Advisory Committee on Infant and Maternal Mortality

Virtual Meeting

12:00 p.m. until 4:00 p.m.

Wednesday, December 6, 2023

Health Resources & Services Administration (HRSA)

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- I N D E X -

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P R O C E E D I N G S

Welcome and Call to Order

MS. PETTIFORD: Well good afternoon or good morning, depending on where you are in the country. It's good to have everyone back for our second meeting, and I call this meeting to order today. Just to make sure we are all here, it is always good to see so many in attendance. I know we have a new Ex-Officio Member that joined a little late yesterday, but I don't see her now. I'll have her introduce herself once she comes into the meeting. But today, again, welcome to Day Two of our Secretary's Advisory Committee on Infant and Maternal Mortality. Thank you all to each of you who've been able to participate in the workgroups that occurred earlier today. Thanks especially to our leads and co-leads that were able to move that work forward.

I had the opportunity to spend about 20, 30 minutes in each of the workgroups, so I was able to get some of the conversation and hear some of what was happening in the different workgroups.

Yesterday was a full day and you all, as I say, were troopers. We didn't get to break, so I think we ended up with like a seven-minute break at one point in time and you didn't really get a chance to ask a lot of questions of presenters. I

definitely want to thank all of the presenters who did an amazing job. We were able to get presentations around data. We had presentations that really connected to our workgroups around the rural health and nature of the work and what is happening in our country around rural health and the systems.

We had presentations on preconception and interconception care and we continue to have conversations around social determinants of health, so thanks to all that were able to join us yesterday. Also, it's always nice to make sure we elevate the work of our Community Voice, so we were able to have a Community Voice yesterday from the Missouri Bootheel area, so we're pleased that Heather was able to join us yesterday, as well as others that work with her on the RMOMS Program.

We also were reminded of the work around our former recommendations with American Indian, Alaska Native, and the importance of not forgetting the fact that we have those recommendations, that they have gone to the Secretary. It was really good to hear from our Ex-Officio Members who've been able to share what they've been doing to continue to move these recommendations forward, so I want to make sure we keep that on our radar.

And then, also, it was really good to hear from some more of our national partners. We had a couple of national partners that joined us yesterday. They had not been with us

before, so that was really nice, and then we also had the national Healthy Start association with Deborah Frazier joining us.

And for those of you who may have been a little tired along the way, Deborah did remind us that in the House part of the budget, the House Appropriations, they have zeroed out this federal Healthy Start Program. What some of you may not be aware is the Healthy Start Program also funds SACIM, so it funds this Committee. So, if that budget is zeroed out, the implications are broad. It is definitely broad by all of the communities that are receiving these resources to improve maternal and infant health, but it also impacts this Committee or the potential to impact this Committee, so I want to make sure everybody picked up on that in case you dozed off for a minute or you were taking your little, short break. I just want to make sure everyone is aware.

Workgroup Report Out

MS. PETTIFORD: So next, we're going to go into our workgroup report outs. Today we've got about an hour, and we want to hear some of the conversation that occurred in our three work workgroups today. We're going to ask each of our leads or co-leads to come on and share a little bit about what was happening in their workgroups. I think each workgroup has at this point a report out, you have probably five minutes to report out and then we want to open it up for questions to see, for those who are not part of the workgroup, what questions, or thoughts they have.

So, we're going to start with systems issues in rural health and this is the rural health group that Kate Menard leads, so Kate, I'm going to turn it over to you.

DR. MENARD: Okay. I thought maybe my co-chair would report out, Belinda. We had a great meeting. I was really, really pleased at the turnout of our ACIMM Members and Ex-Officio Members and then we had some visitors in there who were going to contribute in really important ways, so I was really pleased to see that, lots of interest.

We started by talking about the overarching charge, which is issues in rural health, but also making sure that we're addressing the overarching issue in disparities in health, particularly for Black birthing women, birthing people. We talked about what information we need. I'm so sorry. I think I've got a tickle in my throat.

MS. PETTIFORD: I think it's going around. I think it's going around.

DR. MENARD: I actually don't think it's anything contagious, just me. But data that we would like to be able to see is the maternal mortality and infant mortality, urban versus rural, by state and also looking at overlaying that potentially over maternity care deserts and also looking at the race disparities by state and by deserts.

There are some difficulties related to all of that

based on the amount of data that's available, but I've got some enthusiastic Committee Members that are going to be able to help with that. It's going to be important for us to understand what the childbearing child population is by race across the state as well.

We'd like to get a better handle on the literature that's available on the financing of birthing facilities. (coughs)

MS. PETTIFORD: Kate, I am interrupting you, but apologies. Do you want to go to another workgroup and give you a moment?

DR. MENARD: If you wouldn't mind, that'd be great.

MS. PETTIFORD: Okay. Thank you. And again, hope you're okay. Understood.

DR. MENARD: I'm fine.

MS. PETTIFORD: Okay. All right, if you'll put yourself on mute, we'll mute back, and then we're going to come back to the rural health one. Why don't we move onto preconception, interconception health, which also included reproductive health. And I'll turn that over to Joy, and Phyllis, you may want to chime in. Feel free to.

MS. NEYHART: So, we had a really good discussion and had a really great set of notes from Vanessa. We had a good turnout, and I don't know that we've crafted our charge so much, but we do have two focus of things that came out of this

discussion, and we have a great place to launch on coming up with recommendations specific to preconception and interconception with a focus on African American women.

One thing that we talked a lot about was Medicaid coverage for women continuing more than the six weeks postpartum and what information we can get from the states who have expanded that to 12 months and how much it's helped and making that part of a recommendation.

The other recommendation that we think we'll be focusing on crafting once we get more information is how to recommend paid maternity leave, which should include employment in the lower-wage categories so that women can continue to maintain their health, raise their children, and not be worried about being able to come back into the workforce.

