

Secretary's Advisory Committee on Infant Mortality

Meeting Minutes of September 21-22, 2021

Virtual Meeting via Zoom

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DAY ONE: Tuesday, September 21, 2021

Welcome, Call to Order & Introductions

Vanessa Lee, M.P.H., Designated Federal Official, Maternal and Child Health Bureau, Health Resources & Services Administration

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

Ms. Vanessa Lee called the meeting to order and introduced herself as the new Designated Federal Official (DFO). Dr. Edward Ehlinger welcomed participants to the virtual meeting. Dr. Ehlinger spoke about current events, such as the United Nations' International Day of Peace and the first day of Sukkot and reminded Committee members that both peace and stable housing are social determinants of health that are especially important for mothers, infants, and children.

Dr. Ehlinger also spoke about the dichotomy of the current state of public health, in which there is great opportunity to effect change in the public health system, but also great challenge in working amongst seemingly incompatible perspectives. He suggested that SACIM has an opportunity to model respectful and responsible discourse when discussing controversial topics. He asked Committee members to remain grounded in SACIM's values as they discuss and develop recommendations, and to be bold in advancing those recommendations forward.

Recognition of David de la Cruz

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

Dr. Ehlinger recognized Dr. David de la Cruz for his 15 years of service as SACIM's DFO, and Dr. de la Cruz thanked Dr. Ehlinger and Committee members for the honor of serving. He commented that over the last 15 years, he has seen how SACIM supports a population that does not have a voice, representing them at the highest levels of HHS and beyond. He said that it is noble to serve this community and increase visibility on the policies and programs that can make an important difference. He encouraged Committee members to not be satisfied with the status quo or a "no" answer, but to be persistent in providing a voice to this often unheard and unseen population.

Welcome and Comments by HHS Leadership

Diana Espinosa, M.P.P., Acting HRSA Administrator

Ms. Diana Espinosa, HRSA Deputy Administrator and Acting Administrator, thanked Committee members for their work, especially in the last 18 months as they stayed active and engaged despite the challenges of the COVID-19 pandemic. Ms. Espinoza stated that SACIM provides a respected voice of counsel to HRSA, which shares SACIM's goals of preventing infant and maternal mortality and improving the health of all mothers and children. She noted that SACIM's commitment to eliminate health disparities and achieve better maternal and infant health outcomes in vulnerable populations is very much aligned with the priorities of HRSA and the HHS Secretary.

Ms. Espinosa provided an update on HRSA's recent activities that aligned with SACIM's recent recommendations to the Secretary. She noted the COVID-19 pandemic continues to disproportionately impact health workers serving rural areas and communities of color. In response, HRSA received \$100 million through the American Rescue Plan to fund efforts to

reduce burnout and promote mental health among health workers, including not only physicians and nurses, but also paraprofessionals, public safety officers, and others on the front line of delivering care to vulnerable populations. Additional efforts that she said HRSA has supported in response to the pandemic include a strengthening of telehealth services in rural and underserved communities and support for pediatric mental health care access.

Ms. Espinosa said HRSA is also responding to the recommendation to support pregnant women, mothers, infants, and children at the border and are striving to keep families together and safe. HRSA considers health equity to be core to their mission and will continue to emphasize health equity throughout all of their bureaus. Examples she noted from MCHB included providing supplemental funding for Healthy Start grantees for community-based doulas and infant health equity efforts. Dr. Espinosa then introduced the HHS Assistant Secretary for Health.

Rachel L. Levine, M.D., Assistant Secretary for Health (ASH), U.S. Department of Health and Human Services (HHS)

Dr. Rachel Levine thanked HRSA and MCHB for their dedication and leadership in the critical mission to reduce infant mortality and improve the health status of pregnant women and infants. She talked about the challenges that the COVID-19 pandemic created for public health and medical professionals and encouraged all to receive the COVID-19 vaccination and become spokespersons for the safety and effectiveness of the vaccination program.

Dr. Levine stated pregnant women are at higher risk for severe illness related to COVID-19 than non-pregnant women. Further, pregnant women with COVID-19 were also at high risk for preterm birth and other adverse pregnancy outcomes. She cited the CDC analysis of their [V-Safe](#) program data which indicated that there was no increased risk of miscarriage among those who received a vaccination in the first 20 weeks of pregnancy. Miscarriage typically occurs in 11-16 percent of pregnancies, and the rate for those who received the COVID-19 vaccination was only around 13 percent. Additionally, she shared that data suggested there was no safety concern for pregnant women, or their babies, vaccinated later in pregnancy. Combined, these data show that the benefit of the COVID-19 vaccination outweigh any known risk, and the increased circulation of the Delta variant has made the need for pregnant women to receive a vaccination more urgent than ever.

Dr. Levine said ensuring a healthier future for all means that health disparities must be addressed, and that health equity was a priority for HRSA and also for the Office of the Assistant Secretary (OAS). COVID-19 had disproportionately impacted communities of color, especially the Black, Latinx, and American Indian/Alaska Native communities. She shared how the Biden-Harris Administration was pursuing a comprehensive approach to advance health equity for all, including the creation of the [COVID-19 Health Equity Task Force](#), which would develop recommendations for President Biden.

Other updates Dr. Levine shared were the Office on Women's Health (OWH) was working to expand available maternal health data, creating a network of at least 200 hospitals that would deploy evidence-based best practices for maternity care and analyze outcomes to understand the clinical and non-clinical factors that contributed to health disparities. OWH would use these findings to scale advances in care for mothers and infants across the nation.

The Office of Minority Health (OMH) and CDC's Division of Reproductive Health launched a series of partnerships to support state maternal mortality review teams. They were also expanding the reach of the [Hear Her](#) campaign to include American Indian/Alaska Native women.

Dr. Levine closed by mentioning efforts to develop a standard definition of neonatal abstinence syndrome.

Discussion

Dr. Ehlinger stated that the Committee had sent COVID-related recommendations to the former Secretary last summer and then more recent ones this past August. He asked how SACIM recommendations reach the Secretary. Dr. Levine responded that they often come through the HHS Office of Women's Health, and in addition OAS worked closely with HRSA. Ms. Espinosa also answered that HRSA closely collaborates with the OAS and could look back to recommendations made in the previous administration because they were still relevant. Ms. Espinosa suggested that they could find a way to build in some regular, routine, structured way of making sure that the Office of the Secretary had an opportunity to engage in the recommendations going forward.

Dr. Ehlinger asked how the OAS might leverage SACIM and vice versa. Dr. Levine answered that one impactful action to take now is to advocate for COVID-19 vaccination, specifically for pregnant women. Dr. Levine explained that far too many pregnant women get COVID-19 and suffer medical complications, which has a potential negative impact on their babies.

Dr. Tara Sander Lee asked how HRSA and HHS plan on increasing vaccination rates at the border. Dr. Levine stated that there is an all-government response at the border, including from officers of the Public Health Service Commission, who have the important role of addressing COVID-19 vaccination at the border.

Dr. Ehlinger asked what could be done to restore the credibility of public health in general, when it is currently under attack. Dr. Levine answered that it is important to view public health professionals as frontline workers who need the same level of support, collaboration, and coordination as clinical frontline professionals.

