THE SECRETARY'S ADVISORY COMMITTEE ON

INFANT AND MATERNAL MORTALITY

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

December 7, 2022

11:00 a.m. - 6:00 p.m. EST

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C O N T E N T S

Welcome, Call to Order, and Introductions

Ed Ehlinger: All right. Vanessa, do you want to get us started?

Vanessa Lee: Sure. Thank you. And good morning or good after... No, not quite afternoon on the East Coast. But, welcome. Hello everyone. Welcome to the Advisory Committee on Infant and Maternal Mortality, our committee meeting. Before I turn it over to our acting chair Ed, I just want to introduce myself. I'm Vanessa Lee. I'm the designated federal official for the advisory committee at MCHB, the Maternal Child Health Bureau of HRSA, the Health Resources and Services Administration. So just want to welcome our Committee Members, our federal Ex-Officio Members, MCHB team, as well as members of the public who may be dialing in to listen to the committee meeting. I know we have a full agenda today, so I'm going to turn the meeting over to our acting chair, Dr. Ed Ehlinger.

Ed Ehlinger: Thank you Vanessa, and good morning, everyone. I bring you greetings from Minnesota. As you know, the last time we were together was in September, Minnesota, the land of cloudy waters or clouds on the water. And right now, it is Minnesota since we are having a nice little beautiful snowfall that I can see outside my window. So it is nice to be here in the land of the Ojibwe in Dakota people, the ancestral lands. It is really good to see you on this December 7th, 2022. December 7th, a day that will live in infamy. And depending on one's perspective, there are multiple days that could live in infamy. Given the topic today, October 12th, 1492 could be one of those days that would live in infamy.

But particularly relevant to our topic today and with the United States, there's three days right around this time, on December 8th, 1829, President Jackson in his first State of the Union address stated his goal of moving all Indians out of the Southeast, the United States, to the West of the Mississippi. And then six months later, he

actually signed the Indian Removal Act, May 30th, 1830. Then on December 6th, 1830, President Jackson gave his approval for the removal of the Cherokees. He signed off on that on an executive order. And then on December 7th, today, in history in 1831, the removal process began with the Southeast United States moving folks West of the Mississippi. So, lots of days that could live in infamy.

So December 7th, 1941, when Pearl Harbor was bombed, a day that live in infamy, but it was also the start of something. It was the start of the pushback against fascism and totalitarianism and efforts to help people eventually. It took a little while to keep people from being killed, to address the genocide that was going on. So bombing of Pearl Harbor, a day that was living infamy, but it was a stimulus for action. And so, I'm hoping that our report that's coming out today, that's going to be approved today, will be that next step. It'll be that first step to address the infamy that has happened prior to

now, that it is one of the steps to move us forward to address the issues that are really moving forward. So that's what I'm hoping today. And so, I come to this meeting with bittersweet mixed feelings.

It's the last meeting that I'm having of several members and last time I'm chair. But instead of focusing on the sad part, I think there's some sweetness in this, is that we're going to be culminating four years of effort with I think a really, really good report that I'm really, really excited to discuss and move forward because I think it actually move us forward. But before we get to that, let's do some introductions. I introduce myself as Ed Ehlinger. I'm the acting chair from Minnesota. And so let us go around and introduce yourself, so we know who's here. And I'll just call Sherri Alderman. Introduce yourself please.

Sherri Alderman: Good morning everyone. My name is Sherri Alderman. I am by training a developmental behavioral pediatrician and am located in Oregon.

Ed Ehlinger: Good. Steve Calvin.

Steve Calvin: Hi. Steve Calvin. I'm a maternal fetal medicine specialist and I work with midwives at the Minnesota Birth Center in Minnesota.

Ed Ehlinger: Good. Charlene Collier.

Charlene Collier: Good morning, everyone. I'm Charlene Collier. I'm a general OB-GYN, in Jackson, Mississippi. Good to see everyone.

Ed Ehlinger: Tara Sander Lee.

Tara Sander Lee: Good morning, everybody. I'm a scientist by training with expertise in pediatric development and disease. And I am currently the Senior Fellow and Director of Life Sciences at the Charlotte Lozier Institute. And I reside in my home state of Wisconsin.

Ed Ehlinger: Good. And is Colleen Malloy on? I don't see her name.

Vanessa Lee: Ed, sorry, she was unable to make it. So September was going to be her last meeting.

Ed Ehlinger: Okay. Kate Menard. Kathryn Menard.

Kathryn Menard: Hi. I'm first Kate Menard. I am a maternal-fetal medicine specialist. I'm based in North Carolina at the University of North Carolina Chapel Hill.

Ed Ehlinger: Go Tar Heels. Joy Neyhart.

Joy Neyhart: I am trying to get my technology going. Good morning. I'm Joy Neyhart, a pediatrician working in Juneau, Alaska. I've been here for 20 something years. And most recently have been working with the Southeast Alaska Regional Health Consortium, which is our local tribal health healthcare entity. Happy to be here.

Ed Ehlinger: And I hope you didn't sign on at six o'clock your time.

Joy Neyhart: Seven.

Ed Ehlinger: Good. Good. Janelle Palacios.

Janelle Palacios: Good morning, everyone. I'm coming to you from the ancestral Pomo and Miwok lands in

Northern California. And I'm Janelle Palacios. I'm Salish and Kootenai. I'm a nurse midwife. And I work in the Bay Area. I'm also a researcher and a consultant. Great to see everyone.

Ed Ehlinger: And Magda Peck.

Magda Peck: Good morning colleagues. My name is Magda Peck. I woke this morning in Richmond, California, the ancestral lands of the Ohlone peoples. I work as a public health scientist, strategist, and storyteller for social change and health equity. And I am delighted to have served on SACIMM and also become bittersweet that this is the ending and beginnings.

Ed Ehlinger: Belinda Pettiford.

Belinda Pettiford: Good morning, everyone. I am Belinda Pettiford. I'm also in North Carolina with our state Title Five program. I'm head of Women Infant and Community Wellness. So, it's good to see everyone.

Ed Ehlinger: Good. Marie Elizabeth Ramas.

Marie-Elizabeth Ramas: Good day everybody. This is Marie Ramas, family physician, calling in from New Hampshire. Practicing family physician, have practiced full spectrum family medicine for over a decade. I'm Commissioner in the Academy of Family Physicians Health of the Public and Sciences Commission. And currently I'm part of the New Hampshire Governor's State Health Assessment, State Health Improvement Plan, particularly with the focus on equity. So thank you so much for the time here. I'm looking forward to an active session today.

Ed Ehlinger: Good. Phyllis Sharps.

Phyllis Sharps: Good morning. I'm Phyllis Sharps, professor emerita of John Hopkins University School of Nursing. And I'm coming to you from just outside of Baltimore, Maryland.

Ed Ehlinger: Good. Sharonda Thompson. Sharonda Thompson.

ShaRhonda Thompson: Hello, I'm Sharonda Thompson. I am a community leader and I am calling from St. Louis, Missouri.

Ed Ehlinger: Good. Jacob Warren.

Jacob Warren: Hi everyone. My name is Jacob Warren. I'm an epidemiologist by training. I'm Dean of the College of Health Sciences at the University of Wyoming. Coming to you from Laramie, which is on the ancestral and traditional lands at the Cheyenne, Arapaho, Crow, and Shoshone.

Ed Ehlinger: Good. Well, welcome to all of the appointed members. And now we have the Ex-Officio Members. And I'm just going to ask the Ex-Officios to jump in popcorn style because I'm not sure all of who's here and I don't want to miss anybody. So, all of the Ex-Officios jump in and introduce yourself.

Lee Wilson: Good morning. This is Lee Wilson. First, my position is Director of Division of Healthy Start and Perinatal Services in the Maternal and Child Health Bureau at HRSA. All of you know me from our past work and my filling in as the acting designated federal official. Today my role is serving in proxy for Dr. Michael Warren, who is

the Director of the associate administrator for the Maternal and Child Health Bureau. Happy to be here with you today and to put some finishing touches on this set of recommendations. Why don't we move to Alison if you're on?

Alison Cernich: Sure. Thanks, Lee. Alison Cernich. I'm the Deputy Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development, hereby representing the NIH. Thanks so much for having me. I think I see Charlan.

Charlan Kroelinger: Hey, good morning, everyone. I'm Charlan Kroelinger. I'm the Chief of the Maternal and Infant Health Branch in the Division of Reproductive Health at CDC. And I think I will pass it over to Laura.

Laura Kavanagh: Good morning. I'm Laura Kavanagh. I'm the Deputy Associate Administrator for the Maternal and Child Health Bureau. And I will turn it to... Who else is on federal officials? Lee, I'm going to turn back to you to

Ed Ehlinger: How about Danielle?

Lee Wilson: Tina Pattara Lau.

Laura Kavanagh: Thank you.

Tina Pattara-Lau: Hello everyone. I'm Tina Pattara Lau. I'm the Maternal Child Health Consultant for Indian Health Service. I'm also an OB-GYN. I still continue to practice here in Phoenix, Arizona on the ancestral lands of the O'Odham tribe. And I work at PIMC, Phoenix Indian Medical Center and Valleywise Medical Center. Thank you for having me today.

Ed Ehlinger: Danielle.

Danielle Ely: Hi, I'm Danielle Ely. Oh, can you hear me? Okay. I'm Danielle Ely. I work for the National Center for Health Statistics and the Division of Vital Statistics and the Reproductive Statistics Branch. And I manage the Linked Birth and Infant Death file. Thank you.

Ed Ehlinger: Anybody else who hasn't been introduced?

Magda Peck: Darlene.

Ed Ehlinger: All right. Well, welcome everyone. We've got an exciting meeting. I forgot to mention that my virtual backdrop is Big Medicine. It's part of the blanket that was given to me when we were at together at the Shakopee Mdewakanton Sioux community. You can see the buffalo back there. And I'm getting patted on the shoulder by the hands. So, I feel like I'm in good hands at this meeting. And just to remind you, normally, we would have a two-day meeting for those of you who are relatively new. Most of our meetings are two days long. This meeting is just one day. And we're having just one day because not sure yet about the leadership moving forward, and I didn't want to start something brand new that I could not carry forward. Today, it's just going to wrap up and set the stage for the next iteration of SACIMM that's going to be starting right after this meeting. That's why we're just having one day. And so before we get started, let's have approval of the minutes. Does anybody want to motion to approve the minutes?

Marie-Elizabeth Ramas: This is Marie. So moved.

Ed Ehlinger: All right. Is there a second? Magda seconds.

Joy Neyhart: This is Joy. I would second.

Ed Ehlinger: All right. And just to let you know that I actually did read the minutes and most of you probably did not, because they were quite long, but they're very helpful. And especially as I've been going back over the last four years in preparation for this meeting and thinking through, having those minutes is really important. So I would just encourage that at least somebody on the committee in addition to the MCHB staff review the minutes just to make sure that they collect things because they're important. They're the historical archive for our meeting, so they're important. So, all in favor of or any discussion about the minutes? We got the motion to approve and second. Any discussion? All right. All in favor, wave at me or say yes.

Steve Calvin: Yes.

Finalize Report to the Secretary - *Making Amends: Recommended Strategies and Actions to Improve the Health and Safety of American Indian and Alaska Native Mothers and Infants*

Ed Ehlinger: All right. Good. All right. All right. So, we're going to start like we did with many of our meetings, with community voices. This for me is really nice for me because I know CDC has done the HEAR HER campaign, and they've really done the most recent one related to American Indians and Alaska Natives. It's synchronous with what we're doing. So it really feels good that we can start with one of the video clips from the HEAR HER campaign related to American Indian and Alaska Natives. So, let's start with HEAR HER.

HEAR HER Video: The circle of life begins with the birth of a child, and that journey begins with pregnancy. People who are pregnant or have had a baby know their bodies, and know when something does not feel right. When they speak, we must listen. Hear her. Learn more at CDC.gov/HEARHER/AIAN.

My name is-

Ed Ehlinger: All right. Thank you. It's a beautiful way to start. That's one of the nice things over the years that we've been doing this is to start with voices. Sometimes in person, sometimes by video, it's sometimes virtual. A nice way. And certainly the meeting that we had on the Shakopee, we've been walking in Sioux land where we heard the stories and heard the voices and just added so much meaning to that. So the first part of our meeting is going to be reviewing the report that we've worked on. And I'm not going to go through the report in great detail because it has been shared with the committee multiple times. And you've got it in your briefing book. And also, I sent a copy to everyone last week in preparation for this meeting. So, I don't think we need to go through it objective by objective because we've had multiple conversations about it, and we've had an opportunity. But I'm just going to go over some summary remarks related to that, and then we

can have a little discussion about that afterwards. So, I'm going to share my screen.

All right. Here we go. So our report, Making Amends: Recommended Strategies and Actions to Improve the Health and Safety of American Indian and Alaska Native Mothers and Infants. And this record reflects the fact that have really been trying to focus for all of the last four years on actions, trying to do something that we can actually move on. And that was why we really didn't want to say these are recommendations, but these are recommended actions that we want to move forward. And this all started back, not all started, but our first real focus on American Indian and Alaska Natives occurred in June 2021, at our meeting there, when we were finalizing our second report. We had a report to the Secretary related to COVID. And then a year later, we had another report that focused on a whole variety of things, including COVID. But in that conversation for the June 21st, 2021, we made this recommendation that we should get adequately fund

the Indian Health Service efforts to reduce infant and maternal mortality.

And we recognized that was a fairly, yes, an important recommendation, but a fairly generic one that we hadn't spent a lot of time on it. We realized that if we're going to make some recommendations related to American Indians and Alaska Natives, we really needed to focus attention on it, not just have it be an afterthought. Something that, yeah, we should make that recommendation, but we should actually put some time in on it. So this is where we put this in our recommendations. We did not mention it in our letter to the Secretary, the cover letter. It was in the report, but it was really the beginning of our conversation that... So, during the summer of 2021, we started to really work on the project that we're coming to conclusion on now, or it should say the report that we're coming to conclusion on. The project will continue.

Then we had our meeting in September, and this was important for several reasons. This was our first time when we really had a focused session on American Indians/Alaska Natives. And Suzanne England, who was our health consultant, actually wasn't able to show up at this meeting. So, Linda Frizzell testified instead of Suzanne England. But it was important because Janelle set the tone for this. She told a story, she gave the context. And so it was important for a couple of reasons. One, it set the tone for how we are really looking at our report, from what Janelle did to set the context and the tone at that point in time, but also demonstrated her leadership. And this is something, as I talk most through today, I'm thinking about what we did, but I'm also thinking about the group that is continuing on. What can you do? And individuals who step up and have an issue that they want to lead on can do that and you can actually have an impact.

And Janelle both set the tone but also said, "I need to lead this." And so we had formed a

collaboration to move this forward. And then in December of that year, we had another session. And Captain England was able to join us at that point in time. But we found out that we needed a lot more information than that she provided during that session. So we said we really need to have additional information. So following up that meeting in December, we sent her a letter with a list of data requirement, technical data that we really like, information that we would like. And I have to admit, even to today, we have not received that despite several attempts. And so you'll hear the frustration in my voice about what we haven't been able to get from the in Indian Health Service, which is such an important part of this. But we sent a letter in January, we've had several follow up letters since that time, asking for a variety of pieces of information. Still has not received any of that yet.

And then in March, we had another invitation, the Indian Health Service to join us at the meeting,

but no one was able to attend. But we did have a session on violence on infant and maternal mortality. Even though it wasn't focused on American Indians/Alaska Natives, the issue became very obvious in this conversation that this was an issue of great importance to American Indians/Alaska Natives. And actually Jacqueline Campbell has actually followed up and been part of our work since this time. A lot of the information from this session has been built into our report in terms of interpersonal violence and also incarceration activities. So that is part of our focus on American Indians. And then following that meeting, we started to draft the recommendations because we anticipated that we were going to have an in-person meeting in June of 2022, and that we would finalize the report. As it turned out, fortunately, I think from my standpoint, that was not our last meeting.

And we got extended two more meetings as members of this committee, that allowed us more time to really go into greater depth on the whole issue

of birth outcomes for American Indians and Alaska Natives. But that's when we started. And when we came together in June, this was your second meeting, you came on board during this time and actually participated in several of these conversations. And this is the agenda that we had in June where we really started to focus on some of the very specific issues. SID/SUID, Indian Health Service, incarceration, Missing and Murdered Indigenous Women and Girls, and really started to flesh out really some of the specific objectives that we had. And then during the summer of this last year, multiple drafts that we had, at least fifteen drafts, sixteen drafts of our recommendations that have been supported. But even that is less because there were tweaks all along the way. Each draft had multiple tweaks during it, which brought us together in September at the tribal land of the Shakopee Mdewakanton Sioux.

And these were the people who presented during that time. And really an impressive list. And

those of you who were there, recognized how powerful it was to be on tribal land, hearing those stories, and being able to interact with each other. And so I'm hoping that as SACIMM moves forward, the new group will be able to meet in person a lot more than we were of the cohort that's leaving. We have only had actually three meetings in the four years that we had, we were in person. And those in-person meetings are really important. So, from that, we also got a lot more information. And my hope was that we'd be able to finalize the report at that meeting. But obviously, so much information came in, so much context came in, that it was a blessing. It was a blessing that our terms got extended to December, so we could incorporate all of that. Because I think the richness of the report that we are going to be voting on was really enhanced by the stories that were there.

And you'll see in the document where we've included many of the words of the people who testified, the specific words in the quotes, the

pullout quotes that were there. And so, the process that we developed, I think the process itself was important. Yes, the final report is important, but the process I think is important is that we had multiple meetings looking at the issue. We had an in-person meeting on tribal land. That's one of the recommendations we're going to have is that if you're going to have some issues related to a particular population, you actually should go there and be with those individuals and talk with them and get their input in their community. We've worked with multiple, not only did we have the sake of meetings, but we also had DRAW and the workgroups DRAW and the Health Equity Workgroup had multiple meetings that had lots of input. And so, a lot of other people were engaged. We reviewed numerous reports and you'll see the documentation in the report, all of the publications that we've referenced.

We had the verbal committee testimony, the people that actually came to the committee. But we also

had lots of written testimony and a lot of verbal input from people outside of the meetings over the course of the time that we've been working on. And so that all led to what we are going to be talking about today, which is the report that we're going to send, I hope, to the Secretary in the next day or two after we approve it. And it'll have a transmittal letter, which you've seen. We've had the preface. And language matters. And it's interesting, so I've gotten some feedback from tribal members that, yes, thank you for clarifying what terminology you're using. And you may have not paid attention to the last paragraph on the preface, but two-spirit people actually have contacted me saying thank you for acknowledging our existence.

I think we worded it that AICMM acknowledges that transgender and gendered non-binary individuals also birth and support infants. And just having that acknowledgement, they recognize that we maybe may not through this whole report used language that is totally inclusive, but the fact

that we acknowledge it was really important and we got feedback that way. We have the executive summary. We have the full report, which contains a lot of history and context, which I think is as important as the recommendations. It is the context that makes this really powerful. Then we have the recommended strategies and actions, a lot of references that are there that people can use. And then we have a list of the contributors, quotations from the presenters and the table of some of the recommendations. And you have that if you want a summary, not a brief summary, but a summary on a few pages, I think four pages, where you can actually see all of the recommendations. We had talked about it at our meeting in September.

Well, could we prioritize some and make it less? And the feedback that we got particularly from American Indians/Alaska Natives, is you're not comprehensive enough. There's more issues and we recognize that. This is one chance that we have to actually present something from a federal

committee, include what you can with that. But also that puts us on record that we need to act on it in a different way. The pressures on us to pull out parts of this to move forward in a particular way, that we can prioritize pieces of this, that we can move forward. And we'll talk about that in our next session when we say, how do we use this report? And so the report is based on all of the data that we looked at, particularly the Broken Promises Report, we had three premises upon which we built our report.

One is that the health of American Indian/Alaska Natives has never been a priority in our country. And that has led to a whole bunch of outcomes that are less than optimal. That like every other population, the American Indians/Alaska Natives, their health is determined by the physical, social environment and medical care, so the determinants of health just like everybody else. But because of racism and discrimination, those determinants are not as healthy as many other places. And then some issues because of some of

the environmental factors, there are some specific issues that disproportionately affect American Indians/Alaska Native mothers and infants and children. Incarceration, missing and murdered Indigenous women and girls, substance use, mental health. Concerns that are there for a lot of other folks, but particularly American Indians and Alaska Natives. And then also, as we were talking about this, it really came forward that the communities that we've been focusing on, have some inherently protective practices embedded in their culture and we need to call those out.

So those are the premises upon which we built the report. And from those premises, we basically had three areas for recommended action. One related to making the health and safety of American Indians/Alaska Natives a priority, improving the living conditions and improving access to high quality healthcare, and then addressing those urgent issues that disproportionately affect American Indian/Alaskan Native women and infants.

Instead of having one that was another section just specifically for cultural strength and resilience, we built that into all of the sections so that it is a cross-cutting theme. And in those three areas, so the three areas related to priorities, determinants of health and disproportional issues, we had basically three areas under each one of those. So in the area we're making the health of American Indians/Alaska Native mothers and infants a priority for action, we really had a whole section related to leadership and inclusion and the data sovereignty issue and how who makes determination about what moves forward.

We also have a section on the data because one of the ways that we've not made the American Indians and Alaska Natives a priority is because we have not used the data. We've fallen back, we've collectively said the numbers are small. Therefore, some people think, well, they must be insignificant. So, we've focused on data. And then because we are making recommendations to the

Secretary of Health and Human Services, we're really focused on particularly the two agencies within the federal government, HRSA and the Maternal and Child Health Bureau. Because they are responsible for multiple programs that directly affect American Indians and Alaska Natives. So we've had some recommendations specific to them. When we talk about this, the DRAW group did a lot of work on this. And Magda leading the DRAW group will be able to respond to any questions that might come up about anything in this area.

The second area really focuses on the determinants of health, the social conditions and access to quality healthcare. And Janelle led the work in this area. And we focused on basically, again, on three areas, the Indian Health Service, expanding the workforce and the social determinants of health. And I'm going to spend a little bit more time on this one. The Indian Health Service, we've again, have not been able to get the information that we have. And it is

such an important piece of health or important factor in improving the health of American Indians/Alaska Natives, that it needs a lot of attention. And we heard over and over and over again that there's dissatisfaction with the Indian Health Service. Several people suggested we should just do away with it and start all over.

We also know that they've been chronically underfunded. So what's the chicken and what's the egg? We're making some recommendations on how we think action should move forward, but this needs to be a priority. We did not do justice, I don't believe, to all of the factors that go into the Indian Health Service. And I'm hoping that SACIMM and the Indian Health Service will be able to form a partnership moving forward, that we can go in greater depth to actually come up with some recommendations that go beyond what we make in this report. These are some bold recommendations that we're making, but I-

... these are some bold recommendations that we're making, but I think that it needs a lot more work. Similarly, Medicaid. Medicaid is again another big issue that has a major impact on the health of American Indians/Alaska Natives. And to get into depth in all of the details of it would require a lot more resources and time than we were able to have. So again, this is another issue that I think needs to be addressed somewhere in the future and that is our recommendation to really focus additional attention on the Indian Health Service, additional attention on Medicaid. And then certainly workforce is one that we really need to focus on along with improving the social determinants of health. And then the third area, we both had specific recommendations for Missing and Murdered Indigenous Women and Girls, incarcerated women.

I think this is one of the issues that I think as I talked to SACIMM members, a lot of people didn't recognize how big of an issue this is

among American Indians and Alaska Natives in particular. And I think the couple of presentations that we had just really raised this up and I think that is one of the contributions. But you'll also notice in the report that we don't just say you need to have these things for American Indian/Alaskan Native women in prisons, all women need these services if they're pregnant. All women in prisons need these. And because Indigenous women are disproportionately affected, yes, by making all women, it is going to have an impact on American Indian/Alaskan Native women. So this is something that we really want to highlight. Similarly, the violence, again, the lack of data related to the violence and committees put together to address that are things that we address in our report.

At our meeting in September, we talked about substance use and mental health. And that this is again another big issue that again, I think, needs more attention. We put together some recommendations related to that, but it is far

from comprehensive and I think needs, again, a lot more additional work. But it is there for us to concentrate on. And then those were 58 recommendations and we had one that didn't fit necessarily into any of those categories. It was these final recommendations. Our last recommendation based on the fact of what we learned by being on tribal land here in Minnesota in September, that any federal advisory committee that is focusing on issues specific to particular communities, regardless of the topic, not just maternal and infant health, but also other topics, they actually need to hold those meetings in those communities because it assures engagement and better understanding and representation and ownership and accountability.

And already, the stories that I'm hearing from other organizations that were at the meeting, they're thinking, "Okay, we need to change how we do our work." And I loved the fact that the President Biden just said, "Hey, we're going to hold a meeting on tribal land here in the near

future." I'm going to take ownership that our meeting in September, in Shakopee Mdewakanton Sioux was the stimulus that said maybe we should do that at other levels other than just this advisory committee.

So that's just a general overview. So, I just have some questions. I'm going to open it up and these are some of the things that I want you to think about. First of all, do you have any comments or questions about the report? Anything not clear in the report, just things that you need some clarification about or just some general comments about the report. What stands out for you in the report? What really is like, "Oh my God, this is really important?" And then what have you learned? Have you learned about the issues of American Indians/Alaskan Native? What have you learned about the process of putting this report together? What have you learned about the advisory committee? How functional is it in some of these areas? What can it do? How do we interact? What did you learn about that? And then

I want you to think about, all right, what are you going to talk about, what part of this report are you going to talk about?

I was talking to Magda. She said that she always asked people, "What are you proud of in the work that you're doing?" This is sort of that. What are you proud of? What are you going to raise up from this report? And then lastly, is there anything within this report that you can't live with? Because we're going to be voting on this and if there's something that you can't live with, I need to know that, we need to know that. All right. So I'm going to stop screen sharing and open it up for some conversation related to these questions. And I'm not going to call on anybody. Raise your hand if you have questions related to any of these things. Any comments or questions? What stands out? What have you learned about issues or process or the committee? What do you talk about if you mentioned the report? Sherri.

Sherri Alderman: Yes. Well thank you very much. I think that this report is spot on and comprehensive enough to move the dial with action stemming from the report. And I think that this is a phenomenal opportunity. One thing that I'd like to spotlight that really resonates with me that is in the report are the stories. We often create a very objective dispassionate, if you will, report of including data, which is very important. In fact, that's one of our recommendations is that there be more data. I would like to keep in mind that data also includes the qualitative information and including those stories in the report all along the way, I think really captures so much more than that quantitative data can possibly capture. So, thank you very much.

Ed Ehlinger: Good. One of the things related to the stories, so those weren't edited, those were the words. And that doesn't mean that we necessarily agree with everything in those stories, but that is the perception of the person talking. So I love that we have our data, which we have researched and

have references for, but here's the words of the community that we're focusing on and that gives a little different flavor. Belinda.

Belinda Pettiford: Thank you. And I actually am in agreement with Sherri, I think the highlight of the report to me were the stories of individuals. And I am really excited about recommendation number 59 where we are just reminded of the whole concept of nothing about us without us. And really thinking through how important it is when we're trying to pull these recommendations together or any effort we're working on that we really need the people that are impacted to be leading and being definitely engaged in the work.

I'm also very appreciative of all the time that you and Janelle put into leading this work. We know it was not easy and the fact that we were able to get to this point with very little communication or even engagement with the Indian Health Service, who we would've expected would be at this table, that they would want to be co-

leading with us and still being able to get this much done is amazing.

And I also appreciate the fact that as much as we're wanting to lift up American Indian and the Indigenous populations and how critical this is and how much this is so delayed that we've needed this for a long, long time that we didn't forget about the rest of the populations that are also impacted. So I think you've done a really good job of incorporating that into the report as well. So, thank you both very much.

Ed Ehlinger: And you'll also note, we did use the quote from Julia Lathrop at the beginning of the report that actually by focusing on this population is actually going to benefit every other population, that it is absolutely essential to focus on this population if we're going to make success in the other population. So it's not an either or, it's not a zero sum game. As my favorite Senator Paul Wilson, we all do better when we all do better. Marie.

Marie-Elizabeth Ramas: Yes. Just again, echoing the immense amount of appreciation since I'm one of the newer members on the committee here, just the amount of work, the thoughtfulness and co-creation that was involved with for all intents and purposes, for the amount of resources that were provided, is just absolutely tremendous. I appreciate so much the historical factors that were added into the report to not only justify but to remind the reader of the integral aspect of what our history is. So that really just spoke to me and it made alive the in-person experience even more. It was palpable because of our in-person experience that we were gifted by the thought leadership here. So just bravo. And you are correct, this is really just the tip of the iceberg. But I hope that this can help create some guidelines and some way points that our officials can then leverage to dig deeper in and we can continue in the work.