We went over our schedule, so we know what we're going to be doing for the next few months and identified some other agencies that we might want to ask to provide information to inform us as we go on. And Phyllis, did I miss anything.

DR. SHARPS: I don't think so.

MS. NEYHART: Good. Phyllis is a much more eloquent speaker than I am, so I just try to get the information out, but it might not be coherent.

MS. PETTIFORD: No, thank you, Joy, and Phyllis as well. You say you all went over your schedule, so do you know

when your regular meetings are going to be held?

MS. NEYHART: Yes, it looks like it's going to be the third Wednesdays and from 2:00 p.m. to 3:00 p.m., Eastern Time, which is 10:00 for me.

MS. PETTIFORD: And these will be every other month, monthly, quarterly?

MS. NEYHART: I think it's monthly. I think we've decided on monthly for the first quarter and then we'll see how far we get and what we might need to do to alter that.

MS. PETTIFORD: Okay, thank you. I want to open it up for questions from the Committee. Do you all have questions around some of the initial conversation that the preconception, interconception group are having. It does feel like there may be some overlap with some of the other ones, so that's fine. Yes, Marie?

DR. RAMAS: Thank you, Belinda. I was just wondering was there any conversation around birthing parents who identify as trans or non-binary and implications on their care?

MS. NEYHART: No, not specific conversations. I think that that's definitely something to think about incorporating. I think we were looking more of a higher view of how to extend medical care and keep people employed after having babies, but it would be good to incorporate that. Do you have suggestions as to how we can bring people into this workgroup to help with that

part?

DR. RAMAS: So, there are national organizations around gay/lesbian and transgender care, in general. I can share specific groups that might be helpful in extending some expertise around genera affirming care. And I don't know if it's part of the scope of this workgroup, but similarly chest feeding and breastfeeding and supporting non-binary patients in providing breast/chest feeding services, so I can provide names in the chat as well.

MS. NEYHART: And I agree with what Belinda said. There's so much overlap because, again, everything points to social determinants and improving social determinants is going to improve the trajectory of health for birthing people and then their offspring.

DR. SHARPS: In our preliminary meeting with Sarah, the presenter from yesterday, I did bring up how we could be more inclusive and use gender neutral terms, such as birthing people or pregnant people. And we also talked about today maybe some priority populations used in that transition between adolescents when they leave pediatric care to the next step, which could be either family or primary care, but there's often a gap and how do we reach those individuals in the messaging.

And we talked about particularly women that are incarcerated. As we know, the population of women being

incarcerated or in jails or prisons is increasing, and we probably need to talk about that in light of the racial ethnic issues and we also talked about women with disabilities and that, in fact, many women that in the past who may not have lived to be able to reproduce or have children are living longer with chronic conditions and how do we manage their health, so I actually think the job of this Committee or this workgroup is to whittle it down to something that's doable because it could be very broad.

MS. PETTIFORD: Thank you, Phyllis, and Joy. Other questions from the Committee, including the Ex Officio Members, you're included. I know some of you attended that workgroup. And fortunately, we have about a year to come up with these recommendations, so we don't have to do them overnight, but it does seem like quite a few other partners or individuals or subject-matter experts we may need to bring to the table, so thank you both.

DR. SHARPS: Belinda, we did ask people who attended today if they thought of things -- if you're anything like me, after the meeting is over you think I should've said this. So, if you think of things -- anyone today listening or people that you think we've overlooked or we should include, please shoot an email to Vanessa and we'll make sure that we consider your advice and take appropriate action.

MS. PETTIFORD: Thank you, Phyllis. And Vanessa, if

you'll drop that email in the chat, the second email so not everyone will be sending it to your direct email. I'm sure you'll appreciate that.

Okay, well, thank you. We appreciate it. That's our first workgroup, preconception and interconception. And it looks like, Kate, you may be doing better now?

DR. MENARD: Yes. Sorry about that, but thank you for that grace moment. So, I was talking about the data that we wanted to gather and one important point came up is that we don't really have real time information on hospital closures, which is going to be one of the areas that we're going to be spending a fair amount of time on, so we're going to be thinking about what can we access in terms of the most timely data about hospital closures to inform any recommendations.

And it was also brought up that we need to define what a birthing facility is. What is our denominator in looking at, and we'll be kind of delving into the literature and asking experts about how we should go about that.

Things in terms of things we'll explore, of course, hospital closures is top of the list and looking at gaps in services that result, particularly closures that are obstetric unit, including obstetric unit closures. And then, importantly, looking at readiness. When that happens, what's the readiness and preparedness for those communities for obstetric emergencies and

possibilities about services there.

We discussed the importance of looking at the intersectionality between race, low income in rural communities to really understand how to make some good decisions about informing change. Financing rural hospitals and financing care in rural hospitals, supporting a workforce in rural areas and tele-health may be the themes of recommendations, but we really need to do some learning and exploring before we narrow it down, but there's wisdom from numerous people that says we will, indeed, narrow it down before we make our final several recommendations.

We've got a short list right now of individuals that we'd very much like to invite to meet with our workgroup so that we can learn more, and I think that that list will grow with time, but our timeline for this that we're anticipating is spending the first probably three or four months, maybe through April, with learning. Inviting folks with a once-a-month cadence with learning about some of the issues and educating ourselves of the possibilities.

And then, the third, if you will, concerning narrowing the focus and then considering some solutions, including elevating, hearing from speakers about models that have worked and then spending our third preparing our recommendations for the Committee to review. So, once a month cadence for us as well. We didn't decide on a specific date. I'm going to count on staff to

help identify the best time.

MS. PETTIFORD: But you do plan to meet monthly?

DR. MENARD: Once a month, yes.

MS. PETTIFORD: Okay. Questions from the Committee?

(No response)

MS. PETTIFORD: This was one of those other workgroups I was able to listen in on a while. It does resonate well with me here in North Carolina where we do have a predominately rural state, so thoughts, questions?

(No response)

MS. PETTIFORD: Quiet group this afternoon, recovery from yesterday.