Dr. Magda Peck asked for advice on handling the politicization of data when there is doubt and pushback on the messaging of science. Dr. Levine agreed that the politicization of the COVID-19 response has been a significant challenge and stated the pandemic response is a public health issue, not a political issue. She shared the Biden-Harris Administration was letting the public health and medical professionals lead the way through regular communication and collaboration. She also said the CDC had been transparent with their data, and the data was driving public health decisions. Finally, Dr. Levine commented that there was always an opportunity to improve communication about data and decision-making and they would continue to strive for that. She additionally noted the Surgeon General also had a program to address misinformation in social media.

Discussion of July 2021 Recommendations Submitted to HHS Secretary

Edward Ehlinger, SACIM Acting Chair

Dr. Ehlinger asked Committee members to reflect on how they have shared the August recommendations with partners in the public health and medical care fields. He shared the recommendations with all organizations representing maternal and child health, such as the Association for State and Territorial Health Officials (ASTHO), the American Public Health Association, and with his senators and representatives. Dr. Magda Peck said that she has engaged with her partners at the local level, such as CityMatCH. However, she noted that many organizations fail to understand the purpose and power of SACIM, therefore Committee members also need to communicate the importance of their efforts more generally. She said that the current structure of the Committee allows for greater diffusion of work and faster turnaround on recommendations. Dr. Belinda Pettiford said she shared the recommendations with the Association of Maternal and Child Health Programs (AMCHP), the National Healthy Start Association, and within her own state. She noted, however, that bandwidth has been limited due to the pandemic and the recommendations have not been a priority. Dr. Ehlinger added that there is a need for more efforts to proactively market and broadcast the importance of the Committee's work.

Mr. Lee Wilson said he has since received feedback from the Office of the Secretary to move forward with programmatic review and engagement within the department and across agencies (i.e., CDC, NIH, FDA, CMS) for application and interpretation of the recommendations.

Dr. Peck voiced interest in alignment with other Federal advisory committees related to maternal and infant mortality prevention, including opportunities to leverage parallel efforts occurring within HHS or across the government more broadly. Dr. Warren said some of this happens at the bureau level and through engagement with other agencies and departments across the federal government.

Dr. Paul Wise said his approach was to strengthen accountability and follow-up on the recommendations within HHS and beyond. He shared that he wanted to be able to gauge which recommendations were taken and which were not. He stated that if no action was taken on some, the Committee had a responsibility to understand why agencies may have chosen inaction despite the strength of the recommendations.

Update from the Maternal & Child Health Bureau

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

Dr. Michael Warren provided an update from MCHB, which included a summary of the recent \$350 million for maternal and child health: \$342 million was allocated to the [Maternal Infant Early Childhood Home Visiting Program](#) (MIECHV); and supplements were given to [Healthy Start](#) grantees, including 25 awards of \$125,000 each for doula programs and 21 awards of \$80,000 each to support the development of infant health equity action plans. He shared that the goal of the infant health equity action plans was to help Healthy Start sites engage new partners in the community and integrate a renewed focus on addressing social and structural determinants of health. The last supplement he described was for the State Systems Development Initiative (SSDI) which included awards to 10 states of \$60,000 each to enhance the quality, timeliness, and accuracy of their maternal health data.

Dr. Warren then shared that the President's proposed budget for fiscal year 2022 included several efforts related to the work of this Committee. There was a \$5 million increase for the [Alliance for Innovation on Maternal Health](#) (AIM) program, and a \$30 million increase for the state maternal health innovation program. He described these as grants to states to support the development of a Maternal Health Task Force to leverage data from maternal mortality review committees, vital statistics, and other datasets to identify and respond to areas of need. Dr. Warren also highlighted the President's budget proposed a \$1 million supplement to the Maternal Mental Health Hotline that would be in addition to the \$3 million previously allocated for this. He shared that the proposed budget also contained several new initiatives, including \$25 million for a pregnancy medical home demonstration project, \$5 million for implicit bias training grants for health providers, and \$1 million for a National Academy of Medicine study.

To conclude, Dr. Warren highlighted ongoing work of the Infant Health Equity Initiative, which aimed to eliminate excess infant deaths among communities of color and other marginalized populations and reach equity in infant mortality by 2030. Besides engaging a contractor to support planning, he shared that the initiative had convened federal partners internal to HHS and external to HHS, such as the Department of Housing and Urban Development (HUD). The meetings had yielded important information about ongoing and upcoming plans across the government, as well as alignment of investments across HHS. Dr. Warren also reviewed the work happening with HHS region 5, which has the highest rates of Black infant mortality and the highest absolute gap between Black and White infant mortality. A virtual infant mortality summit for that region was scheduled for early November 2021, which he could report back on at the December 2021 meeting.

Update from the Bureau of Health Workforce

Sheila Pradia Williams, RPh, M.B.A., Senior Advisor, Bureau of Health Workforce, HRSA CAPT Sheila Pradia Williams provided an update on recent activities at the [Bureau of Health Workforce \(BHW\)](#) in HRSA. She explained that the mission of the Bureau is to improve the health of underserved communities and populations by strengthening the health workforce and connecting that workforce to communities in need. She shared that BHW funds grant and direct service programs that seek to impact health professionals from education to training to service.

CAPT Williams shared that in 2021 and 2022, BHW had been emphasizing the importance of health equity. She explained that the COVID-19 pandemic in particular had spurred priority areas in behavioral and community health with a thematic focus on health equity, diversity, and provider resilience. BHW aimed to affect change by impacting access to care, supply of providers, and distribution. She reported that much of this work was supported by the [National Center for Health Workforce Analysis](#). CAPT Williams highlighted BHW's efforts to enhance health care quality through education and training programs that supported evidence-based, culturally competent, patient-centered care.

CAPT Williams highlighted several programs at BHW seeking to increase workforce diversity. One was the [Area Health Education Centers Program](#), which was designed to advance academic improvement-based partnership through longitudinal training and pipeline building among underserved communities. She explained that the longitudinal component involves revisiting

these individuals over the course of their professional education. Another effort CAPT Williams shared was the [Scholarship for Disadvantaged Students Program](#), a grant program that funds health profession schools to provide scholarships to students with economic need. She also mentioned the [Careers Opportunities Program](#), a pipeline program that used nontraditional methods to funnel disadvantaged individuals (e.g., financial need, language barriers) from high school through college and into a professions program. She shared that The Centers of Excellence Program focused on developing and strengthening institutions' capacity to diversify the health workforce in dentistry, public health, pharmacy, behavioral and mental health, and family medicine. Other programs she mentioned included the [Nursing Workforce Diversity Program](#) and the Loan Repayment and Scholarship Programs.

CAPT Williams described BHW's allocation of \$200 million in additional funds from the American Rescue Plan. She shared that to improve and distribute the supply of maternal care providers, BHW dedicated \$10 million for women's health nurse practitioners, obstetrics and gynecology nurse practitioners, certified midwives, and OB/GYN registered nurses. Additionally, she shared that in 2021 they added nurse midwifery as an eligible discipline in the [National Health Service Corps Student to Service Loan Repayment Program](#).