Ed Ehlinger: Certainly, thank you. The context really is important and the fact that Janelle is the only Indigenous person on our committee and that she

was important in helping to bring that context and that tone highlights the fact that advisory committees need to be more broadly representative. Also, the fact that we were able to get stories when we were on tribal land that we could not have gotten any other way, highlights the fact that we as a society need to be more embracing and go away from the way we've always done business. Because I think as was mentioned earlier, the stories are data, they are qualitative data, but they're powerful data, they're accurate data and it needs to be part of our conversation. Phyllis.

Phyllis Sharps: Yes, thank you. Good morning, everyone. I think the report and how we've done it really does very well how I have always framed my research, which is community based and community engaged and that is stories and numbers. And when you can weave those two together, I think you make a much a very compelling document and statement as we've done. I appreciate that if you work in community and you do community research,

you know you have to be in the community and you have to hear the voices. And so having a big tent for this committee and inclusiveness and diversity will help us, I think, identify even more issues and more relevant. And I'm a newbie, I think this is my third meeting, but I like that the committee will be flexible enough to get out of our ivy towers and actually go to the communities and hear what folks have to say.

Ed Ehlinger: Thank you. Charlene.

Charlene Collier: Thank you. Again, I echo the previous sentiments and truly appreciate all of the work that went into the report. And I think the result demonstrates that effort and passion. I echo also the sentiments around recognizing the both hard work of Janelle doing this, but then the fact that being a one and only is a very heavy burden in a committee and a report to this and moving forward that it is not the model. We know how much effort and energy it took to bring in more voices. So I really appreciate that the committee took that effort to not just have one way of

getting those voices represented but truly moving forward when we're thinking about who acts on the report, who is empowered to act on the report and who receives the funding to do the actions should again be mostly representative of the Indigenous community.

And I think that's most important for as a template that anyone who's going to take it and act upon it acknowledges that they cannot do it unless that who is acting reflects the community who is benefiting and who it's addressing. So hopefully we see that throughout. We do see that throughout the report suggesting who owns the suggestions, who has the power in implementing who is brought in and how to do that. But again, I think if I were on a panel right now addressing Black maternal mortality and I was the only Black woman represented, it would feel like a personal burden, not just on the committee. It would seem like, wow, I am both representing this report for our country and I was a one and only and that shouldn't be going forward.

But certainly this represents the need to continue to invest in leaders from the Indigenous community and bringing them in and in the actions, because I know even Janelle is rolling off, the work begins now. It really truly begins now. And this is where the investments have to start happening around who is empowered to carry this message forward. So again, thank you, Janelle and to everyone who put that, and Dr. Ehlinger for making that commitment and not going the easy route. But I hope we won't go the easy route for action as well. So, thank you all.

Ed Ehlinger: Thank you, Charlene. Yes, and I certainly concur with you that Janelle, this was a burden on her. And I want to acknowledge the fact that a lot of people did step up to help, in the Workgroup folks, which was people are willing to come forward and also in the American Indian/Alaskan Native community. Certainly here in Minnesota, my colleagues said, "All right, we're going to step up and help you do this," so that it needs a little... having Janelle be part of that helped

others come forward. It was sort of the stimulus, it was sort of the boiling rock, if you put it in, it makes things happen. So a lot of other people stepped up, but it was a lot of great leadership from Janelle. Janelle, you're on.

Janelle Palacios: Thank you. It was with a lot of mentorship from Dr. Ehlinger and Dr. Magda Peck, both of those, these are amazingly supreme mentors and leaders in their own right with combined, I don't know, should I say a number of years of experience. It feels like 50, 70 years plus of experience combined and an enormous amount of mentorship went through this. And it was through their mentorship that I was able to really have a voice and have a hand in being able to shape this report and being able to share a light on this very dark deep corner of our history and what's going on currently. So I want you all to know that they have heavy hands and influences in the framing of all of this because they've had so much experience. And someone like myself who has not had mentorship in this capacity and being on

this committee, it would not have happened without people putting investment into me.

So thank you Dr. Magda Peck and Dr. Ehlinger, a lot goes to you as well, the trio of us, but a lot of the mentorship for this, what we're about to set forward and hopefully approve very quickly. And I agree that what Dr. Collier was sharing, that now let's see what the action will be. And yes, there should always be more than one person, that is, one person cannot represent alone. So it is with mixed emotions and also very much happiness for being able to step off lightly off of this committee after all of these four and a half years of work that is culminating in today. So thank you all for being here, and thank you all for your consideration for future mentorship of each other and for the next generation of people to come.

Ed Ehlinger: You will note on the transmittal letter to Secretary Becerra, in the past I would sign the letter on behalf of the committee. This letter, it's going to be over my signature and Janelle's

signature as co-chair of the Health Equity Workgroup. But also, I think highlighting the fact that this is not just the report from the committee with my signature, but her involvement in it. You got to raise it up. We have to raise up the next generation of leaders and this is one way to do it. Kate.

Kathryn Menard: So I'll just build I guess on what others have said. I will echo the appreciation for what Janelle has done and the supports she's gotten from others to do that. But I can't say it any better than Charlene, what lift? And thank you so, so much. But just one comment in the report. I love that it's so beautifully referenced to this document isn't going to be a list of recommendations. This document is going to be a resource for people that are going to be doing the work to follow. And I think that that is going to be very, very, very helpful in such a broad way. So thanks for all the work that went into that. But Janelle, maybe you're rotating off the committee, I would've voted for you to keep

on another term, but you're not rotating off this project in any way.

You're going to be tapped and tapped and I hope you're willing to keep your hand up and lean in. Tomorrow, for those that don't know, I think it's tomorrow, Janelle, you're doing your webinar on HEAR HER and just I expect that, I hope that we'll be seeing you over and over again and all the other colleagues that you can bring to this work. So, thank you. What I've learned, I have to just say that I've spent a number of years now in the space of healthcare and kind of walking in the public health arena and I learned so much about what my head in the sand was with respect to the issues that were raised by the development of this report. And I'm embarrassed by that but also energized by that. So you've got me as your fan and someone that will carry the flag with you.

Ed Ehlinger: Thank you. I'd just be curious of the people who came to the Shakopee Mdewakanton Sioux community, what was your take? I know Kate had mentioned

that like, "Oh my God, I never realized what was going on. I know these issues but sort of academically, but this really brought it to the forefront." I'm just curious on what people learned from that experience. Because I think it reflects on what MCHB is going to do, what this committee needs to do, other committees need to do to hear what really comes from that kind of experience. Marie.

Marie-Elizabeth Ramas: The stories and just being on native land and understanding the history of the land that we were standing on, that was extremely moving to me. And as a Black woman and as a first generation American here, just the deep connection between Indigenous experiences and the experiences of other communities affected by white supremacy across the world. I think that was just very moving to me that our experiences are really not a mono, they're not unique, that we have similarities that are threaded in so many ways and particularly in the unspoken American history. That there are so many stories that are

silenced and canceled out of the collective thoughts of Americans that I think that if we knew, our policies would be done in such a different way, work would be done with such a higher level of urgency than it would have.

And so I would not have been able to really appreciate that had we not been in-person. So your recommendation as spot on that when we are talking about maternal infant mortality, and we're talking about a crisis, it is so hard for people who are not affected by it to really understand the impact if they're not experiencing it in some way, shape or form. And that's what an in-person experience has done for me, even as a person who represents multiple historically excluded groups in the United States.

Ed Ehlinger: Thank you. Also, one of my beliefs is that if we're not building community capacity, we're not doing our work well. And I was really pleased to see with that meeting in September that people from across the country actually chose to be there in person. Yes, there are some that had to

do it virtually, but more came and they formed partnerships and relationships that were new to them and they've continued those conversations so that there is now a network of American Indian/Alaska Native individuals that have not been created before that is now functional. It is sort of building community capacity and that's why having that meeting there had multiple side effects that were really positive. Lee.

Lee Wilson: Yeah. Hi folks. Ed, thanks for asking the question. And for me, I maybe have a slightly different view of the takeaway from the meeting. I had two in particular. One, I was so very, very pleased and impressed with the convergence of people situations readiness for the committee to see and hear the messages that were being provided and the degree to which it was sort of absorbed and adopted by the people who were there. So again, thank you, Ed, thank you, Janelle, thank you, Magda and all the other folks who worked to make that happen because it is remarkable how easy in our society it is to

overlook what's under the surface and what isn't put right in front of us. And there's a lot of work to be done. The second piece is just how much work there is that needs to be done.

I worked with tribal communities for the first 15 years of my career in the government and the thing that was startling to me was the impact that this event had on the committee when the conditions of the tribe that we were visiting are so far better than the conditions of the vast majority of tribal groups in the United States, whether they be living on a reservation or in sort of non-reservation urban settings or rural settings. What we saw was a palatial casino with a giant golf course and a lot of people beaming in or coming in and telling very difficult stories, very real stories about their experiences. The shock though comes when you are out on the Navajo reservation and see people in America in the 21st century living without running water or heat or all those other things that we thought we solved many, many decades ago.

And so the degree to which we as Americans, as really educated Americans need to go to uncover what's really out there and what dire circumstances certain people live in. So that's all.

Ed Ehlinger: Thank you, Lee. That was a really important point. The Shakopee Mdewakanton's from what I understand are one of the richest tribes in the country, if not the richest tribe in the country. So acknowledging that this is not representative of everything else, it gave us a view that was important to get. And because it was close to an airport and I could get urban and tribal Indians together in a spot, it helped meet my needs and our-

Lee Wilson: Certainly not intended as a critique.

Ed Ehlinger: No, I know. But acknowledging the fact that we need to always expand our view, and nothing represents everything. No one thing represents everything. So keep that in mind and I really

appreciate you bringing that up, it's an important point. Magda.

Magda Peck: Being there and hearing from our American Indian/Alaska Native folks who came from far and wide allowed me to change the narrative in my head about what this is all about. And we'll be talking a little later about narrative, but as somebody who's focused on urban health issues for most of my career through CityMatCH and otherwise, I had conflated the number that 70% of American Indians/Alaska Natives live off reservation and therefore they must be urban. That is false. And I just want to be very specific as someone who leads our data and research to action, the unlearning that needed to happen was possible because of being on-land and hearing a story told by multiple people from multiple perspectives, that allowed me to literally change the wiring in my brain about who lives where and differentiate between people and population and place, and place matters.

So that was an amazing piece and many people helped tell that story. Whether it came from the urban Indian perspective or whether it came from Don Warne's perspective when he showed maps and a diagram that says this is Indigenous, this is this. It literally is like the hotel map on the back of the door that helps you know how to get where you need to go. So narrative change happened viscerally because of the multiple layers of the stories and the information and voices we heard, the place we were at and a chance to process it in real time allowed me to never think that fact or un-fact again. And it's changed how CityMatCH is going to approach this from an urban perspective. And already relationships that have never existed between CityMatCH, which is urban MCH and Urban Indian Health Centers across the country.

Those relationships don't exist in Omaha where ironically Omaha, where CityMatCH is, or if it is, it's been on a relational level of somebody knows somebody. But structurally, the urban

agenda will be changed in maternal and child health because of the meeting. And a final note, only two, not three. Being on site allowed the divine coincidence of a parallel meeting around tribal health happening in another side of a windowless ballroom in this casino. And to have corralled the women's singers into the room, that spontaneity, that serendipity allowed us to hear their voices. And that would've never happened on Zoom. So a blessing in abundance and may it happen again.

Ed Ehlinger: I smile again just thinking about it. That was very cool. Charlene.

Charlene Collier: Thank you. Those are definitely excellent reflections. And I wanted to talk about the singers and that they had daughters with them, they had little girls, even a baby. And I remember at the very end of the meeting they were running around with happiness and joy and all over and it was a happy moment. But then just the weight hit of the urgency that what we're working on is to protect those small people and that this

shouldn't be a problem for those small people that we saw that day. Those babies, those young people, those little girls. And just acknowledging that it's already taken too long. But being there definitely had that power of connecting with community. And I'm so glad it's in the report as hopefully a requirement that if we're going to travel, that it's not just repeatedly to DC because that comes with money, that comes with booking hotels and fueling conferences and fueling financial places and that could go directly to communities.

We have a financial engine that goes behind committees and meetings and conferences and behind that is the cab rides, it's the food, it's all of that. And when it repeatedly goes to DC, yes it benefits that community in some regard, but then there's this opportunity to be closer to the neighborhoods that are being impacted. And truly not just uncovering, I don't think it's hidden, as Lee was mentioning, it's we don't expose ourselves. And it's not a requirement to

expose yourself, I think we think looking at data or talking to a person is enough, but truly I don't feel yet completely exposed having just been in the area to the casino, watching some of the videos. But knowing that the more we expose ourselves as a requirement to be able to weigh in, I think is important. And I hope it is carried forward throughout MCHB and certainly this committee. So thank you again Dr. Ehlinger, for the persistence. Because again, the easy way out would've been just Zoom, but this was something very impactful and so thank you.

Ed Ehlinger: One of the things that I've certainly learned with working with American Indian/Alaska Natives and what was highlighted at in our time in Shakopee was that the work that we're doing is sacred work. We're dealing with lives of individuals and families and it's a spiritual in a non-religious, well or religious... it's a spiritual kind of activity. And the fact that the tribes will start a meeting with an incantation, with a song, with a prayer. And those meetings

that I go to that start like that always are better. And I think we have to acknowledge the work that we are doing, however you define sacred is sort of the work that we do. And we have to, I think, acknowledge that it's important work. And it's a little different than just crunching numbers sometimes, it is actually dealing with the lives of people. And it was just highlighted when we were in Shakopee that when we started the meeting that way it gave it a different feel. All right. Anything else that folks have? First of all, is there anything that people can't live with? Or Magda, you got your hand up.

Magda Peck: Yeah, I just want to acknowledge how fabulous it was to be with SACCIMM colleagues. Kate, thanks for your little note about it, the warmth of it there. And I missed some of you. I missed your Jacob. I have not had a chance to have a direct one-on-one with you since you joined this committee, and I'm so glad you're on it. And I was just mindful, not only did it help us, including our federal colleagues. Michael Warren

was there for the entire time. He would be here today if he were not on leave. Lee Wilson. And just being able to build the relationships of the people who stand shoulder to shoulder for equity and justice and where we want to wield the influence that we have. And so I was curious at, it's an old Jewish practice that you always tell the story to the person who knows the least and the person who cannot speak or did not experience it. So, Jake, I'm going to pick on you, and others, to say, what is it like for you, and is there anything we can do to try to bring this clearer to life for you so that you are caught up?

And I just am mindful for wanting us to all be engaged, and a lot of us were there but not everyone. So it's just great to see you, and I hope you don't mind my being direct in inviting your reflection, by not being there, which is as powerful but different.

Jacob Warren: Yeah, no. I definitely appreciate that. And I think one of the things that's actually helped is

this, where I got to sort of experience a bit of it vicariously and hearing all of the wonderful things that y'all experienced when you were together was, it was very painful not to be there. I do have to say the timing of my new position was unexpected and just made it where I could not be there. And there was a lot of angst for me in being there because, as someone who focuses on rural issues, and they're not the same domain but there's certainly a lot of overlap in AIAN needs and in the overall needs in rural populations. And us having such a strong tribal presence here in Wyoming, it was very, very painful not to be there and get to experience that in person.

But I thank everyone for their conversation today and their reflections and how it helped shape their thoughts, and allowing me the chance to go back and rethink those elements myself as well. So I just want to thank you all for sharing your experience because it's helped me feel like at least I got to be there in spirit.

Magda Peck: Thank you for that. And anybody else, Ed?

Ed Ehlinger: Well, I would just want to reflect, Magda, and you talked about the relationships. I quote Wendell Berry a lot, the farmer Wendell Barry, who said that, "Speaking about the health of an isolated individual is a contradiction in terms. The smallest unit of health is the community." And health is all about relationships. It's not about individuals. It's about relationships. And so the health of a committee is about relationships, and that's why coming together helped to build those relationships, as you pointed out, Magda. It just adds a different level to our whole conversation. So thank you for bringing that up.

Anybody else who'd like to say something. Magda picked on Jacob. I know others were not there. If they would like to step up and say something. I know, Tara, you came in for some of the meeting. You were there virtually for part of it, but not for the whole thing. Any thoughts that you have?

Unmute. Unmute.

Tara Sander Lee: Sorry. Yeah. I appreciate this opportunity, and I apologize that I couldn't be there. I had requirements. I had to be in DC during that time. I was hopeful that I could have attended had it been in in DC, but I totally understand the need and desire to have it held in Minnesota. It's just I physically couldn't be in two places at one time, but I appreciate the opportunity that you allowed people to attend virtually as they could. And this has just been really helpful. The report is amazing. It's so in depth and thorough, so I just thank everybody for their work that they've done and then just having this recap. It's definitely not the same as being there in person, I know that, but just having this opportunity to hear what your experiences have been has definitely made a difference, so thank you. Always learning. Always learning in this position, that's all I have to say.

Ed Ehlinger: Aren't we all? Thank you all. And we're going to have another session. We're going to be talking

about how do we use this report. This session, the last hour, 45 minutes or so, was to say just our reflections. What did we learn? I get a sense that people are on board. So I'm going to ask Janelle to make a motion to approve this report.

Vote to Approve Report

Janelle Palacios: Advisory Committee on Infant and Maternal Mortality, colleagues, with a full heart and optimism for the health and well-being of our united nation, move that we approve this report and send it forward to the Secretary of the Health and Human Services.

Ed Ehlinger: Thank you. And I would like to have someone from the new cohort of SACIMM members to second that motion. Phyllis, I want you to verbally second that motion.

Phyllis Sharps: I, with great appreciation, second the motion.

Ed Ehlinger: Any comment? Any additional comments? Hearing none, I ask Vanessa to call the roll.

Vanessa Lee: Happy to do so. Sherri Alderman, how do you vote?

Sherri Alderman: I gratefully and enthusiastically vote yay.

Vanessa Lee: Thank you. Dr. Ehlinger?

Ed Ehlinger: Yes, for sure.

Vanessa Lee: Steve Calvin?

Steve Calvin: Yes as well.

Vanessa Lee: Thank you. Charlene Collier?

Charlene Collier: Yes, thank you.

Vanessa Lee: Thank you. Tara?

Tara Sander Lee: Yes, thank you.

Vanessa Lee: Thank you. Kate?

Kathryn Menard: Yes. With enthusiasm.

Vanessa Lee: Joy?

Joy Neyhart: Yes, also with enthusiasm.

Vanessa Lee: Magda?

Magda Peck: Yes, without hesitation, consideration, or doubt.

Vanessa Lee: Thank you. Belinda?

Belinda Pettiford: 100% yes, if not 110%.

Vanessa Lee: Marie?

Marie-Elizabeth Ramas: Absolutely, yes.

Vanessa Lee: Thank you. ShaRhonda?

ShaRhonda Thompson: Yes.

Vanessa Lee: Thank you. And Jacob?

Jacob Warren: Enthusiastic and humble yes.

Vanessa Lee: Excellent. Ed, that is all of the members.

Ed Ehlinger: All right. Unanimously approved. I have to tell you, I got a little few tears in my eyes.

Vanessa Lee: Oh. The whole time I was listening to you guys, I had tissues on hand. I was about to chat, is anyone else needing the tissues?

Ed Ehlinger: I did this more formally than what we would normally would do about everybody saying just say

yes, because I think this is a powerful report. This is an important report. This is something that I hope can actually change the direction. Like I said at the beginning, there's been lots of days of infamy and we need to move forward and rectify some of those. And I'm hoping this report is just... I mean, obviously, it's just one small step. There's much more that needs to be done. But it gives some examples. And just from hearing the conversation that you've had over the last hour, it can have an impact. So I have lots of hope that this can move forward. And I hope the...

I really wanted to acknowledge the fact that Janelle did so much work on this and wanted her to actually move this forward, but also to have the new group, the continuing cohort, to actually just have ownership of this to move it on, to keep this candle burning and move the light forward. It causes me to be a little emotional about this. This is really a great day for SACIMM, I think.

All right. Any other comments before we move on to how to use this report?

Let me look at the chat here that I haven't been. All right.

Discussion: Use and Dissemination of the Report

Ed Ehlinger: So we are going to take the next section of, how do we use and disseminate this report? As you've heard all along, certainly at the meeting in September and in putting this together, and as you read the report in our conversation, we created a story. We collected stories. We put the stories together into a broader story of how to move forward in actions. And so it's the stories that really carried the message forward, carried the data forward, carried the need to act forward. And so how do we tell the story of this report? The data story, the personal stories, the lived experience stories, the policy stories, the programs, how do we move them forward? And so I wanted to spend a little time, the next hour or so, talking about how we move this forward. And so I've asked Magda and Janelle, I know that

they've been working on storytelling, and so I want them to sort of maybe set the frame for us, how do we use storytelling to advance this report, the recommendations in this report?

So I'm going to turn it over to Magda and Janelle, and then we're going to hear from the CDC folks and how they're using their stories to actually move some of the same issues along with the HEAR HER. And then we'll open it up for some broader conversation. So, Magda and Janelle.

Strategic Storytelling

Magda Peck: Sit back. Thank you, all. Janelle and I are delighted to kick off this strategy session that will build upon what Belinda said about the essential need for community voice, what Sherry said about the power of story, what Phyllis said about getting out of our ivory towers, what Charlene said about making the story bring things alive beyond the voice of one.

And so today, for the next 15 or 20 minutes, we're going to try to wrap up this notion about strategic storytelling, so that the power of word and voice can do what has been our commitment, and perhaps, in many ways, an imprimatur of this version of a 30 year old advisory committee to the Secretary of Health and Human Services, that being the Advisory Committee on Infant and Maternal Mortality.

For the last four years, we have been inviting and elevating and honoring the sacred stories that we own ourselves, hear from others as integral to our work for equity and justice and healthier women, children, families, fathers, and communities. Towards that end, we would like to overview for you the power of story and encourage SACIMM as we use this and bring this set of stories to life, for life, that we do it in an evidence-based way, and we build on the practices that exist already, over generations and in current public health practice.

Janelle, help us get started.

Janelle Palacios: Of course.

So, a story communicates fear, hope, and anxiety. And because we can feel it, we get the moral, not just as a concept, but as a teaching of our hearts. That's the power of story.

So, I would like to next share with you Rhonda's story. So, as I cue it up, we will share Rhonda's story. We heard from Rhonda at our in-person September meeting. She's former chairwoman of the Confederated Salish and Kootenai tribes, and most recently, past retired chief lawyer for the same tribe. Rhonda shared her birth experience that happened over 45 years ago. I worked with Rhonda in putting her story into a visual and narrative storytelling. This project was yet to, again, demonstrate the power of story. And in this version, you will hear my voice, but these are her words.

Okay, here we go.

Oops.

Rhonda Swaney: I was newly married at age 24 and pregnant for the first time, working for social services within my rural community. My husband, also young, worked long hours. We had a rocky start to our relationship, filled with violence and alcoholism. But when I became pregnant, we grew as a couple and the violence ended, though his drinking continued. I was dutiful in my pregnancy, scheduling all the prenatal appointments I was told I needed, and rarely canceling them, only when the roads were too icy and dangerous.

When I was about six months pregnant, the clinic nurse told me I had protein in my urine. She notified the doctor who said I was fine, not to worry and to go home. That weekend, I became terribly sick. I had the worst migraine in my life. I was nauseous and bleeding. Something was wrong and I felt awful. It was winter and the roads were icy. But I went to the local hospital. I was transferred by ambulance to a larger hospital sixty-five miles away, bleeding and

feeling worse, with no details from the medical personnel of what was happening to me and why I felt horrible.

When we arrived at the hospital, I found out my daughter had died and I was told they needed to induce me. Shortly after starting the induction, I delivered my stillborn baby girl. I stayed a few days in the hospital, no family or friends at my side. During my recovery, no one educated me on the illness I had just experienced. No one at the hospital asked me how I was doing mentally nor emotionally after having just lost my baby. I was told to take medication to prevent seizures, but no one educated me on how to care for myself postpartum, or after the loss of a baby, nor how long I should wait before trying again.

Wanting to move on, we became pregnant quickly. And because I was considered high risk, my clinic appointments were in the larger town. To attend one 15-minute appointment, I had to drive 120 miles round trip. At the time, we had just one car we shared. Again, I was pregnant during the

winter. The roads were bad, and I had to cancel appointments simply because it was too dangerous to drive.

One day at work, while six months pregnant, something felt off. I did not realize my water had broken. I thought I was having light discharge, but then started spotting. I called the doctor's office and was told to come in. When I arrived to the hospital, I was in pre-term labor and bore my son at midnight at our local small hospital. The doctor told me my son would not live throughout the night. I was not allowed to hold my son. They whisked him away to lay in an isolette, alone within the nursery.

But you see, my son Kelly is a survivor. He lived despite the doctor's prognosis and was immediately transported 500 miles away to a neonatal center. I could only touch my son, not hold him, just touch him. A week later while visiting him, Kelly was born weighing one pound, 12 ounces, and he lost weight his first week of life, weighing one pound, six ounces. Because he

was extremely preterm, a lot of the care he received was experimental, and I signed a great deal of paperwork that I did not completely understand, relinquishing the hospital from reliability.

The hospital social worker told me that my son would likely die, and she encouraged me not to change my routine at home, to continue working and live my life. My son had many near misses that I witnessed when I was present on the short spans of time I could visit, but I was not able to be with my son the entire time he stayed in the hospital far from home.

When he was about three months of age, he was transferred closer to home, to a new neonatal center that had just opened, with staff who were new to their positions, and a number of mistakes were made in my son's care. I was taught CPR in case I needed to resuscitate my baby. And when he was discharged around five months of age, I had to use CPR a few times when he stopped breathing.

When I returned to my clinic doctor without any understanding as to why I had a stillborn baby during pre-eclampsia with my first baby, I went into preterm labor with my second, I remember the doctor encouraging me to continue trying for children. He said...

Janelle Palacios: When Rhonda shared with us her experience in person at the September meeting, she shared how she felt she was perceived, that she was just another young Native woman who was expected to just have children and have no problems. But when she had problems, that she was not capable of understanding what happened, what was going on. And in addition to that, that she'll be fine and have more children, that there's no need to worry about the previous two that she had just had, just to go on living her life.

So she talked about how in that time period being innocent to understanding the dynamics of the larger health system and education, and not realizing that when she brought her child to... When her child was in the hospital and

experimental care was given, she didn't understand the power that she was relinquishing, that very much the work that was being done was in service to his life, her son's life, but that it was not really well explained. It was only when years later, in her fifties, when she went back to school and became a lawyer, she realized, thinking back, just what was going on when she was in her young twenties, and reflectively thinking about the power differences, and then also thinking back on her experience as a mother.

In this meeting, she shared with us that she still, today, carries the burden of feeling responsible for every step of her pregnancies, in both of them, that she is responsible personally for the outcomes that have happened, not that there was an intention to help ease her pain or help educate her or to do that further. And it's only really recently that she's been able to understand what really happened.

So when we talk about stories, we want to think about the dominant stories, the prevailing

stories. On one hand, today, that still goes on. A lot of Black Indigenous people of color, women and pregnant people experience a marginalization that, stereotypically, they're drug seeking. Stereotypically, they have higher tolerance for pain. Stereotypically, they have this or that. So, who drives these narratives? That is part of understanding our history, understanding where a dominant perspective comes from.

This slide is great because it's demonstrating that story is also scientific. When we hear story, there are chemical changes happening in our brains, because we are making connections to the person who is telling the story to the story itself. And then there are also these chemical connections that are also involved in whether or not we are receiving the message, and if we are about to change how we believe something, our attitudes, our practices, our actions. Storytelling is scientific, and we are just beginning to learn the power of story.

Magda and I have worked for some time about how stories can inform, shape, and shift new narratives. And this is where understanding context, understanding someone's story, is helping to reframe the messages that are told or shared about a particular phenomenon. And so Magda will take over next, and she will give a brief overview of... This is very brief. This could be a day-long presentation, but a brief overview of the importance of storytelling, before she gives you examples of storytelling.

Magda Peck: One of the things that makes this report so powerful is that we've contextualized the data with stories and with history. That is one of the leading reasons that we need to bring back a centuries and generational long set of practices that allow us to transmit why, how, what, for whom, so what and what next. So we need to not just come out of the ivory tower, we need to use this report, as we can build upon the prior recommendations of the last several years from data to bring data to life, to honor and utilize

data through story, so that we can humanize our numbers, so that we can know behind every numerator and every denominator is a mother, a father, a child, a family, a community. And we can elevate and honor lived experiences, not as an extracurricular, but as an integral part. That is one of the implicit ways this report that has just been approved begins to demonstrate a valid and reliable new way of doing business to influence policy.

And we do so in an evidence based way, because stories are brain science. Our brains, as the neuroscientists like Antonio Damasio tell us, our brains are wired to make sense. Stories is the way we make sense of what we see, taste, hear, smell, experience over time. So another way to think about is, why not story? Why have we divorced story from data? Our work in bringing this particular report forward, and we hope setting the standard for advisory committees and maternal and child health and public health practice, is to welcome back stories, not in an

exercise of community engagement, but in truth telling and shaping solutions that are much more likely to work and last. Next.

