Secretary's Advisory Committee on Infant Mortality

Meeting Minutes of June 17-18, 2020

Virtual Meeting

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

Wednesday, June 17, 2020

COMMITTEE MEMBERS, EX-OFFICIO MEMBERS, AND SPEAKERS/PRESENTERS

Committee Members

Jeanne A. Conry, M.D., Ph.D., President, Environmental Health Leadership Foundation

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

Edward P. Ehlinger, M.D., M.S.P.H., Acting Chairperson of SACIM

Paul E. Jarris, M.D., M.B.A., Senior Principal Health Policy Adviser, Health Transformation Center, The MITRE Corporation

Tara Sander Lee, Ph.D., Senior Fellow and Director of Life Sciences, Charlotte Lozier Institute

Colleen A. Malloy, M.D., Assistant Professor of Pediatrics (Neonatology), Ann & Robert H. Lurie Children's Hospital of Chicago

Janelle F. Palacios, Ph.D., C.N.M., R.N., Nurse Midwife, Kaiser Permanente

Magda G. Peck, Sc.D., Founder/Principal, MP3 Health; Founder and Senior Advisor, City Match; Adjunct Professor of Pediatrics and Public Health, University of Nebraska Medical Center

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

Paul H. Wise, M.D., M.P.H., Richard E. Behrman Professor of Child Health Policy and Society, Stanford University

Ex-Officio Members

In Attendance at the Meeting

Wanda D. Barfield, M.D., M.P.H, F.A.A.P, RADM USPHS (ret.), Director, Division of Reproductive Health, Centers for Disease Control and Prevention

Wendy DeCourcey, Ph.D., Social Science Research Analyst, Office of Planning, Research and Evaluation, Administration for Children and Families

Kristen Zycherman, Coordinator for the CMS, Maternal and Infant Health Initiatives, Center of Medicaid and CHIP Services, Centers for Medicare and Medicaid Services

Iris R. Mabry-Hernandez, M.D., M.P.H., Medical Officer, Senior Advisor for Obesity Initiatives, Center for Primary Care, Prevention, and Clinical Partnership, Agency for Healthcare Research and Quality

Danielle Ely, Ph.D., Division of Vital Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention

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

Suzanne England, D.N.P., A.P.R.N., Great Plains Area Women's Health Service, Great Plains Area Indian Health Service, Office of Clinical and Preventative Services

Not Present at the Meeting

Ronald T. Ashford, Office of the Secretary, U.S. Department of Housing and Urban Development

Paul Kesner, Director of the Office of Safe and Healthy Students, U.S. Department of Education

Dianne Rucinski, Ph.D., for CAPT Felicia Collins, Deputy Assistant Secretary for Minority Health and Director, Office of Minority Health, U.S. Department of Health and Human Services

Dorothy Fink, M.D., Deputy Assistant Secretary, Women's Health, Director, Office of Women's Health, U.S. Department of Health and Human Services

Karen Matsuoka, Ph.D., Chief Quality Officer for Medicaid and CHIP, Director, Division of Quality and Health Outcomes, Centers for Medicare and Medicaid Services

Elizabeth Schumacher, J.D., Health Law Specialist, Employee Benefit Security Administration, U.S. Department of Labor

Diana Bianchi, M.D., Director, Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health

Dexter Willis, Special Assistant, Food and Nutrition Service, U.S. Department of Agriculture

Committee Staff

Michael D. Warren, M.D., M.P.H., F.A.A.P., Executive Secretary, SACIM; Associate Administrator, Maternal and Child Health Bureau, Health Resources and Services Administration

Lee Wilson, *Acting Designated Federal Official, SACIM (on behalf of David S. de la Cruz, Ph.D., M.P.H.)*; Acting Division Director, Maternal and Child Health Bureau, Health Resources and Services Administration

Michelle Loh, Division of Healthy Start and Perinatal Services, Maternal and Child Health Bureau, Health Resources and Services Administration

Presenters and Speakers

Mary Bullock, L.C.S.W., M.B.A., Social Worker, Eskenazi Health

Joia Crear-Perry, M.D., F.A.C.O.G., Founder and President, National Birth Equity Collaborative

Thomas Engels, Administrator, Health Resources and Services Administration

Jessica Frechette-Gutfreund, L.M., C.P.M., M.S.M., I.B.C.L.C., Executive Director, Breath of My Heart Birthplace

Karen E. George, M.D., M.P.H., F.A.C.O.G., Senior Fellow, Women's Health Policy, Institute for Medicaid Innovation; Clinical Associate Professor of Obstetrics and Gynecology, George Washington University School of Medicine and Health Sciences

Nicolle L. Gonzales, C.N.M., Executive Director, Changing Woman Initiative

Rahul Gupta, M.D., M.P.H., M.B.A., F.A.C.P, Senior Vice President, Chief Medical and Health Officer, and Interim Chief Scientific Officer, March of Dimes

Kenn L. Harris, Senior Project Director, National Institute for Children's Health Quality

Felicia Hanney, M.P.H., Project Manager, Indianapolis Healthy Start, Marion County Public Health Department

Jessica Roach, M.P.H., Co-Founder and Executive Director, Restoring Our Own Through Transformation

CALL TO ORDER

Lee Wilson
Acting Division Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration
(acting on behalf of David S. de la Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, MCHB/Division of Healthy Start and Perinatal Services, Health Resources and Services Administration)

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Mr. Wilson called the meeting to order as the acting Designated Federal Official in the absence of Dr. David de la Cruz. Appreciation was given to everyone for their participation. Mr. Wilson stressed how important this is for the well-being of America's mothers, babies, and families as well as to MCHB, HRSA, and the Department of Health and Human Services. Lastly, a standard set of reminders was given to the Committee.

Dr. Ehlinger greeted the participants and expressed thanks them for the support given by Dr. Paul Jarris and Ms. Belinda Pettiford in running the last meeting during his unexpected absence. Additionally, he apologized for the delayed start resulting from technological errors. Dr. Ehlinger informed the Committee that his opening comments will follow those of the HRSA Director.

HRSA WELCOME

Thomas Engels
Administrator, Health Resources and Services Administration

Mr. Engels began by emphasizing that HRSA understands the current challenges surrounding the COVID-19 pandemic and has become a leader in providing assistance to the American people during this crisis. HHS has provided HRSA the responsibility of managing the $175 billion Provider Relief Fund set up by Congress as a relief to hospitals, health care providers, and frontline responders.

As part of the Provider Relief Fund, HRSA has provided the following funds:

- Reimbursement of lost revenue for health care providers for the testing and treatment of uninsured patients with a COVID-19 diagnosis under the COVID-19 Uninsured Pool beginning from February 4, 2020

- $2 billion across all programs to combat the disease since the Coronavirus Aid Relief and Economic Security (CARES) Act became law in March 2020

- Multiple rounds of funding to nearly every HRSA-funded health center

- $8 million to organizations that provide training, support, and advanced expertise to assist centers in

preventing, preparing, and responding to the COVID-19 pandemic. These centers are providing over 143,000 tests and antibody tests weekly

- Approximately $150 million to hospitals funded through the Small Rural Hospital Improvement Program from the HRSA Federal Office of Rural Health Policy
- $225 million to rural health clinics for testing and related expenses including procuring supplies, training providers and staff, and construction costs
- $500,000 to support technical assistance efforts to rural health clinics
- $15 million to 52 tribes, tribal organizations, urban Indian health organizations, and other service providers based on need and capacity
- $46.5 million throughout HRSA programs to increase telehealth capabilities so individuals will not have to choose between health care and social distancing
- $90 million to 581 organizations serving clients of the Ryan White HIV/AIDS Program
- $5 million to Poison Control Centers for their response to the increase of calls due to the pandemic

In closing, Mr. Engels thanked the Committee for their hard work and dedication. He looks forward to working together in the development of policies and improvements within the systems of care to decrease infant and maternal mortality in the United States.

MCHB UPDATE

Michael D. Warren, M.D., M.P.H., F.A.A.P
Associate Administrator, Maternal and Child Health Bureau
Health Resources and Services Administration

Dr. Warren explained that the mission of the Maternal and Child Health Bureau is to improve the health and well-being of America's mothers, children, and families, and the work of SACIM influences the work at MCHB. The framework used to conceptualize improvements for maternal and child health is called Accelerate Upstream Together. When MCHB was founded in 1912, approximately 300,000 infants died within their first year of life. Currently, infant mortality rate is roughly 5.6% with about 22,000 infant deaths every year. While great progress has been made, the pace of that progress needs to accelerate.

Part of this acceleration includes eliminating disparities across a variety of MCH indicators by looking upstream. There needs to be the inclusion of factors outside of clinical care, such as community and environmental factors, health behaviors, and policy. This also needs to be looked at through life course and with a multi-generational approach. In terms of the life course, the health of an infant directly relates to the health and well-being of the mom. Similarly, a focus on maternal care cannot begin during prenatal care but across the life course. The health of a girl, adolescent female, and young woman must be considered to improve the health of a mother. The other part of the framework emphasizes the need to work together, with SACIM meetings as an example of that. Together, the Accelerate Upstream Together Framework provides guidance within the Bureau's strategic plan.

Dr. Warren briefly discussed what is being done in response to the COVID-19 pandemic and the profound impact it is having on maternal and child health. Traditional forms of care may not be accessible, which may have caused a decline in pediatric immunizations since the declaration of a public health emergency. Some of the many challenges directly impact standard approaches to care, such as labor and delivery, social isolation and mental health challenges, socioeconomic stressors, and intimate partner violence. These challenges are being seen across the life span, which may impact the MCH population for

generations.

To monitor the impact on the MCH population, an incident command structure was established to coordinate a response. An internal workgroup was established to create a clear line of communication between project officers and program staff concerning situational awareness on what the needs are for children and families and facilitate a consistent response across the country. Other actions taken by MCHB include participation in town halls; providing technical assistance and resources to grantees; and funding related to telehealth for maternal health care, state public health systems, family engagement, and pediatric care.

Dr. Warren informed the Committee of the 11 different MCHB legislative authorities with numerous programs funded under those authorities. Demonstrating the importance of working as a national entity, various inputs are gathered through assessments, data, and programing with the strategic plan to guide budgets, performance measurements, potential funding options, and legislation. This ultimately filters down to ongoing program development, work implementation, and the collection and analysis of data. This strategic plan is not only in terms of a three-to-five-year plan, but also a 15-year plan.

Committee Questions and Discussion

- Dr. Ehlinger asked about the balance of investments concerning the $175 billion relief funds to areas outside of healthcare. He also wondered about the stress on the infrastructure and staffing concerns.
    - Dr. Warren explained that the $175 billion is largely coming from the Provider Relief Fund to support providers while MCHB's funding is based on legislative authority with more flexibility. However, it is important that funds are spent in the manner in which they were appropriated by the Congress. Concerning staffing, HRSA has pulled various members of the Agency to work on distribution of the Provider Relief Funds.
- Ms. Pettiford inquired if there was a focus of the relief funding down at the community level.
    - Dr. Warren responded that the intent of the funds is to support the work for patients and families within the communities so they have better access to care.
- Dr. Peck asked if there was an opportunity to go from discussing racial disparities to discussing direct impacts from racism as a public health crisis.
    - Dr. Warren was in agreement on the profound impact racism has on MCH populations and said it is extremely important for the Bureau to listen to those presenting for ideas on how to improve.

SACIM WELCOME

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

When planning began for the June meeting, the COVID-19 pandemic was beginning. It was clear that it would be changing perspectives and would take a toll on our emotional and physical energy. Dr. Ehlinger explained that the meeting was then planned around COVID-19 and its implications, particularly the impact on pregnant women, babies, and the delivery of those babies. Meanwhile, the shadow pandemic of institutional and structural racism within society came to a head after the murder of George Floyd in Minneapolis, Minnesota.

COVID has had an immense impact on populations of color and indigenous people because of the structural disparity of racism built within society. This has enabled the expansion of focus from the relationship between COVID and maternal and child health disparities to include structural and institutional racism. Historically, pandemics have enabled change: the Bubonic plague helped to eliminate feudal government in Europe; Yellow Fever led to the stop of the slave trade; Cholera led to changes relating to sanitation and reworking of those systems. Plagues can change history, and this can be an important time to put in work throughout the country to change for the better.

Dr. Ehlinger explained that traditionally, there is a predictable timeframe to develop comprehensive strategies and execute those strategies over time. However, timeframes now have to be shortened in relation to the rapid changes occurring during the pandemic with a shift in focus on short-term opportunities. The Committee deals with non-linear, complex issues comprised of factors, rules, and players that are constantly changing. Dr. Ehlinger stressed the need for simple rules to collectively and collaboratively work within. These rules include remembering every baby and mother, centering on equity, listening to community voices, building capacity, focusing on connection, asking powerful questions, and seizing opportunities.