In the summer of 2021, she shared that BHW allocated \$16 million to a new effort, called Primary Care Training and Enhancement (PCTE), a community prevention and maternal health program. She explained that PCTE trains primary care physicians in maternal care, clinical services, or population health to improve maternal outcomes and increase maternal health care expertise among primary care physicians.

Through the National Center for Workforce Analysis, CAPT Williams said BHW has projected upcoming changes in the workforce that would inform the development of new policies and programs. She shared that they projected that by 2030, the supply of OB/GYNs would decrease by 7 percent, while certified midwives, women's health nurse practitioners, and women's health physician assistants would increase by 32 percent, 89 percent, and 56 percent, respectively. Importantly, she explained that these increases were not expected to occur uniformly: some states and regions would have an oversupply (up to 157 percent of need) and others would have an undersupply (as low as 57 percent of need).

Update from the Office of Minority Health

Juliet Bui, M.P.A., M.S.W., HHS/Office of Minority Health

Ms. Juliet Bui highlighted HHS Office of Minority Health (OMH) fiscal year 2021 [grant initiatives](#) relevant to the Committee. The first was a "Framework to Address Health Disparities Through Collaborative Policy Efforts" initiative (MP-CPI-21-003, MP-CPI-21-004) to identify and address policies that created or perpetuated health disparities by contributing to structural racism. She explained that the initiative was comprised of a coordinating center and demonstration project sites that work together to demonstrate the effectiveness of a methodological framework for identifying these policies.

Another grant initiative she discussed was the Minority Leaders Development Program (MP-CPI-21-008), which will support a fellowship program at HHS for early-career individuals to provide training focused on health equity issues and to develop the skills and competencies

necessary for federal leadership. She shared that the program will support efforts to promote diversity in senior positions at HHS agencies.

Ms. Bui also mentioned the Center for Indigenous Innovation and Health Equity project (MP-CPI-21-007) which will support education, service, policy development, and research related to advancing sustainable solutions to address health disparities among American Indian/Alaska Native, Native Hawaiian, and Pacific Islander populations.

Last, she shared that the Accessing Social Determinants of Health Data through Local Data Intermediaries initiative (MP-CPI-21-002) will seek to demonstrate the capacity of existing local data intermediaries to facilitate community stakeholder access to and use of social determinants of health data. She explained that the initiative will work to increase community stakeholders' skill and capacity to use and apply these data to reduce health disparities in all racial/ethnic minority populations. She concluded by stating that these projects were anticipated to begin September 30, 2021.

Discussion

Dr. Steve Calvin, as a recipient of a National Health Service Corps scholarship in the 1970s, expressed gratitude to CAPT Williams for her work. He asked how HRSA is communicating these opportunities to potential scholarship recipients. He also wondered about support for the Nursing Workforce Diversity program. CAPT Williams answered that HRSA does conduct engagement activities through social media, schools, health care associations, and virtual job fairs. In terms of support for nurse practitioners and midwives, she explained that BHW grants did not have direct service components, but they did have grants to institutions to strengthen their ability to recruit and train. She shared that she anticipated expansion in the future in the number of programs and institutional capacity to advance the nursing workforce.

Dr. Janelle Palacios asked about plans to expand the [Primary Care Training and Enhancement-Community Prevention and Maternal Health](#) (PCTE-CPMH) model to emergency department staff. Additionally, she wanted to know about linkages to primary care and academic health centers for vulnerable women and infants living in rural communities. CAPT Williams said the programs focused on residency and fellowship training for family medicine and primary care, but there were no specific mechanisms for emergency medicine. She added that each proposal specified a different way to link vulnerable, complicated patients to primary care.

In light of the ongoing influx of refugees and immigrants, Dr. Ehlinger asked whether HRSA was looking to engage foreign-trained physicians in clinical practice. CAPT Williams said that BHW grant programs typically required trainees to be U.S. citizens or permanent residents. There were no particular programs specifically focused on foreign-trained physicians.

An attendee asked about work at BHW to optimize dispersion of limited resources across states in the context of COVID-19. CAPT Williams replied that the pandemic emphasized the importance of training and licensing nurses to practice in multiple states. She shared that from a workforce perspective, BHW planned to encourage promotion of these efforts to state associations and licensure groups.

Dr. Palacios asked about funding or nurse midwifery schools and if there was demographic tracking upon entry into a school (e.g., proportion of self-identified minority students and proportion who graduate). CAPT Williams confirmed that diversity programs collect some of this information during the application process. She shared that institutions may receive priority points based on meeting certain benchmarks for students from underrepresented minorities, of disadvantaged status, or from rural and underserved backgrounds. She further detailed that performance measures have also enabled BHW to track and collect program data, such as enrollment and graduation rate. She explained that they have developed a scorecard to compare certain performance metrics such as diversity of trainees and efforts to retain, support, and graduate them.

Race Concordant Care and Other Strategies to Advance Racial Equity in Maternal and Infant Health

Belinda Pettiford, M.P.H., SACIM Member – Moderator

Ms. Pettiford introduced race-concordant care as a possible way to reduce disparities in birth outcomes. As the Co-Chair of the Health Equity Workgroup, she shared the workgroup's focus on race-concordant care was based on its impacts on access to and utilization of care from relationship-building. The workgroup also recognized that communities should have the option to select providers who look like them and understand their specific needs. She explained that while the majority of the U.S. population already had access to race-concordant care, BIPOC populations typically did not. She then introduced the panel of speakers who would provide an overview of race-concordant care, the importance of respectful care, and methods to strengthen the diversity of women's health care workforce pipelines.

William McDade, M.D., Ph.D., Chief Diversity, Equity, and Inclusion Officer, Accreditation Council for Graduate Medical Education (ACGME)

Dr. William McDade explained that race-concordant care is care by a provider who shares the patient's racial/ethnic identity. He stated that patients may have sought out physicians of the same race/ethnicity for comfort, language concordance, safety, trust, and a shared worldview. He similarly stated that physicians may have chosen to disproportionately care for patients of their same race/ethnicity as a result of race-conscious professionalism, a sense of societal contribution, and recognition of the unique role they can play in their patients' lives. He cited a study from Johns Hopkins that suggested that race-concordant care enables physicians and patients to find common personal beliefs, values, and styles of communication.

Dr. McDade informed the Committee that the benefits of race-concordant care were well known. He explained that perceived personal similarities between patient and physician increase trust, satisfaction, and adherence to medical advice. He additionally stated that clinical access improved among individuals who would rather forego care than receive it in a dehumanizing or disrespectful environment. Dr. McDade also cited an Oakland study that found that cardiovascular disease morbidity and mortality decreased by 19 and 10 percent, respectively, when Black men were seen by a Black doctor compared to a White doctor. He also cited another study that found that Black newborns were up to 56 percent more likely to survive when treated by a Black doctor.

However, Dr. McDade cautioned against dependence on race-concordance care to eliminate health disparities given that inequities are driven not just by medical factors but by social determinants of health, including lack of access to healthy food, community and interpersonal violence, pollution and toxicity, housing insecurity, poverty, inadequate transportation, and other key environmental factors that mediate a person's health outcomes.