(No response)

MS. PETTIFORD: Okay. Well, we're going to go onto workgroup three, last, but definitely not least. Marie, I think you are the presenter for the social determinants of health or the social drivers of health. Thank you.

DR. RAMAS: We had a robust discussion, had a lot of participation around the work. We discussed a couple of things. One, identifying frameworks that are currently being used to structure social determinants of health and how they are being prioritized in order to identify services and then delegate resources and so we'll be getting more information regarding that from Golda and team.

The other aspect is what are non-medical interventions and resources on a community base that are working that have support and funding across different departments and are there any that are scalable. So, just from a high level to be able to share that with the Secretary.

We talked about as well workforce and access, so for those non-clinical extenders, how to ensure and support adequate workforce and creating a closed loop system, meaning that our friends from SAMHSA suggested that there are often services that might be provided and resources provided, even referral networks; however, there are enough people to do the adequate follow up and continuity of care that's needed in order to sustain positive outcomes and so getting information regarding creative ways of creating close loop systems in order to follow these high priority patients is something we'll be looking into.

The last thing is emerging areas of social determinants, social drivers of health.

So, our friends in the Office of Minority Affairs did suggest that it would be interesting to provide information on areas that may not have historically been included as typical social drivers of health; however, with the emergence of the pandemic and other environmental factors, considering stress as a social determinant of health and stressful environments either from a physical environment standpoint, but then also from a

stress and emotional psychological standpoint and how that affects particularly Black birthing parents and their infants.

And then the other is this concept of isolation, social isolation and how that can play into further continuity of care and support of patients in the peripartum, intrapartum areas as well. We were happy to hear that there is significant work being done around drivers of infant mortality around particularly SIDS, low birth weight, and prematurity. And we hope to gather more information over the next three to six months as we're identifying key areas to address in our report out in our section for the group.

The last part that we would like to get more information on, and there seemed to be interest in doing a deeper dive is this concept of payment reimbursement for these non-medical, clinical supports and how that can help to create sustainability models in particularly addressing social determinants of health, and so we'll be looking specifically into programming and innovative either insurance or fee structures that can support the work and embed it within the work. So, those are a few areas of focus that we discussed.

We did decide that we will be starting in January on the fourth Tuesday of every odd month, so bimonthly we'll be meeting, this group, at 4:00 p.m., Eastern, with the hour cadence of meetings and so that will give us three meetings as a group to

do investigation and to do research and we can have some interim intermeeting achromous work to do as well.

So, Sherri, I'm not sure if I missed anything, if you would like to add anything.

DR. ALDERMAN: No, you've covered it very well. Thank you, Marie.

DR. RAMAS: I'll be happy to answer any questions.

MS. PETTIFORD: Thank you, Marie. Any questions from the Committee?

(No response)

MS. PETTIFORD: You can't be this quiet this afternoon. Any questions? I will say one of the areas that we're actually in the midst of piloting in North Carolina through 1115 waiver is payment reimbursement for some of these non-medical drivers. So, we are doing it for transportation, food insecurity, I think housing is on our list, as well as intimate partner violence. So, we've got a couple of pilots that are occurring though our Medicaid program, so good to hear. I'm going to assume we're not the only state, so I'm sure there are others. So, it's good we'll have time to do a little research on that to see who else may be going down this road and looking at this, or if there is someone from CMS that can share what they know what other states are doing because we're doing it through the Medicaid program, so we did have to get a waiver from CMS to do that.

DR. RAMAS: Thank you, Belinda. Interestingly, I did stir up what are current offerings that the federal government provides for birthing individuals and the infants that could be augmented and shared more broadly. One of those examples is CLAS, the culturally and linguistically appropriate organization framework which has a robust program for maternity care and infant care, so that is a program that is free that provides CEUs and gives a handbook on providing culturally appropriate environments, so that's something that came up. And Sherri, you are muted as well.

DR. ALDERMAN: I was just going to thank Belinda for bringing up the Medicaid waiver and the pilots that are happening in various states as it relates to addressing social drivers of health for improved health outcomes and I think it would be very valuable for CMF to educate us on what is happening around the country and what is the process for taking that information, glean from those innovative models to transform into standard coverage for Medicaid.

MS. PETTIFORD: That's a very good point. I don't know, Kristen, but I'm not going to put you on the spot, but I'm wondering -- it may not be you, but I'm thinking there is someone on your team that might could present in the future.

DR. ZYCHERMAN: I'm happy to take that back and find the right person. As you said, Belinda, a lot of these

demonstrations are done under 1115 waiver authority, so it can definitely have someone to come from that shop or someone else appropriate at CMS provide some information on our next meeting.

MS. PETTIFORD: Wonderful. Thank you so much for your willingness to do that. Others?

(No response)

MS. PETTIFORD: So, you could only go to one workgroup, so I'm sure you have thoughts, some feedback you would like to give another workgroup that you weren't able to join today, and I'm thinking most of you are not trying to be on all three workgroups. Thank you, Steve. I see your hand.

DR. CALVIN: We had a very good meeting with the rural group, and we were also grateful to have Julia D. Interrante from the rural health group here at the University of Minnesota. She's got a wealth of information and so I think we're going to be able to talk her into joining us, but then there was a wide representation of other folks who will really benefit from it.

And I'd also like to thank you for yesterday having Julie Wood from the Family Medicine Group and then also Jeff Strickler because those were extremely helpful perspectives, and it was really encouraging to see how many family medicine physicians or just how many folks are being trained in advance life supportive obstetrics care because that will have a be impact in rural health.

MS. PETTIFORD: I totally agree with you. There was some really good conversation yesterday from those two presentations around what is happening in rural parts of our country with maternity care and infant care and how do we manage that. And I think, as you said, you all are talking about it in your workgroup, but it's a larger conversation that all of us need to be considering because most of us live in a state, if not all of us, that have some rural areas and so I think it was Kate that talked about how do we find out.

