how screening and intervention could be addressed from both directions. Dr. Wallace said that although the data she presented were on mortality, there are other useful data sources. It would be helpful, she said, to characterize these deaths as “family deaths” and look more broadly at family violence as opposed to seeing it through a lens of maternal violence or child abuse. Dr. Campbell added that studies have shown that there are pragmatic challenges involved in, for instance, how information is recorded in electronic health records. She noted that women may also fear that they will have to leave if they disclose abuse, preferring instead that their partner is

provided an intervention to reduce the abuse.

Dr. Palacios asked about how the pandemic has impacted intimate partner violence and homicides, given the increased rates. Dr. Campbell answered that the reason for the increased rates may not be that pandemic-related stress increased the prevalence of domestic violence but rather that the stress has increased the severity of the abuse, therefore increasing the number of homicides. Additionally, she stated, there has been an increase in gun purchases and it may be important to educate new mothers how to safely store guns at home.

Dr. Palacios asked what work can be done with states to mitigate the link between firearm ownership and intimate partner violence, especially when some states require certain individuals to sign an agreement to not speak out against firearms. Dr. Campbell said that approaching legislators from a perspective of safety of mothers and children may be more effective. She noted that some states have adopted laws that make it illegal for an abusive individual to purchase a firearm, but there is some organized opposition against such laws. Dr. Wallace agreed that the approach for certain states is to emphasize the safety of mothers and children, which should be a universal population to protect. Dr. Campbell said that among the states with such laws, there has been some issue with the enforcement of the laws, and it is unknown whether this challenge comes from a lack of understanding the law or a lack of willingness to enforce it. She added that NIH and CDC have both released funding announcements for proposals on firearm violence.

Dr. Collier said that it seems that many agencies feel uncomfortable funding the development of programs to support or educate abusers. She noted that there is a lot of discomfort around the idea of addressing the needs of abusers. She suggested that the abuse may be rooted in familial, generational, and historical trauma that isolates abusers from receiving help. She asked where efforts to prevent abuse should start. Dr. Campbell answered that Head Start and Early Head Start have fathering programs. She said that these programs may address relationships, not by calling it violence or abuse, but by stressing healthy relationships and parenting. “Healthy relationship” may not be the most effective language to use for younger fathers and there may be a need to revisit the language being used.

Dr. Menard said that her state of North Carolina implements universal paper screening for intimate partner violence for recipients of Medicaid, unfortunately it is not an interview that includes the “leading questions” that can help identify abuse. She asked if there have been efforts to determine if interviews should be conducted or if a paper screen is effective. Dr. Campbell answered that a paper screen will likely result in misidentification. She shared that a follow-up conversation, even with those who do not disclose on a paper screen, would be helpful.

Dr. Menard talked about the Violent Death Reporting System in North Carolina as a linking mechanism to other records, which increased the number of identified deaths by approximately 40 percent. Dr. Wallace said that death records alone result in underestimates of violent deaths. She noted that pulling in records from law enforcement or the medical examiner provides more context, so MMRC reviewers are able to better identify deaths related to intimate partner violence, as well as whether the person was pregnant or postpartum.

Dr. Calvin asked if abandoned, deceased infants were included in infant mortality rates in states.

Ms. Burner answered that she believes they are being reported by states, but it is unknown how accurate the data are.

Dr. Ehlinger asked the Committee to move forward with recommendations to address violence in all of its permutations that were presented. He ended the session by sharing a quote from Coretta Scott King made on June 9, 1968, a few weeks after her husband was assassinated:

> "I must remind you that starving a child is violence. Neglecting school children is violence. Punishing a mother and her family is violence. Discrimination against a working man is violence. Ghetto housing is violence. Ignoring medical need is violence. Contempt for poverty is violence."

Workgroup Descriptions

***Steve Calvin, M.D.,* ACIMM Member, Quality and Access Workgroup Lead**
***Magda Peck, Sc.D.,* ACIMM Member, Data and Research to Action Workgroup Lead**
***Janelle Palacios, Ph.D., C.N.M., R.N.,* Healthy Equity Co-Lead**
***Belinda Pettiford, M.P.H.,* ACIMM Member, Health Equity Workgroup Co-Lead**
Dr. Ehlinger asked Workgroup Leads to provide an overview of their Workgroup focus and activities so that new Committee members can determine whether to volunteer to serve.

Dr. Calvin reviewed the Quality and Access Workgroup, which focuses on enhancing or promoting strategies that are known to work. For instance, he has looked extensively into state funding of Medicaid and other care models for maternity care and its barriers. He encouraged new Committee members to use their passion for improved care and become involved in the Workgroup, in order to help identify barriers to care models and to increase access to services such as midwifery care.