We have a long tradition in many of our cultures of storytelling. And we also have some current storytelling practices that are happening. I have three slides that just begin to scrape the surface of a diverse perspectives in which storytelling that is evidence-based and experientially-driven by generations of practice are helping us be able to hear, tell, receive, and transmit stories with intention and strategy.

After this presentation, we'll be hearing from the HEAR HER Campaign. But it is an example on Wanda Barfield being one of the faculty that we have recruited in our storytelling work. And training will be the first to say that if we cannot hear her or get others to take her story seriously, there are consequences that are life and death threatening.

We want to recognize that the Healthy Start Association through the community care initiative of the AIM work has developed a Maternal Monologues Tool Kit about how to convene story circles in communities for people to tell their birth stories in a way that both validates and collects the data that will be able to inform strategy and policy.

There's great examples beyond maternal and child health, but a good Young Latina parenting initiative out of Hear Our Stories that UMass Amherst has. It is widespread and growing as a movement for storytelling. And it's enabled with technical assistance and methodologies. StoryCenter in Oakland, California is one of the premier digital storytelling practices that we are brokering, and now that's manifesting in Michigan and Illinois and other places. And you heard a good example of that in the digital story that Janelle told. Both of us are trained by storytelling workshops and capacity building, so that we can spread it on and borrow the

storytelling faculty that will help us lift up those stories in digital ways.

That digital storytelling has also been brought in from an urban Indian and a tribal, especially an American Indian/Alaska Native perspective, into the National Indian Council on Aging, as well as technical assistance that SAMHSA is bringing around mental health. So, we should know that we join and lead current practices, and there are many more. My ask of you, our ask of you, is to help us build this inventory, not only through SACIMM's work, but from what you know is happening. So, on your to-do list or in the chat box, if you know of strategic storytelling that's happening, please help us build this inventory. It does not exist anywhere as a one-stop shop. We want to make that possible so folks can skip ahead and know exactly how to bring this practice and build on our experience at SACIMM. Next.

We also join a larger narrative change that is happening, and the Lost Mother series that ProPublica and NPR put together with reporters

Nina Marin and Renee Montagne starting in 2017, has highlighted over six months, and they collected over 5,000 stories, including Shalon Irving's story, a blessed memory, Dr. Shalon Irving of the CDC. This story became, if it can happen to the person who was working directly every day as a physician on preventing Black babies from dying, how is it that her story was not heard or taken seriously?

Many of us have heard Calvin Johnson talk about his wife, Kira Johnson, and that has led to HR 1212, establishing grants for better outcomes to address racial equity in terms of maternal health. Stories can make that kind of difference. And when it goes mainstream in health affairs, they now have established narrative matters, and other journals have done so as well, bringing into the ivory tower, what has been in town, going to gown, including the stillbirth story from January 2022, which is referenced here. We will make all these slides available to you as

part of the record so that you can have them as access.

And then last, next slide, if we could just recognize that without us, there has been extraordinary grassroots level through these three great examples, of Birthright that Kimberly Seals Allers talks about, not just the loss, but the unapologetic celebration of Black joy in her podcast. Birth Stories in Color include Indigenous women's stories, which will equip parents on how to navigate that journey, given racism and resistance. And even performances like Wisconsin's Poet Laureate Dasha Kelly Hamilton, who is able to create community conversations on culture and class just by Making Cake. She is also faculty in some of our storytelling training about how do you turn moments into the magic of stories.

All of these combined, next slide, into a practice that we encourage for this future work of SACIMM, to be strategic about storytelling, not my Uncle Mickey who goes on for 20 minutes

and loses us, to be knowing about the following factors. Next.

Storytelling has a science, a knowledge, and an experience. And when it is intentional and purposeful with ethical boundaries, in the right context, can be a power tool for change. So we encourage that as SACIMM uses this story and brings it even further to life, it abides by the best practices of strategic storytelling. We, yes, are not done with this work. Janelle and I and Ken Harris and Calvin Williams and Dominique and Walker and Rosemary Fournier in FMIR.

I wanted to mention finally that I've had the pleasure and by full disclosure of being consultant to every opportunity for FMIR Maternal and Infant Mortality Review and Child Death Review to storify the work. So thank you for Marie for posting it. Because storification is what is needed to make amends. It's a word that I don't know if it truly exists, but as it were an official federal body lay, it exists from now on.

To storify this work is to give it the power to go from word to deed.

So, Janelle, help us look at what strategies you and I and Ed have worked on, as we have brought these approved recommendations into fruition.

Janelle Palacios: Right. So definitely, we were all in agreement from one of the very earlier ACIMM meetings four years ago, that the power of story qualitative data was needed. And we were provided an opportunity with the in-person meeting.

Now, I will have to say, and give kudos to Dr. Peck that... Dr. Peck is so brilliant that she had a number of amazing ways that story could have been embedded in this report. It is only that gravity holds her down, that we are not doing something super fantastic, fabulous out of this like sphere. But what we have is amazing.

So, we recognize that data alone is not sufficient, that numbers do not tell the whole story. And that lived experience is really what needs to help put meaning behind the numbers. And

as we have heard by multiple ACIMM members, committee members, that the power of story is real. It is important. They help us frame the narrative, and this is framing the narrative where our recommendations are coming from. So, a lot of you talked about how important it was to get the contextual piece, the history background, that we're backgrounding the recommendations set forth. So, that history piece is important for understanding the recommendations. And then we had lived experience. That is tying in the recommendations, tying in the historical consequences. So, this, making amends, is storifying personified. It's personal. It's interesting, compelling, and universal. We, by engaging people, asking for their stories and then putting it into the report where people can go back and read again and again, it expands the meaningful participation and shared ownership of this. Dr. Ed Ehlinger went back and asked every single person who is quoted in this report if they agreed and making sure that it was

representative of what they were actually talking about.

So, there has been an agreement that this report is accurate with their lived experience, what they shared. By storifying and by gaining, not just having token visualization or a token presence, by actually engaging people, we are getting people's buy-in. So, the people who had joined us in September and others, other Indigenous people from other communities and organizations, have buy-in into this report as well as us on the committee. We have buy-in because we want to see these stories change. So, with this buy-in, it catalyzes a new partnership through the realization of these shared experiences. And we all come to this understanding, and anyone who reads it, that these are real people, be real experiences.

So, we have this commitment that this report will be used as a powerful tool for improving the health and safety of Native American women, American Indian/Alaska Native women and infants

and families. It is with, again, a full heart that I am just thanking everyone who has participated in this and would like to again recognize Dr. Magda Peck and Dr. Ed Ehlinger for everything that they have done in helping moving this forward and help framing this context, as well as all the people involved on all the committees that have reviewed the report, our fellow ACIMM members, colleagues, but also the people who have reviewed this report to make it what it is that participated in September, that people with lived experience, experts giving their opinion, giving their testimony, as well as those who were not able to present or join us, but had a vested interest in this and also put their two cents in, making sure that we were accurately representing and sharing what needs to be done.

And as you heard from Dr. Ehlinger, there was a request for more. There was a request for more to be put in this report. So, we give it to the next

generation to carry forward with the actions. Are there any questions before we move on?

Magda Peck: I want to thank you, Janelle, for partnering on this, and I just want to end with a note that I've been doing this work for a number of years, as you all know. I've been part of national advisory committees, and there's a certain sense that a report can sit on a shelf. Our duty is to not let this sit. And there are ways and tools to bring it forward. As Janelle said, I've got ideas on that as somebody who does strategic storytelling for public health, but I want to make sure that our continuing members know that there is a ways and means to bring this to life and that we're on call to you for this work. So, Janelle, thanks for being a good buddy, and I just wanted to echo questions, observations, ante up with your inventory and let us know how we can continue to be of service.

HEAR HER Campaign

Ed Ehlinger: Thank you, Magda and Janelle. That was great. We'll come back to this as we go on with this session to get some feedback, but let's now move on to another kind of storytelling that you mentioned in your little presentation. That's the HEAR HER campaign, and I think we've got Charlan Kroelinger here and Sarah Carrigan, so I'm going to turn it over to you guys.

Sarah Carrigan: Yes. Thank you very much. It is a little daunting to follow Magda and Janelle, but I'm very grateful to be here and for the opportunity to present today. And just a moment, actually. Sorry. I just shared, but I always forget that I do need to share sound as well. So, pardon me as I re-share here. Okay. Here we go. Now I'm ready. All right. Well, thank you everybody. My name is Sarah Carrigan, and I am a health communication specialist with CDC's Division of Reproductive Health. I'm joined here today by Dr. Charlan Kroelinger, who you all know, chief of CDC's Division of Reproductive Health's Maternal and

Infant Health Branch. Before I begin, I would like to acknowledge and honor the Creek and Cherokee nations and their people on whose ancestral homelands I'm speaking from today. In addition, I do want to note my gratitude to all of the colleagues who have made this work possible. To Delight Satter, Janelle Palacios, all of you in this virtual room, and to others who have helped to raise awareness of the needs of American Indian and Alaska Native mothers and the progress that they've made to improve care.

I'd also like to acknowledge the late Leslie Randall for all of her work to advance this awareness. There is still so much to be done, but I am proud and humble to be here with you today to share some of the work that we are doing to hear and talk to American Indian and Alaska Native mothers, their loved ones, and communities. In this presentation, I will share more information about the HEAR HER campaign and the resources that we have produced to serve American Indian and Alaska Native communities.

Although deaths related to pregnancy are rare, most are preventable. We lose too many American Indian and Alaska Native mothers each year from complications related to pregnancy. American Indian and Alaska Native woman are two times more likely to die of pregnancy-related causes than white women. This is unacceptable. I want to acknowledge the trauma and the systemic barriers that are linked to the disproportionately high maternal and infant deaths that many tribal communities experience. American Indian's and Alaska Native's maternal health is impacted by the ongoing and historical trauma of systemic racism, colonization, genocide, forced migration, reproductive coercion, and cultural erasure. These factors have led to systemic barriers to care, including higher rates of poverty and long distance to quality healthcare services. Given the disparities that American Indian and Alaska Native people and communities experience, it is a priority for us to reach tribal communities with these resources.

Despite these challenges, American Indian and Alaska Native people continue to be resilient and thrive. Many American Indian and Alaskan Native people draw strength from culture and tradition. Their resilience is built through culture, spirituality, shared values, and a strong sense of identity. Culture serves as a protective factor in the health and wellbeing of American Indian and Alaska Native people. We honor the lives of those who have passed on and work to prevent future losses. CDC works to better understand the causes of pregnancy-related deaths and to apply that data to action. Data from CDC surveillance systems and field work has helped to inform the development of the HEAR HER campaign. As many of you are aware, in August of 2020, we launched the HEAR HER campaign to raise awareness of the potentially life-threatening warning signs during and after pregnancy, and to improve communication between healthcare providers and their patients.

It's a priority for us to reach tribal communities with these resources. In 2021, HHS Office of Minority Health provided funding to develop a segment of the HEAR HER campaign specifically to reach American Indian and Alaska Native women and communities. With that funding, we have been working with CDC Foundation, Market Vision, which is a creative agency, Gray & Gray, a native-owned and serving marketing agency, and the National Indian Health Board to develop this segment. CDC has worked to include the voices and perspectives of American Indian and Alaska Native people throughout the development of this campaign, and will continue to do so as we continue to develop materials and implement this campaign. We are so grateful to all of the American Indian and Alaska Native people who have contributed their time, experiences, and expertise to this project.

Storytelling is the center of this campaign. So, now I would like to share Trivia's story, one of the women who shares as part of this campaign.

Before I start, I would like to note that Trivia shares experiences with discrimination when her provider did not respect her cultural practices or listen to her concerns. Her story can be very hard to hear. I encourage you to go off camera or to take the space that you need if this story is triggering for you. We are very grateful to her for sharing her experience, knowing that it could help other mothers to receive better care.

Trivia Afraid of Lightening-Craddock: My name is Trivia Afraid of Lightning-Craddock. My Lakota name is Mahka T'a Tuwanpi Win. I'm an enrolled member of the Miniconjou Lakota Tribe of Cheyenne Rivers, South Dakota. In our culture, being a mother is a great, great honor. When I first became a mother, I was actually a teen mother. I had excellent support because of my culture. My aunts, my mom, they were all supportive, excited. Culturally, there are practices that our grandmothers, mothers, and aunts teach young women when they're getting ready to have a baby. I started having issues in my pregnancy in the beginning of my

second trimester. I had morning sickness every single day. They shouldn't even call it morning sickness. I could not keep food down. And I kept telling the doctor that something was wrong. This is how I know that he dismissed me from the beginning of prenatal care all the way up to birth.

I kept telling him, "Something's not right. I don't feel okay." My OB knew that I wanted my placenta so that I was able to bury it. Culturally, for us as women, it is a part of our body that was connected... It is the life source that was connected to our baby. And they let me know that there was nothing. I was angry and I cried. That night I cried alone holding my daughter. Holding her. I was just crying and I felt like nobody understood or cared. Throwing it away is very disrespectful. It's sacred. So, I go home with baby. I had an infection and I had to go back. They put me on an antibiotic and told me I couldn't nurse my baby. I felt like I had no connection to her. My mom's youngest sister comes

back into the room and she's asking me if I'm okay. "It would be really good for you to talk to a counselor because you're displaying signs of postpartum depression." It lasted until my daughter was about nine or 10 months old. Some of the postpartum depression that I can remember were blaming myself.

I couldn't even be a mother. I couldn't be a Lakota mother. I started to have suicidal ideation of, "Why even be here if you can't do it right?" It was just dark days. My second child I had about a year later. Oh, I went into the second pregnancy with a mission. I was like a mama bear. I was in protective mode. The new doctor that I was working with not only heard me, he validated me. He let me know that he understood Lakota women's cultural practices when it came to packaging up the placenta. I felt relaxed and safe. I was really mindful and needed to advocate myself. Choosing a safe primary care provider has been at the top of my list. If you're uncomfortable that first visit, change.

You do not have to keep that person as your primary. If you feel that there is something wrong, talk to your aunt, your mom, your best friend, your nurse.

Your nurse would tell you that it's okay to call whenever they feel that they need to call. Go in. Have it checked. Never discount your gut feeling. Always talk to somebody about how you're feeling. If you're feeling depressed, if you're feeling that you're not good enough, if you're feeling that you can't go through with the birth, if you're having anxiety, if you're having fear, reach out to someone. Don't do it alone. Voice how you feel.

Sarah Carrigan: Trivia's story is one of the stories that we share through the HEARHER campaign. We were also able to produce the stories of four more American Indian women who experienced pregnancy-related complications, Sarah, Vanessa, Mona, and Takayla. They share their experiences with pre-eclampsia, HELLP syndrome and postpartum depression, and the importance of sharing your concerns if something

feels wrong and getting care immediately. For the sake of time I will not play their stories now, but I encourage you to visit our site to view them. I want to note, CDC also engaged an American Indian photographer to capture culturally relevant photography of American Indian and Alaska Native people, helping to meet another need for diversity and inclusion of this population in public health materials.

In addition to the video sharing these women's stories, we've produced educational materials to help raise awareness of the urgent maternal warning signs and improve communication between patients and providers. These materials are all housed on the HEAR HER website, along with additional context and links to the related resources. The first one listed here is the PSA, which I'm grateful. I appreciate the committee playing that at the start of the meeting. What you see on this slide is the Urgent Maternal Warning Signs poster, which helps to raise awareness of the symptoms that could indicate a

life-threatening situation. This is one of the highest demand resources that we have in the campaign, and there has already been a lot of interest in getting this resource out into clinics and facilities and to translating the resources to make them more relevant locally.

In addition, we've produced conversation guides and palm cards for people who are pregnant and postpartum to help them share symptoms they experience and raise their concerns with their healthcare provider. We also have a handout and palm card aimed at family, friends and other support people. We know that it can be challenging to talk about complications related to pregnancy. This tool can help facilitate conversation and make sure that people who are pregnant or postpartum get the care that they need. Finally, and most importantly, we have materials designed for healthcare professionals. Healthcare professionals play a critical role in eliminating preventable maternal mortality. A critical part of the solution is to really hear

women's concerns during and after pregnancy. The materials we've developed emphasize the importance of building a relationship with patients, supporting their cultural strengths, and ensuring they feel safe sharing their needs and concerns. We also share information and resources on providing culturally appropriate care. Understanding and respecting the unique needs and cultural practices of each patient is an important part of building trust and providing medical care.

In addition to the downloadable and print resources, we've produced a suite of shareable graphics and social media posts for partners to amplify the message and help get these resources to American Indian and Alaska Native communities. These resources were launched three weeks ago, on November 16th. We are very grateful to be working with the National Indian Health Board on the development and implementation of this campaign. Next year, NIHB will help host a tribal learning collaborative and help build capacity for tribes,

tribal organizations, tribal public health, and urban Indian organizations to implement this campaign. We will also use traditional communication strategies, including paid media. Now I'd like to turn it over to my colleague, Dr. Kroelinger.

Charlan Kroelinger: Thanks so much, Sarah. Another place where CDC is working to support American Indian and Alaska Native communities and tell a story is to ensure representation in the data. The work that I'm about to present I want to attribute to the maternal mortality prevention team within our division and within the branch that I oversee, and their team lead Dr. David Goodman. In addition to a data brief on all pregnancy-related deaths from state Maternal Mortality Review Committees from 2017 to 2019, we also looked at American Indian and Alaska Native deaths using best practices for data analysis from organizations such as the Urban Indian Health Institute. Today I want to share that approach and findings from that analysis.

Understanding differences in the underlying causes of pregnancy-related deaths by race and ethnicity is important for identifying prevention opportunities to reduce pregnancy-related deaths. Accurate classification of race and ethnicity can be challenging. Methodological decisions about racial classification can affect the size and characteristics of the population's use in an analysis. Assessments from other groups have demonstrated the importance of examining pregnancy-related deaths among all American Indian or Alaska Native persons, regardless of notation of Hispanic origins or other or multiple races.

This slide describes the alternative approach to classifying pregnancy-related deaths among all American Indian and Alaska Natives that was used for this analysis. As shown in the figure, using this alternate approach to classifying available vital records information on race and ethnicity, 17 pregnancy-related deaths were classified as American Indian/Alaska Native. One death with

notation of Native American and to specify, other free text field was included. Five American Indian and Alaska Native deaths with notation of Hispanic ethnicity or missing ethnicity were included. And two American Indian/Alaska Native deaths with notation of more than one race were included. While this alternate approach resulted in the increased identification of pregnancy-related death among American Indian and Alaska Native persons, because of known limitations of vital records data for identifying American Indian and Alaska Native persons, 17 is still likely an under-count of death among these persons. The next two slides will describe these 17 pregnancy-related deaths.

16 of the 17 pregnancy-related deaths among American Indians or Alaska Native persons had a known underlying cause of death. Among those with a known underlying cause of death, mental health conditions were the most frequent, followed by hemorrhage. A Maternal Mortality Review Committee preventability determination was available for 15

of the 17 pregnancy-related deaths among American Indian or Alaska Native persons. Among these deaths with a preventability determination, 93% were determined to be preventable. The key findings of this report, which is also available on the CDC website, are that methodological decisions about race classification can impact the size and characteristics of the population used in an analysis. The underlying cause of pregnancy-related death among American Indian and Alaska Native persons was mental health conditions, followed by hemorrhage. And 93% of pregnancy-related deaths among this population were determined to be preventable. Thank you, and please use these email addresses to reach out with any follow-up questions or concerns related to the information that Sarah and I have presented.

Ed Ehlinger: Thank you, Sarah and Charlan. I'm going to open it up for a few minutes of any questions or comments that people have, both for Janelle and Magda and also for Sarah and Charlan. Janelle?

Janelle Palacios: I have a question for the CDC colleagues. So, thank you for that presentation. That was wonderful. I just want to say thank you for sharing the lived experience of women of color and especially Native American women. I mean, just allowing a format, a platform for people to come and share that. And I want to also thank you for calling out, Sarah, that Indigenous community representatives and Indigenous community businesses were involved in the shaping and crafting of the visual representation. It was amazing to have that because it demonstrates that there is insight knowing that, from the community, they're going to probably know a little bit more of how to work with other native communities, even though we might be different tribes. It reminded me of the urban legend, which I don't think is urban. When the Chevrolet Nova was pushed out in Mexico, no one bought it.

It dived. It nose-dived because Nova means no go in Spanish. So, they did not have a cultural responsiveness in that business campaign. So,

thank you for not being the Chevrolet Nova of the federal government pushing out something that's very important. Charlan, one of the questions I had. In that free text and when I read the report, I was just wondering, okay, one person wrote in that free text, "Native American." And I was thinking as well, undercounting. Because I know for myself, I personally have written in the free text, "Salish and Kootenai" or "Black." Other people might write in their tribal affiliation and leave it at that and choose not to click a box, but just do the free text box. So, maybe going forward for our partners, think about if you have a free text self-identity box, going through and looking for tribal affiliations, which some people will do, could be another way of capturing a little bit more of the population.

And then the last comment is more that this is so powerful and I was tearful the first time that I saw the HEAR HER campaign Native American rollout of the stories, because it to me was the first

time that on a national level I could see that Native people's voices were brought to light on this issue. And it was federally-funded. But I also want to recognize that I don't know the dynamics of the federal funding, but this is so important that it continues to need to be funded. I once wrote a paper doing community-based participatory research on a shoestring budget. And I don't know if that was the case for work that happens to be culturally informed, but my experience of working with communities tends to be a lot on a shoestring budget. So, I'm just hoping that the Health and Human Services continues to prioritize these culturally informative and actionable interventions. Thank you.

National MCH Organizations from September Meeting

Ed Ehlinger: Thank you, Janelle. I don't see any other hands, so I'm going to move ahead here because we got a couple of other little discussions before we open it up for general comments about how to use this

report. I have invited the MCH organizations that were at our September meeting to come and just share a couple of minutes of what their takeaways from the September meeting was and how they might be using this, our report, as they do their work ahead of time and moving forward.

And I know that CityMatCH is tied up with a bunch of other things so they can't come. I have not heard back from Healthy Start, but NICHQ and AMCHP said that they were going to be here. And I see Scott and LaToshia are here and I'm not sure about Terrence, if he's here. But let me turn it over to Scott. Give us a couple of minutes of what were your takeaways from the September meeting when you were there, which I thank you for attending, for being there for the whole time, and then how might you use what you've learned during that and this report moving forward with NICHQ.

Scott Berns: Thanks, Ed. Hi, everybody. I'm just going to, first, I'm going to ask LaToshia actually to chime in first, but while she's thinking, I'm

going to first say that I'd like to honor and acknowledge that I'm dialing in on Zoom today from the ancestral lands of the Wampanoag and the Patuxet peoples. And LaToshia, did you want to start on behalf of NICHQ and then I'm happy to jump in?

LaToshia Rouse: I will just say that I'm so glad to be here, but this feels so different than it did when we were in a room together. And being able to feel what it is like when someone is telling a story in person is very different than when you're on Zoom. So, that is one thing that I'm taking away right now is how different this feels versus how it was when we were in a room together. And as far as NICHQ goes, we have started the process of bringing in different organizations that can help us to be able to bring awareness around this. So, we're working through the process of what that looks like and trying to get schedules coordinated, and Scott has a little bit more to say about that.

Scott Berns: Thanks, LaToshia. And just as a reminder, LaToshia is a board member at NICHQ and I'm CEO at the National Institute for Children's Health Quality. So, I'd like to share a few other things. First, just a kudos to a tremendous experience at Prior Lake and really we just alluded to, I was dialed in for the last few presentations, the stories that we heard were just so transformative for me personally and professionally, certainly for us as an organization, and so thank you for that. And I was glad to see the stories actually in the report as well, both through written throughout the report and also at the end, the detail there. In terms of takeaways from the meeting, I have to say that I was surprised around the disappointment with the IHS, Indian Health Service, and I do plan on following up with folks there to learn more about that.

I think it was painful to hear that. I think despite all good intentions from folks, there's definitely... And I note that you made quite a

mention of that in the report. I also appreciated bringing the Broken Promises Report to light. I have brought that up a few times in some of my meetings since then, and there are very few people who are even aware of that report. And so that was an eye-opener for me. I mean, all the presentations were very powerful. Certainly, the pressing issues for Indigenous women around incarceration and violence and violence prevention. Don Warne's presentation, I think he actually presented after I was on a panel and I appreciated him. Although he didn't call me out I'm going to call myself out here, call myself in, to the fact that I talked about power during our panel presentation and he pointed out it was more than being about sharing power.

It was about giving up power. And so, I think that, in the terms of NICHQ's anti-racism work and the work we're doing with the equity systems continuum that I mentioned in September, thanks to Dr. Stacey Scott, I need to keep that in mind. And then the last thing I had here was just

another mention around the recommendations and just how impressed I am with the vetting that has happened in the work over the last two years. I didn't realize that you've been working on this for such a long period of time. And so Ed, in terms of the question and what LaToshia started talking about and what's changing at NICHQ, I mentioned that this is definitely transformative. I think many of you saw my LinkedIn post. I don't post on social media very often, much to the disappointment, I think, of my communications folks.

But when I do, I try to make it meaningful. And I did post on LinkedIn, as did LaToshia after this meeting, in that I made a public commitment that NICHQ would do more. And it's been about three months, a little under three months since that meeting, and I do remain committed to that. And I think Terrence may be on the line shortly to talk about the anti-racism commitment and accountability statement that a number of organizations made to each other, including the

folks that were at that meeting in September. And I think that the learnings from Prior Lake will help us be more purposeful, both as organizations but also individually, but also as a group of organizations as we talk about equity and we talk about communities or people of color, that we specifically think about American Indian and Alaska Native communities. I think oftentimes we're talking about the Black community when we're talking about anti-racism efforts and we need to be more...

This is what I learned during those two days, to be more purposeful about our language and our efforts. And certainly at NICHQ, I think I mentioned that equity is infused in who we are, what we say, and what we do. And also in that anti-racism commitment and accountability document, we've already been more purposeful. I'm Scott Berns. I'm sorry. I'm Scott Berns from the National Institute for Children's Health Quality, for someone who just chatted in. I can tell you a couple stories, since we're talking about

stories, in terms of how I am bringing this report and the experience to our work already. We're working on a number of very large proposals right now at NICHQ. I think I mentioned that we're completely grant funded. Most of it is public funding, meaning government funding.

And I found myself and my team now to be much more purposeful in asking questions when we engage families, because we engage families in everything that we do, "What are we doing in the context of the American Indian and Alaska Native community?" So, already in the proposals that we're writing, we're becoming much more purposeful there. I think LaToshia mentioned some meetings that we've been setting up. We do have a meeting next week with the National Indian Health Board, thanks to some connections that we made in Prior Lake. So, that'll be a first for me. And I also can plan...

Prior lake. So that'll be your first for me. And I also again plan on reaching out to IHS. So Ed, those are some initial comments to share with

folks at ACIMM and others that are dialed in. And LaToshia, you asked a question about Terrance Moore. Help me out.

Ed Ehlinger: Terrance is now on. Terrance is now on.

Scott Berns: Oh, Terrance is on. He's the CEO at AMCHP.

Ed Ehlinger: Yeah. Thank you, Scott. I really appreciate it. And it heartens my soul to hear you say the things that you're doing and the things that came from that meeting. That is really good. And Terrance, why don't you give us a couple minutes of your takeaways from the meeting in September, and how this report might change how AMCHP does its work.

Terrance Moore: Thank you all for having us back. And I want to share, I've actually been on for about 45 minutes or so, so I've had the opportunity to listen in on the amazing work from the last panel. And want to also thank the members of the committee for being so thoughtful in terms of preparing an encounter with community. Some really robust recommendations for us to think

about how we actualize. And so I wanted to spend a little bit of time today; I've had the opportunity to review the 50 pages of recommendations and really mull them over, and think through at least preliminary steps that AMCHP can take moving forward. And I want to pause parenthetically, to say what is special about this particular report, and the leadership of the committee, and Ed, you reaching back out in my long career in public health, rarely have I ever been asked back after a panel discussion to provide thoughtful activities that we can do to actualize this.

So I just want to make that note for the record that this is the way we should be doing business in terms of us working in partnership. So I wanted to share a little bit about AMCHP'S strategic plan. This is very much relevant in terms of how we actualize these recommendations. Belinda Pettiford is actually the president of AMCHP. Last month the board of directors approved the organization's strategic plan through 2027.

Front and center is an area that is very timely and noteworthy around advancing health equity and reducing racism, or really adhering to our anti-racism principles. I heard Scott mention a moment ago about the collaboration that NICHQ, AMCHP, and other partners in our field are engaged in. CityMatCH being another partner as well. National Healthy Start as well, A1, joined together around our joint commitment across organizations around anti-racism.