Here in North Carolina, I found out from my Office of Rural Health when we're getting a hospital closure or an L&D closure. That's where it comes from. And even though I'm on the MCH, the Maternal Child Health side, we're not the ones notified first. They do notify the Office of Rural Health, so it's always good to make sure you've got that connection in your states and in your communities with your Office of Rural Health. Yes, Marie?

DR. RAMAS: I was also thinking from the rural health perspective. We heard from Dr. Julie Wood from the AAFP and how family physicians really help to span the gap when it comes to maternity care and infant care in rural settings. I'd be interested in a particular issue for family physicians who want to provide maternity care is this issue of credentialing at hospitals and I think if there is space to go into what standards would be supportive of family physicians to be appropriately credentialed

to deliver maternity care and what are current resources to support that. I think that would be helpful.

Oftentimes, certified nurse midwives will have more flexibility and agency to deliver maternity care than family physicians who undergo specific training for maternity care and delivery. And so, if that hasn't been brought up, I'd be curious to hear more in that regard.

MS. PETTIFORD: Thank you, Marie. Did that come up, Kate, in your group?

DR. MENARD: May I address that? So, Marie, that did not come up in our group, but it's a theme that I have heard over and over again, that credentialing processes are very, very disparate, right, even within North Carolina, of course, which is where I'm most familiar, but the requirements by hospital are really very different and many times not that logical.

I'll give you a personal example of there's a hospital south of us that for me to get credentialed there, I have many, many years of delivering babies, but for me to get credentialed there they wanted me to have done 25 births in a certain amount of time and I'm like, whoa, that doesn't make any sense at all with the amount of experience that I have. It's different, but I thought about it, but I don't know whether HRSA has those levers. When we think about what can HRSA do, so I'm open to ideas because I do think it's important.

DR. RAMAS: I think it does relate as far as national health service core scholarships and family physicians are recognized and do get credit for providing maternity care as it relates to national health service core loan repayment, but there are increasingly higher stories of family physicians who have served in that capacity and even now are having difficulty with getting professional service loan forgiveness because it is difficult to justify or identify their work in the hospital as opposed to in an ambulatory setting. And I think from a matter of HIPSA scoring and identifying maternity deserts that might be an avenue where I can do further investigation.

I do know there's been some white paper documents around particularly maternity care in rural settings that the AFP does have, and of course, I'm partial to that, just given my background.

DR. MENARD: Come join us. Maybe you can come to our meeting too. We'd love to have you. The one important point that I think that the whole group should be aware is that it was brought up and that we have this lovely report, it was a very nice report from the March of Dimes about maternity care deserts and they're defined based on where the hospital is, where the OB providers are that includes OB and midwifery and whether they have insurance, right? Whether they have a means to pay and that's how they kind of get that composite desert, but family medicine is not

on that and they're not on that because not all family medicine providers do obstetrics, right, so identifying which ones do and which ones don't just from the datasets that they have available isn't done enough.

We've done that analysis in North Carolina and we, rather than using licensing and that sort of thing, we use who's billing for births and who's billing for prenatal care and we were able to map it that way and figure out where our counties were that were missing maternity providers and it turns out to be very few when you look at it that way, but it's important, right? So, all of these things have their strengths and limitations in terms of sources.

MS. PETTIFORD: Thank you. Yes, Phyllis? I see your hand.

DR. SHARPS: I wanted to follow up on the point that I think it was Marie who was talking about credentialling. While HRSA might not be able to do anything about that, they certainly can and have, I know, on some of its workforce funding finding special emphasis on preparing providers for certain types of -- . We've had some nursing for rural health care and that kind of thing, so there may be a recommendation that would come related to that.

DR. MENARD: That's helpful, Phyllis, I think for nursing and it's broader than an M.D. provider or even a nursing,

but nursing is a really important thing for us to consider in that as well.

MS. PETTIFORD: And I see that Vanessa has dropped in the chat that we can invite HRSA's Bureau of Health Workforce to one of your workgroup meetings or we have them come to the full Committee maybe and present and maybe even see if there's a representative there that might be willing to join one of the workgroups, at least for a short period of time to bring that level of expertise.

I see that Tina dropped in the chat. She talked about the map of the rural hospital closures. I think these may just be for North Carolina, but I'm not sure, Tina, but I'll click on the link from our Ship Center of the University of North Carolina in Chapel Hill. And then if we also want someone to come and talk about the class standards, the cultural linguistics, I used to know what it all stood for. I forgot the whole acronym, the class standards, appropriate services, so if we can get someone from the Office of Minority Health to speak on that.

So, those are areas that we will take note of and try to get speakers, either for the workgroups if you all would like them, or for our next meeting. Phyllis, did you have another question? Your hand is still up, or you just didn't take it down? And Kate, were you saying something?

DR. MENARD: No, Belinda. Thank you.

MS. PETTIFORD: Okay. All right. Other thoughts or questions from the workgroups? It does seem like everyone has a starting place is trying to pull some of the data and see what the data says in some of these areas, spending sometime looking at what is already occurring, what does the evidence say, are there some really good pilots out there that are working that we can invite to come and share if they're getting really good outcomes, and always we can bring in speakers. So, any other thoughts or concerns? Yes, Kate?

DR. MENDARD: So, Belinda, my question really is about process now. We've got a nice, long wish list of who we might want to bring, getting our meetings organized and that sort of thing, what's the process for getting that work done?

MS. PETTIFORD: The process for getting?

DR. MENARD: Vanessa, maybe you can address that. I mean, I'd be happy to get on a call to go through our thoughts but inviting people to come and set up the meetings and things like that, how are we going to support that.