He stated that accordingly, efforts to improve the workforce are insufficient. He shared that data from the [Accreditation Council for Graduate Medical Education](#) (ACGME) indicated that the percentage of Black residents in the workforce has not changed at all in the last 15 years, and the percentage of Latinx individuals has changed insignificantly. To increase the proportion of health care workers from these historically marginalized groups, he said that workforce efforts must change. ACGME has been working to educate and deploy medical students from underrepresented groups, who are disproportionately likely to report that they plan to practice in an underserved community. Dr. McDade reiterated that communication, trust, safety; fair performance measures; and incentives for non-marginalized physicians to work in underserved areas were key for improving health outcomes in marginalized populations.

Patricia Loftman, C.N.M., M.L.M., M.S., FACNM, Chair, BILPOC Committee, New York Midwives; Member, New York City Department of Health & Mental Hygiene Maternal Mortality Review Committee

Ms. Patricia Loftman provided a midwifery perspective on race-concordant care. She emphasized that maternal mortality remains a key indicator of inequity, which has been more strongly impacted by social determinants of health than by behaviors and clinical care. To illustrate the importance of race-concordant care in maternal health outcomes, she presented data from the Listening and [Giving Voice to Mothers](#) survey conducted by a research group called the Birthplace Lab.

The data Ms. Loftman shared showed that women of color have consistently reported disrespectful care from obstetrical providers, and many mothers have described several discriminatory practices during childbirth and their hospital stay. The data showed that one in six women reported being mistreated during childbirth, including violations of physical privacy and threats to withhold treatment. It further detailed that these mistreatments were more commonly experienced by Indigenous, Latinx, and Black women. It showed that nearly one in three Black women who gave birth in a hospital reported interest in home birth for subsequent delivery, and 28 percent said they experienced more mistreatment in a hospital setting than in community settings.

Ms. Loftman noted that the midwifery community was small, comprised only 13,500 midwives across the country, 90 percent of whom were White. She noted that of the 40 available Midwifery Education Programs, 87 percent were headed by White service directors, and 75 percent of faculty were White. To increase the number of midwives of color, she stated that the field needed to migrate away from predominantly White academic institutions and into historically Black colleges and universities (HBCUs).

To improve diversity along the midwifery pipeline, Ms. Loftman said there was a need to increase the number of students who graduate to become practitioners, to increase faculty in

midwifery education programs, address practitioner retention upon graduation, and strengthen funding for research on race-concordant outcomes. She suggested that efforts to address workforce diversity could include federal legislation for workforce diversification, such as the MOMS Act and the Momnibus Bill. Critically, she stated, funding must include accountability metrics to ensure that students of color are equitably enrolled, graduated, and employed.

Discussion

Dr. Pettiford asked about specific recommendations for SACIM to strengthen and diversify the current pipeline. Dr. McDade cited legislation prepared by the House Ways and Means Committees, which aimed to enhance the pipeline of individuals from underrepresented minority backgrounds.

An attendee pointed out the focus on certified nurse midwives rather than certified professional midwives and certified midwives. Ms. Loftman said that the American College of Nurse Midwives (ACNM) represented certified midwives and certified nurse midwives, while certified professional midwives may have fallen by the wayside because they did not work in hospital settings. Ms. Loftman explained that they were only legal in 38 states, so SACIM could support legalization of certified professional midwives in all 50 states. She suggested that doulas were another opportunity to improve the pipeline into midwifery education.

Dr. Palacios wondered about the activities the Committee should address in the next two or three decades to preemptively address the anticipated shortage of nurses, physicians, and midwives. Dr. McDade said the first step was to address the wealth gap with respect to underrepresented minority groups and the majority community. He emphasized the importance of early education and noted a need to build infrastructure to improve preparation for higher education. Otherwise, he stated, the Committee can work to expose people to job-sharing opportunities and research participation to broaden the pipeline. Ms. Loftman agreed and said efforts should increase the visibility of midwives and especially midwives of color. She said a goal should be to enable any certified professional midwife student who graduates from an accredited formal education to be legal in the state in which they would like to practice.

Dr. Colleen Malloy asked about the overlap between violence and reduced life expectancy in underserved communities. Dr. McDade responded that social determinants of health more strongly impacted poor outcomes in African American communities than did gun violence. He stated that while peaks in violence have contributed somewhat, low life expectancy in these communities largely had preceded rampant gun violence and was more likely attributable to lack of access to care, quality food, education, and transportation. Dr. Malloy also pointed out some concerns about the study that race discordance in a Florida neonatal unit was associated with higher mortality among Black babies. She stated that the physician rated (by photographic identification of race) for race concordance with the infant was the admitting doctor, who may or may not have provided the majority of care for that infant's stay. Dr. McDade agreed that the study had its limitations and added that there was a need to collect race/ethnicity information from practitioners for a more direct analysis of the impact of race concordance.

Dr. Wanda Barfield noted that the Committee should acknowledge historical missteps and systemic obstacles to pipeline diversity, particularly student debt. Ms. Loftman answered that

most midwifery students qualified for national health training for loan repayment, which eliminated this barrier. She said that other obstacles were more challenging, and policy makers should revisit important legislation like the Bakke Decision. Dr. McDade agreed that there was a need for federal support for students in post-bac programs, whose quality of work may have suffered from concurrent employment to pay for the program.

Data to Action: Strengthening MCH-Related Sentinel Event Review Approaches, Systems, and Uses

Magda Peck, Sc.D., SACIM Member – Facilitator/Moderator

Dr. Peck opened the Data to Action panel by talking about how data to action is defined as data that was used for accountability, advocacy, and impact. The panel was focused on maternal, infant, and child mortality reviews, which was a methodology that looked at each event to consider the different determinants of health involved in the outcome, what changes may have prevented the outcome, and at what levels those changes needed to occur. Dr. Peck shared that in December 2019, SACIM received a comprehensive briefing on maternal and infant mortality reviews from MCHB and CDC, which included how mortality review methods were being adapted for morbidity reviews. She reported that as a result of these presentations, SACIM included recommendations specific to mortality and morbidity reviews in their recommendations to the Secretary.

The presentations on this panel took a deeper dive into the comprehensive, coordinated, and community-engaged case review systems designed to yield data for action. Dr. Peck asked the panelists to address how to align data for the greatest impact, what was needed to strengthen their case review tools, what success would look like, and how the COVID-19 pandemic had affected the review process.

Julie Zaharatos, M.P.H., Division of Reproductive Health, CDC

Ms. Julie Zaharatos talked about the Maternal Mortality Review Committees (MMRCs) at the [Maternal and Infant Health Branch](#) of CDC and the state- and local-levels of the maternal mortality review process. She explained that the purpose of the reviews was to gain insight about maternal mortality through a better understanding of the medical and nonmedical contributors to these deaths and to develop and prioritize recommendations to prevent deaths in the future. She shared that the sources of data included death certificates; medical, social services, and mental health records; autopsy findings; and, in some cases, informant interviews. She reported that the MMRCs include representatives from public health, clinical, and community sectors.