Dr. Peck discussed the role and activities of Data and Research to Action Workgroup. The workgroup aims to inform the other Workgroups with a solid evidence base, coordinates a data and research response to improve different issues, and develops specific recommendations on data and research that are sent to the Secretary. She shared, in the last set of recommendations, the Workgroup asked for a strengthening of data systems through interoperability and data sharing; an augmentation in mortality and morbidity reviews; and the inclusion of pregnant women, breastfeeding women, and women of reproductive age in research. She noted that additionally, they recommended an expansion of data collection to include community voices and lived experience. Dr. Peck stated that they are looking to transition in a new lead for this Workgroup and encouraged all members to contact her with their interest.

Ms. Pettiford spoke about the Health Equity Workgroup, comprising interagency representatives who work to ensure that the Committee's recommendations represent historically marginalized populations and include social determinants of health. She shared that the Workgroup also addresses the need for a diverse workforce, race concordant care, and community engagement. Dr. Palacios added that those who work in the health equity space understand how important and pervasive equity issues are globally. She talked about how the simple intervention of handwashing made a tremendous impact on health and asked potential Workgroup members to consider what might be the "handwashing" intervention of the current time to help the nation

address its history.

Dr. Ehlinger invited Committee members to contact him with interest about joining any of the Workgroups.

Public Comment

***Lee Wilson,* Acting Designated Federal Official, ACIMM**
Mr. Wilson said that one written comment was submitted by the National Council of Urban Indian Health and was shared electronically with Committee members. There were two requests for oral public comments; however, only one was available to present.

Dr. Yvonne Bronner is a professor at Morgan State University and spoke about an initiative to bring maternal and child academic programing into HBCUs. She shared that the purpose of the initiative is to address the historical and legacy disparities in infant mortality and the rising maternal mortality ratio in geographic areas where the disparities are very high, which are also areas in which HBCU students often live. HBCUs do not currently have these programs because they would need to house a school of public health to be eligible for its funding. She noted that, with the exception of one, HBCUs only have public health *programs*. She asked that MCHB remove this barrier to maternal and child health funding. She explained that this initiative includes 10 HBCU partners and aims to: 1) develop a strategic plan with short- and long-term objectives; 2) create academic programming that is informed by community needs, includes measures for accountability, and addresses the social determinants of health; and 3) write a funding proposal for a coordinating center and staff at each of the 10 HBCUs. The coordinating center approach would include an administrative infrastructure, as well as a think tank comprising interdisciplinary maternal and child health experts to develop a vision for the program. Dr. Bronner invited the Committee to join the Thrive Maternal and Child Health Summit on April 7.

Discussion
Dr. Peck provided her perspective as a former dean of a school of public health and asked how the initiative plans to address the gap between the time when the public health program goes away and the accredited school of public health begins. Dr. Bronner said they are in process of reaching out to other schools of public health that have maternal and child health programs, as well as other related programs, as part of their strategic planning process.

Discussion and Next Steps

***Edward Ehlinger, M.D., M.S.P.H.*, ACIMM Acting Chair**
***Lee Wilson,* Acting Designated Federal Official, ACIMM**
Dr. Ehlinger provided space for any Committee member to provide their thoughts on topics they would like to address in the future.

Ms. Pettiford emphasized the importance of not framing fatherhood education as one that focuses only on intimate partner violence. She said it would not be a welcomed as an incentive to participate, additionally fathers need the same support that mothers need in terms of parenting education.

Dr. J. Warren recommended considering broader access points for intimate partner violence. He noted that in states that have not expanded Medicaid, many women will lose access to health care six months after pregnancy. It will be important to consider methods outside of medical care settings.

Dr. Charlan Kroelinger, who is the new CDC ex-officio member, provided an update on CDC generally and the Division of Reproductive Health specifically. She stated that the CDC Director has acknowledged the need to transform the agency from identifying markers of health equity to identify and addressing the drivers of disparities. She shared that the CDC has an initiative called CORE, which outlines its commitment to health equity. Dr. Kroelinger said that the Division of Reproductive Health is focused on implementing routine data collection and linkage to include data elements related to the social determinants of health and that this integration should be completed within the next few years. She noted that they are also interested in incorporating community perspectives, including in MMRCs, where those perspectives would help reduce disparities. She urged the Committee to review updates to the CDC's Hear Her campaign and added that they plan to better engage with tribes to include their perspectives.

Dr. Ramas said that she would like to see the Committee leverage new technology and innovation in its recommendations to the secretary, with the understanding that technology itself is a social determinant that needs attention to disparities.

Dr. Neyhart said that she was struck by the presentations that advances in medicine were not as needed as much as advances to increase access to medicine are.

Dr. Ehlinger commented on how underappreciated violence is in maternal mortality is compared to how dire the data were.

Dr. Ehlinger encouraged all Committee members to complete their ethics forms prior to the June 2022 meeting.

Adjourn

In closing, Dr. Ehlinger spoke about using the levers members have to make change and advance the mission of the Committee. He adjourned the meeting at 4:00 p.m.