MS. LEE: So, currently, Sarah Meyerholz, who we all know is our ACIMM program lead, her and I will be leading the efforts to support the three workgroups and then drawing on volunteers from MCHB or HRSA staff that maybe in interested in also helping to staff up or support a workgroup, but for now, yes, we will continue, I think, to meet with Belinda and the leads,

co-leads to get your meetings, meeting invites out, give you the emails and names of those that we're getting in our SCIMM inbox expressing interest in being part of your workgroup similar to those kickoff administrative meetings that we just had in November with the three workgroup leads and co-leads. We'll continue to work with you.

DR. MENARD: That's helpful. One other question I had is related to there's so much good information that was shared yesterday that's relevant to our thing. Will we be receiving detailed minutes of yesterday in advance or will they come later when we approve them at our next full meeting? I'd love to see full meetings early, I guess, is my ask.

MS. LEE: I'm thinking of the order that we receive things, and Emma or E.K. feel free to correct me. I believe the first thing that we'll be able to pass along usually is the slides, the presentations.

DR. MENARD: Slides? Okay.

MS. LEE: And typically, the recording as well as a transcript comes and then I would say the meeting minutes summary is sort of last because that's pulled from the other products by a writer that's contracted with, so we can get you those things as soon as possible, such as the transcript and recording. It takes about a week to two weeks to get it from the contractor and then we just do a quality check. But the slides can be probably shared

a lot sooner and you guys had access to them last night, hopefully, on the website that's just for Members.

MS. PETTIFORD: Yes, the link was sent out for us to get them from the website, so we have the slides and I think a lot of the information from the meeting yesterday are in the slides, but if we can get the recording out, I mean, that means people have to listen to the whole thing, but I guess you can do a fast forward through it to try to figure out where you want to listen, especially if it applies to your workgroup because it does take a little while longer to get the minutes.

MS. LEE: And then the Zoom, any resources that were chatted in, we can definitely get those pretty quickly passed over to the Committee as well from LRG. But Emma or E.K., is there anything you want to add that I missed or anything that I wasn't accurately representing.

MS. ALLEN: I think that was an accurate assessment of the timeline. Some of our delays are to ensure 508 compliance and ensuring that things are accessible, so we can get non-accessible versions of items a little bit earlier.

MS. PETTIFORD: Thank you.

MS. MEYERHOLZ: If you know the next date you want to schedule workgroup meetings, you can send that to me directly and I will go ahead and send the calendar appointment.

DR. MENARD: There were a lot of people on the call

today that I didn't know who really wants to be part of the Committee yet, so I have to establish first who's really going to be part of the workgroup and then I'm going to maybe rely on you to find the most favorite time.

MS. LEE: Sure.

DR. MENARD: That's kind of where we are.

MS. LEE: We can look at the recording from your group and see who all was in there and compare it to who we had previously put in the rural health workgroup and then we can go from there.

DR. MENARD: Thanks.

MS. PETTIFORD: And I think the key to remember is we have to post the date and the time of the meeting at least -- is it two weeks in advance? I think we need to know, Vanessa or Sara, do we have to post it a couple weeks in advance.

MS. LEE: I have to look back at the timeframe, but whatever it is for posting obviously, as you know, Belinda, we need additional time to get it through the clearances and approvals, so we will be working on that. You just provided me the preconception, interconception is the workgroup that has an established date and time for their next meeting and again, that's January 17th from 2:00 to 3:00 p.m., Eastern Time, so we'll work on getting that published in the Federal Register so that the public is aware that we're meeting.

MS. PETTIFORD: As does the social determinants of health.

MS. LEE: Sorry.

MS. PETTIFORD: They're doing the fourth Tuesdays, so their next will be in February because they're doing it bimonthly.

MS. LEE: Okay. Thank you.

MS. PETTIFORD: At least I'm thinking you're starting in February. Is Marie or Sherri on?

DR. RAMAS: We wanted to start in January.

MS. PETTIFORD: You want to start January.

DR. RAMAS: Yes.

MS. PETTIFORD: Okay, but then it will be January and March. Thank you.

MS. LEE: Okay. Thank you.

MS. PETTIFORD: Other thoughts or questions? We've got about 10 minutes before we have to stop for public comments, so I don't want to start another area. Anything else from the workgroups, anything that you think will be beneficial that you feel like you may need for your workgroup, and this is directed to all of the workgroups.

(No response)

MS. PETTIFORD: Thank you, Sarah, for dropping those two dates in the chat. So, we'll have one for the rural health shortly. We'll try to get the date established in December so

that we can try to meet. The group wants to meet in January. Thoughts, questions, concerns?

(No response)

MS. PETTIFORD: Okay, Vanessa, can we start public comments early or just it just depends on if the individuals who want to do public comments are available now?

MS. LEE: I was scanning, and we do have one of our three that informed us, so we are waiting, I think, on two more, but we'll keep an eye out on them. Belinda, do you want me to just quickly do the charter updates? I don't anticipate that taking very long.

MS. PETTIFORD: That will be fine because that's only 10 minutes, so that will work. We'll switch over to do the charter updates. So, where we were running behind yesterday, we may be running a little ahead today.

Charter Updates

MS. LEE: Right. And then if the LRG team could just help us by continuing to monitor for the public commenters, we'll be ready to turn it over at 3:00.

Well, like I said, thank you, Belinda. This shouldn't take very long because, hopefully, the Committee Members you all received my email back in October that shared we successfully renewed the charter for another two years in Septembers, so our new charter goes through September of 2025.

In that email, I gave you a copy of the charter. It's also in your briefing book and we posted it online on our ACIMM website. And we wanted to thank you all for sharing your suggestions and thoughts on the charter with Belinda. After our March meeting, Steven forwarded them to us and there really weren't many comments or suggested changes this time around, so ultimately only minor changes were made to the Committee charter compared to the 2021 charter two years where you may recall we actually changed the Committee's name and made some more significant wording changes to the scope, such as including the Committee should address disparities and examine social and environmental factors, so not much different, again, in this new charter.

No changes were made to the Committee's scope or duties this time around. Under Committee meetings you'll see it still says, approximately four times a year, but we further added, as recommended by this group, it says, either virtually or in person. So, that language was added regarding the Committee's meetings.