COVID-19: SHORT-TERM AND LONG-TERM IMPLICATIONS FOR MATERNAL AND INFANT MORTALITY PANEL

Rahul Gupta, M.D., M.P.H., M.B.A., F.A.C.P
Chief Medical & Health Officer, Senior Vice President, Interim Chief Scientific Officer
March of Dimes

Kenn L. Harris
Senior Project Director, National Institute for Children's Health Quality

Joia Crear-Perry, M.D., F.A.C.O.G.
Founder and President, National Birth Equity Collaborative

Dr. Gupta began the panel with a discussion on maternal and infant health concerning COVID-19 and equity issues. March of Dimes' goal is to end preventable maternal health risks and death and end preventable preterm birth and infant death. Yet, to achieve these goals, the health equity gap needs to be addressed. A Black woman is three to four times more likely to die during pregnancy and childbirth with a 50% higher risk of preterm birth. Similarly, African Americans are two to three times more likely to die as a result of COVID-19. Although pregnant people have the same risk as the rest of the population for contracting the virus, there is a higher risk for serious complications due to older women giving birth for the first time. Vertical transmission has not been demonstrated, but there is a low rate of infants contracting the virus postpartum. Additionally, data suggests that the virus is not transmitted via breastmilk. March of Dimes is continuing to advocate for the improvement of data collection and research concerning pregnant women.

The United States has a total fertility rate of 1.71, and this rate has been dropping 2% on average per year. Based on data published in *The Washington Post* with a parallel assessment from the Brookings Institute, Dr. Gupta predicted that the pandemic could lead to half a million fewer births in 2021. This potential baby bust could lead to drops of demographics and has raised concerns for long-term economic and financial viability. Dr. Gupta provided further examples of what March of Dimes is doing to close the health equity gap through family support programs and the virtualization of those programs provided by March of Dimes. This includes the Implicit Bias Training, a program used to increase awareness of implicit bias and stimulate action among maternity care providers to address and remedy its impact. Yet, there are numerous equity challenges concerning the lack of fetal data, inadequate testing, drug trial enrollment, hospitalization, and death. There is a critical need to address the social determinants impacting the core of society.

Mr. Harris, the second panelist, stated that racism is killing and sickening Black people. To address those disparities, there needs to be knowledge of what led to them to begin with. COVID-19 has three times the

rate of infection and six times the rate of death in African Americans within a community where white people are the majority. Displacement from jobs, access to resources, and day-to-day life have become increasingly more difficult, and this disparity continues to emerge as a theme for the lives of Black Americans and people of color. And yet, as soon as stay-at-home orders began to lift, Black Americans were hit with the trauma of systemic racism. The murder of George Floyd was a catalyst for change, highlighting the broken system worsened by the pandemic. Real-time data show race and ethnicity remain significant predictors for the quality of healthcare received, stating that Black women are dying three to four times the rate of white women.

Beginning in 1991, Healthy Start was a community-driven, community-based program to address infant mortality and the disparities in Black infant mortality. Growing from 22 programs to 101 programs, it continuously leverages and maximizes resources within a community to inspire change at the community level. The Eliminating Racial and Ethnic Disparities in Birth Outcomes (Healthy Start) program has a widespread approach on social determinants to health, equity, and the impact of racism. The framework of this program includes fathers for the first time.

The third panelist, Dr. Crear-Perry, presented from the National Birth Equity Collaborative, whose mission is to create solutions that optimize Black maternal and infant health through training, policy advocacy, research, and community-centered collaboration. Other countries have a human rights framework. However, the United States has policies surrounding sex education, birth control, and other reproductive rights. Reproductive Justice is the human right to maintain personal bodily autonomy and the choice of having children or not. In Louisiana, to qualify for the Medicaid Expansion you must have had a child. This policy instills the belief that a woman's only value is her uterus, and if a woman has not birthed a baby, she cannot get insurance.

Dr. Crear-Perry defined the difference between an indicator and a framework. An indicator is a datapoint whose measurement is limited by current reality. An example of an indicator is marital status and counting those who are and are not married, whereas a framework is a vision that expands current reality, allowing freedom to explore indicators. Another example is to use reproductive justice or birth equity as the framework, but you will not achieve reproductive justice or birth equity through marital status. NBEC defines birth equity as the assurance of the conditions of optimal births for all people with a willingness to address racial and social inequities in a sustained effort. The policy makers who work in the federal government, state government, and local government created policies that are unequal which cause inequity in health. Social determinants of health are not based on decisions, but from factors such as living wage, education quality, social connections, psychosocial stress which lead to disparities and distribution of disease, illness, and well-being. The root cause of social determinants stem from institutional racism, classism, and gender oppression.

Racism affects everyone directly through chronic stress. It also has an indirect affect through race-based discrimination across various systems that lead to differential access to high-quality schools, neighborhoods, employment, and healthcare. In the article, "Look at the Whole Me," Black women who had infants were interviewed around the United States. Fifty various social determinants were used to measure positive predictive values for Black infant mortality, creating a birth equity index. It was determined that the best birth equity rates were in San Diego, California, and the worst were in South Carolina. Dr. Crear-Perry briefly mentioned the Black Mamas Matter Alliance, which includes members whose specialties range from researchers to policy makers and doulas to midwives. The members have formed the Black Maternal Caucus and are pushing for policy changes. A black – not white – paper has been published, titled "Setting the Standard for Holistic Care of and for Black Women" and can be found on the Black Mamas Matter website.

Concluding, Dr. Crear-Perry provided an example of scarcity that has affected her, which now affects all. Before COVID-19, Black-birthing people were already policed on who could be in the delivery room. Now, during the pandemic, this has continued and extended to everyone. With this scarcity, the system responds that no one can have a support person with you. However, having a partner or person present

during birthing is not a fringe benefit but a critical form of support.

Committee Questions and Discussion

- Dr. Ehlinger directed a question towards Mr. Harris: Over the past 80 years, instances showing a decrease in infant mortality disparities has happened during World War II and between 1964 and 1970. What should we be learning from those two instances?
    - Mr. Harris replied that during the ’60s and ’70s, there was an infusion of resources into disparate communities, afterwards, policy targeted those communities.
    - Dr. Crear-Perry added that after a war or crisis, resources are invested into reducing population disparities. The COVID-19 pandemic is another instance to invest in policy-level changes, similar to what was done after the civil rights movement.
- Dr. Palacios commented that there should be a focus on women’s decisions for controlling birth options or delivery and timing options to highlight or support during the COVID-19 pandemic.
    - Dr. Crear-Perry explained that it is important that women have the ability to control their fertility. However, it is also important to invest in wealth building to provide funding for those women as to not impact society’s ability to rebound after the pandemic.
    - Dr. Wanda Barfield added that the CDC and NCHS are attempting to collect the information on presumed maternal COVID-19 status through birth certificate reporting, and they are evaluating vital statistics of wording and formatting to understand items within birth certificate reporting. They will also be doing maternal COVID-19 counts by month and date. Furthermore, they will be developing a report on changes concerning home births, caesarean delivery, and preterm births by month.
- Dr. Conry informed Dr. Gupta that FIGO is developing a website which will list all registries. A comment was then directed towards Dr. Crear-Perry, stating that framework which focuses on human rights paired with universal healthcare is the only way to move forward. Lastly, after hearing the policies from Dr. Warren, it is important that the health and well-being of women is important whether they elect to conceive or not.
    - Dr. Crear-Perry replied that the U.S. is the only high-income nation that has not agreed that health is a right, and she hopes this pandemic will be a turning point in realizing that everyone is valuable and deserves healthcare.
- Dr. Peck wished to look closer at Dr. Crear-Perry’s slide concerning the definitions of framework and indicators. What would be the ideal language used by the Committee in eliminating maternal mortality and the promotion of women’s health and equity?
    - Dr. Crear-Perry replied with pregnancy well-being as an indicator of success. This would create a system and structure based upon what is needed to have pregnancy well-being, no matter a person’s birth choice. The hierarchy of human value has been based on gender, race, and age. If we were to topple that hierarchy, the framework would be freedom and justice, and what would be measured to achieve that?

SACIM MEMBER PERSPECTIVES ON MATERNAL AND INFANT HEALTH ISSUES

Dr. Ehlinger expressed the desire for the Committee members to have an open and honest conversation with the Ex-Officio members on the issues they are seeing in the communities where they live and work. Additionally, some of the federal agencies responded to the request for an update on what is being done concerning COVID-19.

Dr. Ehlinger noted the identification of the deficiencies within the public health and medical care system. For example, his community is advocating for defunding the police and establishing a new way of doing things. There is openness within the community, which is providing the opportunity to do things differently. Are the federal agencies taking advantage of the opportunities to do things differently?

Dr. Barfield informed the Committee that the MMWR talked about the large disparities happening in

Atlanta, Georgia, between Black and white COVID-19 patients in terms of admission and severity. There is the opportunity to study this carefully to develop programs that would help and support change. However, it is important to stay steady with the focus on the issues surrounding maternal and infant health within the African American and minority populations.

Ms. Pettiford explained that in North Carolina there were conversations on how to address telehealth work, but the pandemic hit before research could be done. There are barriers concerning broadband access, cell phone usage, and other similar concerns resulting in mixed reviews. However, it may be a year before accurate data is collected on the rate of home births, but she wondered what the other Committee members have heard. She then inquired if Dr. Barfield could share more information on pregnancy surveillance relating to COVID and if there is a way to get more states engaged in sharing that information. Dr. Barfield deferred the discussion to NCHS and the monitoring of out-of-hospital births to Dr. Ely. However, in terms of working with other states, they are currently needing to respond to COVID-19, but they are actively looking to see if they can get questions out to the field.

Dr. Warren injected that the Bureau is interested in ways to work within the funding legislative authority while also being flexible to emerging needs. Dr. Ely explained that NCHS is working with only a handful of states on birth certificate data collection. Ms. Pettiford then asked if many states are participating in pregnancy surveillance? Dr. Ely replied that several states are limiting their operations as they respond to the pandemic. Dr. Calvin added that there has not been an increase in out-of-hospital births in Minnesota, but there has been an increase in interest in accredited birth centers.

Dr. Conry referenced the importance of a voluntary registry but also the importance of registering all information about every delivery across the United States. Looking back at COVID-19 outcomes without having to be selective or looking at voluntary input data requires a national registry of birth. In response, Dr. Ely stated that within the pandemic response, there is support for pregnancy surveillance and maternal and infant health studies in various studies and programs to get a broad spectrum of information concerning pregnancy and delivery.

Dr. Warren inquired on ways to approach fall as childcare resumes and children go back to school, its impact, and what considerations need to be taken. What are the sources of stressors, such as going back to work and making the shift from social distance requirements? Dr. Ehlinger followed up by highlighting the concern of broadband as things are currently being done virtually. Access to adequate broadband has become a social determinant of health.

Dr. Peck wanted to look toward populations being impacted, such as women who are incarcerated, have housing instability, or are residing in homeless shelters. Furthermore, what is being done to measure and monitor the disproportionate impact on those living in crowded environments? Dr. Barfield explained that they are learning of the issues within the tribal populations in terms of housing and housing sizes. This brings up challenges relating to practical implementation and guidance.

Dr. Palacios added that the ability to work with communities and cultures where households contain multi-generational family members will provide the space to learn from the community organizers or community health workers to inform or help find culturally and socially appropriate ways to minimize the exposure and spread of COVID-19. Dr. Calvin commented on the challenges of childcare and the concerning number of available midwives.

Dr. Ehlinger asked Ms. Pettiford and Dr. Palacios who is working with city council members, mayors, state legislators, and governors to create the policies needed to address all of these issues. The recommendations made by the Committee are at the federal level, but the issues impact communities at the state and local level. Ms. Pettiford responded that teams have been set up with the department to focus on historically marginalized populations and how to reach those communities at different levels and determining the best way to use federal funding.

Mr. Wilson again discussed the topic of midwives, stating that they are at the state level and not the federal level. However, there are initiatives for new health workforce-type activities to fund and support the training of nurse midwives. Dr. Satterfield informed the Committee that the ACOG is working with governors at the local level to initiate collaboration between the state, section, and districts with the goal of permanent telehealth leniency. The federal government has implemented this, but it needs to reach the state and local level. This includes access for people to get durable medical equipment with several private health plans already including the equipment and distributing them to pregnant women. Meetings with big health plan providers have already been taking place.

Dr. Palacios stressed the importance of making the challenges and issues well-known. Her institution has looked into providing doulas with iPads to facilitate communication. There are various policies that could be enacted to support women with perinatal care, intrapartum care, and delivery with doulas. This could also increase the number of midwives.

Dr. Peck brought up two additional points. The first concerned qualitative information and developing methods and approaches within women-centered care and within family-centered care to hear those voices. Her second concerned misinfodemic work, which is understanding that there are disinformation intentional campaigns happening on social media platforms that undermine confidence in public health data. Dr. Peck asked if this is something that is being looked in to. Dr. Jarris confirmed that, saying engineering software organizations and intelligence agencies have been interested in this and have been monitoring social media. Additionally, they are monitoring this in relation to COVID-19.

Ms. Pettiford commented on the Latinx population, who are also vulnerable and marginalized. Many within these communities are undocumented and are fearful of seeking care, treatment, or testing, because of fears of deportation, but many of them are pregnant women who will have children that will be American citizens. Is there any conditional data on what they are being told? The recommendations coming out of the Maternal Mortality Review Committee are for the development of community and statewide maternal health strategic plans. Dr. Ehlinger stated that Dr. Wise would have the expertise concerning this issue, but he is currently working with the federal courts on immigration issues.

FINALIZING RECOMMENDATIONS REGARDING COVID-19 TO HHS SECRETARY

Dr. Ehlinger provided a brief overview of the Committee's recent actions. He sent a letter to the HHS Secretary in March containing unofficial recommendations. At that time, the COVID-19 pandemic was beginning in the United States, bringing many unanswered questions and new concerns. A lot has changed within the three months since sending the letter and the unofficial recommendations should be reviewed by the Committee to form a consensus of what should be presented to the Secretary.