Ms. Zaharatos shared that in 2016, the CDC began to work with the existing 20 MMRCs in the U.S. Since then, CDC has helped the existing MMRCs build better data systems, stood up 25 new state and local committees, and created training and networking opportunities. She stated that there were currently 50 state and local MMRCs. Of these 50 MMRCs, 48 used the [Maternal Mortality Review Information Application](#) (MMRIA or “Maria”), a CDC data system that provided a common data language that facilitated a more comprehensive data collection and, ultimately, improved prevention efforts. She reported that in 2021, CDC received Congressionally-appropriated funds to fund 30 review programs through their [Erase Maternal Mortality Program](#), which has supported mortality review documentation opportunities, training,

and other technical assistance. Ms. Zaharatos shared that these funds were leveraged during the COVID-19 pandemic to provide virtual opportunities for peer learning.

Ms. Zaharatos reviewed some existing MMRC data on pregnancy-related deaths by race, which showed racial disparities. She stated that this data supported the development and prioritization of interventions that specifically addressed these disparities. She offered the example of how MMRIA collected both quantitative and qualitative data on risk factors, such as mental health, domestic violence, incarceration, and substance use, as well as instances of racial discrimination and bias. She noted that this data can lead to change. She explained that states were reporting on their MMRIA data, which led to the development and implementation of state-level policy recommendations, such as extended Medicaid coverage.

She further shared how CDC had invested in data quality processes, ensuring that data collection was consistent, accurate, and timely. They also worked towards ensuring that MMRCs had diverse representation in both clinical and community expertise and experience. CDC intended to invest more in routine qualitative data review processes, including informant interviews specifically from patients and family perceptions of providers and systems. They developed a next-of-kin interview guide that was currently implemented by a few MMRCs. Ms. Zaharatos explained that these interviews are critical in identifying the important role of discrimination and bias in maternal mortality. CDC worked with government and university partners in the development of the Community Vital Signs dashboard, which helps identify community-level indicators of risk and disparities. They anticipated that MMRIA users would have access to Community Vital Signs by September 2022.

Ms. Zaharatos closed by talking about the CDC's work with the National Indian Health Board to ensure that MMRCs have tribal representation to represent the specific cultures and needs of tribal-led communities.

Sara Kinsman, M.D., Ph.D., Director, Division of Child, Adolescent and Family Health, HRSA/MCHB

Dr. Sara Kinsman presented on the MCHB's [National Fetal, Infant and Child Death Review Program](#), which has been in place for over 30 years and provides critical insight for both the [MCHB Title V Block Grant](#) and the Healthy Start programs. The goal of the Fetal Infant Mortality Review (FMIR) has been to increase the number of first birthdays and the goal of the Child Death Review (CDR) has been to keep children alive—both accomplished through the identification of individual, clinical, and community risk factors and the development of recommendations for change.

She explained that CDR is a multidisciplinary process to better understand why children die and develop prevention efforts to reduce those fatalities. The reviews covered child deaths from infancy to age 17. She reported that there were approximately 1,300 CDRs in the U.S. across all 50 states and Washington, D.C. and nine of these states were currently developing tribal CDR teams. She shared that state legislation impacted the types of fatalities reviewed and certain aspects of the review process. Certain states, she noted, mandated or permitted state or local CDR review teams, including if the CDR review was led by the state health department, social service agencies, medical examiners, attorneys general, or hospitals. She stated that some states'

reviews were funded by MCHB Title V Block Grants and others by the CDC Sudden Unexpected Infant Death (SUID) or Sudden Death in the Young (SDY) [Case Registry](#) funds. Dr. Kinsman highlighted that case selection also varied by state—certain types of death, such as SUID, were more often reviewed than others, such as foster care or medical deaths. She explained that the agency leading the CDR typically entered data into the National Fatality Review Reporting System and the CDR team then analyzed the data to determine risk and prevention approaches.

Dr. Kinsman said that FIMR is a more intensive community-based, action-oriented process of reviewing de-identified fetal and infant death cases towards developing recommendations for improved care systems and services. She explained that the de-identified data was an important component of ensuring that FIMR was focused on system changes. There were currently 154 FIMR across 27 states, territories, and Washington, D.C. She reported that most were led by state or local health departments, authorized through local legislative mandates, and funded by MCHB Title V Block Grants and the Healthy Start program. She shared that case selection varied by community—for instance some communities focused on perinatal HIV and others focused on sleep-related deaths.

She explained that FIMRs looked at de-identified data from multiple sources including medical, prenatal, home visiting, and WIC records. She shared that there was also a family interview to include the perspectives of the parents, families, and caregivers on the challenges that may have led to the infant death. Despite the valuable insights these interviews offer, she noted, they have been challenging to conduct immediately after an infant death. She stated that FIMRs have been unable to successfully complete most of their attempted interviews. Dr. Kinsman explained that the FIMR Case Review Team analyzed the data and developed recommendations, which were then sent to a Community Action Team to prioritize and implement through systems or policy changes. FIMR data was entered into the [National Fatality Review-Case Review Reporting System](#).

She reported that since 2000, there have been approximately 250,000 cases entered into the system, which represented about a third of all infant deaths. There has been an effort over the last two years to improve data quality and create standardized reports. She highlighted how this aggregate data helped support a national approach towards reducing infant mortality and racial disparities. For instance, she shared that the data showed that certain infant sleeping practices can contribute to sleep-related infant deaths.

Dr. Kinsman reviewed the new Child Dynamic Analysis and Statistics HUB (Child Dash), which summarized information from child death reviews across state. She also talked about how the COVID-19 pandemic shifted the review process, including a move to virtual settings, inclusion of COVID-19 as a direct or indirect cause of death, and self-care resources for case review coordinators.

DAY TWO: Wednesday, September 22, 2021

SACIM Organizational Issues

Vanessa Lee, Designated Federal Official, Maternal and Child Health Bureau, Health Resources & Services Administration

Lee Wilson, Division Director, MCHB/Division of Healthy Start and Perinatal Services, HRSA

Ms. Lee provided several administrative and operational updates regarding the charter, bylaws, and new membership. She shared that the Committee charter would be renewed by its expiration date on September 30, 2021, and a federal register notice would follow to inform the public. All committee members would receive a copy of the new charter. Mr. Wilson added that the Committee's role continues to include addressing maternal health, which had been added to the previous Charter. Ms. Lee shared that the Bylaws were also in the approval process, having been on hold briefly to ensure consistency with the new charter.

Ms. Lee noted that the charter allowed up to 21 members to the Committee, and MCHB had been working for nearly a year to fill the remaining positions. MCHB was still waiting for background vetting and approval on recommended nominees. Mr. Wilson said that the final stage included ethics provisions to identify possible conflicts of interest or financial issues to be addressed or recused. He added that all nominees under consideration at this point had been contacted.

Mr. Wilson addressed efforts to promote diversity among new members and shared that MCHB was carefully considering factors such as nominees' professional expertise, gender, race/ethnicity, and several other factors to ensure adequate representation in the Committee. Ms. Lee added the factors included early-career professionals and members from the community or those with lived experience, which had been suggested by current Committee members as a need.

Dr. Peck asked how many members were expected to onboard by December 2021 and how many would leave. She also wondered when current members would undergo a second ethics review by HRSA. Ms. Lee answered that, if all nominees currently being vetted were approved, the Committee would welcome nine new members. Mr. Wilson said the ultimate goal was to reach the full complement of 21 members, although these efforts would be staggered to mitigate dramatic changes in Committee composition over time. They also shared that the ethics review occurred annually, and some members might undergo a review prior to the end of their terms next summer.