Under Membership, no changes were made to the types of members or the types of organizations that could be represented on the Committee. And periodically, from time to time, the Ex Officio federal membership is updated in the charter to ensure it really reflects the Committee's current priorities and focus areas.

And so, as this list is updated periodically, we just wanted you to know that we still have the ability to engage various federal agencies, as needed, even if they're not listed as Ex Officio Members, and so we really welcome continued engagement from our federal partners in the ongoing work of the Committee and in these new priority focus areas that you all have chosen.

And I just want to say we're really grateful to those who serve as Ex-Officios and hope those who may be rotating off will also continue to stay engaged with us and the Committee. So, that's all that was modified or updated, so that's all the updates I have on the charter. And I just want to, again, thank all of you for taking the time to review it and give us your thoughts. And again, if you need a copy of the latest charter, it's in your briefing book, but also posted on our website.

MS. PETTIFORD: Thank you, Vanessa. And just to reiterate, please review the updated charter that is in your briefing book or the website.

MS. LEE: Thanks, Belinda. And I'm just scanning now to see if other public commenters have come.

MS. PETTIFORD: Okay. And thank you to Lee and Vanessa and Sarah and all the others that spent time trying to get this charter approved for two more years. We really appreciate that.

MS. LEE: Thank you. It was a very smooth process, I have to say, and we had a lot of support back at the office and at

HRSA helped us through that process. Okay, I think some new attendees have joined that might be transferred over.

MS. PETTIFORD: Well, I'm turning it over to you, Vanessa anyway to manage the public comment time.

Public Comment

MS. LEE: Thank you. So, I will say we received three requests in the registration site for oral public comments to be made, so I'm just going to name the folks and then, again, we're still looking out for about two of them, but we heard from Emily Price. She's the CEO of Healthy Birthday, Inc. In Iowa. So, Emily, if you're on the line, by chance, and we're not seeing you, just please raise your hand or let us know.

Joia Crear-Perry, CEO of the National Birth Equity Collaborative, so good to see you, Dr. Joia from D.C. She's on the line. And then, we also got a request from Amy Stiffarm. She's the Native American Initiatives Program Manager with Healthy Mothers/Healthy Babies in Montana, so we're also looking out for Amy in the Zoom.

And then we had Patrick Ross, I see you're with us. Thank you for joining the meeting. We're just wondering if you wanted to make a comment today or not. You're also free to make a written comment, but we did see your request in the registration site. And Patrick, you're the Assistant Director of Federal Relations for the Joint Commission. So, we do have time if you

would like to make a comment today. But I'm not seeing Emily just yet, and we do have Dr. Crear-Perry on, so I can open the floor now to Dr. Crear-Perry. Thanks for being with us.

DR. CREAR-PERRY: Thank you, Vanessa. Can you all hear me okay. Great. So, Vanessa, your last comments are perfect for what I wanted to say, that the charter's expanding, so being with the SACIMM when it was called the SACIM and now the ACIMM and decided to see us moving from only focusing on infant mortality to also moms and disparities and so I think that's probably why you got your charter through because the will of the people worked, right? We could move this Advisory Committee to really encompass all of sexual reproductive health and also remembering that you, your job is so important, Vannessa, to hold this Committee, but it's just you.

You're really -- I know you know this already, but I just want to remind the Committee Members that this is not a HRSA job. It's only HRSA because Vanessa works there and is chartered to be convened by HRSA, but it's also CDC. So, as an organization who works with local states and international groups, the Secretary of Health, Secretary Becerra, is who this Committee is for.

So, any organization that we can get that come and talk to us to improve outcomes so the Secretary can have a recommendation about infant and maternal mortality and morbidity

is crucial, and so not thinking of this as what HRSA can do because although HRSA has to write it up and has to staff it, it is for the Secretary, so it's also every other, so Joint Commission is really -- I'm excited to be here on the call because I spent a couple of years working with them around the recommendations on maternal mortality, so excited to hear that they're here too.

And I love the three groups, so for the rural, the only thing I would add about rural because I've known Kate for years and they've been working on like Medical Mom models there in North Carolina. We have so many things we have been doing, so I love the fact that you're building on what we already knew and giving yourself a year to expand and create recommendations to the Secretary Becerra, who might not be the Secretary because in 2025 who knows who the President will be and who that person will pick as Secretary.

But thinking of yourselves as creating a map and a guide for whoever will be the new Secretary of Health in 2025, that's how I would see this next year and what you're going to put together and how you're going to put this together. So, you already have a bunch of information, bringing those experts in for rural.

You need to also include birth centers and home births because you're not going to build a bunch of labor and deliveries

or have people driving two hours to have a baby, so until we acknowledge that people are having babies in different ways -- I love the credentialing conversation because credentialing is not just about credentialing of physicians like me at hospitals where they have weird rules because who is my peer? At this point, very few when it comes around thinking about who wants to do things like take care of patients who are willing to have a home birth, right?

So, we have to expand, especially for rural mommas, as a person who grew up in the Deep South in a rural America, we have to expand what we think of when we think of rural and ensure that people have the full range of things, so that includes really a lot more birth centers and lot more acceptance of home birth because they're not going to drive two hours just to have a baby. They can't afford it.

And then for the interconception and preconception, we really were trying to evolve that language. We understood why that was being used, but you also going to treat uteruses and women as a uterus to have a baby, so reproductive well-being is the language that we had as a community outside of the federal government that we've been working on and SCIA is a non-profit that's spent a couple years creating a whole framework around reproductive well-being and having many other groups that are around this country would be a great addition to this conversation

to really expand on this idea that you're only value for payments or a human being if you're having a baby interconception or preconception, but if you're childless by choice reproductive well-being is for all of us, and sex is pleasure and joy and we don't have any of those kind of conversations and that's what people -- I was excited to hear us talk about trans care, but we also need to talk about sex and masturbation and pleasure, because those are realities of human beings living.