The nine recommendations detailed in the letter were:

- Stand-up hospitals, non-hospital-based labor and delivery units, and expanding the capacity in freestanding birth centers
- Expanding the use of licensed and/or certified midwives in within them to practice under their certification
- Expanding access to health with telehealth broadly defined
- Support for community-based postpartum and newborn care
- Support for broad financing, including Medicaid, for telehealth
- The continuation of state eligibility for Medicaid for a full year after delivery
- Expanding some of the federal financing for home visits
- Providing professional liability insurance
- Expanding the data and surveillance systems

Dr. Ehlinger then asked the Committee if any the recommendations were no longer necessary or if there were any recommendations that should be added.

Dr. Peck suggested that the first recommendation should specifically include marginalized and vulnerable populations such as those who are undocumented. Dr. Ehlinger replied that the overall cover letter raised numerous issues to provide context, but he wondered if it should be put into any of the specific recommendations? Dr. Peck stated that it should be put more broadly in the cover letter but feels like it is glaringly missing within the recommendations; Dr. Palacios agreed. Dr. Ehlinger suggested that the Equity Workgroup form recommendations to present to the group as an added recommendation.

Dr. Conry raised concerns on the wording of stand-up hospitals. If the mother is not in a standalone hospital, she is in a hospital-based labor and delivery unit that has full autonomy. Being autonomous and placing labor and delivery as a distinct and important entity is the most important, and a clear statement needs to be made. By addressing the autonomy of a labor and delivery unit, it can reassure patients that they are in a safe environment that will protect them.

Clarifying further, Dr. Conry suggested phrasing it as "labor and delivery unit with full autonomy." She inferred the current wording as expanding capacity with freestanding birthing centers, which may not be necessary. Dr Ehlinger was given the impression from Dr. Calvin that there is an increasing demand for birthing in birth centers paired with capacity issues. Dr. Calvin clarified that they are not at that point, but the wording should be changed. He suggested it should read that mothers should be given the option for care in all accredited birthing sites available to them and that their wishes are to be respected. Dr. Ehlinger requested the wording be worked out within the workgroup to be presented to the Committee.

Dr. Peck suggested being more rigorous with the third recommendation beyond the access to telehealth. It was suggested to explicitly state expansion and sustainable access via viable broadband. Dr. Ehlinger agreed and committed to adding that language to the recommendation. Dr. Jarris added that broadband and telehealth must be considered within the context of a comprehensive system of access for women within the community, with agreement from Dr. Conry. Dr. Ehlinger noted that adding the context of the broader health care community or system in conjunction with Dr. Peck's suggestion will be reworked for inclusion.

Dr. Palacios, bringing back up the second recommendation, requested the removal of the word "licensed" when referring to midwives. The State of California is the only state using the term licensed midwives. She believes it should read only as certified midwives. Hearing no objection, Dr. Ehlinger called for removal of the term "licensed" in the second recommendation.

Dr. Barfield commented that it is important to avoid the implication that maternity wards and labor wards are solo entities, as they have access to laboratory support, respiratory therapy, ICU transference, and other supporting units or departments. It is pointed out by Dr. Ehlinger that she is building on the comments made by Dr. Conry, that it is part of a system. Dr. Conry agreed that it should be viewed as part of an entire support system. Dr. Barfield noted that some hospitals are explicitly keeping their pregnant patients away from the emergency room to avoid exposure. Dr. Jarris added that nurses working in rural hospitals rotate between Med/Surg, ER, and labor and delivery. Dr. Palacios recommended moving forward with the thought of the hospital as a unit and a safe place for all patients.

Dr. Peck addressed the Committee and asked the members if the recommendations are bound by pregnancy and newborns, specifically in the short term, as an opportunity. Elaborating that the nature of the question is within a framework, she asked if there is interest in building on the notion of prenatal and pregnancy-related care assurance to also include contraception or family planning. Dr. Ehlinger responded that these recommendations were specific to health care systems relating to COVID-19, and any recommendations presented both in and out of the context of COVID-19 should be presented when discussing the Committee's formal recommendations.

Ms. Pettiford was in agreement with Dr. Peck. The sixth recommendation provides an opportunity to

address chronic health conditions, putting a mother at greater risk for being infected with the virus, with the inclusion of contraception language. However, she had no objection to discussing it at a different point during the SACIM meeting.

Wrapping up the discussion, Dr. Ehlinger requested the Committee to come to a general agreement to change recommendation one, expand on recommendation three, and add recommendation 10. The wording and specifics were to be discussed during the second day of the meeting.

Dr. Lee mentioned the ethnic disparities concerning COVID-19; however, there is a lack of specific data on ethnic disparities in pregnant women. There needs to be a focus on collecting that data within the context of COVID-19. She suggested it be included within recommendation nine. Dr. Conry interjected that there are a number of registries taking place. The Priority Group is harmonizing all the data collected, thus fulfilling the need for data on the ethnic disparities in pregnant woman relating to the virus.

Dr. Ehlinger provided an overview of the changes discussed by the Committee and asked for an approval of the agreement concerning the recommendations. However, Dr. Jarris asked if the same database used to monitor pregnancies during the pandemic could be used for monitoring the long-term effect of COVID-19 in children in some capacity. Dr. Ehlinger reiterated that the recommendations have a very specific focus, but it could be added within the letter to the Secretary. He stressed that the Committee needs to move the set of recommendations forward. Seeing no objection to the agreement, the recommendations were approved.

PREEMIE ACT DISCUSSION

Lee Wilson
Acting Division Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration

There have been a number of questions from Advisory Committee members about the PREEMIE Act, the authorities it provides, the requirements it stipulates, and HRSA's administration of those authorities and requirements. The PREEMIE Act, as reauthorized in 2018, among other things affirmed HRSA's activities aimed at promoting healthy pregnancies and preventing preterm birth. The Act restated HRSA's previous authority for a committee to advise the secretary on infant mortality, as well as on matters related to promoting healthy pregnancy and preventing maternal mortality. Finally, the Committee was charged with drafting a report to Congress on its deliberations and recommendations.

As with the prior PREEMIE Act, Congress did not follow the authorization with funding in an annual appropriations bill. Without an appropriation, agencies in the Federal government are not obliged to execute aspects of the authorization that would require resources, unless those expenditures aligned with other authorized and appropriated activities.

HRSA met with numerous House and Senate staff before and after the recent reauthorization of the PREEMIE Act. The Agency's efforts to provide expert support and advice to the Secretary through the Secretary's Advisory Committee on Infant Mortality were described to the Congressional staff, and that HRSA's preference would be to avoid creating another, possibly duplicative committee to SACIM in order to meet the requirements of the Act. HRSA also reiterated to congressional staff that without an appropriation, the Agency would not have the dedicated funds for developing and drafting a report to Congress. However, HRSA will make available to the public and to Congress regular summaries and reports on the deliberations and recommendations of the Committee.

Committee Questions and Discussion

- Dr. Ehlinger asked if there was anything that the Committee can do to relating to the PREEMIE Act report and if the work being done concerning the creation of preliminary recommendations is to be

relayed to the Bureau?

- Mr. Wilson suggested reviewing legislative language. He also encourages the acknowledgement of any recommendations in affirmation of what is said in the legislation. Additionally, if there are any recommendations the Committee wants to make, SACIM is empowered to do so, and it is within the Secretary's purview to deliver them to Congress if he so chooses. He confirmed that Dr. Ehlinger can provide reports directly to him, but because there is no appropriation there is not a report, and he does not recommend relying on the report to be the vehicle for any program or policy recommendations. Therefore, any recommendations that the Committee intends to make or vote on should be sent to the Agency for transmittal to the Secretary.

- Dr. Barfield commented that there are not appropriated funds for the PREEMIE Act, but the division within the CDC, Safe Motherhood, has roughly $2 million in funding being used for it. However, this is not appropriated, and the information will be provided within the report on what HRSA and NIH are doing.

WORKGROUP PRAXES

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Dr. Ehlinger provided a quick synopsis of the work currently being done concerning charters for the Committee's three workgroups, which are now referred to as "praxes." The workgroups were tasked with creating their own praxes outlining the purpose and methodology or outputs of their group. Presented by the workgroup chairs, Dr. Ehlinger wanted to get the input of the Committee for each workgroup's praxis and come to an understanding of what each one is doing.

Presenting on behalf of the Quality and Access to Care Workgroup, Dr. Calvin elaborated that the group's perspective is identifying what the quality options are for high-quality care ranging from traditional systems to expansive systems in order to honor the mothers' choices and what they want their birth experience to entail, and to identify access issues or barriers within the high-quality care. Dr. Ehlinger asked if there was any type of expertise they would want added to the workgroup. Dr. Calvin's response was that there has been no communication with group member and Ex-Officio member Ms. England, but her focus on rural health challenges would be beneficial.

On behalf of the Data and Research to Action Workgroup, Dr. Peck introduced the praxis its members developed. They are to assure that SACIM's ongoing deliberations and decision-making for producing strategic policy recommendations for preventing maternal and infant mortality and promoting health equity based on the credible and reliable available at the time. The group has defined a series of overreaching goals. Generally, these goals are identifying access and using research and data to work across various sectors, identifying gaps and deficiencies in data but also build capacity, and evaluating research results from a variety of voices and communities to illustrate findings. Goals specific to the pandemic include looking through the lens of COVID-19 and advocate for a different 21st century surveillance and data system. Dr. Peck also presented a series of questions that are to be used to guide the workgroup's conversation that are aligned with their goals.

Dr. Palacios presented for the Health Equity Workgroup and provided the current praxis of promoting common understanding to identify gaps, generate plans, and take actions with health equity as the framework. However, this may be expanded based on the Committee's discussions. The group wants to ensure that the considerations and policy recommendations given by SACIM are grounded by shared understanding of, and a commitment to, health equity. Lastly, the group wants to include the social determinants of health to address areas needing improvement. The workgroup's goals are to guide the discussions and promote the use of specific common terms grounding health in social circumstances; to

advocate for the discussion, planning, and actions taken by SACIM to address race and other public health crises; and to ensure all immediate and long-term recommendations made by SACIM safeguard and protect maternal and infant health during the COVID-19 pandemic.

Committee Questions and Discussion

- Dr. Palacios commented that all workgroups should adopt the core ideas of the other workgroups within their core foundations.

- Dr. Peck commended the structuring and efficiency of the workgroups to continue working within the groups to expand out to work within the Committee.

DAY 1 MEETING WRAP-UP

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Dr. Ehlinger wanted to mention that due to the large number of attendees, introductions were not done in order to preserve time for the Committee to get through all the topics scheduled. As everyone splits into groups, he asked for everyone to take some time to introduce themselves in a meaningful way and to share how the current issues have made an impact through deep conversation.

There was input within the webinar chat box, and Dr. Ehlinger stated he would be addressing the input that has been given and work on revising the COVID-19 recommendations. The meeting adjourned for the day at 4:10 p.m. and split into three workgroups.

Quality and Access to Care Workgroup

WELCOME AND INTRODUCTIONS

Steven E. Calvin, M.D.
Workgroup Chair, SACIM Member

Dr. Calvin began the meeting and asked for all the group members and new participants to introduce themselves:

Katherine Avery, M.D., was invited to the SACIM Meeting and provided several speakers during second day of the meeting. She is the Maternal Health Program Manager for the Department of Health in New Mexico and coordinates the state maternal mortality review committee. She is also a licensed midwife, which is a requirement within her program.

Cathy Emeis, Ph.D., C.N.M., a nurse for 40 years and a midwife for 22 years, is the chair of the Quality Section at the American College of Nurse Midwives. She has been a Program Educator and Director of the Nurse Midwifery Education Program at Oregon Health and Science University for the last thirteen years. Her expertise is in nurse midwife regulation, and she is an expert consultant to the Oregon State Board of Nursing. She directs two faculty practice sites that deliver roughly 500 babies per year.

Suzanne England, D.N.P., A.P.R.N., is an Ex-Officio Member of SACIM.

Colleen A. Malloy, M.D., is a member of SACIM. She a neonatologist in Chicago and is currently pursuing her Master's in Health Informatics. As a neonatologist, she has become increasingly aware of the need to develop a middle ground between the levels of care and believes the workgroup can help to improve those levels.

Tara Sander Lee, Ph.D., is a trained biochemist with extensive experience running research and clinical laboratories at academic centers and hospitals. She is involved in public policy and heavily involved in understanding how birth defects can lead to infant mortality or morbidity. She is interested in expanding perinatal healthcare for pregnant women whose babies have been diagnosed with birth defects that can be treated in utero.

Lisa Satterfield, Ph.D., is the Senior Director of Health Economics and Practice Management for the American College of Obstetricians and Gynecologists and the primary person working on telehealth advocacy for ACOG. Having been involved in health equity discussions, paired with her experience in telehealth, she believes she can be of help to the workgroup.

TELEHEALTH AND TELEMEDICINE

Colleen A. Malloy, M.D.
Assistant Professor of Pediatrics (Neonatology)
Ann & Robert H. Lurie Children's Hospital of Chicago

Dr. Malloy presented a telehealth document she prepared which includes many sources of data-based articles describing different methods of care for pre and postnatal care to mothers and infants. In light of the pandemic, babies are being sent home as quickly as possible, and it is important to maintain high-quality care for those newborns through at-home telehealth services. This can be done through informative and supportive programs on infant care or education on how to cope with and care for a baby that is crying. In a document containing postnatal care articles, included are articles relating to prenatal care in terms of dietary management and management methods for mothers who can participate in office visits over the phone.