We meet regularly, bimonthly, to really talk through how we advance our internal efforts, but also how we are working as a collective through this. Why is AMCHP strategic plan in this group important in this discussion? I think all aspects of health equity across all communities, particularly as it relates to Native Americans, Alaskan individuals as well, is area that we see great potential. So, when I was going through the report, there are a few areas that I wanted to flag that I think our organization can commit to right away. It was not lost on me the

recommendations and the discussions related to ensuring the end to data erasure.

I think as public health institutions it is paramount that we think through, examine, interrogate our systems and figure out roots and ways that we can collect data better. And that means working in partnership with our colleagues and friends at CDC and HRSA and in other areas of the federal government to ensure that we're collecting accurate data. And data that is not simply just quantitative in nature, but we're looking at qualitative information. Magda Peck talked about, and others, the value and necessity of storytelling.

And so in addition to the quantitative information, I think that there's great opportunity to open spaces to allow stories to be part of our overarching narrative and our responses to these grave issues. I think another area that; as part of our anti-racism framework, that was called out in the report is acknowledging the profound harm of the doctrine

of discovery that has been part of our discourse as a nation since its inception. And I think as a public health institution it is important and necessary that AMCHP make that a part of every convening and opportunity that we have. That we are part of an infrastructure that essentially is the outskirts of lands being stolen from peoples. And I think we have to just speak truth around where we are and how we got here. So I think that is something we can commit to.

I've been talking to our partners internally, our conference leads, our other staff, and there's a discussion that we're having around how we can really open our agendas and meetings. As well, AMCHP's conference is coming up in May, in New Orleans. And I would like to share; you've heard it here first, we would like to open and create space and work in partnership with the committee and others to have a session or sessions to review the recommendations, and to also invite storytelling at our conference. And so I would love to talk specificity with you all and how we

might do that. How we might convene the persons that we think could really help us shape sessions during our conference.

And then finally, I think the last piece is, just really how do we meaningfully engage the communities? And more than just one set of conferences episodically throughout the year. AMCHP remains really open to meaningful community engagement in all of its forms. And so we hope that this is one of multiple opportunities that will continue to expand those opportunities with community and partnership. So those are my preliminary take takeaways from last month's meeting. And just, again, want to thank the committee and my colleagues for the opportunity to really do deep thinking on this.

Ed Ehlinger: Terrance, thank you. I had mentioned earlier that part of our job is to build community capacity, and what I'm hearing from NICHQ and AMCHP is that this conference that we had, the meeting that we had, is building capacity in our community, our MCH community, broadly defined. So, I really

appreciate that. And I know, Scott, you said you had a couple of extra other comment to make following up.

Scott Berns: Yeah, you sent four questions. I don't know if you're going to get to all of them, but there are a few thing other things I wanted to share. I'm trying to be cognizant of time. In reflecting on some of the other things we're going to be doing, I guess I just want to say that to your last point, Ed, I really feel like we as MCH organizations need to be ambassadors of this report. I think it was Magda who mentioned earlier, we don't want this report to gather dust on a shelf. I've seen many of those over the years, but this is such a powerful document and such important work, and so I've already started doing this. I know Charlan and other folks from the CDC are on the line. And we were in Atlanta last week for the launch of a big project around our perinatal quality collaboratives work, and this has already come up, including some of the data that Charlan showed.

And I actually had a meeting with a group of states and they were talking about what they could be doing, and I mentioned this report. Because Ed, I got the report, the draft report two days before that meeting down in Atlanta. And I had asked there as well about the Broken Promises Report; and I was in a room of about 15 people in an ad hoc meeting, and not one person raised their hand when I asked if they had actually heard of the Broken Promises Report. And then I mentioned the recommendations coming out. And the folks I was talking to basically work primarily with hospitals who were working to reduce disparities, and tackle equity in the context of maternal morbidity and mortality and infant morbidity and mortality. And it really got the gears going, specifically around data and some of the, they termed it, low-hanging fruit, in terms of some of the data collection that is done.

And they don't really have a good grasp on the American Indian/Alaska Native data in terms of

outcomes to some of the... I think Janelle mentioned this as well. So anyway, I do think that point is important that we need to take this with us, not literally carry around 50 pages, but take the three large recommendation buckets with us as we're talking. And then in terms of NICHQ's work, I should also say that in our current projects, I mentioned some of the proposals we're working on, but in our current projects we have about a dozen projects including the CDC-funded National Network Perinatal Quality Collaboratives. But much of our work, actually most of our work is funded by HRSA.

I should mention that we are the TA and support center, as I think you all know, for Healthy Start and the 101 Healthy Start Communities. And getting back to storytelling, we are launching a story work project. And thanks to Dr. Peck and Dr. Palacios for your help in that regard. And Janelle is taking quite a leadership role there in terms of our specific reach out around the American Indian/Alaska Native community. And so

Janelle, I don't know if you want to comment on that, but we are already bringing this to life in terms of the current work that NICHQ is doing. I don't maybe a little handoff to you, or do you want to save that for later?

Janelle Palacios: Oh no, I think this is a great time. Just that it was brought up earlier in our conversation that what was recorded in the report is frequently not known, it's not in the public view. It's not in a public consciousness, we're not really taught about the details of our history. And some of the work that I'm working with NICHQ TA Center, is to bring that history to life. So creating more of a contextualized history for understanding the doctrine of discovery, dominant worldviews, and bringing that into how policies and practices were set up in our country, that have created the conditions and outcomes we have today. So that is part of that work, tying in with storytelling, that some Healthy Starts are able to do.

Scott Berns: Yeah, thanks Janelle. And there's more to come for sure. And we're gathering ideas, and I'm looking forward to working with all those groups that Terrance and I alluded to, to see what else we could do in the future. And I guess I just should speak for NICHQ, and I'm sure AMCHP feels the same way, I would welcome the opportunity to return whenever you'd like us to return. It's been a great opportunity to continue to check in and check back with y'all, particularly as there's some changeover in some of the leadership there. We're all about continuity, for sure.

And I would be remiss to not mention Ken Harris, who is vice president Engagement Community Partnerships from NICHQ, leads the TA support center for Healthy Start, and his commitment not only to that work, but to ACIMM. He's been on the Health Equity Workgroup Committee, and he plans to continue to do that as well. And who knows, maybe there'll be someone from NICHQ in the future who's a formal member of ACIMM, but if that doesn't happen, does not preclude us, will

not preclude us from continuing to communicate with y'all, and to disseminate and be ambassadors for particularly, this excellent report that is going to the Secretary soon.

Ed Ehlinger: Now, if you guys could hang out for a little while, we have one voice that we haven't heard yet, and that's the Indian Health Service. And I know Tina Pattara-Lau is on, and I'd just like to have her comment a little bit about what she's been hearing. And Indian Health Service, we know, is a crucial part of this whole universe that we have to deal with. So, Tina, welcome. I'm glad you're here with us, and listening, and just any comments that you might have to share with the group.

Tina Pattara-Lau: Thank you Dr. Ehlinger. I wanted to acknowledge Dr. Peck had her hand up.

Magda Peck: I can go after you. I actually just got some information from CityMatCH folks because they want to be part of this narrative, and I can go

after you. I would love to have your voice come first.

Ed Ehlinger: Yes, please.

Tina Pattara-Lau: Of course. Thank you. Thank you to the committee again for the opportunity to participate. Thank you to Dr. Edward Ehlinger, as well. After I reached out, he invited me to comment. I really do appreciate your team's hard work and dedication to focus and really strengthen the spotlight on American Indian/Alaskan Native maternal and child health over the past two years. As many of you know, I am the Maternal Child Health Consultant for Indian Health Service. This position, before me, was previously vacant for two years. And then before that was about an eight-year term. I'm also an OBGYN, and I'm still actively practicing to serve AI/AN populations, still delivering babies and working in the clinic. So, this is very close to me. Everything I do is to bring our care to the patient. These recommendations will

be really helpful in guiding the MCH priorities for IHS.

It's a good reminder that we all share the same goal, to continue to improve maternal and child health for all AI/AN communities. For all pregnant people, we can all do better. When I onboarded in June, you heard from myself, as an IHS physician, as well as from Dr. Christensen, our CMO and Elizabeth Carr as our senior staff. In September, it was an honor really and truly to hear aloud the stories and the bravery from the folks who did share. Something that as a healthcare provider, we only have the privilege of hearing behind closed doors, and sometimes under great duress. I am here today to affirm that IHS is present and listening. I'm here to support this committee moving forward. I do comment that, and I agree that words do matter, I'm looking ahead to the sustainability of the healthcare workforce. I remember that it does start with our youth, an influence that the words

and stories have on their choices, and then shape the future fabric of our society.

I'm one of 76 PHS and IHS physicians who serve as mentors to the next generation of applicants and students in training. And so as we say to them, as they make their decisions about what practices and communities they want to serve, I encourage them to physically visit and rotate at IHS Federal, tribal and urban sites. Talk to the providers, the midwives, nurses, and support staff on the front lines. Listen to the patients in the waiting room. Offer prayer, smudging traditional practices, especially after a loss. Decide what practice is best for you and your family, whether it be the brand-new tertiary care center in the city or a small remote clinic accessible by air. Also consider where your skills are needed. Where will you have an impact? What do you want your legacy to be? It's an honor to serve alongside the people in IHS, who do the work every day, and advocate for our staff and patients.

If you'd like to collaborate moving forward, I'll put my email in the chat. You can certainly reach out to me. In line with the CDC report that was released in September of this year, acknowledging the majority of the postpartum deaths occurring postpartum most commonly due to mental health conditions, being suicide and disorders of substance use. We have been working on a couple of initiatives behind the scenes, that I'm happy to share with you at a later time when I get the green light. So again, thank you for the opportunity to participate today.

Ed Ehlinger: Thank you. Thank you, Dr. Lau, Tina Pattara-Lau. Appreciate that. And we're going to take a break in about 10 minutes. And I want to have some discussion among ACIMM members about how to use this report. But I built in enough time in this agenda, so we'll be coming back when we talk about the next steps for ACIMM. We'll be able to come bring that up. But Magda, did you have some feedback?

Magda Peck: Yeah, I just wanted to be... As Senior Advisor to CityMatCH, in one of my roles. Dr. Denise Pecha was at our meeting and is unable to be with us today, but wanted to affirm, as with the partner MCH organizations, that CityMatCH has already began to run with what was seen, heard, experienced, and learned in our time in Shakopee Mdewakanton Sioux on site. And so specifically three things she asked me to share. One is that given that over 50% of American Indian/Alaskan natives live off of tribal land, and impetus has been initiated for every CityMatCH member health department in local areas to strengthen ties with Urban Indian Health Centers and have other opportunities for unique urban Indian maternal and child health connections. Second, as has been done at the CityMatCH meetings over the last several years, particularly since the time in Rhode Island, the next meeting will be in New Orleans in September 2023.

And not only will the local host be the local health department but working directly with

tribal communities and populations and organizations within the New Orleans and Louisiana area. And third, the Urban Indian connection was made with relationships, which just reinforces what we heard from the other two organizations, but specifically with the Urban Indian Health Board. And so I think that the catalyst nature is playing out from an urban strategy in addition to what we heard from NICHQ, AMCHP, and indirectly Healthy Start. So Terrance, you're right, oftentimes you give a talk and then you're like, "Huh, what happened to that?" It is our intention to engage the primary MCH organizations, particularly those devoted to health equity and opportunity, not only to carry it forward individually, but ideally for you all to work collectively together in this unique time of opportunity, to address the specific conditions and opportunities of American Indian/Alaska Native mothers and infants. So, thanks on behalf of CityMatCH.

Ed Ehlinger: All right, so this is my challenge to the sake of moving forward. I think ACIMM, as an organization or as a committee, I think we've developed some relationships with AMCHP and NICHQ and Healthy Start and CityMatCH, and I hope that organizational relationship continues and grows. But for each individual member, you live in a state, get to know your state MCH director. You live in a state where many of you have Indian health boards, get to know somebody from your Indian Health Board.

You live in places where there's cities, and CityMatCH probably has an MCH director, urban MC, get to know that person. We can build these relationships at the local level, at the state level, and at the national level. And that's what I would really encourage you. And certainly, the tribal epidemiology centers, where good source of data, develop some relationships that'll help you. I think no matter what you're doing as individuals, it'll help your professional lives, but it'll also help our work collectively as

SACIM, and as a group trying to work for improving ANAI health in our country. Any comments, questions for our panelists? Either CDC, our storytellers are AMCHP and NICHQ? Any questions, comments?

Charlene Collier: Hey, this is Charlene. I really enjoy having our colleagues here. I know Scott, LaToshia well. I'm a board member of NICHQ as well, but I think this is the space we should be bringing people in. If the committee begins and ends with us, then we haven't done our job. So I really like the idea of a warm handoff and making it very easy and accessible and talking through it. Because it really is; the document's a document, we read it, but having the ability to talk and see the faces that put it together, to know the effort and work, and know the process. Because the process, even though it was documented, can't be fully lived or experienced. So, I really appreciate the organizations that have joined, and really encourage us to think how, even in small groups within the committee, throughout the

year, if it's just that brief meeting to share the report, to really make it a warm handoff.

To be something that we, as you mentioned; even if it's in our local state, but even as a committee, even if it isn't a formal full meeting, but inviting partners within communities to be able to... Because I do think it takes that explaining. It's still a government report, it's still from that level, and being able to gain that trust.

And I think that is best represented face-to-face or being able to see the faces who are put together, so people aren't like, "It's just another report." And I think it will require verbal communication, face-to-face communication. And it is not enough to post or tweet about, or share, because it is... Alone, it's a document, but when we bring it with ourselves, it becomes something else. And so not to lose that emotion and power that we came to in voting, to affirm it. We don't want to lose that throughout the year, because I think we're at this height of

energy now. And to keep that going, it really will be through stories.

It'll be through the story of sharing how this report came to be, and not letting that story be lost. And so the more we can continue to plan and be intentional about bringing people in, and repeating the process, and sharing that process. Today should be the first time we do it, but not the last. So yeah, again, I want to thank everyone from AMCHP, the CDC, and the teams who are here. And hopefully it won't be the last time we get to promote the report together.

Ed Ehlinger: I talked about health is about partnerships. And being in partnership actually requires some accountability to each other. And that's the reason of inviting these folks back again. Because they need to be accountable to us, and us to them. And so you have that accountability with each other. It keeps the partnership active, keeps it current, keeps it moving forward. And so, I hope that SACIMM continues that partnership, and holds each other accountable. We

need to be accountable as a committee to keep moving the needle forward. And you as partners, NICHQ, and AMCHP, and CityMatCH, and Healthy Start, are also part of that partner. So that's the accountability piece.

Magda Peck: And to follow up on that quickly, is that four years ago; and we'll talk about this at the end of the day, SACIMM was dismantled, not visible, not terribly viable. It had not met for two years or more. And one of our commitments, as we came on, 10 or 12 of us at most, was to raise the visibility and viability and voice of SACIM. And I just want to acknowledge that this conversation is demonstrative of that restoration and growth, and opened doors for the next iteration of SACIM. So that the silence will not be acceptable. And the strategy makes us be the ambassadors for word to deed. So, Ed, great leadership on that intention. And this is a manifestation that I observe, is different from four years ago.

Break

Ed Ehlinger: All right. Well, we've been sitting... At least I've been sitting for a while. I think it's time to take a break. More conversation will continue. This is never a be all, end all. But I think we need to take a little break, so let us take a 17 or 18-minute break. We'll be back at two o'clock for some public comment if there is some. So, thank you for joining us. Terrance, Scott, LaToshia, Tina, thank you. And Charlan and Sarah, all great presentations. A lot of good information. And we'll see you back in about 15 minutes.

Public Comment

Ed Ehlinger: All right. Welcome back. It is now afternoon here. I know some are still in morning mode, but it's good to be back. We'll wait till we see a few more images. That's good. So I have to share a little bit of something that just brought a little joy to me just now. So as we were ending up the last session, I'm sitting here in front of my computer listening to all of these wonderful

discussions. The snow stopped falling, and the sun came out. And I don't know about where you are, but here in Minnesota at this dark time of the year, people put lights out and they have this new thing where you have little sparkly lights that go all over people's houses, little dots of light, of different colored light. I don't know if that goes on in your territory, but here in Minnesota that happens.

And so, I'm sitting here, and the sun comes out, and all of a sudden, I see these little sparkles all over my wall. What's happening is the sunshine is hitting this tie that Janelle gave me. And it is like a prism that's just sparkling throughout my wall. There's got to be some symbolism in that. But it was like, "Oh my goodness, this is just way too cool." So, thank you, sun. Thank you, snow. Thank you, Janelle, for the gift. And it just seemed appropriate at the time where we were sharing the connections that we had with what the work that we're doing, with what's going on in NICHQ, and CityMatCH, and

AMCHP. So it was just a nice convergence of stuff. All right. We're at a point where every meeting we... Because we're a public group, it needs to have some public comment. And Vanessa, are there public comments that are going to be available to us?

Vanessa Lee: Thank you. And yes, we have one person who has requested to provide public comments orally to the committee, Joy Burkhard. Thank you for being on. You're from 2020 Mom, so I'm going to turn it over to you to introduce yourself and share your comments with the committee.

Joy Burkhard: Great. Hello, everyone. Like you heard, my name is Joy Burkhard. I'm the founder and executive director of the nonprofit organization 2020 Mom, soon to be called the Policy Center for Maternal Mental Health. We are a national nonprofit whose mission is to close gaps in maternal mental health care. We've recently been named a field catalyst by Bridgespan for our 10-plus years of work, advancing the field of maternal mental health often in unseen ways. And my job as the

executive director is to be sure that we are being seen and our important messages, and work together, continue to move forward. I want to acknowledge, just like so many of you have today, that I reside on the homelands of the beautiful and wise Tataviam people. And Tataviam is a Serrano word meaning people facing the sun. I think that's very apropos for what we just heard about with the sparkles on the wall and so much more earlier.

It's also a unique opportunity for me to honor the dear Navajo woman that helped raise me and my twin sister who were born prematurely almost 50 years ago. She nurtured us in powerful ways and her name was Gussie. And Dr. Peck, it's nice to see you again, and also colleagues from AMCHP, CityMatCH, and NICHQ. Dr. Peck, we've met at APHA and at UCSF from various projects. And I also had the privilege of being honored by the APHA with the Maternal and Child Health award for leadership and advocacy in 2019. So I just wanted to make remarks to just thank you this committee

for lifting up the important work, not just in infant health and prevention of mortality but also maternal health and maternal mortality, and for acknowledging the critical intersection that for so long, I think, has gone unnoticed.

And I'm here today to share with this esteemed committee the importance of continuing to prioritize maternal mental health. As you may know, it's one in five women on average who suffer from maternal mental health disorders. And Black women, and Indigenous women suffer at nearly twice the rate as white women. And as you know from the latest report issued by the CDC in September, which we're so grateful, was unveiled at a congressional briefing that we hosted through our project called the Mom Congress. We heard from our colleagues from the CDC today that maternal mental health conditions, defined by the CDC, as suicide and drug overdose are the leading causes of maternal death. Native women and white women are particularly at risk of death to these conditions. At 2020 Mom, our work involves

centering mother's stories and lifting critical and creative policy solutions that are aimed at closing gaps in the health care delivery system.

And we're interested in reducing birth trauma, which we heard about in stories today, and also ensuring that all women are screened, accurately diagnosed, and offered a range of evidence-based treatment options. Your new report is an important one, and the stories we heard today illustrate the critical need to do more and to do much more quickly. I wanted to share three opportunities that struck me as you were making remarks. One is to highlight the opportunity to further interagency and inter-committee work around the issue of maternal mental health. The TRIUMPH for New Moms Act addresses this. It's a pending piece of legislation, and this need, and it's expected to pass through the omnibus and be signed into law. But regardless of its fate, given things are so touchy on the hill right now, I really want to emphasize there's an important opportunity here.

Again, regardless of its fate, given maternal mental health has not fit neatly into any one agency or committee's scope, and deserves to be lifted out of the cracks it's fallen into. I also wish to share there is, for the first time in the US, a set of US data on how often women and other birthing people are being screened for maternal mental health disorders through a new set of HEDIS data. The results show that less than 20% of all women in the US are being screened, which we expected, but it's no less heartbreaking. I'm happy to share more about those rates with any of you in the chat here. And then finally, I want to invite the committee to join our 13th annual Maternal Mental Health FORUM this March to present the new report on Indigenous maternal health and maternal mortality. Thank you for your leadership, and for all that's yet to come for maternal mental health. Thank you.

Vanessa Lee: Thank you so much, Joy. Any comments or questions from the committee members for Joy? Oh, Belinda. I see your hand is up.

Belinda Pettiford: Thank you, Joy, for coming and sharing your comments today. Two quick questions. I would like to hear more on the HEDIS measure, because that is an area that we've been looking at in many parts of the country, and I know my own status and area that we have been trying to elevate with some work. And then the second thing is probably a quicker thing. You shared a forum that you're hosting in March. Do you actually have the dates that you can drop in the chat or you can share them with the group?

Joy Burkhard: Yep. I can drop both links for both of those. The HEDIS data and the forum into the chat. It's March 22nd through the 24th, and I'll drop that into chat here in just a moment. Thank you for the questions.

Belinda Pettiford: Thank you so much, and thank you for continuing to remind us to make sure that maternal mental health is on the forefront of our work. Thanks.

Joy Burkhard: Thank you.

Vanessa Lee: Janelle, I saw your hand.

Janelle Palacios: Oh, thank you. No, just thank you as well, Joy, and I would've echoed the same questions that Belinda shared. And just... Again, as a clinician, lend my voice to the experience that nearly every person, that pregnant person I take care of on the floor, the unit, the labor and delivery unit, and postpartum has some degree of mental health concern, and that there needs to be much more awareness about this. I'm really glad to hear about the work that your organization is doing. And then when we talk about Native American women in particular, or women from marginalized communities, historically marginalized communities and backgrounds that contextualizing this whole historical piece and all the systems in place, that there is ample room for more work to be done, understanding the perinatal mental health concerns and its effect intergenerationally. So, wonderful to hear that this is work that you're doing and that you have

a forum focused on Native American people. Thank you.

Vanessa Lee: Great. Thank you to the members. And thank you again, Joy, so much. And we see your resources put into the chat. Thank you again. Magda.

Magda Peck: Yes. Joy, how great to see you again. Thanks for your continued leadership. It's more of a question back to Ed and to the committee. Your third point was an opportunity to have the findings of SACIMM and this report presented at your annual meeting. And I thank you for that opportunity on behalf of this group. And it begs the question about dissemination that we can come back to Ed about how... If we all are ambassadors for this work, in what form can we put together some tools that will allow us to be able to make presentations and some clarity about who speaks for SACIMM going forward, would be helpful, given this entrée that we have already from Joy and her group. And as folks will be in demand, how do we tell one story, and what are the storytelling tools that we shape together as we serve as

ambassadors in the field? So Joy, thanks for the question and I'll refer it back to Ed as we do further conversation about dissemination.

Ed Ehlinger: That will be part of the conversation a little bit later, without a doubt. And Marie?

Marie-Elizabeth Ramas: Yes, thank you for the presentation. I echo the resounding need for better support services for our birthing parents and behavior health. I know that many facilities are requiring depression screening to be done when birthing parents come in to deliver. The problem is, is what happens after they screen positive, and the vast majority of... Well, I can't say that. A disproportionate amount of BIPOC birthing parents don't have the same measure of access to Quality Behavioral Health Services. And so I'm wondering if there's a space here, Ms. Burkhard, of incorporating and aligning with primary care, specifically with our family physician and internal medicine to help create a continuum of care for our birthing parents. So I know there's that six-week postpartum phase, obviously, then

afterwards, then what? And oftentimes, coming back to their medical home, there might be nuances in presentation that is not necessarily picked up immediately, postpartum that needs to be followed through with. So, I'm curious if you have any insights on that as we think about how to share this information to our circles of influence.

Joy Burkhard: Thank you so much for the question, and I will do my best to keep it brief and welcome some ongoing conversation in whatever way works best for the committee. Certainly, the challenge even outside of hospital settings in some states including California where I reside, there are mandates for providers to screen for maternal mental health disorders. But then what question is quite a significant one, and unless you're in a community that has built up these systems, largely, the health delivery system in part because of the bifurcation of payment, I need to add, is that important challenge is one I think needs to be addressed. But the bifurcation of mental health

delivery from medical care is a real challenge for us, and I think is really at the root for this lack of referral pathways. But we also have significant workforce shortages in the behavioral health system with psychiatrists and peer support workers according to HRSA's analysis being the fields that have the greatest opportunity for growth or the greatest workforce shortages.

But every single state has significant workforce shortages, particularly post-COVID for behavioral health. So it's an opportunity for us to really lean in. We have identified essentially 50 levers that need to be pulled to address this substantive problem. It's why none of us have solved this problem yet because it's so complex in part, because of these health delivery issues. And the last thing I will say... And about twenty of them have been pulled. One is that there should be a HEDIS measure. We just we're successful in getting that HEDIS measure through a few private funders developed, tested, and now, results shared. There's about 30 levers still to

pull in this space, just to give you some context. So a lot more work that we need to do together, which is really why I wanted to come here. The last thing I'll say is that there's really an effort in the field to identify obstetric providers as the medical home for pregnancy in the perinatal period as an important place for screening to happen and to begin early in pregnancy given the links to preterm birth and poor birth outcomes.

And also because of the number of women entering pregnancy with undiagnosed, untreated mental health disorders like anxiety and depression. And so my personal perspective is there's no wrong door. It doesn't hurt for a hospital to necessarily screen, but the home base in terms of who should be responsible. Some obstetricians don't necessarily agree, although the field, I think, is acknowledging this, including ACOG and our midwifery societies that the obstetrician should be the home base for screening and initial treatment plan development. We're doing some

interesting work to study the use of peer support specialists to augment obstetric capacity to screen. So having a peer assist with screening, brief intervention, and even care coordination. But there's a lot of work to do in all these spaces. So just to acknowledge that it's quite complex, and appreciate the question, and happy to talk more offline.

Marie-Elizabeth Ramas: Thank you.

Ed Ehlinger: One more comment. Lee.

Lee Wilson: Sure. Thank you. Joy, I appreciate your comments, and just want to remind the committee that HRSA MCHB has a number of programs that are focusing on the maternal behavioral health issues, maternal mental health issues. We have our MDRBD program, the Maternal Depression and Related Behavioral Disorders program, which is in seven states. We're looking at recompeting this program, and potentially, depending on what we receive in 2023, to complete that program and award a larger number of grants. That program is

a Doc-to-Doc program. So if a healthcare professional identifies an individual who has a condition that they can't quite get a handle on or they feel they need some other professional support, they can use this line for that. We also have presented to you on a couple occasions about the maternal mental health hotline, and we are using that to try to reach more individuals who are experiencing perinatal mental health issues, and to link them to available services in their community. So if in the future you would like more background information or materials, we can arrange for presentations on that. Thank you.

Joy Burkhard: Thanks, Lee. I'll just quickly add. We hope that someday there might be a national hotline for Doc to Doc consults. Just given the challenge it is for states to get these lines up and running could take another 20 to 30 years to reach all states. So anyway, more to come on some possible policy solutions there. We're told that it is not probably the congress to introduce such a measure, and to let this work take hold with

increasing the number of grants to states through HRSA and the current structure. So, thank you, Lee, and to HRSA for all your work.

Lee Wilson: Keep up the good fight, Joy.

Joy Burkhard: Indeed. Thanks, everyone.

Vanessa Lee: Thank you. Thank you, Joy. And that concludes our public comment segments. I'll turn it back over to you, Ed, for the next piece of our agenda.

Ed Ehlinger: Yes, and Ms. Burkhard, thank you for your comments. And you raised a couple of issues. One, there are myriad issues facing moms and infants, and there are multiple partners. So, I think that we need to look at the broad range of issues. What can SACIMM actually do something about, and who are the partners we need to partner with? Yes, CityMatCH, and AMCHP, and NICHQ, and Healthy Start are among those, but there are a whole bunch of others that we need to reach out to. So, we'll keep that in mind as we move forward.

Federal Update: Healthy Start Program

Ed Ehlinger: All right. Next, we're going to move on to our federal update and some information about Healthy Start. And I know Benita Baker is here. Benita, are you going to be starting it out?

Benita Baker: Yeah, I'm going to start it out. Lee's going to help me. But I'd like to welcome everyone. Good afternoon. My name is Benita Baker. I am the branch chief for Healthy Start in the division. While we know ACIMM is charged with providing the Secretary advice and recommendations on how to improve infant mortality and related adverse birth outcomes, including the administration of the Healthy Start program. We wanted to give you a brief overview for the new folks and the current on the Healthy Start's current activities. Receive your feedback on how MCHB and Healthy Start can help communities advance social determinants of health in Healthy Start. So, I will start out with a little bit of background on Healthy Start. As most of you know, Healthy Start was first established as the presidential

initiative in 1991. It started as a community-driven demonstration project based on nine interventions.