And then, lately, of course, the social determinants of health is excited to see that you had our framework included. And you're right, there's a lot more. There's obstetric racism, Karen Scott's work. We work respectable maternity care, which is a WHO framework, so around the world people are moving towards really understanding how to not blame and shame moms, not using words like Caucasian that are scientific, really understanding that our words matter.

And we also moved away from only focus on infant mental health to perinatal health because you can't just focus on the baby's brain because it's inside of the momma, so that's really what Michael -- there are two Michael, Michal Lou and Michael Warren, when I would have coffee and tea and talk about really not focusing on one or the other, but really expanding it, so this really a combination of the two Michaels' brains, so let move into this new ACIMM and so I'm excited to see what we all build

together next. So, that is it. I hope I didn't ramble too much.

MS. LEE: Thank you, Dr. Crear-Perry. Before we move to the next question, any questions for Dr. Crear-Perry or comments from the Committee, any thoughts?

(No response)

MS. LEE: We're getting the next person queued up.

MS. PETTIFORD: I don't have any questions, Dr. Joia, but thank you for your comments and we always appreciate being able to hear from you and to see what is actually happening out in the field because we know you've been doing this work for quite a while, that you bring the voice of community, as well as the provider community, so thank you so much for coming today. Thanks.

DR. CREAR-PERRY: Belinda, honestly, hearing your voice reminded me I didn't hype up Healthy Start, which is what I usually do.

MS. PETTIFORD: I know you normally do.

DR. CREAR-PERRY: I cut it off and just said Medical Director Healthy Start and that's really, really looking at how that has been a model that's working and has worked and needs to be invested in. It's not a demonstration. It's demonstrated that it works, so we can stop calling it a demonstration project, so that's my soapbox for the day.

MS. PETTIFORD: Thank you. But I see Kristen's hand is

up, so Kristen is your question for Dr. Joia?

DR. ZYCHERMAN: It is. Thank you for your comment. I just had a question. I'm from CMS and coverage of CPMs is an optional benefit that states can provide. What do you think the barriers are to states extending Medicaid coverage for this group of providers?

DR. CREAR-PERRY: Thank you. That's similar to the privileging conversation, so there are some states like New York who doesn't separate out CPMs versus midwives who are nurse/midwives. They just have a standard language for midwifery, but a lot of the other states -- that you must be a nurse/midwife, so that's why when you put that nurse language in there, you're not going to be able to get the CPMs into the Medicaid pool. Does that make sense?

DR. ZYCHERMAN: Yes. Thank you. So, is that legislative, largely?

DR. CREAR-PERRY: It is, yes, yes, yes.

DR. ZYCHERMAN: Thank you.

MS. LEE: And then, Dr. Joia, I think you guys published a paper on the change on the language and framing that you talked about. If you wouldn't mind dropping that in the chat.

DR. CREAR-PERRY: For sure.

MS. LEE: Thank you.

DR. CREAR-PERRY: As a matter of fact, I'll do that

now. Thank you all so much. I don't want to be too obstructive to the meeting, so I appreciate you all, really, I do.

MS. LEE: Thank you so much for your time and joining us. Next, we have Emily Price. Thank you so much for being here, Emily. You're the CEO of Healthy Birthday, as I mentioned, and we appreciate your being here. I'll give you the floor for your comments to the Committee.

MS. PRICE: Thank you so much. I'm so grateful for this time and I see many of my personal public health heroes on this call, so I just want to say thank you for this opportunity.

Healthy Birthday, Inc. was founded 15 years ago out of the loss of five baby girls in Iowa. We're best known for the creation for the Count the Kicks Stillbirth Prevention Program that has been hugely successful in saving babies' lives.

I'm here to send a huge thank you to HRSA and its leaders for creating an outcome measure dedicated solely to stillbirth for the first time earlier this year. We asked and they listened. We are so grateful for these amazing leaders.

I am here representing tens of thousands of families and maternal health professionals who have endured the tragedy of stillbirth in America, which is defined as the loss of a baby at 20 weeks or greater during pregnancy. Right now, one in 175 pregnancies ends in stillbirth in our country, and unacceptable racial disparities persist. Black families endure stillbirth at

more than twice the rate of White families in our country.

For Black families, it's one out of every 97 pregnancies ends in stillbirth. Overall, in this country, the stillbirth rate has mostly stalled in recent years, despite research showing more than a quarter of stillbirths in this country could be prevented. We ask that stillbirths continue to be elevated in conversations related to improving birth outcomes and outcomes for moms.

Just this morning, ACOG's newsletter featured a new study that shows stillbirth as associated with the increased risk for severe maternal morbidity during delivery, hospitalization, and up to one-year postpartum. The health of a mom and the health of her baby are intrinsically connected. Maternal mortality and stillbirth are linked.

Moms who endure stillbirth are four to five times more likely to lose their own life. We often talk about maternal mortality and infant mortality in this country, yet extremely important and devastating issues that must be addressed, but we often leave out stillbirth. This advisory committee itself is called the Advisory Committee on Infant and Maternal Mortality but mention of stillbirth and no committee on stillbirth, which actually claims the lives of more babies each year than infant mortality and maternal mortality combined.

If we want to talk about equity, if we want to say

equity is at the center of our maternal health work, we must include stillbirth in all of it. The tens of thousands of American families who will face the tragedy of stillbirth each year deserve the same urgency, the same level of funding, and the same level of prevention awareness.

With your continued help, we can make this happen. Our organization created Count the Kicks 15 years ago to raise awareness about the importance of paying attention to a baby's movements in the third trimester of pregnancy. A change in a baby's movements is an urgent warning sign, but many expectant parents are never told this or they found out way too late.

The results of Count the Kicks, which you can see in one piece of our educational materials here, are so compelling that we must act now. These posters and brochures are hanging in more than four million locations across the country as a way to raise awareness about the importance of tracking your baby's movements.