Dr. Calvin opened the discussion up for other perspectives of telehealth and telemedicine:

Dr. Calvin summarized the concerns made by Dr. Jarris on the negative impacts of telehealth on rural communities, such as the possibility of healthcare facilities going out of business. There is also a concern of the proprietary nature of establishing a new healthcare system. He added that some newborn care and prenatal care can be done remotely, but there is a point where meeting in person is necessary.

In the context of Indian Health Services, Ms. England pointed out the obvious increase in telehealth due to COVID-19 as they try to keep pregnant women home during a resurgence of the virus. She explained that within their facilities, they have access to phones with built-in cameras for video calls. The day before a scheduled appointment, the patient is telephoned to confirm their telehealth appointment. At the scheduled time, a video call is made, and the appointment is conducted that way. However, if there are any concerns, they are able to schedule an in-person appointment and are instructed to come alone. Ms. England said she feels as if many people are a bit frightened to come to the facilities to get care and prefer the telehealth method.

Dr. Avery has been particularly concerned with potential issues. Project ECHO is a program that began at the University of New Mexico and follows a model to confirm if a service was accessible to rural providers, solo providers, and system providers. Project ECHO began as a way to support rural providers and review cases with them. Now, the program is a more telehealth-focused method with provider-patient visits being done through the video format, leading to its potential ability to engage with rural providers and rural systems.

For example, UNM and Project ECHO would work together within a telehealth model to provide team care within rural communities, specifically areas with below level one to level two care. Having not been introduced to proprietary topics within telehealth, she has not considered it as a potential issue. However, Dr. Avery believes that the biggest issue within rural areas would be bandwidth with video visits being difficult to maintain without the proper technology.

Dr. Satterfield informed the group that telehealth has been an asset to ACOG. There has been a focus on working within the audio-only options and the payment priority process through evaluation and management codes, which has been a success. Many health plans pay for audio-only based on the general knowledge of inconsistent bandwidth availability. A lot of Medicaid programs are beginning to include audio-only telehealth, but they are also supplying DME. Dr. Satterfield reported hearing concerns of the commerce of telehealth, but if health plans are picking up telehealth a platform and management program will be necessary, and she could see potential issues in that regard. Dr. Calvin suggested mentioning the potential issue in the presentation to the Committee. Within a recommendation it could really draw attention to the potential drawbacks and benefits.

Dr. Malloy added that she has done extensive research into various modes of offering telehealth and telemedicine and has not seen anything demonstrating a decrease in engagement within the medical system. If anything, she believes people are more engaged, she said. These services are not meant to replace anything that requires an in-person provider, but as a way to augment the healthcare system.

Dr. Emeis informed the workgroup that Oregon is considered a rural state and that telehealth was utilized prior to the COVID-19 outbreak. The Governor of Oregon signed a bill into law a few years previously for all first-time mothers to receive up to three home visits after delivery with pilots currently being conducted. Discussions amongst the Committee today may have influenced heightened concerns on this issue.

THE PERINATAL REVOLUTION

Tara Sander Lee, Ph.D.
Senior Fellow and Director of Life Sciences, Charlotte Lozier Institute

Dr. Lee restated that she and Dr. Malloy worked closely together on a project that resulted in the publication of information and data on the total area of fetal therapy entitled *The Perinatal Revolution*. She said this workgroup presentation will provide a brief summary of the publication, and then she will highlight some gaps with the potential to increase infant survivability. Birth defects are one of the leading causes of infant mortality and morbidity, affecting one in every 33 live births in the United States and accounting for 20% of infant deaths across all races.

The premise behind fetal therapy is treating a fetus within the womb to repair structural defects before birth and potentially curing diseases during the prenatal period. Studies demonstrate positive outcomes for both the infant and mother. Instances where in utero babies have been diagnosed with Spina Bifida and undergone surgical treatment have led to numerous improvements in the babies' mental and motor functions and can decrease their risk of death. Twin-to-Twin Transfusion Syndrome can lead to the death of one or both babies. Therapy can potentially save both babies, but this is extremely time-sensitive, requiring early discovery and immediate treatment. Fetal therapy directly affects the health of the baby, but it also impacts the mothers and families when coping with the potential outcomes of their child and what those children can and cannot do.

Although there are centers performing fetal therapy throughout the United States, not all women have easy access to them. There are geographic issues, and there is also a lack of awareness. Published reports have found that mothers were never informed of fetal therapy as a treatment option. Even if a mother is aware, there are significant financial burdens. For example, due to availability, the mother may have to travel to another facility, where she will have to be on bed rest and will require 24-hour care and support. Other access issues include a lack of mandatory reporting of fetal surgery outcomes and no accredited fellowship training program, with training being done on an apprenticeship basis, insurance eligibility, and a lack of clinical trials.

Workgroup Discussion and Questions

- Dr. Avery asked what Medicaid's approach is toward coverage of treatment and if they would cover the costs.
    - Dr. Lee stated understanding that Medicaid only covers procedures deemed necessary and, so some would be covered and some wouldn't. This would also tie in with telehealth and the ability to spread information on treatment options that way.
    - Dr. Malloy reported being fairly certain that treatment for Spina Bifida repair in utero would be covered. The vicious cycle is that insurance companies don't cover the cutting-edge treatments, hindering the ability to obtain data, but in order to convince insurance companies to provide coverage, there needs to be more data.
    - Dr. Calvin commented that he used to perform fetal transfusions. Twin-to-Twin Transfusion was treated by taking the amniotic fluid off the sac that was expanding, which did not solve the issue.

PAYMENT OF CARE

Steven E. Calvin, M.D.
Workgroup Chair, SACIM Member

Dr. Calvin informed the workgroup of another access issue that he has seen firsthand is paying for care. Throughout his career in medicine, he has noticed issues with the flow of money. The online Medicaid system is being managed through care organizations, but those organizations are only managing cash and not

managing care. For example, in Minnesota there is a program that provides monthly direct deposits for women who are pregnant and then for newborn babies for the first 12 months of life.

CMS reviewed that maternal and newborn care program and found that $20,000 is given by the state to the managing organization for that program with many states providing less to similar organizations. The Centers for Medicare and Medicaid Innovation determined that the funding is unsustainable. He would be further discussing this topic during the following day's meeting.

Workgroup Discussion and Questions

- Dr. Emeis explained that in Oregon, a lot of Coordinated Care Organizations co-opt Medicaid, causing restrictions to hospital birth centers and closing doors on women to deal with only Medicaid-covered women. A bill was being sponsored to correct this, but since the pandemic, women have been willing to pay out of pocket or on a sliding scale for birth center care. Lastly, stating well-intended policy does not always end up helping or advancing health the way it was designed to do.
- Dr. Avery commented that the infrastructure of MCOs is another area where money is flowing. In New Mexico, the continuum of care is only six weeks and follows an evidenced-based model to address the needs for wraparound care that is reliable and consistent. This type of care coordination has proven to be particularly successful within the substance-abusing population. Conclusively, there is the need for a solid system of care that is consistent and does not lose contact with the mothers with resources to provide appropriate attention to or intervention for some circumstances and within some populations.

WORKGROUP WRAP-UP & ADJOURN

Steven E. Calvin, M.D.
Workgroup Chair, SACIM Member

Dr. Calvin asked the members if there were any additional thoughts or comments. He briefly answered structural questions posed by Dr. Avery of SACIM. He then thanked everyone for their contributions to the discussions and adjourned the meeting at 5:58 p.m.

Data and Research to Action Workgroup

WELCOME AND MEMBER INTRODUCTIONS

Magda G. Peck, Sc.D.
Workgroup Co-Chair, SACIM Member

Dr. Peck began the meeting by providing a brief background of SACIM and the three workgroups. She said the group meeting provides an opportunity to discuss the goals and set impacts we can have during the current COVID-19 pandemic and generally on maternal and infant mortality prevention.

The workgroup members were asked to introduce themselves:

Danielle Ely, Ph.D., is the Manager of the Linked Birth Infant and Death File at the National Center for Health Statistics where she looks at national level data on the infant mortality in the United States.

Wanda D. Barfield, M.D., M.P.H., F.A.A.P., RADM USPHS (ret.), directs the Division of Reproductive Health in the National Center for Chronic Disease Prevention and Health Promotion at CDC and is on the verge of publishing the *Data to Action* E-Book.

Jeanne A. Conry, M.D., Ph.D., is retired from clinical practice as an OB/GYN at Kaiser Permanente after working there for 30 years. She was a past president of the American College of Obstetricians and Gynecologists and is its Chair of the Women's Preventative Services Initiative. She is the President-Elect for the International Federation of Gynecology and Obstetrics and would normally be spending half the year in Europe.

Ellen Tilden, Ph.D., C.N.M., is an Assistant Professor at the School of Nursing at Oregon Health and Science University and also serves the Department of Obstetrics and Gynecology at the School of Medicine. She's been a practicing midwife for 21 years and has transitioned to clinical research on health system questions in maternity care.

Carol Gilbert, M.S., A.B.D., is from CityMatCH, where she is the Health Data Analyst.

Cheryl S. Broussard, Ph.D., is an Epidemiologist at CDC for the Division of Birth Defects and Infant Disorders and is currently holding four different positions.

Magda G. Peck, Sc.D., has been working in maternal and child health research and data through CityMatCH, which she is the Founder, former CEO, and currently the Senior Advisor. She is a Professor of Public Health and Pediatrics at the University of Nebraska Medical Center. She is the second Dean of the University of Wisconsin, Milwaukee, New School of Public Health. She also had a consulting group that is now called MP3 Health Group. She is participating in the meeting in her independent capacity.

Dr. Peck gave a brief overview of some key moments from Day One of the SACIM meeting. The Committee was given an explanation and clarification on their association with the PREEMIE Act and how their involvement includes reporting about recommendations of Data to Action. Although the group has no appropriation, it does provide accountability that could be used as leverage for changes in the data system.

The Committee also invited Dr. Crear-Perry to speak during the meeting. She presented issues not of race but racism in the context of systems of care responsive to women, specifically women of color. She advised to differentiate between indicators and data points within the framework of the language and consider how data is generated and used within that language. Furthermore, we must recognize the opportunity the COVID-19 pandemic has presented in highlighting strengths but also pointing out weaknesses in data systems.

CONSULTATION 1: SPECIFIC TO COVID-19

Magda G. Peck, Sc.D.
Workgroup Co-Chair, SACIM Member

Dr. Peck provided an overview of the letter sent on March 27, 2020 to the Secretary of Health and Human Services containing nine informal recommendations for immediate consideration to strategically respond to the unfolding pandemic. One of the recommendations, the ninth, is specific to data, and the work being done during the group meeting will be presented to SACIM and has the ability to influence that recommendation.

The floor was opened for discussion.

Dr. Conry stated there are two broad elements to focus on. The first is to determine what the measure of a mother's wellness is within the context of maternal mortality and morbidity and how the infant's health is impacted by it. The second is to look at the data already collect and determine what needs to be accomplished.

Dr. Tilden noted the outstanding work by CMQCC. In terms of major gaps, she feels there are shortcomings in capturing meaningful postpartum data. There is a loss of access to women in their postpartum period because of the way insurance is structured and because focus is shifted to the baby the mother gets neglected. More data needs to be collected on their mental health, breastfeeding outcomes, and vital signs such as blood pressure.

Dr. Lewandowski introduced herself as a maternal and child health epidemiologist in Arizona's Department of Health Services. In terms of COVID-19, the "disconnect" between mothers and the healthcare system has been exacerbated as they are seeing their providers less. Her work on surveillance projects dealing with maternal mental health and the pandemic have punctuated the need for more, better data in general. Dr. Peck shared her view that there is a need for baseline COVID-19 variables by gender, race, ethnicity, and age specific to pregnant women and infants.

Dr. Barfield shared a belief that it is very important to learn from the past in terms of surveillance system evolution for the future. She commented on the impressive speed in delivering national data by NCHS. She stated innovation has come from emergency pandemics such as Zika and pointed to the PRAMS surveillance system in Puerto Rico. Hurricane Katrina demonstrated how women were dispersed and how to follow them. Another example is the opioid epidemic and the innovative work within the data to ask questions on opioid use and provided the opportunity to follow up on infant care. In terms of well-being, it is noted that there is an important need for a strong surveillance to measure it. The inherent challenge is the lack of unique identifiers to link data systems together. Some of these include identification, facility-based data systems, and the lack of health surveillance outside of health care settings. Lastly, on issues of race and ethnicity, there are issues with access to care, access to treatment, and access to a potential vaccine.

Dr. Peck then broadened the scope of discussion by recognizing that vulnerable populations face higher incidence of violence, incarceration, and immigration brought on by sheltering-in-place. Dr. Barfield responded that it circles back to the history of surveillance. States facing the biggest health and capacity challenges are also facing challenges in the capacity to collect data.

Dr. Ely pointed out obstacles to data collection, both the types of data and the time necessary to collect data. Data transmission by states of data on maternal infections presumed, tested, and confirmed are limited due to Vital Statistic Departments being overwhelmed and the need to respond to the pandemic. To help alleviate the burden, they are to send only basic information that will be merged with the overall data being collected.