I won't go into those, but outreach and recruitment, adolescent services were a few. Started with 15 sites, and at that time, they received a significant amount of funds, around 4.6 million per year for five years. The goal was to identify community-based driven approaches that would help to reduce infant mortality by 50% over a five-year period. That was a very lofty goal. As you know, we did not make that. We continued to strive. A lot of the original 15 are still Healthy Start grantees to this day. Next slide, please. I'm going to skip forward to our most recent competition that occurred in 2019. After multiple rounds of funding since that first funding, we went through a demonstration phase, we went through a mentoring phase, we went through a replication phase, and we're at the phase now where we are on the four approaches, which I'll go over a little later on.

Currently, the project period was April 1, 2019 to March 31st, 2024. There are 101 Healthy Start sites located in 35 states. The District of Columbia and Puerto Rico funding at that is 125,000,000 for the program, but 980,000 per award. Next slide, please. Okay. So, this is just another overview. The purpose of Healthy Start is to improve health outcomes before, during, and after pregnancy, and reduce racial and ethnic differences. The reach, we talked about the reach, and that should indicate as of 2021. So where Healthy Start works in communities with infant mortality rates of at least one and a half times the national average and high rates of low birth weight, preterm birth, and maternal mortality. Slide six, please. Current Healthy Start core elements. Healthy Start services are currently within four core elements which focus on decreasing infant mortality and emphasizing women's health-

Mortality and emphasizing women's health, family health and community and population health. Next

slide please. These are the populations we serve. Birthing people, fathers and partners, infants, and children up to 18 months. Next slide please. These are the current Healthy Start Program Services. This is not an all-inclusive list. We have grantees who have resources from all different places other than the feds and are able to provide more resources such as job placement, job readiness, things like that, that did not typically fall under the normal base services for Healthy Start. Next slide please. Healthy Start, our current Healthy Start legislation, and it has since its inception, called for establishment of a community consortium. At this time, we call that a Community Action Network. It consists of organizations in the community that serve the same populations as Healthy Start or address the same issues that Healthy Start addresses. It also includes organizations which are not typically at the MCH table, such as HUD, Department of Transportation, which that's now getting a lot better, and also people with lived experience.

Next slide please. To support, in addition to our Federal Project Officers, we have a TA and support center we call the EPIC Center. The National Institute for Children's Health Quality is the organization providing those services. The TA and Support Center supports our Healthy Start grantees in improving their service delivery, in meeting their required benchmarks that have been established for Healthy Start. In addition to providing topical webinars, learning cohorts and academies on various topics and emerging issues, training and certification scholarships, such as lactation consultants, and individualized technical assistance for each grantee.

I'm sorry.

I'm sorry. Okay. Next slide please. So, in addition to the base Healthy Start activities, there are a few activities that have come about since 2019, funding that has come about in order to provide additional activities. One of those activities is what we call Clinician Funding Congress, in 2019, appropriate around $15 million

a year for our grantees, to increase clinical services within their project. So, they were to hire clinicians to provide postpartum care, prenatal care, to expand the capacity for direct assets to care for the Healthy Start participants. Next slide please. Last year and this year, we gave money to our grantees, this was not appropriated money, this was leftover money that was unobligated, but we were able to provide supplements to our grantees, to increase availability of doulas, and these funds were provided for hiring, training and certification of doulas. Next slide please.

So, I know Dr. Warren has talked a lot about his Infant Health Equity by 2030, I call it initiative. So, we're doing a lot of work around that throughout Healthy Start. One of the things we did last year was to provide supplements to our grantees to develop action plans for systems level changes, and to address social determinants of health that may impact disparities in infant mortality in their communities. The overall goal

of this was to reduce disparities within the counties that had the highest number of excess non-Hispanic Black and non-Hispanic American Indian/Alaskan Native infant deaths. So, our grantees last year developed these action plans. They are working with our TAS, our TA and Support Center for any additional TA that is needed, any community workshops that they may need to help support bringing their community on board with implementing these action plans.

Again, next slide please. I'm sorry. The listening Session. So, again, one of the goals in this MCHB strategic plan is around achieving health equity. We know that American Indians/Alaskan Natives and African Americans experienced poor perinatal outcomes. Again, many of these outcomes are due to systemic inequities and limited access to care. So, maternal child health, the division has facilitated and attended a few listening sessions, with the idea in mind to help with developing new or revising current programs, in order to receive information to help

us increase equity in our programming. As well as framing NOFO, Notice of Funding Opportunities, so that grantees can incorporate equity in all their activities that they provide. Next slide please.

One listening session was an HHS Roundtable with community-based doula organizations. There were other organizations, federal organizations invited, CMS, of course HRSA was there, doula organizations and individual doulas. Some of the points that came out, this is not all inclusive, but some of the key themes were that we should include mentorship in doula trainings. Some doulas are very experienced, while newer ones are not, so we should include those in our programming fund, doulas, doula training and mentoring, and strengthen the administrative support for doula programs, offered tiered doula training and certification requirements, and fund models that support both doulas and midwives. Next slide please.

The division held four convenings for MCH alignment and impact towards Infant Health Equity. These convenings were specifically to address Dr. Warren's 2030 initiative to bring together MCH stakeholders and partners from a variety of levels, national, state, local, federal, to again work toward reducing those high disparities among Black, American Indian, and other groups. Some of the key themes that came out, again, not all inclusive, were that we had to make community engagement stronger somehow. Workforce development, include people of all populations in our workforce development activities. Strengthen community relationships again, and look beyond the clinical perspective and tie program requirements to funding. Next slide, please.

When we in the division held two Listening Sessions with our current grantees, just to attain their perspectives on the strengths, challenges, any emerging issues on the current Healthy Start program, to help and provide

recommendations to inform us on the next phase, iteration, of Healthy Start. Healthy Start recompetes in FY24. So, we're gathering all the information from all of these Listening Sessions to help inform our programming. Some of the key themes that came out of those Listening Sessions, one was funding. It's always funding, funding, more funding. I just pulled out these two. There were themes around funding for all types of activities. Behavior health, they want more funding for behavior health. This has been a stickler with our grantees again because they screen but have nowhere to refer. Possibly don't have the resources to hire clinicians to provide these services.

In addition, they want to focus... In 2019, we had a larger focus on fathers. We had a larger focus, but we still are not there with fathers as we are with pregnant women. Of course, that's really not our charge, but we do know it helps with women's health and reduction of infant mortality. So, they want to focus a little more,

have benchmarks around men's health and that kind of thing. They focused on data. A lot of requests for changes in our data collection tools, and Healthy Start has, I believe, nine benchmarks. So, they gave us suggestions for changes in the benchmarks to make them a little more relevant to the programming. Healthy Start has a required participant count of 300 pregnant, actually it's total 700, which includes 100 men. A lot of the grantees want us to take another look at that count, because they believe it's too high based on the amount of funds that they receive, and the activities that they are required to perform. Eligibility, again father/partner engagement, workforce development, that comes up again, and they want us to strengthen our requirements for local evaluation.

Okay. Now we get to questions for consideration. The redesign, as I said, the redesign of Healthy Start will... We hope to have an increased focus on equity and requirements for the grantees to focus more on equity. So, we have a few questions

for you, the body. You don't have to answer them now. We do have a Federal Register Notice that is coming out here shortly, probably either later this week or early next week, where we're seeking input from the public on topics related to design, implementation, evaluation. Your input and expertise would be invaluable to our efforts to better support the Healthy Start grantees and their families. We hope that you could circulate that RFI around to your networks and partners. That is all I have. Lee, do you want to add any additional information?

Lee Wilson: Thank you, Benita. No, I appreciate you taking the time to run through this. I know for, excuse me, those committee members who've been working with the projects and with the committee and Healthy Start for quite some time, are familiar with a lot of the base information. We have gone through a number of different permutations and are seeking input based on, not only the continuing desire for the program to be addressing the perinatal health outcomes of the

underserved, and the individuals who have greatest need in the community, but also some of the priorities that have evolved over recent years. Especially as it relates to racial and ethnic disparities, and access issues that we are all very, very mindful of.

So, we are beating the bushes to make sure that we seek whatever input we can, from as many sources as we can. So, this is an offer to you to provide input now, to provide input to us later. We'll provide an opportunity at our next meeting, since our anticipated release of the announcement will be sometime late summer, early fall of 2023. So, this isn't the only opportunity you will have to provide input, but we wanted to give an opportunity for you to think good and long on these issues. You can also respond directly to the Federal Register Notice, which will be tabulating the input that we receive from other sources, outside sources. So, thank you very much, and we are open to questions.

Ed Ehlinger: Lee, I have a question. When you talk about 'we' are seeking input, are you talking about HRSA, MCHB, or are you talking about HRSA, MCHB and the projects themselves? Because the community engagement strategy, how you do that will depend on the numerator you're using. There's some techniques of getting community engagement and you need some training. So, I don't know if you're talking only federal officials, or if you're talking also the local folks at the same time.

Lee Wilson: We're talking to all of the above. The information will be disseminated broadly to various target groups. If there are recommendations that are specific to how programs might want to operate, our intention is to share the input that is received with existing grantees and future grantees, as well as to use the input by HRSA, MCHB, to make adjustments in the design. Tighten up in areas where there might be recommendations that we think should be supported for tightening, or loosening. A lot of what we've

been hearing from various sources, including from this committee on issues like doula support, on issues like community outreach, the individuals that we're hiring, is to allow for maximum flexibility for culture and community to reflect their own desires.

So, we will be cataloging it and as we are trying to hit as many bases as we can, we are also trying to be responsive and share that information with as many as we can. Our Federal Register Notice and some of the questions that we have put in there, have gone through review from our data people, our Office of General Counsel, and different sources. So, we are trying to make sure that it is a comprehensive and reliable source of input for us.

Ed Ehlinger: Good. Good. Steve?

Steve Calvin: Yep. So, thank you. Thank you, Lee, and thank you, Benita. I have a question. Since federally qualified health centers are... They're under HRSA I think. Is there any dovetailing of the

work that you're doing? The reason I ask is that here in the Twin Cities, just recently, we've had an outreach from one of the FQHCs to say, how can we begin to provide comprehensive care, particularly midwife directed care, things that fit within the context of the Strong Start Study results, do you have any guidance on that or any thoughts?

Benita Baker: So, FQHCs would be an eligible entity to apply for Healthy Start, and we do have several FQHCs that are Healthy Start projects.

Steve Calvin: Okay. Well, maybe I should just do a little looking into... I'll look at your grantees and see what kinds of things have already been done.

Lee Wilson: So, Steven, let me burrow in a little bit on the question. As Benita said, we do have a number of Healthy Starts that are dual grant recipients, so they're a recipient of a Healthy Start and of a Community Health Center award. Many of our health centers, if they're not attached to a Community Health Center, have referral arrangements to

either Community Health Centers or other health providers. Is there something that you're looking for related to Strong Start, or some other program that you want to make a recommendation about?

Steve Calvin: Sure. Maybe I should end up doing that separately as well. It's just that, we do hear a lot, and I totally understand because the value of doula services and midwife-led primary maternity care, it's just really well known that that all works. But it seems that in many states, and even on the federal level, we just do it piecemeal. We kind of say, "Well, let's support doula services." It really needs to be comprehensive. I think FQHCs are definitely a good forum. I know there's one in DC, and there's one in Chicago, and early in my career I worked in one in Tucson, that has subsequently become much bigger. So, I don't know. I suppose maybe I'll look at the links that you both provided and see what kind of opportunity there is for input. Because I think I

could give at least a sense for how things might be done a little bit differently.

Lee Wilson: I think that would be helpful. I also think that it may be helpful for us to tap into you for input in the future. You may be aware, I think Dr. Warren presented at our last meeting, that Congress has proposed providing additional resources to us to develop a doula grant program. One of the priorities that that grant program is bound by, is the desire to make doula services more institutionalized, and more professionally sustainable in the community, so that individuals can be doulas as a profession and live off of whatever that salary might be, and that it be more of a recognized and reimbursable approach, that is not just underwritten by some other nonprofit organization, but how do we institutionalize it so that there's Medicaid reimbursement, if that's a possibility?

AIR has just released a report on a number of states that are using the Medicaid 1115 waiver and as an option for testing out the funding of

doulas through Medicaid. There are a number of strategies that we're all pursuing on this front, or at least rummaging through. If this is something that you're interested in, we could keep you in the loop on the discussions.

Steve Calvin: I'd appreciate it. Thanks very much for your work.

Lee Wilson: Sure.

Ed Ehlinger: Magda? You're muted. You're still muted, Magda.

Magda Peck: All right?

Ed Ehlinger: There you go.

Lee Wilson: There you go.

Magda Peck: All right. Try it again. It automatically muted me. I just want to thank you for the update. For those of us who've known the Healthy Start Project since its preconception years, it is great to have a new snapshot for the refrigerator of the kit. So, thank you for that, number one. Two quick questions. The first is general, the

other is quite specific. The general is just, how optimistic are you, or how likely is it, that the Infant Health Equity goals by 2030 can be reached? Given that, as you described them, lofty goals of 1991, were only reached, by Belinda's note, by one Healthy Start site. So, I'm trying to get a sense of the goal setting for 2030, and how optimistic you are that can be reached, or is that aspirational? Just to calibrate. That's one.

The second is that our focus of our current Making Amends Report is specifically to the American Indian/Alaskan Native families. Those numbers, as we know, were quite small. Those numbers have been accompanied by marginalization and data erasure. Under many of the previous Healthy Start applications, the numbers of deaths would never have been large enough to qualify for a Healthy Start site. So, I was wondering if you can comment on strategies for reaching the American Indian/Alaskan Native populations, where they are, with targeted impact, and how Healthy

Start can be part of this movement to make amends. So, optimism and numbers.

Benita Baker: I'll tackle the second question first. So, we are looking at strategies that will ease some of the burden on those populations in applying, and both activities, required activities. Now, Lee, I'm not clear on how much, because this is a competition, how much I can say around that. So, if you want to step in.

Lee Wilson: Sure. Magda, and the rest of the group, I will talk about this later on. I know that Etta is going to ask us for input on what we've taken away from the various meetings that we've had in recent years. One of the most important things I think for HRSA, is to provide us, that the committee provides us not only with a set of recommendations, but language from an outside body that is representative of a cross-section of experts and key informants, on directions that we should use. So, that we can then turn around and say, not only is HRSA thinking about this, but here is this advisory committee which has advised

us to do X, Y or Z. The whole doula initiative and the way we crafted it as a supplement to the Healthy Start grants, was heavily influenced by the recommendations that this committee made to us about two years ago, or a year and a half ago.

Similarly, we are taking these recommendations from the last meeting in September, which had some very strong recommendations for Healthy Start, and the fact that it excluded a number of communities because of size or rurality and numbers. So, we are very mindful of those recommendations, and we are boiling them into the soup that we're making here, which will be the new Healthy Start. I don't know that I really like that analogy, but it seemed to fit when I was speaking.

Magda Peck: I thank you for that. I just think that the paradox that we point out is that numbers are too small to be counted, therefore they don't count. Yet the criteria of the guidance is what reflects policy. I'm also mindful of the voices of testimony that say, "Why are we competing for

something for which we've already paid?" So, both issues, the, why are we an equal competition when it's an unequal oppression, and how do we then not get penalized for the small numbers for which we are not responsible? So, the paradox feels very strong when it comes to this programmatic level, and I just think this is where the accountability is. Thank you for the invitation for us to help you shape that guidance in a way that can make amends.

Lee Wilson: We have many, many, many competing priorities, and sometimes we are maybe not as genius at addressing all of them. I know that part of our charges to do demonstrations, part of Dr. Warren's charge, is to move the needle on the numbers, and to bring equity into play in what those numbers reflect. Part of the commitment that the federal government has made, whether that be assigned to HRSA or to somebody else, is to care for the health needs of American Indians and Native Alaskans. That being said, we also have very large populations of African Americans

who have very, very troubling health outcomes too. We're also wrestling with compounding social issues of poverty and access, and other resulting consequences. So, would that we had more resources to be able to address all of these things, but we definitely hear you. We are definitely trying, and the reason we bring you here to put us to the test is because we want to do our best here.

Magda Peck: Thank you.

Ed Ehlinger: Belinda?

Belinda Pettiford: Thank you, Ed. Thank you, Benita, so much for your presentation, and Lee, for your comments and full disclosure. I've been engaged with Healthy Start for the last 25 years, being a site here in North Carolina. I mean, I think one of the areas that I stay focused on and stay concerned about is our conversation on community engagement. I'm wondering, with the new competition, is there any consideration of giving sites a menu to select from, versus requiring

everything? Because when you are having a conversation with a community and you're saying, "Well, tell me how this can be designed," and it's really already designed for you, it is really not being true to the community engagement process. I think if there's any opportunity to think through, is there a way to give a menu and say, "These are the 10 things that Healthy Start wants to focus on. Are there six of them that you think will work best in your community, versus seeing all of them?"

Because that is some of the pushback we get in our community engagement discussions is, "Well, you already tell me you've got to do this, this, this, and this, and you're telling me this is how much money you've got, so tell me really what engagement are you providing me?" So, it's just something to consider. I realize that you may or may not be able to do it, but if we're going to tap the conversation around community engagement, we really want to make sure that the community is at the table, and we're listening to the feedback

that they're giving us. I think that is one of those critical pieces that is easy to get lost in the process, and tell everyone we're doing community engagement. Communities know better, if it's not genuine, if it's not authentic. So, thank you.

Benita Baker: Thanks, Belinda.

Ed Ehlinger: ShaRhonda? ShaRhonda, unmute yourself and ask your question.

ShaRhonda Thompson: Okay. Sorry about that. My question is back to the doula, the doula program. When it comes to that, I know training is involved and that training has a price. Are we looking at ways to ensure that once we get to the point where the doulas are being paid and it's actually a career, are we going to make sure that the people who are using doulas basically are represented? So, people of color, are we going to do something to make sure that they can afford the training to become doulas, so that they can represent the community, so that they match the community? Are

we going to do something like that? Because I know in our area, we're trying to use Medicaid for doulas, but the training, the cost of the training for people, women of color to become doulas, usually is too much for them to pay based on the area that we live in, and the poverty that we're facing. So, now you have doulas can get paid with Medicaid, but we don't have enough doulas to match the community.

Benita Baker: So, in 2023, this is a proposed budget, the $20 million, these grants are open to-

to all entities, whereas the previous was open to Healthy Start. And what we are looking at doing is writing the NOFO in such a way that those higher-risk communities can come in for the grant. I don't know if you've ever heard of Adarand, but we cannot direct funds to a specific population. We have to sort of tweak things. And that particular grant covers the training for the doulas that will be hired and the certification. It will if we get the funds.

ShaRhonda Thompson: Okay. Thank you.

Ed Ehlinger: All right, Benita, thank you. And Lee, thank you.

Benita Baker: Thanks.

Ed Ehlinger: Appreciate that. It's a good lead into our next conversation since Healthy Start and SACIMM started at the same time.

Review the Work and Accomplishments of ACIMM

Ed Ehlinger: So, we're going to take the next hour or so to look back at what SACIMM has done over the last four years, but do this not because for just recalling history, but actually as an example of setting the stage for what needs to happen moving forward. I mean we learn from what has happened in the past and we use that as a springboard to move forward. So, I'm going to go back through a little bit of history and what has happened over the last four years. Then going to have Dr. Art James who kind of kicked off our session back in 2018 to do about 15 minutes to set a little stage about racism that formed the basis of a lot of

our work. And then look at what the workgroups have done over the last four years. See what MCHB has thought about the last four years and then get some feedback from the members in terms of what we have learned. So let me again share my screen here.

All right. So, we came on board, at least a group of us, in 2018. We were appointed way before that, but it took a long time to get the committee started. It had a hiatus as was mentioned earlier for several years. But we had our first meeting in December 2018. But as Benita said, the advisory committee, infant mortality was started in 1991 and it was linked directly with Healthy Start and we were to serve as its advisory body. And I'm not sure how much that happened in the earlier years, but we've had certainly some conversations about Healthy Start. But I'm not sure it was as robust as what was thought about initially.

But also as I thought about the 1991 start, Paul Wise, who was a member of this committee for the

last four years and I were actually people who testified back in the eighties, that led to the start of Healthy Start, which was in response to some major changes in public health that really disadvantaged maternal and child health and the establishment of Healthy Start was in response to community pressure, particularly from the American Academy of Pediatrics among others to actually do something.

And as Magda pointed out, I was running or she pointed out, you mentioned about the disadvantage of some group. I was working as the Maternal and Child Health Director in the city of Minneapolis. And even though we had the greatest disparities among African-Americans in terms of birth outcomes and we had the third largest population of urban American Indians in the country, we did not qualify because our numbers were too low, even though the statistics were... The data were pretty startling. We just didn't qualify. So, it was basically a... Hate to say it, it particularly disadvantaged American Indian

communities. And it could be talked about as being structural racism that got perpetuated. But be that as... So that's why I make the argument from history that I think this committee needs to have some young folks and it needs to have some people with some history that can bring all of those perspectives together so that you learn from what it is.

Because the experience that I've had has dictated a lot of what I've done and I've learned from a lot from others as the process goes on, so one point to make. The other is that here we are in 2022. Our work has been built on the work of previous committees and as best we can, we learned from that. And certainly, there weren't a lot of reports that came out from ACIMM over the years, but the ones that we sort of reviewed were the ones in 2001 and 2013, the group with Kay Johnson as the chair and we've learned from that. The other thing that came out was that ACIMM was linked to the Preemie Reauthorization Act, again, which is something we've talked about in the past

but we've not done a lot of work on. And I know that Lee had some plans on how we're going to be doing that.

So I'm just thinking that it's part of our history and it needs to be part of our future. And then part of our history is the charter reauthorization, how we had our charter from 1991 and how we reauthorized it and expanded in 2019 and 2021. We came on board in '18. We had nine members that we started in 2018; Tara Sander Lee, and Steve Calvin came on in 2020. Vijya Hogan was part of our original group, and she left us very shortly after starting, so I think it was in 2019 that she left. And Paul Wise, Paul Jarris, and Jeanne Conry were with us pretty much through this last year. We had a good group and now we got the new group that has come on in 2022. One of the accomplishments that we made was the charter. It was scheduled to be disadvantage or... Well, I'm not sure if I have that.

At one point the committee was going to be gone away because of the president wanting to increase

the efficiency of government. And we argued about it and we were able to maintain the advisory committee. So that was one of the things that we did just to maintain SACIMM. The other is that we expanded the charter to include maternal mortality and severe maternal morbidity, which had previously just spent infant mortality because the dyad was so important, we argued that it needed to have including maternal mortality. And then we also expanded it to include disparities in inequities and some of the social issues that caused the disparities in inequities, particularly around health and social and economic and environmental factors. Those were new things that were added as we started to realize as public health said, as institute of medicine said what public health is what we do collectively to assure the conditions in which people can be healthy.

And those were some of the conditions that we started to focus on as opposed to simply the medical care or the diseases, really focusing on

the conditions that really affected it. And that act impacted a lot of what we did over the last four years. As I went back over the history and I look back on our second meeting. Our first meeting was in December 2018. Our second meeting was in April 2019 and on that meeting, this is what we talked about and what we thought about. We should build a strong research base, build on that, that was established by previous advisory committees because they had a lot of academics, did a lot of research, looked at a lot of data. We wanted to use that and build on that for looking at programs and policies. We wanted to center our issues around poverty, economic policy, and social and economic safety net.

Work to advance equity, expand our focus to include maternal mortality and focus on the impact of racism. That is what we decided on in the first couple of meetings. And that's what I think our actions over the last four years have really continued to be fairly consistent with focusing on those issues. And also in that

meeting adopted some simple rules. Simple rules are when you're dealing with complex situations, when you're dealing with complexity models, you need to have some simple rules to move. And the simple rules that have sort of guide guided our work. Remember every baby and mother, center on equity, listen to community voices, build capacity, focus on connections, ask powerful questions, and seize opportunities. Just our conversation in the last couple of hours were really said. We're centering on equity. We're listening to community voices. We're building capacity. We're focusing on connections. We're asking the powerful questions. It just is... And now I think looking forward, seizing the opportunity. I think we've been true over the last four years to the simple rules that we set about on back in 2018, 2019.

This is what I had... So one of the things that we really accomplished was we preserved ACIMM because the White House had an executive order that wanted to reduce the number of advisory

committees and we argued that we needed to continue ACIMM. And so, we did that. We expanded the charter. I think the fact that we got the Secretary of Health and Human Services to actually come to our meeting, even though it wasn't in-person, it was virtual. I don't know if any previous ACIMM had the Secretary actually come to the meeting. That I think is a success. We had the Assistant Secretary for Health come and join us. We had all the HRSA administrators, and I know they've come to previous meetings, but every HRSA administrator came and met with our committee, which says that we're building the gravitas of the committee and we're actually getting some visibility.

We're being recognized as some group that needs to be at least listened to. And then we submitted three reports. I think this is fairly remarkable given the fact that there's not a lot of staff dedicated to this. We have great staff and I want to compliment the MCHB staff who've worked with us over the years. Really good staff, but they don't

have a lot of resources to help. A lot of it is the volunteer work of this committee. Oh yes, we get paid or whatever for the meeting, but a lot of work goes on besides that. And we came up with three reports. The first one was in June 2020, which was really focusing on COVID-19. I think that had a huge impact because nobody was paying attention to the maternal and child health outcomes of COVID and we called attention to that.

With our second report in August 2021, we again updated some of those COVID recommendations. Again, bringing forth the issues that moms and babies really needed to be paid attention to during COVID and I think that added a lot to the conversation. Similarly, in August 2021 with the report that we had, we broke some new ground with migrant and border health, with the physical environment, the environmental toxins, and workforce, and systems of care issues that we really brought forward to the Secretary. And then certainly then the third report that we approved

just earlier today was the American Indian/Alaska Native birth outcomes report. So I think in having three significant reports over these four years has been quite an accomplishment. So I really appreciate the work that all of the individuals who were involved on the committee, but also the people in the workgroups that have been part of this have been really, really helpful.

And just from my personal... I think I love the fact that we've been able to listen to community voices. I think we've elevated those stories. We've elevated the community. We recognize the importance. I think the gravitas of ACIMM has increased, just the connections that we have with the major MCH organizations and others. I know just from ASTHO, the Association of State and Territorial Health officials, which represents Commissioners of Health. They recognize what we're doing and pay attention and they've taken the recommendations that we've had and built them into their policy statements. So people are

looking to our committee as a place for information and some leadership. We've certainly enhanced partnerships. Also, think this is a mixed measure. When we first started we had two meetings a year with an issue as important as infant and maternal mortality. Two meetings a year was not enough to actually do the work.

Now we've got four meetings a year, but that requires a lot more work and that will require a bigger investment, certainly from MCHB, in terms of supporting this committee because it's difficult as they are well aware. Every three months comes pretty quickly. Having a meeting outside of DC was no small feat. And again, I thank Lee for making that happen, but I think that is a major accomplishment and that set... Just by doing it once it sets the tone that it can be done again. And I have to... I'm probably overstepping here. But I think that the White House Initiative on American Indian/Alaska Natives actually was probably stimulated at least a little bit by what we were doing and the work

that we've been doing. They're following our example. And then I think the fact that we expanded our scope to include the border issues and immigration and environmental health issues and racism and equity broke some new ground that really had not been broken in the past.

So I think we have done a lot. I've been really proud of the work that this committee has done. I think we have done a lot and we'll be hearing from others, but this is just my kind of rapid overview of what I've seen over the last four years. But I wanted to go next to reflect back to the very first meeting we had in December 2018. At that meeting, we invited Dr. Art James who had been on the previous SACIMM committee to talk about inequities and racism because he had been doing some work on it and we were thinking that we should probably focus on that. So Art came and gave a talk and the slides of his talk are in the briefing book. I've asked him not to go through that whole presentation, but to sort of now come back four years later because his work really

stimulated us to really focus on structural racism as one of the major causes of the problems that we have.

So I've asked Art to come back and in 15 minutes sort of give us... All right, where have we come? What has happened in the last four years, and what still needs to be done? Thinking in terms of the next iteration of SACM, how can it next move this work where we're really advancing health equity and optimal health for all mothers and babies? So I'm going to turn it over to Art. Art, like I say, a former SACM committee member and Art just recently was awarded the Martha May Elliot Award from the American Public Health Association for his many years of work on advancing health equity and addressing racism, particularly in Ohio and also in Michigan, but also being just a great role model for a lot of folks working on equity in the maternal and child health world. So I'm going to turn it over to Art. Welcome back to the committee.

Arthur James: Thank you very much.

Ed Ehlinger: Glad you're here. And I hope you're doing okay.

Arthur James: Yeah, I'm doing well enough, let's put it that way. Let's see if I can share my screen here. Doesn't look like it.

Marie-Elizabeth Ramas: We can see your screen.

Ed Ehlinger: There you go.