Health of Indigenous Mothers and Infants and Their Communities: Context, Current Conditions, Challenges

Janelle Palacios, Ph.D., C.N.M., R.N., SACIM Member -- Facilitator

The session began with an invocation from Wakinyan Sky LaPointe from Minnesota. He was an indigenous human rights advocate and co-convener of the Mni Ki Wakan. He centered Lakota knowledge, language, and ways of life in his work to advance human rights and water justice, particularly in his work in partnership with indigenous peoples and with youth.

Dr. Palacios acknowledged the ancestral land upon which she stands, paying homage to the ancestors who were displaced by federal, state, and local policies. She then presented a visual storytelling of Indigenous history to contextualize the panel that followed. She emphasized that storywork was an important way to understand and improve maternal-infant birth outcomes

among Native people and reminded the Committee that Native people remain resilient in the face of immense hardships.

Her presentation reviewed background data. She shared that Black and Indigenous women died at higher rates than White women during pregnancy or after birth, and their outcomes worsened as they aged. She also highlighted that Indigenous infants experienced the highest rates of sudden infant death syndrome (SIDS). Dr. Palacios explained that reproductive and perinatal health among Indigenous people was substantially mediated by traumatic childhood experiences, which also were associated with increased risk for long-term negative health effects such as smoking, alcoholism, substance use, suicide attempts, depression, diabetes, obesity, and other conditions. Furthermore, she shared that as the number of adverse childhood experiences (ACEs) increased, so did the risk for negative health outcomes throughout the lifespan—including fertility problems, such as recurrent miscarriages. She explained that many ACEs have been related to historical trauma, a cumulative multi-generational experience of emotional and psychological injury to communities and their decedents as experienced by a specific culture or racial/ethnic group.

Dr. Palacios then illustrated these concepts by presenting vignettes of maternal-infant morbidity and mortality from four women in her life: her grandmother, her mother, her great aunt, and her best friend. She explained that the estimated size of the Indigenous population prior to Western contact in 1492 was roughly 60 million people, similar to the population of Europe at the time, however 1600, only about 4 million Indigenous people remained. Those who survived, she noted, were forcibly removed from their homelands and pushed farther west by legislation, such as the Indian Removal Act in 1830, which culminated in a winter death march known as the Trail of Tears. She also shared that government policies also effectively eliminated the U.S. bison population to control Indigenous people's food resources.

Dr. Palacios also discussed other traumatic historical events such as the Dawes Act, the massacre at Wounded Knee, and boarding schools. She explained how Indian boarding schools forced students to assimilate to Western culture and forced detribalization. She detailed how these children were subject to verbal, physical, emotional, and sexual abuse, and were cut off from their families and communities. She noted that the Indian Relocation Act of 1950 further decentralized families and led to rapid dissolution of tribes.

Dr. Palacios stated that these policies and procedures devastated—and continued to devastate—Native American populations. She reported that in 2015, Indigenous children were overrepresented in the foster care population relative to any other ethnic identity. She further shared that Natives were nearly twice as likely to live in poverty than the rest of the U.S. population, and their median household income was \$10,000 less. She explained that life expectancy was 5.5 years less than the U.S. general population, and unintentional injuries, suicide, and homicide were the three highest causes of mortality among young Indigenous women. She noted that in 2016 alone, 5,712 Indigenous women and girls were reported murdered or missing, and about 84 percent of Indigenous women have experienced violence in their lifetimes, and more than half have experienced sexual violence. Finally, she reported that non-Native men perpetrated 96 percent of rapes of Indigenous women but were rarely prosecuted.

Dr. Palacios also emphasized that the U.S. government's pedigree-based approach to Native identity was fundamentally incompatible with Indigenous people's understanding of tribal membership. She noted, however, government-defined tribal membership has dictated a Native person's ability to own land and access other resources. Consequently, she explained, at this time more than 300,000 Indigenous people were underhoused or homeless, and about one-third of reservation housing was overcrowded. She further detailed that only one in ten families have stable, reliable internet connection, and one in three reservation-based families live without plumbing.

She also discussed the Indian Health Service (IHS), which was intended to serve Indigenous peoples but has been involved in eugenics campaigns that forcibly sterilized more than 3,000 Native women from 1973 to 1976. Dr. Palacios reported that experts hypothesize that 25 to 40 percent of the Native childbearing population had been sterilized at this time.

Dr. Palacios highlighted other pressing issues among Indigenous peoples, including mass incarceration and the COVID-19 pandemic. She shared that recently, Native women giving birth at a hospital were racially profiled by household proximity to a reservation, and they were forcibly separated from their newborns, even on reservations with no active COVID-19 cases. She explained that the top three causes of maternal mortality among Indigenous women were hemorrhage, cardiomyopathies, and hypertensive disorders. She also highlighted that Native American women traveled significantly farther than White women to access obstetric care, and they were twenty times more likely to give birth at a facility that lacked an obstetrics unit.

Dr. Palacios concluded by reiterating that a history of severe trauma has facilitated a breakdown of traditional Indigenous family values, increased alcohol and substance use as self-medication, rising rates of mental disorders and suicide, and rampant child abuse and domestic violence. She concluded by stating that all efforts to effectively address these health disparities among Native people must consider the violence and abuse perpetrated upon them over centuries of Western expansion.

Susan Stemmler, M.P.H., Ph.D., FNP, CNM, CA Midwife, Liaison for Women's Health in IHS/Tribal Communities, American College of Nurse-Midwives

Dr. Susan Stemmler was the first person of American Indian ancestry to serve as the American College of Nurse-Midwives liaison to ACOG. She shared that ACOG recently celebrated its 50th anniversary as a contractor with IHS for evaluation of women's health care across all 12 areas of the IHS but particularly those that provide direct services to Native women.

Dr. Stemmler shared that data indicated that 78 percent of Native Americans now reside in cities, and youth were disproportionately represented among this urban population. She stated that while people that lived on their native lands had access to IHS facilities for health care, those that lived in urban areas had fewer available resources. The Affordable Care Act (ACA) expanded Native people's ability to sign up for health care, but Dr. Stemmler posited that the IHS may now be in jeopardy in areas where non-tribal site health care was available.

She briefly told the story of a young pregnant Native woman named Jean Bear who had to drive 82 miles to the nearest hospital with prenatal care and delivery services. Dr. Stemmler explained that the IHS facility on Ms. Bear's reservation stopped delivering babies in 1970, and many other sites have closed maternal and childcare services since. After finding she was pregnant with twins, Ms. Bear had to drive more than 300 miles total to receive adequate care. Dr. Stemmler highlighted how Jean Bear's story underscored the importance of transportation to health care, childcare, and support for women living in rural areas who were seeking important pregnancy-related services.

In her work with ACOG, Dr. Stemmler visited facilities in IHS areas, where she identified a substantial number of fundamental issues. She reported that rural IHS facilities suffered a provider shortage, inconsistent recordkeeping and update of medical procedures, poor community outreach, and few professional linkages with local health care facilities. Dr. Stemmler also reported that in urban IHS facilities, care delivery was complicated by non-uniformity of services, inconsistent community linkages, and limited 638 Federally Qualified Health Centers (FQHC) options.