Dr. Peck steered the discussion toward the third and fourth question. There are other sectors monitoring COVID-19 in pregnant women and infants, and within their extended family. She asked how to make connections with those sectors collecting data.

Dr. Wise introduced himself, stating he's with Stanford University's International Studies and Pediatrics and Health Policy. He voiced two additional factors to consider in working with data, from an interdisciplinary perspectives. First, be thoughtful and creative toward relevant data sets and the analytical architecture to determine those datasets. Second, be purposeful in building new interactions and engagements with other sectors.

Dr. Wise highlighted that the real question is how maternal and infant health outcomes support the basis of broader issues. Focusing only on the tragedy and injustice of disparate birth outcomes would be considered a distraction. He stated the need for SACIM's public role to evolve to eloquently frame maternal and infant health outcomes within a creative framework to discuss COVID's impact on disparities and racial justice.

Dr. Tilden asked for further discussion on interdisciplinary approaches. She was given the impression it has been tried before without success. Dr. Wise explained his view that the group of individuals working on infant mortality had grown so large that it appeared that they felt it was unnecessary to include others outside the group. Dr. Peck noted that this should be seen as a strategic issue, if there is the intention to make improvements in health outcomes. Dr. Conry voiced the need for a progressive agenda. She stated that questions need to be more open-ended about how to approach, interpret and bring about change with COVID-19 and with racial disparities.

Dr. Peck provided the opportunity for any further discussion before moving on with the meeting. Providing her own thought, she would be able to link housing security with the notion of housing policy and eviction for women of reproductive age or pregnant and parenting women. Ms. Gilbert stated there is an obvious connection between economics and health at the local level. Such an idea would provide an opportunity to collect economic data on housing, crowding, and unemployment.

Dr. Peck encouraged the group to balance the ideas of what could be national systems and what could be local and state systems. Ms. Gilbert explained that CityMatCH is an opportunity to find local bridges as opposed to waiting for them nationally. Dr. Conry added that, with a daughter living in Paris, she sees there is a different safety net in other countries that is remarkably different than what she sees in the anxiety in the United States.

CONSULTATION 2: OVERALL

Magda G. Peck, Sc.D.
Workgroup Co-Chair, SACIM Member

Dr. Peck explained that, as seen through the first consultation, many of the topics for discussion spill over to the second. However, she instructed the group to think about the questions in terms outside of the pandemic, discontent surrounding racial injustice, and innovation. She encouraged the group to broaden the discussion.

Dr. Ely noted the struggle with training individuals in hospitals on how to submit data and how to submit it correctly. For MCHS and CDC more broadly, offering states grants to help implement different systems or training in various aspects of data collection, could help.

Dr. Barfield agreed that there are opportunities for involvement. Currently, the CDC is involved in data innovation activities to discover and develop different types of systems. Yet, there is the question of how much data is enough data or what is the right data. You need to look at what has worked previously and build upon it with innovation. Dr. Peck, took it a step further, stated the same process could be used on what has already been collected but also used across sectors.

Using this method of innovation, Dr. Peck asked what would be changed or improved. For example, in terms of surveillance within technology, specifically social media, has created negative virtual environments that intentionally change and manipulate misinformation to undermine science and data to service ideology or politics. There are also implications within artificial intelligence and structuring those systems without implying biases. She prompted the group to provide any examples that they have observed.

Thinking in terms of "misinfodemics" specifically to work within SACIM, Dr. Wise expected the greatest disinformation relates to stereotypical depictions of U.S. problems within diverse political environments.

WORKGROUP WRAP-UP & ADJOURN

Magda G. Peck, Sc.D.
Workgroup Co-Chair, SACIM Member

Dr. Peck invited everyone present at the meeting to sit in on the second day of the SACIM meeting. After thanking everyone for their work and insight, the meeting was adjourned at 6:06 p.m.

Health Equity Workgroup

WELCOME AND MEMBER INTRODUCTIONS

Janelle F. Palacios, Ph.D., C.N.M., R.N.
Workgroup Co-Chair, SACIM Member

Dr. Palacios welcomed the workgroup and had the external workgroup members (Non-SACIM members) introduce themselves:

Joya Chowdhury, M.P.H., serves in the U.S. Department of Health and Human Services Office of Minority Health.

Ashley Belton, M.P.H., (introduced by Ms. Chowdhury), is the Project Officer for the Perinatal Mental Health Grant within the Division of Healthy Start and Perinatal Services.

Avareena Cropper, M.P.H., works for Centers for Medicare and Medicaid Services in Monterey. She leads a few health projects, including R5, which has been submitted for comment and recently polled access, outcomes, and quality of maternal care in rural communities.

SACIM Members and others present for the Workgroup were the following:

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

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

Kacie McLaughlin, M.P.H., Health Resources and Services Administration, Maternal and Child Health Bureau

Janelle Palacios, Ph.D., C.N.M, R.N., Workgroup Co-Chair, SACIM Member

Belinda Pettiford, M.P.H., B.S., B.A., Workgroup Co-Chair, SACIM Member

Dr. Palacios encouraged the group to look toward the future, to consider what needs to happen to get there, and to consider what a healthy nation looks like. America is one of the worst-rated countries in terms of maternal and child health, and that needs to be addressed as one of the components within the framework for basic human rights. She stated that this is something the workgroup should be looking at addressing moving forward.

IMMEDIATE IMPACTS SACIM CAN MAKE ADDRESSING COVID-19

Janelle F. Palacios, Ph.D., C.N.M., R.N.
Workgroup Co-Chair, SACIM Member

Dr. Palacios wanted to find out the actions that can be made over the following six to 12 months to improve maternal and infant health in the time of the COVID-19 crisis. The Committee has discussed the letter that is being sent with informal recommendations, such as telehealth medicine and out-of-hospital care. There have also been discussions on testing and conversations about the pandemic-wide response and how testing and contact tracing need to be implemented, along with a policy for hospitals and organizations to follow for standardization of testing. She prompted the workgroup for their general thoughts on what SACIM can do immediately to address issues concerning the most vulnerable populations.

Ms. Pettiford brought up the topic of historical trauma and the historical issues of racism in the country. She feels that the effort should not be just equity training or bias training, but how to connect that to the overarching efforts. She cited the need for information on the importance of training within the country, how it's impacted populations, and how individual biases impact how people are treated and how situations are handled, and programs are developed. She highlighted the need to look at the smaller areas that piece together to form the large ones.

Dr. Jarris noted a tendency for some people to look at interpersonal racism as the problem, but there is also underlying institutional systemic racism that needs to be addressed. So, how do we create an environment or take advantage of the attention brought into the spotlight? Birth inequities are not something you can dramatically portray on video.

Ms. Pettiford agreed with the sentiments from Dr. Jarris. The murder of George Floyd brought are calls for justice and change within the police department, but people are not looking at the entire institution of the systemic inequalities. There needs to be a step back to look at the big picture, she said. The Racial Equity Institute in North Carolina does national "groundwater" foundational training, which is a three-hour course that shows the bigger picture through analytical data.

Ms. Cropper noted that a lot of conversation has been on understanding how the systems have evolved to become what they are, requiring a multi-disciplinary approach. The ultimate goal of establishing a new system that is committed to health equity must include champions for health equity champions within organizations, champions who specifically focus on policies that unjustly impact certain populations. Ultimately, without the establishment for the accountability and acknowledgement within the injustices, nothing would change.

Dr. Palacios responded that during a prior meeting for SACIM she had made a comment about underlying things that have to change, such as social norms. But it needs to be more than that now; there needs to be real consequences for the justice system. She noted that large corporations are making those changes to address their own issues within their companies through awareness and training programs.

Dr. Jarris stated that training is important, but it is not sufficient. Agreeing, Ms. Pettiford felt training was one of many steps. Organizations need to implement an assessment tool to dig deeper within themselves to address what they need to change.

Ms. Cropper suggested the option of training simulations, to know how to respond. It's beyond the conceptual knowledge of what to do and how to respond in situations; there are compounding issues in every situation, as a clinician, of what support and understanding is needed. Ms. Chowdhury responded that the Office of Minority Health has been developing a maternal health simulated training for providers. She is not leading it and does not know details about it, but it would cover how to address certain situations with topics such as racism and implicit bias.

Dr. Jarris suggested the possibility of looking at CLAS standards (National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care) and potentially implementing it along with the simulated training or education courses. He believes training on CLAS to be a requirement of accepting CMS money. Ms. Pettiford did not realize CLAS standards were a requirement of CMS. Ms. Chowdhury committed to confirming whether it is through her colleagues.

Dr. Palacios prompted the group for further immediate actions SACIM can take. She asked about the discussion on misinformation and the potential for a form of public service announcement relating to proving the inequities of maternal and infant health during COVID-19 or other sort of immediate steps.

Dr. Jarris explained that search terms need to be defined, in order for those things to work as they use AI to

find messages consistent with malicious language or ideas – or one hears the message and tries to develop a counter message. This is his first experience with it, so he is still trying to fully think of how it can be used, he stated. Much of the misinformation out there is type of echo chamber and if you leave it alone they will talk amongst themselves; it's when it is amplified and magnified that it requires shutting down.

Ms. Pettiford wondered how to be sure that resources are getting to community-based organizations or those that are hiring community health workers where trust may already be a big issue due to interrelationships in those communities. North Carolina is issuing an RFQ for funding focused on those organizations at the ground level, but there are also organizations that are smaller without the experience in writing a grant for the state to get those resources. How do we add to that and help them?

Dr. Palacios moved the topic along by asking what needs to be improved in order to help the women who are incarcerated, undocumented, or sequestered.

Ms. McLaughlin circled back to the need for accountability, especially for those who are in power. Dr. Palacios used the example of the hospital in Albuquerque separating babies and mothers who were assumed to be Native American and testing them for COVID-19 and cited the reaction of the public. Yes, there needs to be a system for accountability, but the judgements of the public opinion with real-life consequences can sometimes be the best method to invoke change.

Ms. Pettiford addressed ensuring protection to vulnerable populations. People need to have a safe space to improve and seek help when they can't go to a provider or entity, and to know they are going to still be heard and cared for. An example of this is in Indiana. Project Swaddle uses paramedics to help bridge gaps by sending a paramedic to women in the program to offer services to improve maternal and infant health. It has been seen to be working in those areas.

Some policies that could benefit vulnerable populations, suggested by Ms. Pettiford, include the access to electricity and not having the power turned off. Additionally, in her state, families that had school-aged kids were still getting their free school lunches. That sort of service can be extremely beneficial. Dr. Palacios followed up about increasing access and policies of that sort. Ms. Belton provided possible policy-related items being affordable childcare and paid family sick leave. Those barriers definitely inhibit families from moving upstream. Ms. Pettiford added that some of the schools in the school-lunch policy would run the bus routes to transport food.

Dr. Palacios expressed the need for community organizations and divisions to work together within government. Ms. Pettiford suggested working with the Department of Corrections to help with the incarcerated women and working with faith leaders to get messages out to their congregations to wear face masks and go for testing.

MID- AND LONG-TERM ISSUES TO IMPROVE INFANT MORTALITY

Janelle F. Palacios, Ph.D., C.N.M., R.N.
Workgroup Co-Chair, SACIM Member

Dr. Palacios shifted the focus toward mid-term and long-term issues that need to be addressed. Ms. Pettiford provided an example of what Dr. Peck brought up and the focus on women while they're pregnant and shortly afterward. The healthier a woman is before she is pregnant, the greater likelihood that she delivers a healthier baby. She believes that sometimes the whole concept of a healthy woman is missed as the focus is on conception and maternity. There needs to be accessible care for these women to deal with any and all health issues, not just during COVID.

Ms. Pettiford addressed that this is another equity issue. As people think of where you have access and feel safe to move about and live, there are some communities where you don't feel safe or have access to healthier grocery stores. Rural communities are some of these instances. Dr. Palacios believes that at some

point, the community in which a woman lives will be included within the terms of healthy environment.

Ms. Chowdhury reported that she is working on her dissertation around the preconception and life course of women and has been seeing a gap in care falling into two areas. The first area resides in the number of visits a woman has to deal with for preconception health care issues, such as annual visits, which concentrate on keeping a woman healthy so she can reproduce a healthy baby versus talking about your pregnancy intention or how to be a healthy person in general.

Ms. Chowdhury noted the second area, as ACOG refers to it, is the fourth trimester. This concentrates on the visits you need until a year after postpartum. This also asks the question of who cares for the woman versus caring for her because she had a baby. She shared a personal example: Her primary care provider told her to not come see her until after she had the baby. Ms. Cropper expressed a similar experience even though she was dealing with hypertension and felt uncomfortable not seeing her primary care physician for a year. Mothers need to be safe, not just for the baby, but also because women need to be safe and healthy.

Dr. Palacios explained that when she was in midwifery school, a woman would have between 10 and 12 prenatal care visits. However, now it is fewer, between eight to six visits. This relates to another equity issue, that a woman's access to health insurance needs to be able to cover the cost of a certain number of doctor visits. Ms. Cropper added that there is also a need to consider personal help and support at home while she's recovering. Availability to information on how to support women during and after pregnancy is important.

Dr. Palacios asked when women are released from the hospital, what happens when they don't have someone to support them? This addresses issues already mentioned within family leave and community aid. Dr. Jarris believes there is a need for services for women without the access to resources or support that is so critical for them. Dr. Palacios added that an unintended benefit from prenatal group care is that it creates a social support system for them to identify and be comfortable with.