Arthur James: Great. So I had the pleasure of serving on SACIMM for several years just prior to the current group that is stepping down. It was a big pleasure. I think all of us recognize that we have few opportunities to influence policies and things nationally, especially where something is as important as maternal child health is concerned.

I've used this title slide often in my talks because in my opinion, I think that the biggest challenge that maternal child health faces is the racial disparity in birth outcomes. So I start with this slide that looks at maternal mortality on the left, infant mortality on the right. What I want to point out is that in both examples,

Black in maternal mortality is the worst followed by the maternal mortality for Native Americans. The same is the case for infant mortality. And since we know that the International Genome Project says that we're all 99.9% genetically the same. So that tells us that physiologically there are no significant differences in us by race to account for the disparities that we see in death. The question for us is how long are we going to tolerate this? How long are we going to accept these kinds of patterns because they're wrong?

Let's see if I can, and in order to eliminate the disparity, I often digress to this slide which says that if we want the guy who was behind to catch up to the guy who was in front and we want to do that without the guy who was in front slowing down, then we have to figure out a way for the guy who is behind to run faster than the guy who is in front in order to eliminate that gap. And so it is with the disparities that we see in maternal and infant morbidity and mortality. We have to double, triple, quadruple

down in the communities that are suffering the most in order to eliminate the gap and the opportunity to survive childbirth in the first year of life. But having given versions of this talk in actually 38 of our 48 continental states, I often get a lot of pushback.

People tell me that it would be wrong for us ever to think about decreasing the infant mortality rate for one group more than we do for another group. That it would be immoral, unfair, and unjust. But in fact, we've been doing that for decades. But it has been because the White infant mortality rate has been the benefit that we've behaved as if that's normal. I won't go through my full data presentation, but there are a couple of characteristics of the data that I do want to point out. So this is looking at Ohio, although we've done this for the United States and for several other states, it's called a crude survival time lag. What I mean by this is that if we look at the most recent Black infant mortality, in this case in the state of Ohio, and

go back in time to find a comparable White infant mortality rate in Ohio, we have to go back 44 years.

This suggests then that if we allow this pattern to persist, if we don't disrupt this pattern, then what the state of Ohio is telling people who look like me is that we have to wait until the year 2063 for Black babies to have the same opportunity of surviving the first year of life as White babies did in 2019. And we think that's wrong and we know that we can do better. This looks at a similar dataset, but for a century, essentially. Black infant mortality in red, White infant mortality in green. The first thing I want you to notice is the disparity curve and how the disparity curve for the most part increases. It increases because we have improved the White infant mortality rate at a faster pace than we've improved the Black infant mortality rate.

We have to continue to work real hard to improve the White infant mortality rate to the best of our capability, but we have to do much better for

communities of color. But I want to look at this same data set and apply that crude survival time lag because I think it adds some urgency to the work that you're engaged in. If we look back in 1935, we had to go back 15 years to find a comparable White infant mortality rate. 1960, we had to go back 20 years to find a comparable White infant mortality rate. 2017, we had to go back 37 years. The point here is that this is work that we can't keep delaying. We can't keep kicking this equity can down the road. It's not working. We are allowing mothers and babies to die for reasons that we can prevent.

Martin Luther King said this, "We are confronted with the fierce urgency of now. In this unfolding conundrum of life and history, there is such a thing as being too late. Procrastination is still the thief of time. Life often leaves us standing bare, naked, and dejected with a lost opportunity. The tide of in the affairs of humans does not remain at flood - it ebbs. We may cry out desperately for time to pause in her passage,

but time is adamant to every plea in rushes on. Over the bleached bones and jumbled residues of numerous civilizations are written the pathetic words, 'Too late.' There is an invisible book of life that faithfully records our vigilance or our neglect. Omar Khayyam is right: 'The moving finger writes, and having writ moves on.'"

This is part of your biggest challenge in accepting the responsibility of being a part of ACIMM. We have to move this equity issue forward. Another piece of this that I think drives home the point. Again, I'm going to use Ohio data to make this point is that in the state of Ohio where healthy people are concerned. We have achieved healthy people infant mortality goals, three of the previous four decades of healthy people.

And we did so in advance of the goal date for White babies. The state of Ohio has never achieved any healthy people goal for Black babies. I highlighted Ohio because that's where I live, but there are several states that fall into

this category. We have to change this. It's just totally unacceptable. So I posed this question, why do Black mothers and babies... Do Black mothers and babies matter or to soften the question, do they matter as much as White babies? And while everyone says yes, I don't think our actions support this response. So why does this disparity exist? Where Native Americans are concerned, does it have anything to do with this history of taking their land from them, subjecting them to marginalization and reservations, chasing them away in this Trail of Tears and almost committing complete genocide to a population of people?

Where African Americans are concerned, does it have anything to do with since 1619, Africans being brought here and enslaved for 246 years followed by 99 years of Jim Crow? It has only been 58 years since the passage of the Civil Rights Act and I think most of us who are Black would suggest to you that the playing field has never been leveled even since the passage of the

Civil Rights Act. The 246 years of slavery and the 99 years of Jim Crow to this day account for 86% of the African-American experience. But when we compare Blacks and Whites in any domain, we never mentioned this history. We never admit the significant period of time where we've provided substantial advantage to those of us who are White while simultaneously subjecting those of us who are Black to a significant disadvantage. And these efforts have not diminished. Think about what's going on nationwide with the efforts to suppress the vote, for example, in communities of color.

My point is that the racial disparities that exist in this country exist because we made them this way. They are not natural, but we behave as if they are. We act as if there's something physiologically so substantially different between those of us who are Black and those of us who are White, that those differences explain away the disparities that we see. And that's just not the case. The disparities occur because we

made them this way. Richard Wilkerson, who's one of the co-authors of the World Health Organization's work on the social determinants of health, talks about the impact of inequality and how being subjected to inequality or racism, the stress that it creates over a long period of time, that it changes our physiology and as a consequence, places us at increased risk for cardiovascular and immune system problems, makes us vulnerable to a wide range of diseases.

When we see pregnant women today, if they've experienced a substantial amount of stress, we are not reluctant at all to suggest to them that the experience of that stress can increase the risk of a compromised outcome to the pregnancy. That the stress somehow gets under her skin and gets incorporated into her physiology. Not only that, but the experience of that stress and the incorporation in her physiology also influences her fetus and can place the fetus and increased risk for a compromised outcome. But the other piece of this is that we also believe that the

baby who survives a stressful pregnancy can pass on those physiologic changes to subsequent generations.

And so this is something again where we can't keep kicking this can down the road. Nancy Krieger tells us that social inequality kills. It deprives individuals and communities of a healthy start in life, increases their burden of disability and disease, and brings early death. Poverty and discrimination and adequate medical care and violation of human rights all act as powerful social determinants of who lives and who dies, at what age, and what degree of suffering. So what do we do with this situation that we've created where we've provided a substantial advantage to one group while simultaneously subjecting another to a substantial disadvantage? Having heard a portion of your conversation earlier about the important work of the doulas provide, I think that that's extremely important.

But doulas don't eradicate these obstacles that this person is being subjected to. I'll talk a

little bit more about that in a couple of other slides. We've set up the rules in this country so that some of us have more of an opportunity to be successful than others. And it's not because those of us who are successful are better than or more deserving than others, and it certainly isn't because of group-level flaws amongst those of us who suffer disproportionately. Again, this is not natural.

In maternal child health, this is our challenge. We have to stand in this gap while simultaneously working to eliminate the gap. And a big contributor to that gap is racism. What we do currently is we invest in a lot of help programs. So we help the lady on the right by carrying the ball around her ankle, by helping her negotiate around the obstacles. All very important stuff that we need to do. But at some point in time, we need to change our focus to permanently remove the obstacles that are put in her place so that she has the same opportunity to be successful as the individual on the left.

Therefore, I've tried to make the point that our goal is not health equity. Our goal should be to achieve overall equity. Camara Jones has taught us that in order for that to happen, at least three things need to occur. We need to value all individuals and populations equally, we need to recognize and rectify historical injustice, and we need to provide resources according to need. Nelson Mandela has taught us that it always seems impossible until it's done. Thank you.

Ed Ehlinger: Art. Thank you very, very much. And I think the members of the committee who didn't hear Art's presentation back in 2018 can see why we really chose to focus on the issues in the path as opposed to focusing a lot on the medical care pieces. As important as medical care is, they were not what we viewed as the most important thing that SACM could be doing over the last four years. And so that's why we focused on equity and particularly on structural racism. A lot of our recommendations were really about doing that. So I'm going to open up for a few minutes here just

to see if anybody has some comments related to what Art has before we move on to other reflections of the last four years. Marie?

Marie-Elizabeth Ramas: Thank you so much for our compelling presentation. And it is good to see once again that we are amongst family at this virtual table. So thank you so much for your work that you are doing. And this really highlights for me why it is extremely important for bodies such as this to be representative of the groups that have historically been silenced. And that last picture, Mr. James, of all of the obstacles that one faces in order to get to the goal of wellness is daunting, and those obstacles were placed in her path. They were not natural, which I recognize as well. And so my question is, with all of us having our own circles of influence all across the United States, what have been some key mitigation strategies that you have observed in your journey as a leader that has supported

accountability in policy work, in providing necessary funding and support to result in better outcomes. Can you share from your wisdom?

Arthur James: Yeah, so I'm going to start moving backwards and I'll start with actually the work provided by Dr. Warren and Dr. Hirai a journal article that they published in February of this year, Journal of Pediatrics, Accelerating Upstream Together, where they actually talk about the importance of achieving equity and they get more granular about it. Not only talk about the importance of achieving equity, but what it's going to take in terms of the number of babies that we need to save every day, every month, every year in order to achieve equity. And I want to make clear that when we're talking about achieving equity, we're not just talking about achieving Healthy People 2030 goals for Black babies or for Native American babies. We're talking about equity, which means that our goal is to achieve the same degree of successful birth outcomes for those groups as we do for whites.

It's a tall, tall task. I honestly don't know that we can accomplish it by 2030, but it's important that we put it out there as our benchmark, and not just that. We are in 2022 now, essentially 2023. We can calculate what it's going to take in terms of the degree of improvement in the infant mortality rates for all groups between now and 2030. So it gives us a barometer for where we are in terms of achieving that goal of equity. And almost in all cases, we're going to document falling behind. What that ought to tell us though, is the degree to which we need to step up our efforts in order to achieve those equity goals. I also think since we've talked about Healthy Start, that since Healthy Start is one of the projects in this country that receive so much support from the federal government that at the very least we ought to hold Healthy Start sites to achieving equity for a lot of different reasons, not the least of which is that it proves to the rest of the nation that it can be done.

I also would encourage you all who are part of this group to use this bully pulpit, to use it aggressively to make the point that needs to be made in order to try to save our babies. Because what we're doing now is just totally, absolutely beyond any shadow of a doubt unacceptable, because we know we can do better. Yes, it means that we have to address things like poverty, but we can do that. I know it means that it's going to take a lot of money, a lot of resources, more than just HRSA is going to be able to put on the table, but if we make it a priority, we can move this needle in the right direction. And I also want to make sure that I don't demean the importance of the research that's gone on in terms of improving clinical care, but I think most of us know that the biggest contributors to the disparities that we experience are the nonclinical issues that adversely influence populations of color.

And we have to have the courage to support those communities to get out there and advocate for

that. In another city, maybe we'll have an opportunity at some other time, or I can send you some additional information. But in Kalamazoo County back in the year 2000, we were able to help Kalamazoo County get close to achieving Healthy People 2000 goals for Black infant mortality. One of the few counties in the country that got so close to accomplishing that goal. Nothing special about Kalamazoo County, I guarantee you. When we started the project, Kalamazoo County had the highest Black infant mortality rate in the state of Michigan. The state of Michigan at the time had the highest Black infant mortality rate in the nation, and we were able to decrease the infant mortality rate from about 30 to about 10, 9.9. So, it can be done. It takes a lot of work to do it and sometimes it gets discouraging because it takes so much work, it requires so much of us.

Ed Ehlinger: All right. Before I turn over to Janelle, I do want to make one point that you made related to

the question that was just asked. One of your slides that you used.

Arthur James: Yep.

Ed Ehlinger: Let me just bring this up. This slide. You'll note that the times that there were three times in this chart when the disparities went down. One was in the early 1900s when a social model was used as opposed to a medical model was used to deal with all of the poverty issues, the children's rights issues, the women's issues, women got the right to vote during that time. The second time it went down was during the Great Depression and the World War because people, one, we had the Social Security Act with the maternal and child health, but also all of the social security issues, it brought down disparities. And we got together in photo war. We all came together as one people.

The third time in this 100 years was during the War on Poverty when we had a health and all policies approach to health. The War on Poverty

and the Great Society Program was very successful in reducing disparities. Those were all policy issues. It was a health and all policies approach. And I think that is what I was hoping, and that's what I'm hoping that SACIMM can do, is focusing on the same kinds of approaches that were used in the early 1900s, the mid 1930s and forties. And in 1960 or in 1960s. Janelle?

Janelle Palacios: Dr. James, it is always, always a pleasure to learn from you and to be here with you. And every time that I hear parts of your presentation, new thoughts come to mind. And from the very beginning of being on ACIMM, I have advocated that we have to see each other as humans and that we have to have nationwide recognition and healing together. That there has to be where we are in relationships and in community with one another because we don't see that. And it has come to the surface more so in the past eight years than any other time.

And we have to be very frank about stating which people are valued more in terms of funding, in

terms of our outcomes, because we see that. So we have to be very frank of keeping that at the forefront and asking why can't we all have an equal access to health and wellbeing? Why can't we all be at this same level? One of the parts that jumped out to me is that it is newish, scientifically discovered what many Indigenous communities knew around the world, that the health of the pregnant person and the infant relied on what her relationship in the world was. So being in a stressful environment was going to impact both of them. And that there are cultural protections in a number of Native American cultures where a pregnant person should not be around death, should not be around war, and that was just to protect that dyad.

And it is only now recently that we were coming that Western science is able to document this in terms of risk for hypertension, risk for preeclampsia, other kind of comorbidities and chronic health diseases. So it's great to get recognition that our cultures and committees that

have been marginalized, in fact were very, very wise and have been practicing healthy ways of keeping and protecting their families and people healthy and we have a long ways to go to be there. I look forward for any additional other wise thoughts you have in terms of, what else is needed? What else has to be done? What action has to be taken immediately now to achieve equity on a fast track? Because we know that we can take a few centuries to get us to where we can all be at a more equitable place, but we don't want that, we want it fast tracked. So what does that look like when we fast track it? Aside from doing more funding, what else has to happen?

Ed Ehlinger: So be before I have Art answer, I would like to have Charlie make the last comment and then we'll give Art the last word before we move on.

Charlene Collier: Okay. I'll be quick. Thank you so much Dr. James. As a OBGYN, and you're one of my true heroes and I thank you for your comments and particularly acknowledging the mindset of resistance as it relates to focusing on the

populations who need it most and not making the assumption that everyone believes that those who need the most should get the most. And I think that scarcity mindset has been present throughout, of course, all of our culture. It is a reflection of white supremacy and racism and I think calling it out, naming it, and really pointing to who's responsible for continuously breaking it down because it continues to be this silent thing when it's said, we're going to apply practices that everyone can benefit from, but as you mentioned, it is going to accelerate improvements in some, but it's not enough for those who need more.

And so, it's this unspoken thing often and I think it's being able to break it down. How does it get called out more when it's happening? And just, I appreciate you really voicing that that is an underlying theme within both hospital initiatives, public health initiatives, that there is a willful resistance to the attempts to apply the funding, apply the focus where it is

needed most. It's not just, oh, there's not enough funding, it's really acknowledging that discomfort that is part of our culture and how we have to break that down. So I just want to thank you for that and just see as you answered Dr. Palacios, if you have other suggestions on how we continue to name that specifically as something that we see in public health and in health policy. Thank you.

Ed Ehlinger: All right, we'll give you the last word before we move on so you can...big challenge again.

Arthur James: Janelle, I'm sorry, but my computer went offline while you were talking, so I didn't hear your final question. I do want to say the following for those of you who are new to this committee, that one of the wonderful things you have is the group of people that you're working with at HRSA, they get this. They get it, they want to do something about it. So, you have to help them. And that's a big part of the task that is on the plate for you. Janelle, what was your question? I'm sorry.

Janelle Palacios: No, my pleasure. No, Art, what recommendations do you have? What guidance do you have in terms of fast tracking that we get to equity? We don't want to wait a few centuries, we wanted immediate. So what other ideas do you have for this committee and for our partners to fast track?

Arthur James: Yeah.

Janelle Palacios: Thank you.

Arthur James: I think that and in general is that we need to begin a much more earnest effort to address the social determinants and the disparities that exist there. Often I'm asked, well, which social determinants should we address? And I don't have a pat answer for that because I think every community is different enough that my suggestion is that you start with the social determinant in your community that you can garner the most support for. Sort of what Belinda was talking about earlier when she asked about a portfolio approach, if you will, for Healthy Start

projects. But that once you pick a social determinant to work on, let's say you decide to work on housing, that in addition to working on that, you need to schedule a time to onboard addressing the other social determinants because they're like dominoes. If you don't graduate from high school, that influences the kind of job you're able to get, how much money you're able to make, whether or not you have insurance, the neighborhood that you live in, et cetera, et cetera, et cetera.

So that you have to onboard addressing them all. And just like I've tried to show in the disparity data in this quest for equity, how we can measure our progress, you can do that for each of the social determinants. So that's one piece. Obviously, I also think we need to work on the clinical stuff, but my emphasis would be on the social determinant piece. The challenge for the social determinant piece is that of course it's going to take a longer period of time for us to reap the benefits from doing that work. So it's

not a fast track, but it's a track that we need to be on.

Ed Ehlinger: Thank you very much, Art.

Arthur James: Thank you. Appreciate the-

Dr. Ed Ehlinger: That was very helpful in both in reflecting back but also giving stimulus to move forward. That is exactly what I was hoping you would do, and you did it with such grace and wisdom. Thank you, thank you, thank you.

Arthur James: Thank you. Good luck to you guys.

Ed Ehlinger: Thanks. All right. Now over the last three years, three and a half years, a lot of the work that we've done has been done through the workgroups. So I'm going to just ask each of the chairs of the workgroups to give just a brief summary of what happened? What have we learned? What kind of accomplishments do we have? And let's start with Steve. He is the head of the chairing the Workforce and Qualities of Care Workgroup. Had a lot of work early on when we were looking at

COVID and the systems reform of our first two recommendations. Your Workgroup did a lot of work on that. Give us a little background, little update on what you see happened over the last four years.

Steve Calvin: Sure. Well, it's very abbreviated in the last year and a half or so, and I think I'd have to apologize for that. But it was quite interesting, particularly when we had Suzanne England and others join us because that was the first time... I mean, I've had a peripheral interest in kind of what was happening, especially out in the tribal lands in South Dakota. But anyway, the workforce issue is, it's a huge one. And I think as we go forward, all the folks that have joined us from various places all the way from Alaska to North Carolina, I mean we have a wide range of experience. So we know for sure within the profession of those who care for pregnant moms and babies, that we are going to have a shortage of physicians and midwives. And I think that's going to be a very important issue for access.

And then as we develop those workforces, having those workforces look a lot more like the folks that they're caring for will be incredibly important. So that's my summary.

Ed Ehlinger: All right, good. I forgot to mention that the workgroups are not statutorily there. They were just ad hoc workgroups that the committee decided that that's what we needed. We wanted to have one on data, wanted to have one on health equity, and we wanted to have one on care and workforce. And so whether those continue will really be up to the group as they move forward. But they've been very helpful to me in terms of helping get the work done and moving forth an agenda. Janelle and Belinda, the two of you co-chaired the Health Equity Workgroup. What have you learned over the last four years?

Janelle Palacios: Belinda, would you like to start?

Belinda Pettiford: Sure, I'll get started, Janelle. I think the main thing was, I think the insight of just actually standing up a Health Equity Workgroup

was important. I think we all knew it was needed and I think Art kicked off our earlier meeting, as you mentioned earlier, and reminded us we have got to make sure we have a Health Equity Workgroup, but we also need to make sure it's infused with all of the other work. I think the opportunity to bring others in, so like the rest of the workgroups, we didn't limit it to just the members of ACIMM. We just wanted to make sure that people that were interested, we reached out and we accepted all. I think we spent quite a bit of time looking at the inequities, especially around COVID early on and I think that was an important piece. And it was, as I think you said earlier, one of those areas that we hadn't talked much about and we were in the midst of it and everybody was struggling and we were really concerned about it.

So, I think the Health Equity Workgroup took that on as a challenge and said, these are areas that we needed to focus on. I think the other area that we were excited about was workforce

diversification. I mean, we spent time on having conversations around race concordant care, and cultural sensitivity, and making sure that the workforce was representative of the populations being served. And if we couldn't get to concordant care that we at least make sure people felt comfortable and that people were culturally sensitive and understood and took in the cultural perspectives of the people that they were actually serving.

We spent time and elevated the work of doulas. We talked about nurse midwives and the importance of them and them being able to practice under their own authority. We talked about community health workers. I think we went the gamut on that. And then I think with Janelle's leadership, this is where the work around the focus on American Indian and Alaska Natives started. I think we started those conversations and that workgroup and with Janelle's leadership, we're able to elevate it and bring it to the recommendations we

bring forward today. And I'll turn it over to you, Janelle.

Janelle Palacios: No, everything ditto. Carbon copy of what Belinda just shared. It was really wonderful to be able to work with a diverse group of people on the Health Equity Workgroup. That was really, really wonderful. We had community people involved, we had academic people involved, we had federal organized partners involved. We had a lot of representation. And so it was really wonderful to be able to have people's insights from different career pathways and different slices of looking at maternal child health that has really given him a rich experience and enlightenment to that work.

So I do want to say I have a very special place and thanks for recognition for Belinda in working on all of this as well, because Belinda really also was a mentor and helped shape the Workgroup that we were working on and had a lot of knowledge and access to the different partnerships that were going on. So that was

really wonderful. And then the second person I'd really like to call out and thank and I'm not sure if she's even present is Pat Loftman. Pat was really instrumental in working on both our Health Equity Workgroup and then also she worked a little bit more, some with quality and access, but really brought forward the voice of diverse care experiences and allowing pregnant people to have a choice. And that was really important to have her voice in that work.

Ed Ehlinger: Thank you, yes. And we raised the issue of bringing in new folks. So, we got a lot of new people who came in and worked with us. They expanded the workforce working on all of this, and Magda was the head of the Data and Research to Action Workgroup, DRAW.

Magda Peck: DRAW. If you don't have a good acronym, you don't usually get funded. So old habits die hard. I was hearkening back to when we first met and tried to figure out how to organize the work and we came up with these three workgroups and some of us had some suggestions about having these three parts

work together. And I just want to reflect for a moment that it comes from the ideas and leadership of a former surgeon general named Julius Richmond, who together with Milton Kotelchuck, came up with a tripartite model of how to make policy happen. And it would take a knowledge base, the data, the research, it would take a social strategy that programs and the services we do and it would take political will. And that if you have only two, the stool won't stand. And in many ways, the Data and Research to Action Workgroup is the knowledge-based part of our three-legged sacrum stool to get work done.

And the social strategy focusing on healthcare and access and workforce was one of our major areas. And in many ways the Health Equity Workgroup was the anchor for political will. As you had heard from Art James, the willful resistance that we can expect when we want to fast track the oppression undoing and taking and dismantling the obstacles in her way. So in that context, it's both what we did, but it's as much

what we did together. And the overlap between the first two groups reports that you heard, Ed's prior report, let me just compliment that. So that's the context and framework for my just summing up four years of working in this workgroup. We were initiated to serve a very specific purpose, to assure that our ongoing deliberations and decision making for producing strategic policy recommendations were based on evidence and science that was credible and reliable and timely and relevant.

And we did an initial assessment more broadly when we were still trying to figure out what do we respond to beyond COVID. And we acknowledged low capacity, and under staffing, the inability for the workforce to do its job around data and the incompleteness of data, particularly missing on race and ethnicity, that it was not uniform and there were no unique identifiers and that hard sources were hard to talk to because of HIPAA. And it was timely in a slow way overall. And that especially data on racism was

unmeasured, unavailable, uneven. And there were such limited data about special populations, including we said four years ago, the incarcerated, undocumented, people at intimate partner violence risk, housing, and crowding, and insecurity, homelessness, or shelter based. And that there were silo data and there was very little interoperability to link systems together across housing, and criminal justice, and food and nutrition.

So that this social determinants health had a knowledge base that was integrated that told a more powerful story. And we were also reminded by Paul Wise, a former member of SACIMM and also an earliest member of DRAW, that we needed to build cross-disciplinary bridges for a common wisdom and that we had to be as much about redesigning the architecture of data as deciding which variables we might want to measure. So when I think in that context about what were our leading accomplishments as the Data and Research to Action Workgroup, cumulatively through two

administrations, racial reckoning, pandemic and COVID-19, a major economic downturn among other challenges, we focused on what the knowledge base needed to support in a supporting role around COVID-19 prevention, around undoing racism and racial equity, around strengthening data systems and building data capacity and data workforce. And through expanded mortality review and then specifically focusing on American Indian and Alaskan Native photos so that the report we gave has the research base, has the evidence base, has the stories all wound into one compelling report.

We did that with a lot of volunteer effort and amazing people. And before I thank them, I just want to end with recognizing the other consequences and advancements besides the work. SACIMM allowed us through DRAW and to bring back to you all to validate the power of stories as data that lived experience is valued expertise to storify the work that's in SACIMM recommendations from the first to the second to the last. And may it continue not to have stories illustrate, but

stories drive. We provided timely consultation so when CDC is going to revise PRAMS, they could come to draw at SACIMM and we could convene partners and experts and be able to give back within three days the results that they needed to be able to inform their own new recommendations and guidance. So this notion of a timely consultation of a broad group of people was there because we had the architecture, the human architecture of working collaboratively and as needed, we brought in the other two workgroups because they were seamlessly interrelated.

We were a catalyst for some strategic collaboration across generations, across sectors, across disciplines, in a diverse kind of way. I love that we brought the housing folks in, which was never been at this table, has not been yet mentioned in our accomplishments, but we didn't need recommendations, we just needed people to talk to each other. So when Housing and Urban Development leaders showed up, it was a catalyst for HRSA and MCHB to be able to do their job even

better. As Art said, help them do their job as an independent outside group.

And last, in the process part of the benefits of DRAW was capacity building. I had the joy and pleasure of mentoring people and learning from a younger generation. And so the leadership is stronger, the innovation is greater, and the science has even more robust integrity. I thank Sherri Alderman and Ndidiamaka Amutah-Onukagha, Wanda Barfield, Cheryl Broussard, Jackie Campbell, Alison Cernich, Cheryl Clark, Jeanne Conry, Ada Determan, Danielle Ely, Rosemary Fournier, Carol Gilbert, Neeru Gupta, Leslie Kowalewski, Charlan Kroelinger, Janelle, Ed, and Paul Wise, and Ellen Tilden among many. I know this sounds like the Academy Awards, but it really is all of the 20 people who showed up again and again and again to do the work of translating data to action. It's been a hoot and I hope that you continue to engage and expand this diverse representative group of people to

make a greater difference together. Thanks for the opportunity, Ed, for the reflection.

Ed Ehlinger: Yeah, thanks Magda. Thanks, Janelle. Thanks, Belinda. Thanks, Steve. You guys did great work that that's where really the rubber met the road of moving this forward. The other place I would like to have some feedback or some insight is from MCHB, who has worked with us over these four years and helped us move along. I'm just curious on, I don't know, Vanessa or Lee, thoughts about what did we get done? What didn't we get done? How did we do it? What was our report card?

Lee Wilson: I'm going to let Vanessa go first.

Vanessa Lee: Oh, okay. Thank you. I was going to let you go first. I'll have to pull up my notes. I just jotted a few. I knew many of what I was thinking was already going to said, but yeah, you have an A plus from me. It's truly been a gift and just a tremendous professional opportunity to get to work with all of you. And I love working with the committee. It's going to be in my future for as

long as I can tell, and I'm excited about working with the other members continuing on. But I think this group, as you said, Ed and others, I've really appreciated just you drawing more attention to those social and structural determinants, especially after we saw Art present, just how critical that was back in 2018. And I think you really have moved us in MCHB as you can see, hopefully in some of our funding opportunities to not just focus on that clinical care or those medical interventions.

So I've appreciated that and I think that's a huge accomplishment to see within our portfolio, the work moving again towards social and structural determinants. Ed, you said this earlier and so did Terrence Moore, but I truly believe you've increased the knowledge and capacity of MCHB staff, our HRSA grantees who call in to listen every quarter, all these public health professionals that I see coming just to listen in on your committee business. So I really think you've changed the field around the

country, again, by increasing our knowledge and our capacity. You've brought such amazing speakers, guest presenters, people with lived experience, the community members. I hear every time we have a meeting afterwards, "Oh my gosh, I learned so much. I want to get connected with this person and that person." I think that's a huge accomplishment of you all as a committee.