Dr. Stemmler reviewed urgent needs in maternal and child health care in Native communities. She stated that they needed earlier linkage to prenatal care; enhanced perinatal education and community involvement strategies; and efforts to address pressing concerns such as obesity, diabetes, and substance use. Dr. Stemmler emphasized that at-home nurse visits at days 1, 3, and 7 postpartum were key for promoting health among new mothers.

To care for providers, Dr. Stemmler recommended the use of professional collaborative care, professional in-service, telemedicine, and contingency plans for early delivery. She stated that there has been a troubling dearth of Native midwives, and that health care professionals who need to support their families rarely receive opportunities to grow within the profession beyond work at community hospitals. Lastly, Dr. Stemmler pointed out that geographic hurdles (e.g., large snowdrifts in Montana) can challenge patient transfer across facilities.

Linda Bane Frizzell, Ph.D., Associate Professor, School of Public Health, University of Minnesota

Dr. Linda Bane Frizzell began by acknowledging that she stands on Dakota land. Her presentation focused on policies and procedures that have shaped Native life in recent years. First, she explained that the federal government recognizes 575 tribes and 74 states. She shared that in the mid-1970s, Public Law 03-638 required every tribe to have a constitution, which discarded millennia of cultural traditions, judicial systems, and education practices. She explained that because tribes have constitutions and operate with their own governmental policies and procedures, American Indians and Alaska Natives are identified as a political group rather than a racial/ethnic group. She noted that this is beneficial in that tribes have stronger capacity to directly meet the needs of their people.

Dr. Bane Frizzell then discussed health services provided by tribal governments. She shared that the Balanced Budget Act of 1997 was a missed opportunity to apply for direct funding, which tribes typically prefer. She explained that currently 50 states had different quote-covered

services, and tribal advocates were working to encourage CMS to establish a core set for behavioral health. She detailed other important legislation that included the Indian Self-Determination Education Act and the Indian Health Care Improvement Act, which were both submitted in the late 1990s. Notably, she pointed out that the Indian Health Care Improvement Act has established a pseudo-national license for health providers to conduct telehealth in any area. She explained that in 2010 Native populations were added to the Affordable Care Act but were considered “domestic dependent nations.”

Dr. Bane Frizzell then reviewed the basic infrastructure of the IHS, a federal agency established in 1955. She shared that IHS served federally recognized tribes and tribal organizations at 31 hospitals, 83 health centers, 2 school health centers, and 31 health stations, while the [Urban Indian Health Program](#) (UIHP) consisted of 35 non-profit 501(c)3 programs nationwide. She stated that nearly half of UIHPs received Medicaid reimbursement as Federally Qualified Health Centers. Dr. Bane Frizzell pointed out that the IHS receives an insufficient amount of money to meet Native people’s needs.

Despite ongoing problems with IHS data, Dr. Bane Frizzell stressed that there remained clear evidence that significant health disparities still existed among Native populations. She cited that homicide and other forms of violence remained rampant, and drug trafficking was an ongoing concern. She additionally pointed out that poverty, gang activity, and repeated losses have led to significant trauma among Native youth. She also noted that Native populations suffered inordinately high infant mortality rates; lacked consistent access to fresh, healthy foods; and lagged in basic health education. She concluded by emphasizing that Native people continued to demonstrate immense resilience in the face of ongoing hardship.

Financing of Care for Pregnant and Postpartum Individuals

Steve Calvin, M.D., SACIM Member

Dr. Calvin said that, despite being a world leader in technological advances and spending more than any other developed nation on health care, the U.S. consistently lagged behind other developed nations in terms of maternal and infant health outcomes. He said a more significant problem was that these outcomes demonstrated significant disparities across race and geography. Dr. Calvin then reviewed how care was paid for. He cited that as of March 2021, 42 percent of pregnancy care was funded through Medicaid and 50 percent through private insurance. The remaining care was funded through self-pay or other means, such as military or IHS programs. Of those who had care funded by Medicaid, Dr. Calvin highlighted that over 65 percent were Black and less than 30 percent were White. Conversely, he pointed out, of those who had care funded by private insurance, less than 30 percent were Black and nearly 64 percent were White.

Dr. Calvin concluded that Medicaid reform was therefore crucial towards addressing maternal and infant health disparities. Dr. Calvin recommended reviewing a [2020 study](#) published in the Journal of the American Medical Association (JAMA), which showed the distribution of costs across eight pregnancy-related conditions. He highlighted that the study showed that 42 percent of all U.S. births were paid for by Medicaid, but 70 percent of pregnancy and newborn care were paid for by private insurance and out-of-pocket payments. He suggested that the implication of this finding was that there was significant private subsidization of the public program for pregnancy care. He additionally cited a Truven Health study that showed that two-thirds of the

amount spent on pregnancy was spent on facility fees, with the remaining spent on professional fees, imaging, labs, and pharmacy.

Dr. Calvin shared that Medicaid eligibility ranged across states from 138 to 326 percent of the federal poverty level. Further, he pointed out that there had been an accelerating transition from direct fee-for-service to managed care organizations (MCOs). He stated that Medicaid MCOs currently provided 69 percent of Medicaid care nationally, and that number was growing. He highlighted the Medicaid and CHIP Payment and Access Commission (MACPAC) report called [Value Based Payment for Maternity Care in Medicaid Findings from Five States](#). The report indicated that performance value-based models incentivized limited quality measures, focusing mostly on health screening, but not cost of care. In his perspective, Dr. Calvin said the solution for high value perinatal care was transparency in reporting; accountability through patient satisfaction and financial and outcome data requirements; and culturally-competent, patient-focused care that was paid for by value.

Discussion

Dr. Ehlinger asked if MACPAC had recommendations that SACIM could use. Dr. Calvin answered that there were no specific recommendations in the report, but that it was an opportunity for SACIM to look at the data and develop recommendations. Dr. Ehlinger also asked for clarification about the differences in percentages of pregnancies paid for by Medicaid. Dr. Calvin said 42 percent of pregnancies were paid for by Medicaid and 70 percent of total spending on pregnancy care was private. He explained that this indicated a payer mix of public and commercial payments, with public payments paying significantly less.

Dr. Barfield asked about the relative disincentives for delivery, which was tied to access to care issues because most of the cost was in the delivery event. She also asked about time limits in care for high-risk infants. Dr. Calvin answered that spending on neonatal care was the most complicated and depended on availability of neonatologists across the country. He stated that most spending on neonatal services was in the intensive care unit (ICU). Bundled payments, in some cases, he suggested, resulted in better outcomes for lower costs. He added that there needed to be incentives for collaborative teams so that an anesthesiologist was not worried about being paid for an epidural or a perinatologist was not worried about being paid for the ultrasound. He concluded that there instead should be a comprehensive package of care.

Ms. Pettiford asked if enhanced reimbursement for pregnancy covered all of Medicaid or only clinical services. Dr. Calvin said that it is all of Medicaid, including centering pregnancy and doula services.