COVID-19 RECOMMENDATION FOR SACIM

Janelle F. Palacios, Ph.D., C.N.M., R.N.
Workgroup Co-Chair, SACIM Member

Belinda D. Pettiford, M.P.H., B.S., B.A.
Workgroup Co-Chair, SACIM Member

Ms. Pettiford brought up the need to discuss the recommendations being put forward concerning COVID-19, Dr. Palacios wanted to include language dealing with human rights as a foundation for health equity situations. Dr. Jarris provided the two bulleted points relating to equity that the Committee was working on during the meeting.

Ms. Pettiford asked if there should be a new recommendation or if they are to strengthen the nine recommendations already discussed. Dr. Jarris believed it would be easier to strengthen the existing recommendations.

Dr. Jarris suggested, under the fourth recommendation, to focus on community health centers lacking underlying resources. Ms. Pettiford suggested a new recommendation, as the first one instead of the tenth, giving special attention to vulnerable populations. The workgroup discussed the recommendation's focus and agreed on the key words being "focused attention," "vulnerable or at-risk," and "resources."

Dr. Palacios asked the group about calling out or recognizing the significance and impact on vulnerable populations. It was then agreed by Dr. Jarris, Dr. Palacios, and Ms. Pettiford to provide an offline e-mail to Dr. Ehlinger for the recommendations. Dr. Jarris added to number nine the need for adequate and detailed

data on the impact and vulnerability of COVID. Dr. Palacios added a thought on independent or external audits to ensure data accuracy. He agreed to a standard of data that allows interoperability.

WRAP-UP & ADJOURN

Janelle F. Palacios, Ph.D., C.N.M., R.N.
Workgroup Co-Chair, SACIM Member

Belinda D. Pettiford, M.P.H., B.S., B.A.
Workgroup Co-Chair, SACIM Member

Ms. Pettiford invited the participants to join the workgroup in future meetings and an invite will be e-emailed. They meet every other month.

Dr. Jarris thanked everyone and the workgroup meeting was adjourned at 6:05 p.m.

Thursday, June 18, 2020

WELCOME BACK

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Dr. Ehlinger welcomed everyone back to the virtual meeting and expressed his disappointment in not being able to see everyone in person but looks forward to doing so soon. He reminded the Committee of the simple rules to focus on: remember every baby and mother; center on equity; listen to community voices; build capacity; focus on connections; ask powerful questions; and seize opportunities.

STORIES FROM COMMUNITIES

Felicia Hanney, M.P.H.
Project Manager, Indianapolis Healthy Start

Marry Bullock, L.C.S.W., M.B.A.
Social Worker, Eskenazi Health

Ms. Hanney shared a scenario with the Committee that mothers in her Healthy Start program have experienced. A mom with a part-time job and two children, ages two years old and six months old, was scheduled that day for her postpartum appointment. She had made arrangements to switch her work shift, planned for childcare, and calculated which bus route to take. The day of her appointment the infant's childcare center was full and her two-year old's school was closed, forcing her to take her children with her.

Travelling with the infant in a baby carrier, her two-year-old, a stroller, and two bags for her children, they set off on their one-hour-and-thirteen-minute bus ride that would take only 20 minutes by car. After getting off at several stops and walking to other stops, with her last bus running late, she arrived at the clinic and checked in at 11:50 a.m. for her 11:30 a.m. appointment. The receptionist informed her she missed the appointment and would need to reschedule. Unsure of her work schedule, she declined and left. She then had to inform her job she could not work that day due to childcare issues.

Ms. Hanney demonstrated what the mother would be carrying with her to make it to the appointment she could no longer attend because she was late. She was encouraged to attend the appointment knowing that it would impact her work schedule and the ability to care for her children. Unfortunately, she could not afford to reschedule the appointment and jeopardize lost wages that provide care. This scenario goes unseen and unspoken of.

Ms. Bullock stated one group of women she works with are non-violent offenders who keep their babies with them in prison. Housing prior to the COVID-19 pandemic was a large issue and has become more so since. These women would provide their probation office with an address of a family member or friend, but if they lived in public or Section 8 housing, taking in an ex-offender could cause them to lose their housing.

She tells a story of a client who was eight months pregnant in a prison where one of the guards died from COVID-19 and allowed the women to leave if they had somewhere to go. Her client was desperate to leave, but she was unable to arrange for a place or shelter to go to. After two weeks, Ms. Bullock received a call from her and scheduled an immediate appointment to visit where she was staying. Arriving for the visit, an elderly man in his late 70's or early 80's came to the door and took Ms. Bullock back to meet with her client.

As Ms. Bullock and her client were talking, she came to find that the elderly man used to pay her client for

sex. The conversation shifted to the dangers of sexually transmitted diseases for her and her unborn baby and the resources available to her. The next day, the client called and stated she could only stay with the man if she had sex with him. Luckily with the aid of Ms. Bullock, arrangements were made so her client could stay with a friend. This story is just one of so many examples of the housing crisis people are experiencing.

Committee Questions and Discussion

- Dr. Ehlinger, directing a question to Ms. Hanney, asked how changes are made to accommodate every pregnant woman and community member and whether there is flexibility to accommodate those challenges.
    - Ms. Hanney explained that they are lucky to have community partners to provide financial assistance, coupons for baby supply stores, and funds to provide bus tickets, and are trying to partner with Uber and Lyft. They are also connected with a local hospital, Eskenazi Health. Many moms do not go to postpartum appointments for various reasons, but they are trying to work on expanding their hours to include weekends and evenings to accommodate more mothers, she said.
- Dr. Barfield asked how telehealth would be able to help or hinder in the scenario she provided.
    - Ms. Hanney stated that at the moment, the program can only provide telephone visits, but they are trying to do live webcasts as a way to connect with the mothers. Issues arise with mothers not having a smartphone or access to a computer. But with COVID-19, home visits are on hold, and they would need to come in face-to-face. Additionally, there are a lot of barriers that may not have been at the forefront, so things are being done to help as much as possible during this time.
- Ms. Pettiford asked Ms. Bullock what work is being done with the correctional system to support incarcerated pregnant women during COVID-19.
    - Ms. Bullock responded that recently they have been able to counsel and work with those women to enroll them over the phone. In prison, you have to pay for telephone calls, so she has had the opportunity to directly speak with those women and help them transition from incarceration. She explained that they are also working with the housing authority to change the circumstances for housing formerly incarcerated people in public housing.
- Dr. Peck asked Ms. Hanney what she and the Healthy Start staff are doing and what they need to do better, particularly related to the extra pressure and burden with helping your community while dealing with personal stress.
    - Ms. Hanney said that since telecommuting in March, she has implemented a wellness check with her staff/team as a way to help structure work while at home. This has provided a time for everyone to get together on a video call to socialize and lift everyone's spirits.

REVIEW AND APPROVE MINUTES FROM DECEMBER MEETING

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Dr. Ehlinger informed the Committee that the meeting minutes from the December meeting were included in the briefing book they received. Dr. Janelle Palacios made a motion to approve the minutes and after a virtual vote, they were approved.

IMPROVING MATERNAL HEALTH ACCESS, COVERAGE, AND OUTCOMES IN MEDICAID

Steven E. Calvin, M.D.
SACIM Member

Karen E. George, M.D., M.P.H., F.A.C.O.G.
Senior Fellow, Women's Health Policy, Institute for Medicaid Innovation
Clinical Associate Professor of Obstetrics and Gynecology, George Washington University School of Medicine and Health Sciences

Dr. Calvin introduced the next presenter, who is part of the Quality and Access to Care Workgroup. Dr. George and her colleagues at the Institute for Medicaid Innovation produced a comprehensive study entitled "Improving Maternal Health Access, Coverage, and Outcomes in Medicaid." The work being done utilizes resources from all around the country to determine both backgrounds on where Medicaid funding stands and the access and coverage for maternal health. The co-presenter was having connectivity issues, and only Dr. George presented.

Dr. George explained that the Institute for Medicaid Innovation is a non-profit, non-partisan research organization dedicated to providing information, data analysis, and innovative solutions that address the important clinical research and policy issues in Medicaid. The project included a large group of stakeholders who function across clinical policy and research. The scope of the maternal health disparities for individuals enrolled in Medicaid include: the rising rates of maternal and infant mortality and morbidity, an increase in costs, the traumatic experience patients have, a shortage in the workforce, unmet social needs, implicit bias, and structural racism.

The Midwifery-led Models of Care has provided comparable or improved care for low-risk women across decades compared to physician care. However, many women enrolled in Medicaid don't have access to that model of care and they believe expanding the option to the Medicaid population provides an opportunity to improve maternity care value. So, the key elements of the project were to focus on the was Midwifery-Led Models of Maternity Care, both in-hospital birth centers, and Home Visiting Programs that include community health workers and doulas to serve this population.

The project involved many components of work which were:

- Comprehensive review of the current evidence
- Environmental scans of innovation initiatives and the best practices
- Developing the value proposition with added interest in business case and a return on investments
- Identifying the variation between states and the opportunities or barriers within policy
- Developing the tools and resources to support the implementation of the project

Dr. George detailed that through their research and environmental scans, the group was able to identify several recurring and interconnected themes. Establishing a business case was necessary, and the group recognized that midwifery-led model expansion depends on the return of investment. Organizations faced financial barriers with the Medicaid population, including reimbursement, certification, and licensure challenges. These barriers were common across all organizations. Furthermore, the organizations were community-focused and already aided the improvement of health equity.

Falling into three categories, the group identified opportunities for expanding midwifery-led models of care:

- Clinical Opportunities:
    - Developing care team models to increase access all stages of maternity care
    - Increase professional and public awareness of benefits
    - Assessing appropriate levels of risk to drive the type of care options for the individual when they need it
- Research Opportunities:
    - Identify ROI for the inclusion of Medicaid within the model of care
    - Documenting state-to-state variation between Medicaid policy with midwifery practice, integration, access, and birth outcomes

  - Continuing to develop models of evidence within Medicaid
  - Developing public reporting metrics

- Policy Opportunities:
  - A statewide, multidisciplinary, maternity-led model of care commission
  - Removal of barriers of equitable reimbursement
  - Statewide billing requirements
  - Supportive statewide policy increasing and supporting freestanding birth centers that are led by and serve people of color

The project's next phase is the development of a national web-based learning series slated to begin late summer 2020 and run through spring 2021. This series will consist of eight learning sessions on six core areas. Dr. George provided her contact information so any interested parties can contact her about the event as it is by invitation-only.

Committee Questions and Discussion

- Dr. Ehlinger asked for her experience in clinical practice during the current pandemic.
  - Dr. George is an obstetrician at George Washington University Hospital. They have been "platooning," working in teams where they cover labor and delivery for a week and then rotate to clinic for a week and then rotate back. This is meant to decrease exposure. She added that everyone admitted into the hospital is tested and that the majority of COVID-19-positive patients are asymptomatic who did not know. At GW, Hispanic and Black patients are testing positive more than white patients.
- Stated within the webinar chatroom, a high percentage of midwife-assisted births tend to be wealthy white mothers. The commenter asked how it is managed when measuring the impact of midwifery models versus traditional hospital births.
  - Dr. George stated that it was not controlled but was looked at. By understanding the barriers states have, that can help to improve the outcomes.
- Dr. Conry commented that ACOG and ACM have a history of collaborating around certified nurse midwives and certified midwives, and they are seeing a trend starting. She has the privilege of collaborating in managing labor and delivery, managing patients, and assisting with needs, all of which helps with birth outcomes.
  - Dr. George agreed completely from experience in working collaboratively with midwives and stated she has learned patience for the natural process from them.
- Dr. Barfield asked: Given the need for more midwife providers in this area, how would issues of increasing diversity and reducing cost of training for midwives be impacted? She commented that education and areas of certification may cause disparity or reduced opportunities for minority midwives to advance within the profession.
  - Dr. George said that it is a very important pipeline issue and that midwifery schools are making diversity a prime goal. Women who are certified and culturally conforming are more comfortable with their care and provider, and any effort to help create educational opportunities and relieve financial burden will improve outcomes and diversity.
- Dr. Ehlinger shifted the topic to doulas and the diversity of the workforce for a group that's underpaid or not paid. How do we advance that and how do we get them paid? Furthermore, is there enough information that doula services would qualify under the clinical preventive service task force criteria for preventive services?
  - Dr. George replied that they definitely should be. There is an abundance of data that supports increased outcomes for women who have doula support during labor and delivery.

We've become increasingly aware of the problems pregnant women have accessing work and their appointments, and it would be beneficial to have someone help them navigate that. Doula activities can provide better birth outcomes.

- Ms. Pettiford noted that North Carolina has had issues getting obstetricians to allow certified nurse midwives to practice with full authority. It would require legislative change, and the OB/GYN society is not supportive.
  - Dr. Conroy commented that, when it comes to legislative decisions, it has to do with defining a midwife and lumping midwives under one category. She suggested to speak with the state board to determine the issue and work around that.
  - Dr. George replied that if more residents are trained with midwives and directly supervised by them, she believes there would more understanding of their value.
- One question grew out of the discussion regarding recommendations to support and sustain birth centers that are led and owned by women of color.
  - Dr. George believes that the Medicaid reimbursement is not enough to keep the lights on. It's through commercial insurance or cash payment, and many end up doing that, but it is not sustainable. She stated that she feels there is the need to pay people for the work they do. Additionally, a lot of times a patient is transferred for a higher level of care and services. Prior to the transfer, the patient is not covered.
  - Dr. Calvin responded that progress is being made but sometimes it is very slow. Innovation could really help with payment of maternity care.