And then again, your helpful advice and recommendations to HRSA on what we need in membership. I know you guys give us a lot of thoughts and input on that, and we really are taking that in. You've reminded us who's missing from the committee, what perspectives we're missing, who we need to include. Just make a plug. As you guys know, we have that federal register notice out right now calling for new member nominations. We have kept in mind all those recommendations that Belinda, you and the workgroup that you led gave us.

Now, that's about two years old so we want more thoughts from you all on who's missing. Again, what is that expertise or experience that we need to make sure the committee has so that we stay on the pulse of what's needed to, again, eliminate those disparities?

And Lee, I'll turn it over to you. Those were my three.

Lee Wilson: Vanessa, that sounded like a lot more than three and it covered a lot of what I was going to say. For me, coming into this role three years ago this month and having you, Ed, Jeanie, Magda, Janelle, Belinda, and others here, many of you I had met before, but your reputations preceded you. Having you as a real... The words I jotted down are touchstone, anchor, guide, source of input, knowledge, and balance in a situation where the division was having some difficulties. We were having to be facing COVID. We were looking at reorganizing. We had tons of staff who were being deployed or sick or pulled out.

I may have not said it directly to you, but there was this sense that I could lean a little towards the wall that was the advisory committee. Or if I got too far afield, that one of you would've picked up the phone and called me and said, "Something's going on here. What are you doing?" Knowing that it wasn't going to be self-interested because you wanted me to give you a grant for something to do it, although I'm sure that some of you will be coming later on to do that.

But the point was that you have been very much an informed and objective source of information, both for me and for the division. I have greatly appreciated that, not only in guiding me as I've tried to work with our staff to clarify what our direction is, especially as we have been strapped, but fortunate enough to get additional resources.

I think most concretely, your input, as I've said on so many occasions, is what we have used to ground and justify many of the advancements that

we are trying to bring to program. As I've said, Doulas is a good example that some of the idea, design, and factors that we have tried to build into the Doula Program, into the Catalyst Program are those things that Art James has raised because you've brought Art to us are the things that Ed has tried to attend to, that Magda has raised in the data activities, and frankly that Belinda has told me from her couple decades worth of work on the Healthy Start program. We have just benefited so greatly from the work that you've provided, especially in this last couple years.

And Ed, I'm going to say my farewells in a little while to those of you who are going off, but the stature of the committee is so different from where it was 3, 4, 5 years ago when the committee was really in question of its continued existence. I think I'll leave it with that.

Ed Ehlinger: Thank you, Lee and Vanessa. I appreciate that. The purpose of this reflection was not to try to get kudos about what has happened because I think

we've done a whole lot, but actually to set the stage for the next step. What did you hear? Somebody says we have big shoes to fill. That means you have some obligation, you have some responsibilities, you have to carry on whatever. I mean, we all carry the baton for a while and then hand it off.

I hope this last hour, just what we've done, how we've done it, what's worked, the accomplishments we have is just to set the stage for the next step.

Break

Ed Ehlinger: And after a break of 15 minutes, we're going to come back and talk about that next step. Refresh your water or your coffee or whatever lovely beverage you're doing and we'll see you back here at 4:30.

Magda Peck: I would say we are not adjourned, Dr. Ehlinger.

Ed Ehlinger: Say that again.

Magda Peck: Right. No, the slide said adjourn, and I was like, "Not so fast."

Kathryn Menard: Slide said adjourn.

Ed Ehlinger: We are definitely not there yet. We have work to do. We can't shirk our duty. We have to fulfill all the requirements. Everything on the agenda has to be covered.

Magda Peck: And you're keeping it very well on time. I so appreciate that, Ed.

Ed Ehlinger: Well, being a chair of a committee has some responsibilities and I try to take them seriously. I take them seriously. I don't try to. I take them seriously.

Magda Peck: And you do. Well done.

Vanessa Lee: Going to say, Ed, if this is just you trying to take them seriously, I can't imagine what taking it seriously would look like.

Ed Ehlinger: Yeah. People say, "I would like to thank you." I say, "No, just thank them." Don't say, "I would like to." Just thank them.

Vanessa Lee: I have a list of things I've learned from you, Ed, and that's one of them. There was a letter we were trying to write; it was an invite letter for the September meeting. It was something along the lines of just invite me instead of saying, "I would like to invite you."

Ed Ehlinger: All right, we got another minute yet before we reach the witching hour of starting.

Next Steps for ACIMM

Ed Ehlinger: All right. Welcome back. We have an hour and a half left on our agenda. Whether we take all that time is up to us. But there are three things that I want to accomplish at least. I want to get an update from MCHB of all of the administrative stuff, so I'll start with Vanessa. Then I'm going to want some response from all of you about how are you going to use the report that we approved

earlier today? How are you going to disseminate it and use it? Then we can talk about the next steps for ACIMM moving forward. Then we can say goodbyes. We've got time to do that.

Initially, I had thought that we would know who the next chair is going to be, but that's not possible. I was going to hand it off to let that person, whoever that might be, to take that part of the agenda. But I will work to fulfill my role right up to the end of this meeting, and hope that those of you who are staying on will keep in the back of your mind, all right, one of the things we're talking about that you might be able to use as you move forward as members of SACIMM.

Vanessa, why don't you give us an update of where we are, whatever the administrative issues that we need to know about at this point in time?

Vanessa Lee: Okay, thank you, Ed. Yes, we had hoped we would be able to share who the next chair of the committee was by this meeting. It is our intention to have that resolved by the next

committee meeting, which is slated for March. I'll just say we have dates still to be determined, but the next meeting would be virtual and in March. Again, our plan is to have the next chair in place by that meeting, or before that meeting, excuse me, so that they can be running the meeting in March. Otherwise, I learned it defaults to the DFO as your chair. I would rather be working with somebody than running the meeting.

Marie-Elizabeth Ramas: Do we have dates for that, Vanessa?

Vanessa Lee: We do not yet have dates for the March meeting, but Abigail, if you're still on, or Lee, maybe we can look back at what week we were looking at in the contract with the logistics with LRG. If I find that before the end of our call today, I'll put it in the chat.

Then thanks, Marie, for meetings for 2023. We have planned through the remainder of this fiscal year. As I mentioned, in March we are planning for a virtual meeting. And then in June of 2023,

again, exact dates to be determined, we are planning for an in-person meeting. Then actually next summer, are recompeting the logistics contract. That's just why we don't have dates or months yet for the remainder of 2023. But we typically hold another meeting in the fall, as you guys saw, in September or October sometimes. And then another one towards the end of the calendar year. But we should know more by the summer in terms of the remainder of the meetings in 2023. March and June, we'll be in touch with dates, or we can do a Doodle poll if we have some dates in mind among the members.

Again, working on solidifying the next chair. And then in terms of filling the remaining and also new vacant member spots on the committee, as you guys know in the charter we're allowed to have up to 21 members on the committee. It's always been our goal to get as close to that number as possible or a full set of 21. We are at a point where the terms are pretty staggered now, so it's continuously people rolling off and us bringing

on new people. But our goal is always to get as close to 21 as we can.

We have a package of seven nominees that is in the process of being reviewed for approval. We hope that at some point in early 2023, we can bring on potentially up to seven new members through the committee. Again, that is under review and going through the approval process right now. I think we had mentioned that package to you all before.

And then as I said earlier, we have a new call for nominations out. The last time we did a call for nominations was January of 2020. That list now is two years old so it's coming up on expiring. For federal advisory committees, those nomination lists last about two years. We just put out a federal register notice soliciting new nominations. People can self-nominate. Please help us spread the word. The nomination packages are due January 23rd. I can put more information in the chat to the link and also where you can find it on our website.

Yeah, we're doing a call for nominations. We hope to use that pool of nominations that we get to probably fill more slots in 2024 since we think a set of nominees will come on already in 2023. Sure. Janelle, I'll put it in the chat, the link to where you can find that call for nominations and what information's required, how to submit, things like that.

That's nominations and membership chair, meetings. Anything, Ed, that I'm forgetting or Lee that you wanted to add?

Ed Ehlinger: I would be curious about what plans you have for supporting the committee because that is one of the things that we've been talking about. I mentioned in our meeting today you had limited staff. Are you writing reports, doing some research, just organizing meetings, scheduling, and things like that? Any support that's going to be enhanced at MCHB over the next year or so?

Vanessa Lee: I don't know. I think we dropped off. I know our division is committed to continuing this

logistics support contract that we have with LRG. It is always, unfortunately, just a one-year contract, so we continuously have to complete it after a year's time. But we are committed to keeping that logistics contract in place to support the committee in terms of meetings, any kind of report writing, we can build that in. Of course, they support travel for speakers, presenters, the honorarium, things like that.

But as we re-complete that and put together that scope of work, if there's needs that you guys feel like you have that weren't being met previously in terms of logistics or that type of logistical support, please let me know. We're committed to continuing that contract.

Then in terms of staffing and MCHB support, I will remain the DFO. I have half of my time to support the committee. It doesn't always seem like that probably, Ed, or feel that way, but I've gotten assurance from our leadership that more of my time hopefully can be freed up to fulfill that time allotment.

And then we did get approval for another halftime person, half of a person's time to, again, support the committee as a programmatic lead. They would have program content background and be able to support the committee with that knowledge base. They're called typically the principal staff person.

And then we will continue to have Abigail as the contractor officer's representative who focuses on the meetings. And then Michelle Lowe, of course, who many of you know, and has supported the committee as the management analyst for years. She does all of the administrative travel, other tasks to help me and the principal staff person.

And then Lee will remain heavily involved as well, as you've seen in the past few years since he's been the division director. He has no plans to step back. I think he also enjoys working with the committee and sees the importance of the committee, so I know he plans to continue his involvement as well and support.

Ed Ehlinger: It just struck me when we were meeting at Shakopee that that was a crash course in maternal and child health. An intern working with that would've been just so much really helpful as an education experience and the connections that are made. Any kind of work that can be done to have internships or students involved or something to help support would be helpful. Because I put in a lot of time and I guess whoever is going to be the next chair might actually have a real job and may not have the same amount of time that I had, so it would be nice to have that support.

Vanessa Lee: Yes, and I will take note of that. We have been involving our division of MCH workforce and development more. They are helping us get the word out in terms of nominations to the MCH training programs, a lot of their grantees that are in the training and workforce development space. We've noted, Belinda, as you and others have said, we need more early career professionals hopefully on the committee. They

are crafting some language to hone in on in their outreach and promotion.

And then they also have connections with the Historically Black Colleges and Universities. They sent out the call for nominations to that group that they now organize again with the HBCUs. We were excited about that. And then our office of tribal affairs at HRSA has blasted out the announcement to all of their connections and networks, listservs, to hopefully get more American Indian/Alaska Native, and Indigenous representation on the committee.

Ed Ehlinger: And then before I turn it over to Magda, because I see your hand up, Magda. I'm not ignoring you.

Magda Peck: I was just playing with my CI. I was adjusting my sound, Ed.

Ed Ehlinger: Well, one of the-

Yeah. But one of the things that has happened is that things happen at the federal level that I was not aware of until right at, like the Tribal

Summit that's happening, was unaware of it. The Women's Health Initiative wasn't aware. I mean, there needs to be better connection between what's going on federally and getting that information to SACM so that it can actually either participate in or something. So I mean, I hope that there'd be a little bit better connection. That would be one of the things I would suggest working on. Magda.

Magda Peck: Well, I'm going to underscore something you already brought up, Ed, with a little more specificity. When I think about the number of volunteer hours just between Janelle and Ed and me and trying to get this report done without any real staffing, it is a labor of love, but it seemed like such a missed opportunity. As somebody who graduated from an MCH training program at one of your schools, if I had had the opportunity to be able to get credit and be able to be aligned with as student staff to SACIMM, it would've been extraordinary. In fact, that's a role that I played as a student with other

conferences, and that's how I got to know Julie Richmond. That's how you get to know and network.

So it's not so much the, yes, we could use the help, but it's such a missed opportunity. I would say that it's also a missed opportunity to forge the connections between those that are in nurse midwifery programs and those that are in physician training programs and those... So if we're looking for, and those are from other sectors, so I know that's its own infrastructure to develop, but strong ideas and strong commitment to try to make that happen because students will be the pipeline for SACIMM, but a pipeline for policy. I think that it's an extraordinarily missed opportunity to not have them see how the sausage is made.

Ed Ehlinger: Thank you, Magda. All right. Anything else, Vanessa?

Vanessa Lee: I don't think so. I'm taking notes, so thank you. Those were all really helpful recommendations. Yes, Magda, I remember sitting in a committee

meeting in 2013, which I realized, "Oh my gosh, that was almost 10 years ago," and watching Kay Johnson facilitate. They were approving the 2013 recommendations actually, and hearing and learning. I was taking all these notes. So yeah, I agree. It's an opportunity that should be shared and I will try to promote that more.

Magda Peck: It could be built into the MCH training grants, just saying. It's all in the guidance. Sorry. I'm done.

Ed Ehlinger: All right, good. All right. I'm sure we'll come... If there's anything else, we got a little time at the end. Let's now talk about the report, the use and dissemination of the report. I'll tell you what I'm going to do with it. I'm really proud of this. I am going to send it to my two senators with a personal letter saying, "Dear Senator Smith, Dear Senator Klobuchar, this is what happened. This is what... And Senator Klobuchar, as you're thinking about running for president, thank you for coming to our meeting and giving us a video welcoming. Here's what

needs to happen." Sending it to my governor. I'm sending it to all of the agency folks, the different agencies. I'll send it to the Astro director and I'll send it to some of the schools of public health folks to just say, "Hey, look at what happened. This is what we did."

I will send it to all of my American Indian colleagues that I worked with in public health to say, "Thank you for your input. How can we partner in getting this out and accelerated out there?" I mean, it's a communication tool. I'm going to send it to students who have expressed... I mentor a lot of students. They're going see this and say, "Oh, look at what can happen if you get a group of folks together and work together. You can create something like this." That's where I'm going to start. So I'm curious on how you are going to use this report. It's comprehensive. It's got a lot of information. You've got 59, and Janelle said you want to make it 60. We have 59 recommendations, but it's a tenant upon us to take that apart and

use it in different ways. So I'm just curious on how you're going to use it. Kate.

Kathryn Menard: Well, I'll tell you what I'd like to do is, of course, I want HRSA to use it in a big way, but I'd like to spread the word in my realm of influence. That includes, I have an academic community, of course, but more importantly, I'm part of the Maternal Health Learning Innovation Center, which is HRSA funded, which has a really broad reach. I'm the executive group, executive leadership for the AIM initiative, which touches a lot of PQCs across the country, perinatal quality collaboratives, across the country. I'm on the Society for Maternal Fetal Medicine Quality and Safety Committee that touches a lot of maternal fetal medicine specialists that are interested in improvement. Anyway, there's a list, but I don't need...

But what I would want or need to do that would be like I'd maybe get about 10 minutes on their agenda, on one of these meeting agendas where I could run through something. So if I had a cliff

note, executive summary, slide deck, here's the language, run it presentation, I could get it out in a lot of places with that warm handoff that Charlene was saying is important, right? Because they know me, and they trust me. That would be a way that I think a lot of us could use those avenues through various paths.

Ed Ehlinger: That raises the question that Magda raised earlier about this meeting that's coming up in March. Who's going to present at that and could present at that would require putting together a short presentation that might be helpful. So I think that just needs to be a strategy to think about, because I will be using this and I'll be probably synthesizing some things for, depending on who I'm talking to, making my own slide deck about what's going to happen. But I think I will certainly continue to work with Janelle and Magda on as we go back and forth, because we've developed a nice little relationship here around this report to try to help each other. I know they're going to be doing it with something

related to the storytelling. So there might be some slide decks going with that. So it's a good question of how we're going to do that, but I think it's possible.

Kathryn Menard: Yeah, I think audience is important, Ed, but I think consistency is really important too. So it would really be great to have something that we could all get behind and modify as necessary per audience.

Ed Ehlinger: Good thought. Marie, I know you said there would be a press release. I wondered about that in the past with the other reports, and HRSA does not have a mechanism for press releases that I'm aware of. So I've been trying to work with AMCHP and CityMatCH and March of Dimes to see if they could do a press release about this report that just came out. I'm going to continue to do that, and maybe we'll have to ask Lee and Vanessa if HRSA ever puts out press releases for stuff like this. But now...

Marie-Elizabeth Ramas: Yeah, I think this would be a missed opportunity, particularly for the NHSC scholarship program and loan repayment program. These are the people that should know about a report like this. If there's certainly mechanisms for HRSA to contact the health centers and clinics that are involved in that program. So at a minimum, I would hope that this is communicated to that group. If not, then that will be my number one recommendation for the American Academy of Family Physicians to release a press release specifically around this document and this list of recommendations, like I mentioned earlier, on the Commission of Health of the Public and Sciences for the American Academy of Family Physicians. So, I will put this as a new agenda, a new topic to present for our February meeting that we have every year. I, too, will be sharing with my state governor and as a president of the New Hampshire AFP chapter in the Medical Society Governance Council for New Hampshire, I can share this amongst multiple medical associations. I think this would be of importance

to share with our National Association of Community Health Centers as well.

So I plan to submit a possible speaking presentation for the national, the NAC essentially, annual meeting to talk about social determinants and health equity regarding this report. I think another opportunity, and again, I have to agree with Kate, not only releasing information in a wave, but being consistent, just like contractions, to make sure that we come and we come with a level of intensity and frequency. So really planning out how are we going to create a cadence of remembrance to keep this information in the forefront of policy-makers, decision-makers in our respective fields. I really do, and Kate, if you want to collaborate, I'm happy to try to do some respect with the immense amount of work that Ed, Magda, and Janelle have done in curating a template of a deck at least. But I think having some uniformity in how we message will increase the impact at the end of the day

and making sure that we're sharing stories. I think that is so powerful.

So I had put in a couple of my colleagues that are storytelling strategists, and I think this would be a unique possible project that we can do in sharing stories that reflect the work here. In addition to sharing stories, how can we think about involving our media, our local media outlets, our local newspapers and journals. So those are just some things that I've been thinking about in preparation for the meeting on how to continue to move the work forward and bring it in front of the eyes that probably need to see it the most.

Ed Ehlinger: I like your metaphor. So how I've forgotten, how many stages of labor are there? I know how many trimesters there are. How many?

Marie-Elizabeth Ramas: They say there's three.

Ed Ehlinger: The first stage of labor and the contractions have to...

Marie-Elizabeth Ramas: That's right. So we can build some of that energy up, right?

Ed Ehlinger: Yep.

Magda Peck: Latent phase, active phase.

Lee Wilson: Don't they say when you're a hammer, everything's a nail, when you're an OBGYN, everything's a delivery?

Marie-Elizabeth Ramas: Or a family doctor that delivers.

Lee Wilson: Or a family doctor.

Marie-Elizabeth Ramas: Correct. You're right.

Ed Ehlinger: Lee, is there any problem with any member of the committee speaking about this report? I mean, we can't speak for the federal government for sure, but any cautions that we should be aware of?

Lee Wilson: I'm going to ask for Vanessa to chime in as well. You are committee members and so you can speak as committee members. You are not taking a position for the federal government in its use of that information or whether it's directing. I mean,

that's up to the Secretary on how the Secretary wants or chooses to pursue the recommendations that you have provided. But I do think HRSA's in a really weird position on this because we facilitate your work, we send it up to the Secretary, the Secretary's supposed to make a decision. The Secretary’s going to come back and ask us what we think and ask us to draft a response to the letter that we helped you write but based on what the Secretary wants to commit or not commit. So I do think that it is probably... You're going to get a less massaged letter to go to the Secretary and public comment if you do it separate from having HRSA drafted for you because of that very middle role that we play.

Ed Ehlinger: Well, we drafted... I mean, we have drafted a letter and it's been approved.

Lee Wilson: No, no, no, no, no. I understand. I'm saying if you want to make hay out of this, if you want to go to the press or do those sorts of things, we're not going to do that because it would then,

as an arm of the Secretary, imply the Secretary has adopted.

Ed Ehlinger: Okay, I see. Okay. Thank you. I misheard that. Janelle?

Janelle Palacios: This question is for Lee. So as of tomorrow or maybe 4:00 PM my time or 2:30 PM my time, am I technically off the ACIMM committee?

Ed Ehlinger: December 15th, you're off? Yeah.

Janelle Palacios: Okay. I have a few more days. Okay. That is just a question because then once I'm off, I can then have an opinion about this recommendation and report. Okay. Because I have just been texting and I am setting up a local NPRKQED podcast interview that will hopefully come to fruition where we can talk about this report. So I will be contacting you and looping you in as well, Alexis Madrigal, on the forum. Yeah.

Magda Peck: Big one.

Janelle Palacios: Okay.

Magda Peck: Excited about this.

Janelle Palacios: Encouraging people to look at your local NPR stations, your local radio stations as well, podcast hosts.

Lee Wilson: Fantastic.

Magda Peck: Excellent.

Lee Wilson: Congratulations. Keep up the good work. Keep up the pressure. I may get my hand slapped for saying keep up the pressure, but my job is actually to help advocate for these particular issues. So as I said, your job is to advise the government.

Janelle Palacios: Well, I hope Secretary Becerra would extend don't do mild to MCHB staff as well.

Lee Wilson: I have no fears. That's why I just said it. If I did, I would've kept my mouth shut.

Ed Ehlinger: I know when we were in Shakopee, the newspaper was here and we got the articles. So I, again, will follow up with the news media to say, "All

right, you've heard it earlier on and here's what the result was." I'm sure we'll get some meetings with the editorial writers. Particularly those of you who have American Indian communities within wherever you live, meeting with the editorial boards would really be a good thing to do. Belinda?

Belinda Pettiford: Yes, I was looking at Vanessa's note in the chat, but at the same time, I was thinking of the places that... Well, of course I've already shared it with the board of AMCHP and I plan to do the same thing with the Board of the National Healthy Start Association. The National Healthy Start Association conference is coming up in March, and I think this is an agenda item that that planning committee was looking at. So, there may be another opportunity there. I know it's coming up in March, I just don't have the dates in my head right now. Then also just thinking about it in my own state, I mean, I've sent it out, those recommendations out to our North Carolina Commission of Indian Affairs early on to

get feedback and have since scheduled a meeting to just sit down with the executive director and walk through it. Because they take the leadership in much of the work with our American Indian community and our state. But we have strong partnerships with many of them and actually fund several American Indian organizations. So we're looking at ways to spread it out.

We're also planning to share with our Maternal Mortality Review Committee that Kate Menard sits on and our Perinatal Health Equity Collective, and others, and looking at the recommendations and how they connect to the recommendations of our perinatal health strategic plan, which we have buy-in from many around our state, which includes our village-to-village team, which are community leaders and individuals with lived experience. So I think there's tons of opportunities for us to get this information out. I think in partnership with our Commission on Indian Affairs, I think it could also end up being in the media. I will ask our commission to

take the lead, but I think in partnership with the commission and me being part of State Title V, there's an opportunity for us to work together on making sure these recommendations are shared broadly around our state and looking for other opportunities. We have 12 tribes in North Carolina and lots of opportunities to connect with them. Some urban, some not as urban, only one is federally recognized.

But we have several, quite a few, that are state recognized. So I do think there are opportunities, but we will not limit it to just American Indian/Alaska Native individuals and organizations because we think this is a message that should resonate with everyone. That's why we're really looking at our Perinatal Health Equity Collective and potentially looking at our February meeting to share this more broadly with them.

Ed Ehlinger: Thank you. Other thoughts? Certainly, I'm going to be... There are a couple of edits that I went through just commas here and periods there. So

I'm going to be finalizing the final copy tomorrow morning. So if you have any little teeny tiny edits or I know there's some Workgroup Members that didn't get listed, I'm going to put those in there. Nothing substantial because that would mean another revote. But just any kind of edits, get them to me by tomorrow morning, before tomorrow morning or before noon tomorrow because then I'll get it to Vanessa and we can get it out. Janelle, I'm sure they will need your electronic signature in order to put... They have mine already, so we'd like to get this out as soon as possible. Magda?

Magda Peck: I want to go back to, on a personal note, certainly through my networks will continue to encourage its dissemination. That's obviously through CityMatCH, through the University of Nebraska where I still hold a faculty appointment, and in other venues. So, ditto and the like. It might be one of the things that I wanted to go back to, the comment about strategy is to ask how we do both, sow the seeds of it,

just put it out there as much as you can and let it organically take root and, or can we track, it's a natural experiment. How do you use strategic communication to impact policy at different levels, and how do we leverage each other's communications, and how are the tools that we use to communicate about this now that there is an executive summary and a table, at least, how do we create other tools that allow us to be able to send the same subset of information in strategic waves? Last, how do we track this?

So, with the three of us stepping off, who've been the ones who've been living with this for three months, who, and we don't have a new chair, I'm curious about who gets copied. Is there any opportunity to report back so that Ed is copied or Vanessa's copied or someone? There's a repository of a three- to six-month strategy of disseminating this so that it is elevated and illuminated. So, I'm curious who's the CC to when, Belinda, you send it out, or who would be the blind copy? But I think it'd be fascinating

to know because we're committed to go from word to deed and a lot of people will do a lot of stuff, but I don't have a sense of how we will know what the collective impact is of our various levels of communication and networks.

So, I'm curious if there's a central way to track that or a place to put tools of letters we've written so you don't have to write a new letter. There's an efficiency that we can introduce and I'm curious if SACM is willing to continue that in some level, some ad hoc collection of a few of you and to the degree that you want any of our help still, you can ask, but it just feels strategy would be really important because it'll get old real soon and it's so old a grievance anyway, we can't afford to let it be declared stale.

Sherri Alderman: I just want to add. Well, I just think one possibility to get this out there in the media, I wonder if Ed and Janelle and Magda should write an opinion piece, an op-ed, contact Washington Post, New York Times, see if they're interested.

I think that would be the way to get it out. Then once you have something like that, then you're going to have multiple media sources that are going to be interested. So, I think that the three of you did so much work on this, I think you should maybe write up something.

Ed Ehlinger: Yeah, that was my plan after I get off the committee when I can do it as a private citizen and not a member of the committee, will be that. Also, thank you, Tara. I think that's a great idea. Also, second, what Lee said, I think any communication we have, we should BCC Vanessa, blind copy Vanessa on it. She would be the place at least until SACM gets official leadership and then they can figure out how best to do that. I'm also curious, I don't see any other hands of appointed members. I'm curious about the Ex-Officio Members. How are you going to use this report?

Magda Peck: Crickets.

Ed Ehlinger: That's right. I can wait.

Charlan Kroelinger: No, sorry. This is Charlan. I was just having to unmute and turn on the camera. Apologies. I think we at CDC really value the words, the presentations, and the thoughts of this committee. I take everything back to the division and the branch. Wanda also, even though is not so active a member of this committee is engaged in conversation with me constantly about this. So as Kate mentioned early on, we plan to highlight this once it's released among our programs in the division. I'm sure my colleagues and other parts of the agency have similar thoughts.

Alison Cernich: I'll just second Charlan's comment and I apologize. I'm covering for our director today, so I've been in and out all day, but I've already distributed the report to our entire Internal Health Task Force internally. We've also taken it into consideration. I shared an early draft with those who did a tribal consultation around our maternal health research centers of excellence. So that has already been incorporated into the

design of our funding opportunity. It's a $24 million funding opportunity that went out this year. We are planning to do another tribal consultation after the awards, especially with those organizations that may be partnering with tribal communities. But in addition, we have other opportunities that are being shaped with this consideration already in mind. So, we absolutely value this and have already really disseminated it pretty widely across NIH, especially with leaders in maternal health.

Dr. Ed Ehlinger: Great. Yanique?

Yanique Edmond: Well, I am having issues trying to get on camera, but want to echo what others said. As far as OMH, this information is really, right now, we're reviewing it to see how it aligns with some of the work that we're doing around perinatal, around our Center for Indigenous Health Equity. So really wanting to be very purposeful and strategic in how we use the information within this report for not only current projects, but how do we operationalize it? How do we use the

recommendations to assess kind of actions? So right now, my role in representing the deputy director on this committee is to bring it to them and to have a dialogue around the alignment of the recommendations with the vision of the Office of Minority Health.

Ed Ehlinger: Excellent, thank you. Lee.

Lee Wilson: Yeah, I've mentioned this before, but just to say that our office will be responsible for working with the Office of the Secretary on generating any specific responses that will come out of the department to the recommendations that you're making. So, we'll have a hand in that piece. The other thing that is particularly useful for us right now is as we're working to design some of our newer programs or redesign existing programs for the competitions in pretty much every program that we have in the division of Healthy Start and Perinatal Services will be recompeted over the next two years to try to incorporate the recommendations that you're making into the design work of those new competitions. So, for

doulas, for the Maternal Health Innovations program, for the Healthy Start program, and any other activities, MDRBD and things like that. So, it will be a very useful and practical tool for us.