Dr. Ehlinger asked if there was a way to extend enhanced care and financing for all, and in particular, for the American Indian population. Dr. Calvin responded that a voucher program could be helpful, but that it was important for that community to be able to choose care that best served them. Dr. Stemmler added that the majority of people covered by the Affordable Care Act do have an option to choose their health program, including the ability to receive care at IHS facilities. Dr. Bane Frizzell also responded that, historically, IHS used managed care that many perceived as rationed care. She shared that there had been a recent change in the system and now tribes could choose the care they wanted, and then bill and reimburse the facility.

Public Comment

Vanessa Lee, Designated Federal Official, Maternal and Child Health Bureau, Health Resources & Services Administration

Ms. Lee announced that the Committee received two written comments and one request for an oral public comment from Dr. Barbara Ostfeld. Ms. Lee introduced Dr. Ostfeld as a professor in the Department of Pediatrics at Rutgers University, Robert Wood Johnson Medical School, and the program director at the SIDS Center of New Jersey. Dr. Ostfeld addressed SUID and the potential impact of the pandemic on increasing SUID rates. She recommended that the impact of COVID-19 be measured not only in terms of morbidity and mortality of the disease itself but in terms of other adverse outcomes on individuals and their families. She also expressed concern about mounting evidence of significant racial disparities in COVID-19 outcomes. Data indicated an increase in preterm births among women diagnosed with COVID-19 in addition to changes in smoking habits, a decrease in breastfeeding, economic instability, and disruptions to prenatal care. She stated all of these factors had the potential to disrupt safe infant sleep practices. Dr. Peck thanked Dr. Ostfeld for her comments and noted data on this from the National Center for Fetal and Infant Mortality Review.

Data to Action Discussion: Strengthening MCH-Related Sentinel Event Review Approaches, Systems and Uses

Dr. Ehlinger briefly summarized the content of the previous day's Data to Action presentation and opened the session to questions and comments. Dr. Palacios began by asking about efforts to address the disproportionate impact of child loss on smaller communities, particularly tribal communities. Dr. Kinsman answered that the Centers for Disease Control and Prevention is working closely with six tribal entities and the Casey Family Foundation to develop protocols that protect the community. She added that FIMR interviews were delivered by trained social workers who are skilled in bereavement and may offer opportunities for community healing.

Dr. Palacios commented that law enforcement on tribal reservations was complicated. She pointed out missed opportunities for appropriate collection of information and evidence in this regard. Dr. Peck said the Data to Action Workgroup will remain mindful of this consideration. She stressed that the goal is to develop qualitative and quantitative community-driven data from mature, well-aligned health case review systems. Dr. Bane Frizzell mentioned the 280 Law, which further complicated tribal law enforcement efforts.

Dr. Peck asked about the alignment and interplay between FIMR and CDR, wondering how the Committee can further encourage integration of these data systems. Ms. Zaharatos said the two can be difficult to align. Dr. Kinsman said that the Maternal Mortality Review likely will inform important recommendations related to social determinants of health, and because the FIMR was de-identified, these reviews could also inform general ways to improve systems of care. Dr. Bane Frizzell reminded them to remain wary of data misclassification; for instance, any person using a tribal facility is coded as a Native person.

Dr. Ehlinger asked about messaging to the general population about safe sleep practices. Dr. Kinsman replied that her team used the American Academy of Pediatrics' 17 recommended

behaviors for safe sleep and narrowed these down to three most common causes of infant death in Philadelphia. Dr. Kinsman shared that they created language and simple images for in-home providers to educate families. They also conducted a breastfeeding campaign. Dr. Ehlinger pointed out that messaging is a societal issue, and there was a need to change the narrative about what promotes health.

Narrative Development: Healthy Mothers, Healthy Babies, Healthy Society

Edward Ehlinger, SACIM Acting Chair

Dr. Ehlinger introduced the importance of narratives in public health efforts. He explained that President Lincoln intentionally ensured that his Emancipation Proclamation of 1862 would change the narrative of the Civil War from a struggle to preserve the Union to one focused on ending slavery. Critically, he stressed, one who influenced public sentiment was more powerful than one who enacted statutes or pronounced decisions because public sentiment enabled successful execution of this legislation.

Dr. Ehlinger also cited other powerful examples of narrative changes, such as the Think Before You Drink [article](#) that challenged narratives about fetal alcohol syndrome disorders (FASD) in Canada. He highlighted how the article pointed out that the current narrative about FASD in Indigenous communities focused entirely on personal choice with little regard for the societal injustices that created these conditions, such as settler-colonialism and historical trauma. Consequently, these narratives perpetuated existing disease inequities and prevented enactment of policies that addressed unmet needs of FASD-affected individuals.

Dr. Ehlinger discussed an [article](#) published in the *New York Times* in August 2021 that discussed the 1910 Flexner Report, which encouraged regulations for medical education and adherence to professional standards. He stated that although the Flexner report revolutionized medicine, the author's recommendation to adopt a northern city training model resulted in closure of seven of the nine existing Black medical schools. He pointed out that from this narrative emerged the vision of an "ideal doctor" as a White wealthy man from a northern city—a concept that has persisted for more than a century.

Given the immense social and policy impact of health narratives, Dr. Ehlinger urged the committee to consider narrative development as a key activity. He would like the Committee to create a report analogous to the Flexner report that changes the narrative about the importance of mothers, babies, and families to the long-term success of the country.

Next Steps

Edward Ehlinger, SACIM Acting Chair

Vanessa Lee, Designated Federal Official, Maternal and Child Health Bureau, Health Resources & Services Administration

Dr. Ehlinger asked Committee members to comment on next steps for mobilizing energy to make powerful change. Dr. Pettiford said they needed to include discussions about diversifying the workforce through financial support for individuals from underrepresented communities. Another member suggested giving more attention to advancements in detecting and treating

congenital anomalies before birth. Dr. Ehlinger invited Dr. Lee to consider a presentation on this topic in the future.

Dr. Palacios volunteered her time to the narrative reframing initiative. There was a history, particularly in Black and American Indian/Alaska Native communities, that would be relevant to thinking about public health messaging, such as for safe sleep or breastfeeding. Another member spoke about falling short in the diversity of the current health care workforce and the importance of race-concordant care. Dr. Peck added that the increasing effort to include the interview component of lived experiences in mortality reviews was encouraging and that she would continue to push for strategic storytelling to inform the work.

Dr. Malloy reiterated the importance of elevating pregnancy, and the role pregnant women play in society. She also suggested hearing from a speaker who has published on the link between surgical abortion and prematurity, which is a leading cause of infant mortality. Dr. Ehlinger said that looking at objective data on this issue would be helpful and asked Dr. Malloy to identify the data to raise the right questions. Mr. Wilson added that all topics that were raised by Committee members should be considered and explored. He asked Dr. Malloy to clarify the questions she would like raised for discussion at a future meeting in order to prepare background information and data, as well as identify expertise on the topic, for thorough consideration by the Committee. Dr. Malloy thanked them both and agreed to work on this.

Adjourn

In closing, Dr. Ehlinger asked Committee members to summarize their takeaways from the meeting and adjourned the meeting at 4:00 p.m.