QUALITY AND ACCESS TO CARE WORKGROUP REPORT OUT

Steven E. Calvin, M.D.
Workgroup Chair, SACIM Member

Dr. Calvin explained that during the breakout conversation, Dr. George put forward the important issue of maternal health across coverage and outcomes of Medicaid. The other two topics discussed were telehealth, with a number of concerns. One is the lack of broadband access, which is an equity issue.

From that, there were great comments from Dr. Avery on Project ECHO and a model for telehealth/telemedicine. Ms. England also provided comment from the perspective of Indian Health in western South Dakota. There was also some information provided on newborn care and the types of consulting or care that can be provided via telehealth.

The other area the group discussed was fetal therapy issues and how congenital anomalies are such a large portion of infant mortality. There are problems around the country in dealing with these in utero issues and a lack of comprehensive evaluation.

Workgroup Discussion and Questions

- Dr. Calvin asked Dr. Barfield if the CDC has any ideas about the reporting and coordination of outcomes from fetal therapy or the access level to families.
  - Dr. Barfield responded that little exists, as they lack ways of determining prenatal or neonatal levels of care. The fetal therapy component is in discussion, but she is unsure of the progression. Organizations have been interested in looking at fetal therapy as well as the levels of fetal therapy care. She believes this may evolve as more is learned.
- Dr. Ehlinger asked if there is anything that should be considered as planning goes on for the September meeting.
  - Dr. Steven Calvin said that the telehealth/telemedicine evolution will prompt a workgroup report on Medicaid access for both newborn and maternal care and maximizing the use of

funds in a reasonable manner. Something will be presented to the Committee during that meeting.

DATA AND RESEARCH TO ACTION WORKGROUP REPORT OUT

Magda G. Peck, Sc.D.
Workgroup Chair, SACIM Member

Dr. Peck stated that there were more than 10 participants during the breakout meeting. She thanked them for their work and engagement. The group's framework is to stay grounded by health equity, set the framework for SACIM, be informed by and learn from MCH history, bridge maternal and infant health with data for unified advocacy, and foster cross-sector collaboration. The gaps in perinatal data systems do not have overly new issues but have been exacerbated by the COVID-19 pandemic.

Some themes the group touched on were low capacity to generate data, incomplete datasets, the lack of a universal unique identifier or non-uniformity of data, hard or difficult sources, and the timeliness due to a slow government pace. There are issues within the data systems that have been considerably highlighted by the current situation, including gaps or limitations in unmeasurable or uneven data on racism, special populations such as incarcerated or undocumented, and unlinked data systems across various disciplines or sectors.

There are opportunities for innovation to strengthen data systems and capacity by taking what has been learned so far, adapting, and developing new surveillance approaches as seen in prior times of crisis. Opportunities are present in the way social media can be utilized as a tool for surveillance, data collection, and translating data into evidence-based messages. Other surveillance systems can be used to our benefit, both nationally and globally.

Dr. Peck presented that the group's opinion that more data may not be necessary, instead better use for the data already collected. There need to be connections made with other sectors and disciplines to create an architecture for trans-disciplinary intersectional data sharing. The group advised not to waste the crisis but seize the uninvited opportunity of it.

Workgroup Discussion and Questions

- Dr. Ehlinger noted that the report highlighted the need for all three workgroups to work collectively as their agenda fits in nicely with the other two, which is why the liaison group meets regularly to determine and promote collaboration, support, and the meaningful work of each workgroup.
- Dr. Barfield added that another thing noted by the group is the need for good data systems at baseline to enable quick action during other times of crisis and to continue to be innovative in all circumstances. For example, when issues surrounding Zika were compounded by Hurricane Maria hitting Puerto Rico, it provided an opportunity to develop a new hospital-based model to survey women in the hospital. The team implemented the survey and overcame physical and geographic barriers with a 92% response rate of pregnant women that included an 83% response rate from their husbands, partners, or fathers. The team was able to adapt and be nimble in the way they got the information.
- Dr. Peck added referenced the use of social media more broadly regarding technology. For example, Harvard School of Public Health launched a women's health study with Apple and tech-based surveillance utilizing Apple watches. She stated the need to think about private-public partnership opportunities and nimble innovations with surveillance. She suggests inviting the Dean of the Faculty at Harvard School of Public Health and MCH Epidemiologist, Dr. Michelle Williams.

EQUITY WORKGROUP REPORT OUT

Janelle F. Palacios, Ph.D., C.N.M., R.N.
Workgroup Chair, SACIM Member

Dr. Palacios and Ms. Pettiford are workgroup co-chairs, and the SACIM meeting highlighted their group's work even further. Understanding that health equity may take time to achieve, they provided some steps for the future. They discussed a number of underlying frameworks or systems, including human rights, life course, birth equity, and keeping institutionalized and systemic racism at the forefront.

The group identified some immediate steps for the Committee to take to improve maternal and infant health, such as champions of equity and accountability. There remains the need for protecting and focusing on a woman's health outside of her ability to reproduce. The group also gave examples of policies and programs that help vulnerable women and families and that provide critical support systems for maternal health, including surveillance. The group ended with discussions on long-term needs for a healthy environment and health equity with the other two workgroups.

Dr. Palacios concluded by addressing the Committee, referring to all the members are gatekeepers, each with power in our respective committee and organization roles, to know their privilege, and to share their power and wisdom and censorship so that we can guide the next generation. Furthermore, she wants everyone to think about moving some allies to accomplices, and to be aware of the injustices around them.

Ms. Pettiford added that connecting conversations and information is needed to bring allies to the table. The Committee needs allies to truly address equity, and they cannot just support the same entities as they always have but must think differently.

Workgroup Discussion and Questions

- Dr. Ehlinger asked how they are going to be an accomplice with the other working groups and if there are suggestions on making sure that happens.
  - Dr. Palacios clarified that in the first two group meetings, he asked the members if they were able to get to the core of the issues without fear of repercussion, and she believes that is one of the ways to be an accomplice – by being beside them, encouraging them, and/or lifting their voices with them.
- Dr. Peck commented that Omaha, Nebraska, recently declared racism as a public health crisis. She asked what that sort of policy looks like from a maternal and infant health perspective and challenged them to stay grounded in health equity but also an anti-racist entity.
  - Ms. Pettiford stated they have been discussing with national entities and levels of alignment and have reached out to other national and state efforts to have similar conversations around racism as a public health crisis. That is a larger conversation that the workgroup and the Committee need to have moving forward.
  - Dr. Palacios recommended staying informed by the history of MCH and work in racial justice, to connect with colleagues in food, housing, and criminal justice to work together and strive to dispel racism.

STORIES FROM COMMUNITIES: Continued

Jessica Roach, M.P.H.
Co-Founder and Executive Director, Restoring Our Own Through Transformation

Nicolle L. Gonzales, C.N.M.
Executive Director, Changing Woman Initiative

Jessica Frechette-Gutfreund, L.M., C.P.M., M.S.M., I.B.C.L.C.
Executive Director, Breath of My Heart Birthplace

Ms. Roach addressed some of the actions within the organization's community that are directly related to Black maternal and infant health. She prompted the Committee to imagine what it is like to be an 18-year-old, single, Black woman living in project housing and preparing for the birth of her child. Although she falls within all of the social determinants considered to be risk factors – a Black woman, living in poverty, lacking education, and unmarried – she has a strong social support system through her family. She ultimately had a healthy pregnancy and gave birth to a healthy child.

Seven years later, she was married, working as a nurse, and pregnant with her second child. At 20 weeks, she had fluctuations with hypertension and blood pressure readings, which led to preeclampsia and needing an emergency induction at 34 weeks and five days. Concerned by the difficulty of her pregnancy as she had a healthy and successful previous one, her provider told her that these are the risk factors and complications because she is Black. During her third pregnancy, she was immediately informed of the high risk for a premature birth because she's Black and has had one before.

Deciding the problems were not because she was Black, but instead the environment she lives and works in, she chose a different form of care, one following a midwifery model with a culturally competent healthcare provider. She gave birth to her third child with no issues at 42 weeks. There were no issues for baby or mother. No matter what this woman has achieved or done, institutional and systemic racism consistently place the blame on her as a Black woman.

Ms. Roach said stories like these are why it is so important to continue working to address these issues. She then revealed this was her personal story. She now is the Founder of ROOT, which and serves the Black community. Her organization currently has a 0% Black maternal and infant mortality rate.

Ms. Gonzales is Navajo from the Navajo Nation and has founded the Changing Woman Initiative to serve Native American families. Native American women have higher rates of infant and maternal mortality. She has been working with Native families within the Pueblo and Navajo communities since transitioning out of hospital work. She hears the stories from the communities and is privy to the dynamics of the systems and barriers for those women, particularly if they have care through Indian Health Services.

Her organization supports traditional indigenous birthing practices and working with traditional healers for women who want their babies born within their traditional songs and ceremonies. They provide support for their local healing providers but also from the perspective of a nurse midwife or midwife who is Native. One story is of a woman she had provided care for in Gallup, New Mexico, a three-and-a-half hour drive each way. She was living with her partner's family where she had no privacy or space. She was working through the traumatic events from her past, including physical abuse from prior partners, sexual abuse from a family member, as well as personal trauma.

While she was living with her boyfriend's family at the time, she had a tough situation to navigate to experience giving birth at home. There were concerns and fears of having a safe home delivery. The home birth was a beautiful experience with the living room full of relatives, including her grandmother, mother, and aunties to welcome the baby. She felt empowered to deliver in a traditional manner and with a traditional midwife.

Six months postpartum, she and her partner broke up. Not having a place to go, she had to continue living with him and experienced severe postpartum depression. At times, she had tried to ask for mental services through the IHS Hospital ER, and they felt her needs were not important enough. She also sought help through another local mental health provider, but she did not have transportation for the hour-long commute. Additionally, throughout her postpartum depression, she was using medical marijuana to help with her mood and depression. This caused her mother-in-law to threaten to take the baby away and call the police on her under the assumption that she was doing drugs.

Ms. Gonzales' organization put her in touch with an attorney to protect her rights as a mother and with a mental therapy service to get help through her postpartum time. This situation reflects the lack of support for Native American women in their communities, in their own homes, and in their families. These are common family issues that are experienced in all Native communities, and Native women will experience some form of trauma that will impact their ability to have a healthy future. To support mothers, the Changing Woman Initiative focuses on providing paid care for doula support. It also provides a weekly delivery of healthy and nutritious food up to six weeks postpartum. The deliveries include plant medicines from traditional medicine herbalists and local herbalists and are funded through grant money.

Native moms generally come to the organization for care feeling emotionally distraught and feeling judged. When they go to see their healthcare providers, they see them for 15 minutes or less and are asked many times if the person with them is the father of the baby. They feel disrespected and do not know how to express their needs in a hospital setting. For example, a hospital in New Mexico with COVID-19 guidelines was quickly separating moms and babies. These policy decisions are typically made behind closed doors and do not include the voices of Native women, so it is the organization's job to help navigate these systems, policies, and guidelines. Her question to the Committee was: How can you support Native women in these dynamic and trauma filled families where they are not supported?

Ms. Frechette-Gutfreund noted the repetitious patterns surrounding the combined effect of intergenerational trauma and how it impacts birthing people. She introduced her practice, Breath of My Heart Birthplace, a licensed birth center in Espanola, New Mexico, serving the rural and Pueblo-speaking tribes in that area. Compared to the national trend of women birthing at older ages, the population they work with is very young, providing an opportunity to understand those specific barriers experienced by young people of color within maternity care.

Sandy Martinez was a 17-year-old daughter of Mexican immigrants, and she and her partner were pregnant with their first child. She had left hospital care because she felt disrespected. She spoke with someone in the community who had birthed with their facility, and because New Mexico Medicaid would pay for her to have an out of hospital birth. With an indigenous doula, she had a very successful birth, and she was followed through the postpartum period. Her second child was born with the aid of Breath of My Heart Birthplace. Her second birth was more difficult for her due to a significant hemorrhage leading to very significant postpartum depression.

Sandy became an employee with the birth center doing advocacy work. She is now able to identify and put into words the experiences of other young birthing people. This has really helped the center identify specific barriers due to stigma, issues of systemic racism and poverty, personal and family trauma, and specifically, age discrimination. In New Mexico, age discrimination is a huge issue. A person needs to be 19 years or older to get social services or, otherwise, be legally emancipated. Many young mothers who qualify for food, transportation, housing, and medical supplies through the state do not have access, as they would have to go through their parents.

Before Sandy transferred care to the birthing center, her OB provider insisted that her mother sign all her paperwork. The provider also insisted that her mother was the legal decision-maker of the pregnancy, which is not the case. There is a lot of misinformation in the system regarding the decision-making power young people have for themselves and their children. This stems from age barriers and limits to decision-making power. There is also a significant issue with age discrimination in employment. Low-wage jobs are the only available positions, as management positions require being 21 or older. Other issues include the misconception of young parents not raising their children well, as well as racial profiling and deportation targeting.