Ed Ehlinger: Good. Thanks. Danielle.

Danielle Ely: Hi. So, I know that I'm a little lower on the totem pole than many of the other federal members here, but one of the things that I have been trying to do is sending the different recommendations to my supervisor and different people in our department. One of the things that I have been able to convince them of is possibly doing some reports on American Indian/Alaska Natives, specifically just focusing on those because historically, we have not been able to... I shouldn't say we have not been able to, but the number's been small, so it's harder to manipulate or to show the data. So we've been in discussion of how we can show data, different information we could include just to push forward these different outcomes for infants as well as some of

the prior information in the last meeting or the last few meetings actually about how to include not just non-Hispanic, but also Hispanic and multi-race when counting American Indian because of the history involved.

Ed Ehlinger: Thank you. You raise a point, Danielle, that as we transition to the next phase of our conversation here about how to use this and how SACM should move forward, it reminds me of the quotation that Mandela used. There was a quotation for Marianne Williamson, I'm sure you've all heard it. It says, "Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure." Wherever you are in your organization, it is our light, not our darkness, that most frightens us. We ask ourselves, "Who am I to be brilliant, gorgeous, talented, fabulous?" Actually, who are you not to be? You are a child of God, your playing small doesn't serve the world. There's nothing enlightened about shrinking so that other people won't feel insecure around you. We are all meant

to shine. I think that's how often are you asked to be on a federal advisory committee? How many people in this country get the opportunity to be on a federal advisory committee? That is a big deal. Whether you think so or not, I think it's a big deal. You are here for a purpose.

You've got a reason. You are here because you've got some connections, you've got some talents, you've got some experience. So don't be small, don't be small. Be bold and be bright and shine, which takes us to, all right, what are we going to do now? We, meaning I'm going to be a SACM alum, so I'll continue to talk about we. What are the next steps for this committee moving forward? Now, I did one-on-one interviews with all of the members that are going off the committee and I did one-on-one interviews with all of the committee members who are going to be staying on, and these were just some of the things that I heard in those one-on-ones. Then just as a kickoff, we talked about several people said, "Whatever we do, it has to be actionable and

sustainable, actionable and sustainable, rural issues, funding particularly around that community health workers, health equity and social justice, value-based care, the role HRSA can play in infant and maternal mortality around community health centers, levels of care, safety bundles, community engagement, pregnancy medical homes, mother and infant separation."

We heard about that in terms of the incarceration piece is a huge piece. "Domestic violence, home visiting, early childhood mental health." We heard about that again today. Those were some of the issues of people when you came onto this committee, said those were issues that you wanted to be engaged with. So, what are the issues? What are the things? How is this committee going to move forward? I'm not going to be the chair, but you guys are going to be members. Where do you want to go? Where do you want to take it? What are the issues you want to deal with? Let's do a little brainstorming here so that you can get it into the minutes and whoever ends up being the

leader chair can have something to start to react to.

Charlene Collier: I mean, I think I would throw out stress or toxic stress as a thing that is, to me, underpinning. It's like when you say, "What is the path?" We saw it with Dr. James' talk and when you say racism or when you say social determinants of health, they have this common pathway of putting people under these toxic levels of stress. I think there's spaces as an OBGYN when I hear presentations on work and what is a normal amount of work. I feel like so much of it is grounded in the history of slavery about what a pregnant woman should or shouldn't do while she's pregnant is upholding a system of don't rest. I see doctors fight giving a note to take a day off almost harder than I see them fight to end the maternal mortality they get their ruffles...

I see them fight to end maternal mortality and they get their feathers ruffled. So, I think it's, even in medicine, we just haven't

acknowledged stress as a true thing and how we combat it and how it gets acknowledged. I myself was told by a doctor when I was having trouble getting pregnant, when I said, "Oh, I think it's stress," and then he learned I was an OB-GYN, he said, "Now I find it laughable to know you're an OB-GYN and you thought your fertility was related to stress." He took time to go back and say, "Oh yeah, that's funny now. I can laugh, because you're a doctor and you should know better that it isn't related to that."

So, it's just something out there that I think the pathways that lead to stillbirth, to preeclampsia, to preterm birth, which is a leading cause of infant death, to the hypertension, where's all this hypertension coming from, we have a toxic environment in so many ways. And I feel like calling that out somehow. But that's where...

Ed Ehlinger: All right. Good. Phyllis.

Phyllis Sharps: I think we have to continue to emphasize in all that we do the health equity issues and moving that forward. I think as Dr. James pointed out, there is still a lot to do, and I think we have the power to keep pushing it and keep pushing it. The other thing is I think there's going to continue to be a challenge on how we keep women's health and reproductive healthcare safe for women. And current things that have happened in legislatures and how states are going to make decisions have, I think, the potential to really increase the disparities in perinatal and women's health, and particularly for the populations that tend to bear the burdens the most. So, I think we need to keep a watch on that and what we may need to think about on how not only keeping it safe for the women, but the providers also.

Ed Ehlinger: Thank you. And certainly, one of the things I'm hoping that we were unable to do very much, I think the focus with Indian Health Service. So much work needs to be done with the Indian Health

Service. We need the data that we asked for and we need to start a... somebody needs to start a dialogue with them to actually have an evaluation of their contract with ACOG, what compacts, and the various ways that they provide care. I hope somehow that keeps on the forefront, because that ball has started to roll, and we need to keep it moving. Janelle.

Janelle Palacios: Thank you. I would just lend my voice in support of that, that I would hope that the committee would continue to follow this thread with action and to keep pushing and keep asking, because as you have heard from Ed, that Indian Health Service has been invited a number of times and high level officers, and it's been very, very difficult to have them engaged on a meaningful level where we are actually getting answers.

So, one of the critiques we've heard about possible inability to access data through Indian Health Services, that local tribes, for their protection, might choose or might desire not to share that information. And I would advocate that

then we will never know the true disparity. So, if any organization hides behind or uses that as an example or an excuse for not being able to release data, then we are not able to truly understand what really is happening in the community.

And so, the other larger picture is that for as much as Indian Health Service has... the history has been rocky and it has been intentionally made so. It has been hobbled by how much funding they have been given historically. It's been hobbled by lack of accountability on a number of measures. So, it has been intentionally designed not to fulfill its obligation in the most optimal way.

And so that is not necessarily a reflection on Indian Health Service and the people who work there, but it is a reflection of the government, that those involved in being able to have the power to fund, make decisions, and provide more access, resources, and services have decided not to. And this is where we are.

The last thing I would just say, following about what Charlene was saying, talking about with this thread of looking at clinical practice, I would ask that my clinician fellows out there continue to watch the rates of C-sections and if they rise over time among low risk people as we institute new criteria for what is considered hypertension, chronic hypertension, because... And for the people who are not clinicians, there's been a change, a movement of change of how we rule people in for hypertension.

And if we are looking at hypertension as a facet of stress, toxic stress, and if we aren't taking blood pressures correctly in clinic, someone, I, when I was 23, could have had an elevated blood pressure of 132 over 90, and then seven years later present and be pregnant and in pain, going through labor, have an elevated pressure of 145 over 97, I could technically, and some hospitals are using this, technically be ruled in for chronic hypertension and be treated as someone who has chronic hypertension and be encouraged to

be induced or have my labor affected because of this new diagnosis. So just please pay attention. There sometimes is a very big disconnect between science and clinical practice and common sense.

Ed Ehlinger: All right. Interesting.

Kathryn Menard: Got you on that one, Janelle.

Ed Ehlinger: Marie. Oh, Marie and then Kate.

Marie-Elizabeth Ramas: Kate, is this in relation to what Janelle was talking about? No?

Kathryn Menard: Please go ahead.

Marie-Elizabeth Ramas: Okay.

Kathryn Menard: Please go ahead.

Marie-Elizabeth Ramas: Sure. A few things come to mind that I think would be good synergy with the work that's been done and bring meaningful information for where our healthcare system is going. So, the first thing is this concept of what a clinician is and defining clinicians around the infant maternal space. We had some compelling stories

that, depending on one's cultural background, the traditional idea of a maternal clinician provider may not be as inclusive with certain cultures, particularly with our Indigenous brothers and sisters.

And so, are we missing opportunities for paraclinical support to be extensions of clinical team? And then also, how do we incentivize the pathways that lead to more support? So, the defining clinicians and then also workforce comes just naturally to that.

The second thing is data, data, data. There is a lack of congruency from the federal side to the state side and even from an institution to an institution basis on what demographic information and how it's defined and how it's documented. We cannot understand disparities without understanding data and having consistent and congruent ways of measuring success and measuring demographics. And I think we heard allusion to that earlier today. So that would be, I think, a real important area of necessity, particularly as

CMS and HRSA are starting to talk about wanting to reduce health disparities and using segregate data and codes, diagnosis codes in order to help identify disparities and reduction in disparities with their payment models.

And then the third aspect to follow with that is really doing a deep dive in what is the return in investment of investing in social determinants of health and picking maybe one area to do a deeper dive in and creating a model that really can explain what is the return of investment for particular aspects of social determinant support in medicalized settings.

So, I think that we're starting to understand, for instance, providing transportation vouchers and we're seeing some health insurance payers paying for certain aspects of social determinants in order to help improve access to care. But there really is not, that I can tell in the work that I do, a lot of concrete information that can further support the work.

So, I think particularly around maternal infant health, we could provide a compelling argument if we wanted to use or build upon the information that we've curated in our American Indian/Native Alaska populations and using those as case representations to help create essentially a fiscal model. I think that would be very compelling as well.

So those three areas, workforce pathways, and then how do we redefine and reorganize the clinician and paraclinical support in maternal infant care data, and how do we create more consistency and congruency in data reporting from a federal level and state level if we can create recommendations? And then the third thing is, what is the return on investment, the fiscal investment, when we are now talking about social determinants and health outcomes?

Ed Ehlinger: Great. Kate.

Kathryn Menard: So, I'll first say that I fully... I hope we don't finish our meeting tonight without having a

real plan for carrying forward how we're going to really catalog how we're going to disseminate this work and share this work across. If no one else wants to volunteer to serve as the repository, I'll put my hand up to gather that information and bring it back to the committee when we reconvene. But I think that that's going to be really important so that we can, from that, have a work plan for going forward with respect to the work you all have already put into this.

The next big thing, and I think in my mind, I think the members are all taking this responsibility very seriously, and I think we need both a short-term and long-term plan. I think we heard very clearly from Dr. James that the marathon is going to be picking up some of the really underlying social determinants of health that need to be tackled. Our resources aren't there for a quick fist on any of that, but we do have influences. The sprint is things that we have immediate influence over, that the committee members and HRSA have immediate

influence over. So, I think we should pick a blend of short term and long term.

And I guess I would put forward as our sprint our short term is improving access to culturally congruent and respectful, risk appropriate care. That lumps together a lot of things we've talked about. It's bringing more to those who need more. It's identifying the pockets that need support, rural health, and distance travel. We've heard so much about inner cities and the poverty that's there, access to specialty care, access to mental health services, access to substance abuse. Just taking that umbrella look at where access is and isn't and not separating the social determinants of health from the clinical work, because I think getting over some of those barriers that Dr. James showed on the path toward better health is what we have to do now until we can figure out the longer term solution to removing those barriers. So...

Ed Ehlinger: Good. Well, you'll notice in our report, we put social determinants and clinical care, the Indian

Health Service as direct care, under the same category, because they are.

Kathryn Menard: Same. Yeah. Same.

Ed Ehlinger: Yeah. Steve.

Steve Calvin: Yeah, I just wanted to second. I'm really grateful to have a colleague. Kate's insights are really valuable. And we have pediatricians, obstetricians, and family medicine. I really hope somebody will be able to... They won't replace Janelle, but we have to have a midwife or two. That has to be the case. And having community members. ShaRhonda, her perspective, your perspective, ShaRhonda, from St. Louis as a consumer of healthcare and a leader in your community is really, really valuable. Anyway, we have to get a midwife. So, listen up, Lee and Vanessa.

Ed Ehlinger: Thank you. Thank you. Magda.

Magda Peck: Actually, Belinda, you had your hand up before me and then you dropped out. Do you want to speak?

Belinda Pettiford: No. Mine was around social determinants of health, so I dropped the rest of my comments in the chat. I was following up on what Marie said and then what Ms. Janelle put in a chat. So, I'm good. Thank you.

Magda Peck: All right. Just want to make sure we're queuing up right. And so, there's not more to add. The list is quite extensive as I hear our new colleagues and continuing colleagues move forward. I'm wondering about how the three different missives reports that we have sent on also continue to stay on the burner as opposed to falling off.

And what I mean by that is, in the first, the response to COVID and then the follow-up response to COVID, there's a series of sequelae of COVID and pandemic. And there's the tri-demic and there's RSV. There may be some urgent issues. And I would encourage our members that are continuing to not put that on the back burner or take it off, but to be able to continue to say, "Well, is

there anything more that needs to be done?" even if it's just a proforma review.

With focus on environmental health and climate change, we didn't go very far or deep. And it's not like, "Oh we did that. Check the box." So, I'd encourage you to think about how can we drill down deeper, the way we went from Indian Health Service down to a full report. So, I'm curious about how particularly physical, environmental health, and climate change and climate science, we can continue to stay on the forefront of that.

Immigration and what's happening at the border and global migration and movement and displacement, particularly in times of war, is something that has an impact on our populations. And so, circle back to that and say "What has been done, hence accountability? And what more might we want specifically to dive into?"

I would add to that housing and housing security, because as pandemic protections are easing and abating and disappearing, the crunch on housing

and the affordability of housing and people who are unhoused and are housing insecure is going to be paramount. So how do we circle back to what we already reviewed in one meeting and ask, "Is it time for us to go deeper on this, beyond making the connections between HUD and HRSA stronger?"

So, I don't want to add anything new. I want as a parting member to be able to say, "Review the recommendations that were sent before and don't let them die." Hold their feet to the fire on accountability because the tepid letters that come back are like, "Well, thanks so much. We'll be in touch." And I think that, if not for SACCIM, it will not be elevated again in the same way.

So as Art said, "Use the bully pulpit, but hold the folks we advise accountable." So, I just encourage you to start there and be able to connect what else you want to do with what has already been said and done. I don't think it's necessary to go back to 2013, but there are now three substantive documents that give you a place

to jump off from and go deeper while holding them accountable for what they already received. Thanks so much.

Ed Ehlinger: Magda, you said, "If not for SACCIM, many of the issues would be forsaken."

Magda Peck: I was tempted to say that. That was your pun, not mine. Heard it.

Ed Ehlinger: But you prompted it. Sharonda.

ShaRhonda Thompson: What I want to say and just remind everyone is what the Secretary asked us, to be bold. I don't want us to lose that fire. I don't want us to lose our way. I want us to remain bold in what we say and what we recommend, because it's going to take that in order to get any type of a change. Sometimes, it's more than just making a suggestion. It's, "Hey, look. This is what needs to be done," and I just want us to remember that and stick to that in the days coming forward.

Ed Ehlinger: Yes. I love that he put as a challenge, "Don't do mild when it comes to making a difference." And

so, I think that is your charge that we've got. And we will do that.

And one of the things I will certainly do, I will connect with Vanessa next week and try to figure out how to communicate back some of the next steps that we're hearing in this little conversation and see where we go from here. But it really will be the next group that will take leadership. I will certainly be around to help. I'm an alum now and so is Janelle and Magda and Belinda. But we won't go away. This is our work. It's part of our life's work. It's not just a job once you get done and you go on to something else.

So, all right. There's a lot of challenges, and I will certainly be glad to help whoever gets to chair this just to facilitate she, her, him, they in whatever the work that gets done. Be glad to help.

Wrap-Up and Transition

Ed Ehlinger: But let's wrap up. I would like to give the members who are leaving a chance to say a few words. We've got not everybody. I think we've got Belinda and Janelle and Magda and myself. Belinda, any comments that you would like to leave with this group?

Belinda Pettiford: Sure. Yes. I will say this has been such an amazing opportunity to work with an awesome team. I feel like we have tried our best to move this work forward, and I don't think we're leaving anything on the table that we thought we shouldn't try. And I will say that the lifelong friendship that I now have with Janelle will remain. She and I truly bonded over this work with our cohort with the Health Equity Workgroup.

But I also think it is just such an awesome team to work with that I feel like the four of us that are leaving are leaving you all in a good place. I think it is totally up to you which direction you choose to take it in. I think the work of

health equity has to be part of this. That is my virtual soapbox or in-person soapbox or whichever soapbox you want to put it on, because I think the data is very clear. If we don't address our inequities, we are not going to continue. We're not going to see improvements. And that is with all populations.

And so, I think it is so important that you all continue this great work and know that I am here, willing and available to assist any way that I can. And I know that Janelle and Ed and ... so much. I consider it a pleasure to have worked with you all in this great group. Thanks.

Ed Ehlinger: Thank you. Thank you for your work. It's been incredible. You're a good colleague. Magda, what would you like to say?

Magda Peck: Well, I want to first respond to Vanessa's question, which is really great. What does it look like? How does accountability work? That's my first comment, which is don't let them off easy. I started with the easiest thing is for us

to write a bold report and then it like rain on a hot day dissipates on the pavement and there is no trace. We better leave a trace. Part of that is this notion of accountability. It's to ask for a report, to get a reporting back. And this happens with the Ex-Officios. We've heard them say, "This is what we're going to do with this report." At your next meeting, I'm encouraging a pattern, like Terrence Moore noted today, follow it back. Don't just do the one-off and check it and say, "Well yeah, didn't we already do housing?" So, I'm just encouraging an iterative way because it's the tenacity and the iterative circling back that will serve you well.

It has served us well. I really loved having a conversation with Kay Johnson who is the prior chair, just about what advice she had. She didn't have an opportunity to have a handoff like this. The notion about continuing to turn the heat up and hold them accountable was something that she taught me. So that's the first, is continue to politely push back and just keep the heat on.

This is adaptive leadership. If you don't turn up the heat, it is not going to change, because that's what we're thinking about as systems change.

And the second is I'm hugely proud of the story work here. This is not rocket science. It's not the first. But as a scientist who's been a storyteller, I felt like it had a bifurcated life and a bifurcated soul, and to weave the story and the science together. Data never speak for themselves. It's not data to policy. So, fuel it with stories. I love how many of you are captivated and compelled to do the story work. Be strategic and evidence-based about it and bring the data and the recommendations to life.

And the last is that we've experienced with the newbies a lot of concordance. It's been a really joyful, easy, and not terribly noisy time. It's not always been that way in SACIMM over time in its 30 years. I think it's essential to create a place for disagreement and doubt, to be able to have the courage to challenge each other. So,

Tara, you and I do not agree on some fundamental approaches to women's health, and we both are passionate about needing to get there for the greater good. Building a respect with people with difference and a diversity of perspectives and beliefs has to be brought into SACIMM so it is not group think.

And for those of you who I've disagreed with, thank you for that gift and thank you for allowing us to find common ground. We can model that in a polarized nation, especially now. So don't be afraid to take on the hot stuff and welcome doubt, not as disloyalty but as the giver of truth. So, I just hope that you find a way to welcome the tension that can be creative with respect. Then we can model away on taking on the toughest stuff in SACIMM and not avoid conflict, but mine it for the best possible result, because that's what folks are counting on us for. That's what doing bold is for me. So, thanks for the accountability and the heat. Thanks for storifying the space. Thanks for finding a place

for doubt not to be disloyal but the handmaiden of truth. And thanks for the opportunity to be a collaborative leader for the greater good. On call to you. You know where to find me. Back to you, Ed.

Ed Ehlinger: All right. Thank you, Magda. That highlights that where there's tension, that's where the energy is. So don't avoid tension. Certainly, in my leadership, you go where the tension is because that's where the energy is. Janelle, some comments from you at the end here.

Janelle Palacios: Yeah. Thank you for this opportunity to share. I agree that what has been shared already and a big key experience that I have come to realize is very precious is definitely the relationships that I have formed with my colleagues and the mentorship and it's the friendships. Having not participated in this forum, I would not have made those friendships. And the fact that in our in-person meeting I also happened to bring my oldest child, my daughter Zaya, and it was a move to demonstrate what her

mom does because she doesn't know what I do when I walk into the office and I'm on the computer. She knows when I go to work in the clinic and the hospital and that I'm going to go help people with their babies, but she doesn't know what this is. This is very abstract. So, she got a little peek at what I do and she took notes because there were some free pamphlets to take notes on, and she shared with me some of her notes and it was very adorable.

One of the things she wrote in her notebook was that she was very inspired to see a powerful woman, her mother, doing work. And then she had another note. Her note was in reference to what Lee Wilson had said to her about how she is the next generation, she is the next person to take on this work as well. So, it inspired my daughter that when we returned home, she is a very shy person to begin with, but she started raising her hand, participating and then she was tapped to participate in her school's anti-bullying two-day mentorship program. So it was really great to see

that just a few minutes of someone's time and seeing a model of what a different future could look like, inspired my daughter to go down a different path. So, we talked about pipeline, we talked about mentorship and so I really encourage you to continue with that along the way. Build relationships with one another. Yes, tension helps people grow and be challenged. Finding commonalities and finding common ground.

I will end with another little anecdote that as a midwife, I meet people on a day-to-day basis, or I should say night-to-night basis because I only work at nighttime. I have no idea who these people are. I've never met them before. People come with all sorts of emotions, whether it's someone who's having a very fast labor and they're scared and terrified of the experience they're having, the fear about their previous childbirth experience or someone who's new to this experience and being induced. I am there to help them and to care for them and to give them my love basically. That's what I'm doing. I'm

sharing myself with them and I'm holding their hand and I'm reassuring them that I'm there with them and I'm going to be present. And that is something that we need more of in our nation, more in our community. And the more that we can model that, the more that we can care for one another, I am very hopeful that we can change hearts and minds. Thank you.

Ed Ehlinger: Thank you, Janelle. Another anecdote. After our meeting in September, Magda, Janelle and I and Janelle's daughter went to the cultural center and we're going through there, and just seeing Janelle sit down on the floor with her daughter and talk about stuff in this cultural center, it was remarkable. The parent-child connection that was being modeled was just wonderful. It was just great. Lee and Vanessa, any thoughts that you have as we're starting to close?

Lee Wilson: So, I'm going to go first since Vanessa stole my suggestions last time, my comments. I'm going to possibly steal hers. First, it has been a great honor and privilege to participate in this

activity over the last three plus years. It has really influenced me on how much committees are dynamic and how they have the ability to be great or be small depending on the constellation of individuals who are involved, and in particular the commitment that the individuals choose to invest in the direction of the committee, the recommendations that it makes and the obstacles that are put before it. So, what I would like to say, A) is you have made change in me and I appreciate that and I thank you for that. And then B), what I'd like to do is just say thank you for the extraordinary work that the four of you and the larger committee, but the four of you who are rolling off have brought to this work.

At the end of the day, all relationships are in some way mirrored on family. So, there is this side of Ed and Magda that have been the parental units of this endeavor for the last couple years, at least to me. So even though I've been charged with managing this, it's definitely been out of respect and deference to the input and

suggestions, even when the agency has said, "Try to tone them down a little bit." It's always go to them and politely say, "Well whatever, and wink wink, but that's just a suggestion. You may want to do what you want to do." But to the two of you, thank you for modeling commitment and dedication when this was done for basically free on your part. That says a tremendous amount not only to your commitment but to the energy that the two of you have brought to the table.

We will sorely miss Ed and his energy. It does wear us out periodically, but it has really made for his goal and my goal of turning this advisory committee into something that needs to be reckoned with and something that an organization that has a voice and a reputation that is making change in the community and in the country. So, to that, I thank you.

To Belinda, Belinda and I are a little closer to brother and sister and so I would like to say thank you to her for just the little nudges now and again about looking this way or looking that

way. A little reinforcement sometimes when I felt like I might be stepping out of turn. And then just her gentle grace, her intellect and her expertise have been truly, truly remarkable, valuable, and influential both on the committee and on me. I look forward to working with her more, given the fact that she is a long-term investor in the Healthy Start program and in these efforts.

And then finally to Janelle, who since I don't have any children, I can't say daughter, but who is very much like one of my nieces in many, many ways, especially appearance. And just the surprise and excitement and potential realized and being realized that I see there in you and the modeling that you're doing for the generation below you and that sense that you're not going to rest until things are resolved and put right. I respect that and I value that, and I offer and extend my support in the future as your bright future is realized. So, thank you to the four of

you and to the convergence of the rest of the committee that have made this all possible.

The rankling and wrangling of some of these ideas, the different people who disagreed not only on wording and the amount of wording discussions that went into those minutes that we just shared with you this last time around, but also really trying to resolve some intractable issues that we are all dealing with here from different angles and perspectives. So, thank you to you all. The committee will continue in part because of the great investment that you all have made. I am saying these words for myself, but I'm also saying them for Dr. Warren and for the agency and for the department. Many, many thanks. You'll be receiving gold embossed little sheets of congratulatory paper with signatures on it to acknowledge your hard work, but that's just a token of what is really behind a great deal of thanks and appreciation.

Ed Ehlinger: Vanessa.

Vanessa Lee: It's hard to follow that. Lee, you're right, you got to go first, so you took some of mine. I won't say too much. I'm like Belinda and Janelle. I will need the tissues if I start to go off, so you can expect, I think personal emails from me with more of my thanks and gratitude. But I just will sum it up by saying, as Lee said, you guys have just really influenced me. I feel like a better person because of you. Better definitely public health and maternal and child health professional, but even just a better parent. I mean I've learned so much from all of you guys on a professional and personal level. So, thank you.

Ed Ehlinger: And certainly, my thanks to Lee and Vanessa and Michael Warren. Really good colleagues to work with. The support that they've given has just been great. The risks that they've taken, I mean, I don't know about risk, but the energy that they've expended to make some things happen that wouldn't have happened otherwise, I really appreciate that. And certainly, I appreciate all of the new friends that I have gotten. I wish I'd

be able to spend more time with the new group because I'm just really impressed with what you bring to the table. Certainly I've learned a lot from all of the colleagues, the three others on this call, but also Paul Wise and Paul Jarris and Jeanie Connery and Vijaya and Colleen I've all learned something from because they all bring something different. Just having those partnerships and those friendships has just been really, really good.

I just really appreciate the opportunity that I've had. Like I told you, how often do you get to be on a federal advisory committee? I mean, of all of the three hundred million people in this country, how many people are on federal advisory committees? I mean, it's infinitesimally small, so this is a big deal. Having the opportunity to work with other people on something like this is really important, so it has been really gratifying for me. It's bittersweet because it's been fun working with you and it's bittersweet ... The bitterness is, not bitterness. The

sadness is that there's so much that needs to be done. The work that's coming ahead is going to be really, really important.

So, I'm going to end with just a thanks all around, but it wouldn't be me if I didn't end on some historical note. 58 years ago this week, Dr. Martin Luther King Jr. gave his Nobel Peace Prize lecture. In that lecture, he identified three existential challenges facing the world in 1964: nuclear war, poverty, and racial injustice. Poverty, nuclear war, and racial injustice 58 years ago. Those are still with us today. Now we have to add pandemics and climate change as other existential threats, but I'm sure he would've done that at the same time. And he identified the fact that all of those existential threats were linked. He said, "Each of these problems, while appearing to be separate and isolated, is inextricably bound to the other." And in my time in public health, I realize that they are all bound and they are all bound by the values that we bring, the narrative that's created in our

society, and that if we can deal with inequities, if we can deal with the disparities, we will actually impact climate change, we will actually impact the threat of nuclear war, we will actually impact poverty.

Focusing on inequities is crucial to all of the other issues that we faced as a society. He also said, "We live in a day when civilization is shifting its basic outlook, a major turning point in history where the presuppositions on which society is structured are being analyzed, sharply challenged and profoundly changed. What we are seeing now is the realization of an idea whose time has come. Yes, we are shifting our basic outlooks." I think COVID has been a gift and the racial justice protests following the murder of George Floyd has been a gift in that it has identified the fact that all of our systems are failing. All of our systems need to be transformed. So, we are at a time with the realization, as Dr. King said, of an idea whose time has come. And you're at the cusp of that.

You have a place to actually impact how we shift, how we structure the world, how we structure our systems moving forward for moms and babies.

He ended his comment in his Nobel Peace Prize lecture 58 years ago this week by saying, "There is no deficit in human resources. The deficit is in the human will." I trust that you've got ... You know resources, yes, they're an issue, but there's no deficit in those resources. It's in the human will if there is any deficit at all. I just trust that each of you moving this forward will not shirk from the duty that you've got, the political will, the human will, the social justice will to move forward. So, I trust that you're going to move forward and it's going to be fun watching you move the needle. So, thank you all. It's been a great meeting, a great four years. Done a lot of work and we're moving on with gusto and we're not doing it mildly. So, thank you all. Have a great holiday season, whatever you celebrate.

Adjourn

Magda Peck: Thank you, Ed. Let's give him a round of applause.

Ed Ehlinger: Bye-bye.