Committee Questions and Discussion

- Dr. Ehlinger asked if there is a sense or pressure to move towards more home births. He also would like to get more insight on the relationship between mainstream medicine and its impact on health outcomes.
  - Ms. Roach reported seeing what has always been happening; there is not enough diversity among healthcare practitioners, and that causes significant distrust. Additionally, racism is not listed as a health risk factor. There is an assumption by many providers that Black women have higher risks for complications and are telling those women they are at risk because they are Black, leading to a coercion with types of care.
  - Ms. Frechette-Gutfreund agreed and pointed out the pattern seen by her center's population with coercion, especially with young parents and people of color around birthing choices and the type of care they receive, which should be their choice. There is a reaction of surprise and awe when they are asked for their decision or opinions on matters relevant to them. They are used to being told what to do, not asked. This is something that white people, particularly affluent educated populations, are not experiencing.
  - Ms. Gonzales noted that the IHS system on the Navajo reservation is a closed system and impacts the access of the number of home birth care and birth center care, and the policy impacts care providers' ability to serve them. All the rights and options of care are not being made available to Native women. There are a lot of challenges imposed on reproductive choices and options based on where the access of care is.

PUBLIC COMMENT

Lee Wilson
Acting Division Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration

Mr. Wilson stated that any written comments HRSA had received will be provided to the Committee and read out loud. None were received. There were a few requests from people who registered for the meeting to make an oral public comment. Each person was called by name, but none of the five people who requested to make on oral comments were present on the call. It is unclear whether this was due to technical issues or not being present on the conference line. The floor was then opened for anyone who would like to make a public comment.

Jessica Frechette-Gutfreund, L.M., C.P.M., M.S.M., I.B.C.L.C.
Executive Director, Breath of My Heart Birthplace

Ms. Frechette-Gutfreund reintroduced herself as one of the presenters, and she asked the Committee how community organizations can directly engage in more meaningful ways. She believes there is a consistent pattern where community organizations share stories, but there is no reciprocating response or invitation to the table of decision-making for maternal health policy and reimbursement on the federal level.

Mr. Wilson noted her comment and explained that the Committee has discussed this issue during this meeting and at previous ones. He explained that the reason the meetings are made public is to allow for public voices and opinions to be heard and to influence discussion and decision making. He encouraged to check the SACIM website for more information.

BY-LAWS DISCUSSION

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Dr. Ehlinger said that in SACIM's 31 years of existence, there have not been any official by-laws, only a statement from the Secretary on what the Committee does. The Committee asked questions about the need for by-laws and discussed what might be put into final form for the next meeting. He provided a list of

questions he thought of and wanted to get feedback on.

Dr. Ehlinger asked for input on having the appointed members changed to voting members and for the ex-officio members to become appointed members. He asked whether they should be included and added as voting members.

Dr. Peck added a technical comment, that as sworn-in members under the new title of voting members, the by-laws should cross reference the name changes when appropriate. This will add formality for the members who are voting. Additionally, this decision needs to reflect the fact that the Committee may be reporting directly to Congress because of the PREEMIE Act. Dr. Barfield suggested that as a full-time federal employee and the work the Committee does direct the activities of federal agencies, it is not appropriate for ex-officio members to be able to cast a vote.

Dr. Ehlinger asked if there are any thoughts on the establishment of standing committees, the ongoing tasks of them, and the rules for them. Dr. Peck expressed hesitancy to add formal structures, especially considering the need for flexibility in moving from deliberation to action, with the current iteration in place until 2021.

Mr. Wilson clarified that the current operations of the Advisory Committee on Infant Mortality are authorized and in place as its own Advisory Committee to the Secretary, and not held to the law concerning the PREEMIE Act since it was not appropriated. However, SACIM is working to meet the intent of legislation even without the appropriation. Essentially, it is not mandatory for a report to go to Congress, although, as an advising body, the Committee has the option to send such a report.

Dr. Ehlinger asked again about the idea of standing subcommittees, stating they could be handled either way but doing so would provide accountability with structure. Dr. Wise asked if there is value or improved functionality with having standing committees over working groups. Dr. Ehlinger believed it would add accountability through a necessary protocol in appointing members. The workgroups are temporary and provide flexibility. He doesn't believe it to add a lot at this point. Dr. Wise agreed that the Committee is small enough and grouped together well now but may be worthwhile should more members be added.

Dr. Peck explained that the by-laws should address what the Committee's operating principles are. The membership composition is lacking in terms of voices of color, which would hold the Committee accountable to the principles it strives for. She would include language about accountability, representation with membership, and leadership specifically on anti-racist work done by SACIM for preventing maternal and infant mortality. In response, Dr. Ehlinger asked the Equity Workgroup to review the by-laws to verify that SACIM has equity considered within every aspect. In terms of representation issues, he does not believe the by-laws are the place for that. He does believe that one of the recommendations of the Committee, not to the Secretary but a lead up to MCHB, is to look at membership and leadership to include individuals from communities and population groups that experience poor maternal and child health outcomes or stated similarly.

Mr. Wilson noted that the comments were being recorded. He also noted that the Committee had been asked previously to identify priorities for consideration in identifying and selecting future members of the Advisory Committee. A call had been made through the Federal Register for nominations for new or additional members. The Agency has since received those nominations and has begun the process of reviewing the applications and resumes. Dr. Ehlinger clarified that there is the availability to add 11 members, but he recommended that they should not all be added at the same time or the whole group would cycle off at the same time as well. Mr. Wilson stated that between 100 and 150 nominations were submitted.

Dr. Ehlinger expressed interest in working with those people within contexts of the workgroups or potential workgroups to begin to engage with them. Ms. Pettiford added that she is interested in how to go from the 150 down to five. Dr. Peck explained that a call was made in the Federal Register, but notice went out prior

to the pandemic and the current elevation of racism, racial injustice had not been as pronounced a public health issue. Further, would it be of advantage to revisit and provide clarity on the priorities and criteria or the filters for potential manner and proactively provide specific recommendations that way? Dr. Ehlinger asked Ms. Pettiford if she would be willing to survey the Committee members given her experience, and compile that for MCHB. She responded that she would be able to do that and provide the questions to him for review first and potentially to Dr. Palacios for an equity perspective. Dr. Ehlinger asked to include Dr. Calvin and Dr. Peck, as they are the heads of the other two workgroups.

Mr. Wilson stated that MCHB would welcome input and comments from the Committee. The process stipulates that those presented must provide resumes or CVs. A matrix for identifying important characteristics and representation is often used to manage skills, qualities and descriptions of those being considered, in order to guarantee broad representation. The final decision is made outside of MCHB; it is submitted to the Office of the Secretary, HHS. He again welcomed the Committee's input.

Dr. Ehlinger asked if there was any other feedback on the topic of by-laws. Dr. Peck expressed curiosity about why he had been serving as Acting Chair for a long time. Are there any implications or status considerations in having "acting" in his title? He believes there is no difference in role, but if he was named chairperson instead, it may extend his term. He doesn't want to speak for the Secretary and is content being an acting chair and doesn't need an official designation.

RESOLUTION ON RECOMMENDATIONS REGARDING COVID-19 TO HHS SECRETARY

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Dr. Ehlinger made the revisions concerning the wording and language used within the informal recommendations that are to be sent to the Secretary concerning COVID-19. He provided the Committee with those the previous evening and sent the ones provided by Dr. Conry from the Data and Research to Action Workgroup only recently.

Providing a quick review, the issue that came up on the second recommendation, originally the first, regarding the wording, which implied the expansions of capacity to freestanding birth units only. Alternative language was provided. He wanted to discuss it further with Dr. Calvin.

Dr. Ehlinger explained there was the suggestion of adding something that would bring attention to the most vulnerable populations. A new recommendation was added, since Recommendation One stated that, in light of the impacts of COVID-19 and vulnerable populations, investment and policy priority should be given to women and infants who are low income, homeless, immigrants, incarcerated, or members of a population of color or indigenous groups. Dr. Peck suggested a slight revision, adding "not to do worse living together." Ms. Pettiford mentioned when Joya Chowdhury was presenting to the workgroup, she had a hard time with the wording, something along the lines of "at risk". Dr. Ehlinger asked if everyone was in agreement with newer terminology and continued.

Moving through the document, back to the second recommendation, Dr. Ehlinger asked for Dr. Calvin's thoughts. Calvin replied that his primary issue was that the language made it seem like hospitals were the only option, even though they might be at capacity. Dr. Conry clarified things and that she wanted to be sure to prioritize labor and delivery. Dr. Jarris asked about the implications of the word "autonomous."

Dr. Barfield repeated her comment from the day prior, that autonomy would not be helpful during times of emergency and that it needs to be pro-collaboration. Dr. Jarris said he wanted to be shown the language as he is not sure on the wording. Dr. Calvin also reported not having the document available but believes to be following the changes accurately. Dr. Palacios then requested to change the wording on expanding access to birth options, accredited birth options through birth centers, accredited birth centers, and then recognize there may be labor and delivery units during a time of crisis.

Dr. Ehlinger made the comment that the reason these cannot be official recommendations was because we didn't have to vote. He feels that if it is postponed and done via email, it may have to wait until September, because he is unsure if they can get by with a non-public vote. He recommended leaving this as it is and approving it. Hearing no response, he moved on.

Dr. Ehlinger noted that Dr. Palacios suggested just having certified midwives, but he asked if putting in "certified nurse midwives and/or certified midwives" is agreeable within the whole document, which she agrees to. For Recommendation Six, the term "home visitors" was questioned by Dr. Conry, but Dr. Warren noted that within MCHB it is an accepted term and can be quite broad. It was then agreed to leave the term as is.

Dr. Ehlinger reviewed Recommendation Nine, on continuing eligibility. The comment provided by Dr. Conry was that it is covered through FMAP. Dr. Conry asked for confirmation. If it is, a reference should be included. Dr. Ehlinger agreed, said he would check to be sure, and he said he would put in the reference when confirmed. For the profession liability recommendation, Dr. Conry suggested using the term professional liability "protection" instead of "insurance" to broaden the scope. Both changes were agreed upon, hearing no concerns or comments.

Discussing the next recommendation, now number 12, Dr. Ehlinger asked what the Data and Research to Action Workgroup had put together. Dr. Peck had previously posted the recommendation into the webinar chat; she introduced the Strengths in Data and Surveillance Systems Across Sectors to Monitor Impact recommendation. The recommendation is: expand investments within robust data and surveillance methods systems, ensure the data be uniform and standardized, with the collection of full reports on race and ethnicity data, and that they support strategic research and evaluations, in order to monitor impact.

Additionally, she provided recommendation 13, which utilizes accepted data standards, promoting and supporting greater data sharing, and is compatible with systems across sectors. She noted that both of these recommendations could be reworded and consolidated. Dr. Ehlinger asked for feedback on the two recommendations presented. They were agreed upon by the Committee.

Dr. Ehlinger briefly reviewed the revisions and additions to the recommendations and asked if there were any concerns about them. Dr. Ehlinger asked for a motion to approve the recommendations with the provision that he write them all down and deliver them to the Committee. Should there be any major concerns, the Committee could have a call to revisit them, as well as the letter, which is not being voted on but will act as a cover letter for the recommendations.

Dr. Peck made a motion for the Committee to approve the current, edited recommendations to the Secretary with the understanding that final editorial improvements be made by the acting Chair and be submitted prior to July 1. Ms. Pettiford seconded the motion. Dr. Ehlinger asked if there was any further discussion.

Dr. Sander Lee added that there have been so many changes that she feels she is not ready to vote and approve the recommendations. Dr. Palacios and Ms. Pettiford emphasized the need to approve the recommendations during this meeting or it will never get done. Dr. Palacios then shared her screen so they can make the changes for everyone to clearly follow.

After a comprehensive review of the document, the motion was voted on and passed.

Dr. Ehlinger congratulated the Committee on the ability to address and work through issues to keep moving forward.

COMMITTEE DISCUSSION AND PLANNING FOR NEXT MEETING

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Lee Wilson
Acting Division Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration

Dr. Ehlinger expressed that the Committee still has work that needs to be done, and as a way to help with this issue, MCHB is supportive of it conducting three meetings per year. Hopefully they can all be in-person once the situation with COVID is addressed. He expressed how great presentations were and stated that the three working groups would be working over the summer. He said he would coordinate with the three chairs to harmonize them. He believes all three will be working to provide some recommendations during the September meeting. Additionally, he will finalize the by-laws with MCHB for the next meeting.

Dr. Sander Lee wanted to mention on the research she has been doing on infant mortality and COVID-19 and to work through the fears to review the numbers, which are pretty good, seeming to follow the pattern of SARS and MERS. Infant death and maternal death are rare. Dr. Ehlinger responded that he appreciated the information.

Dr. Peck added that the framework in maternal and child health about life course demonstrates the stressors and exposures. Dr. Sander Lee thanked everyone for their comments and added there would be a lot of work done before the next meeting.

Dr. Warren thanked the Committee and noted that the meeting had been remarkable to watch as they worked across the two days. He was appreciative of the voices of those invited to speak. Dr. Ehlinger noted that the Committee depends on them, the moms and their babies, their families, and communities, to really understand what is going on in the communities and what is impacting the health of everyone.

WRAP-UP AND ADJOURN

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Dr. Ehlinger thanked everyone for all their hard work and said he would be in touch with the minutes and the letter to the Secretary. He adjourned the meeting at 3:37 p.m.