In Iowa, the state where Count the Kicks began, we saw a one percent stillbirth rate reduction every three months for an entire decade. Within that, we witnessed a 39% stillbirth rate reduction for Black women in our state within just the first five years of the program. No other state has seen such a change. Monitoring your baby's movements daily in the third trimester of pregnancy needs to be commonplace in America like it is in many

other industrialized countries.

Health departments, health systems, A1, AMCHP, the National Center for Fatality Review and Prevention, Healthy Start Coalitions, MIECHV, health insurance companies and many, many more have become key partners in this work. Today, free Count the Kicks stillbirth prevention educational materials like the ones I just showed you are available for free in half the country, while the other half can get them at very low costs.

The materials spark the kick counting conversation between patient and provider about how a change in a baby's movements can be a red flag in the third trimester. It is simple, it's easy to understand, a program with health equity at the center. You can visit Count the Kicks.org to order your own prevention materials, if you're interested, or to learn more about our proven, evidence-based work that saves lives and it does not lead to unnecessary doctor and hospital visits, instead, it sends in the right people at the right time. Together we can get more babies here safely and improve outcomes for moms at the same time.

Today our simple ask is to keep placing an increased focus on stillbirth prevention within this conversation, name it, talk about it, fund it, and keep working together to make stillbirth a maternal health tragedy of the past. Thank you so much for your time.

MS. LEE: Thank you, Emily. Any questions or comments,

reactions from the Committee Members? Steve, I see your hand is up.

DR. CALVIN: Emily, Steve Calvin here. I'm a maternal fetal medicine specialist. I agree with you. I mean, probably the definition of perinatal mortality too, and also pointing out there is some really good work happening now. Welcome Leap has funded research on fetal status internationally, but now there's a program at Washington University, led by Michelle Owens, that's looking at placental function and its relationship to stillbirth. So, that's all good news, but I agree with you that I'm not sure which of our three workgroups would be the best place for this, but it is, I think, important to recognize that the number of fetuses lost after 20 weeks adds up to more than the infant and maternal mortality numbers, so thanks for point that out.

MS. PRICE: Thank you, Steve.

MS. PETTIFORD: Hi, Emily. This is Belinda, so it's good to see you. So, I don't know if there's a specific workgroup that we would want to connect this to, but maybe we should talk offline maybe about getting a presentation for this group so that they'll understand the whole Count the Kicks Program and the effort and the work that you all have been doing because it could be other opportunities, even outside of the recommendations.

MS. PRICE: Thank you so much. Appreciate that. Thank you.

DR. CALVIN: And, Belinda, too, I'd be happy to connect with Emily about that.

MS. PETTIFORD: Okay. Thank you.

DR. CLAVIN: Put your contact info in the chat.

MS. PRICE: Will do. Thank you so much, you guys. I appreciate it very much.

MS. LEE: Thank you again. I think we have one more public commenter and thank you for bringing her out.

MS. PETTIFORD: Alison's hand is up right now.

MS. LEE: Sorry.

MS. PETTIFORD: I don't know if you saw that.

MS. LEE: I didn't. I'm sorry. Alison, go ahead.

DR. CERNICH: It's all good. I just wanted to note for this Committee that we've been running a group specifically, and it is interagency, on stillbirth at NICHD and I'm going to put the link in the chat. We are running the first pass through this and have been working with a number of federal agency partners and private partners and folks with lived experience. And so, we have our schedule of meetings on this website, and we also had a formal request for information that we went out publicly with last year and I'll put a note also. We launched a challenging combination with our colleagues at the National Institute of Biomedical Imaging and Bioengineering at the request of the groups. There was a request to better technologies to monitor fetal health to

prevent stillbirth, and so we have launched a challenge to help with care or wearable diagnostics for that, so I'll put that link in the chat. The other is that we're also working with CDC and we're able, both through some of our research networks and some of their surveillance systems to increase the amount of data related to stillbirth by bringing either resources together on the NICHD side from our maternal fetal medicine network and our neonatal research network and CDC is looking at some of their surveillance systems. So, just know that this is something that is a major focus for us at the NIH level and we have leads that would be more than willing to come talk to you all about it as well.

MS. LEE: Great. Thank you so much, Alison. I'd forgotten about that, so thanks for raising that. All right, thank you again, Emily. And as I mentioned, we had one more request for public comments from Amy Stiffarm. Thank you for being with us, and again, Amy is the Native American Initiatives Program Manager at Healthy Mothers/Health Babies in Montana. I will turn it over to you now, Amy.

DR. STIFFARM: Thank you and thank you for having me this afternoon to make a comment. My name is Dr. Amy Stiffarm. I am Aaniiih from the Aaniiih Nation of the Fort Belknap Indian Community here in Montana and I'm also a descendant of the Chippewa, Cree, and Blackfeet Tribes of Montana.

I am a recent graduate of the University of North

Dakota Indigenous Health Program and I work for a statewide nonprofit here in Montana where I lead initiatives focused on improving perinatal health and infant health, child health for Native American families and I just wanted to make a comment to just call out again the importance of the Making Amends Report.

This is a report that I cited heavily within my dissertation and point to quite a bit during many presentations to different groups about the importance of looking at the recommendations, especially for non-Native groups working with Tribes and I just wanted to call it out again. Dr. Palacios did a great job in the video yesterday explaining about the inequities that is experienced in maternal health among indigenous people of the United States.

I just felt it was important to provide additional comments about how those recommendations some of them would translate in Montana. For one, the surveillance I think it's really important, and in the report, it calls out the importance of working with Tribal Communities and having it be indigenous lead and being rooted in indigenous perspectives and looking at PRAMS, for example. There is a recommendation about supporting Tribal PRAMS and I just want to echo that because doing surveillance and data collection work in Tribal Communities is so much different than PRAMS in even just the wordings, how questions are worded.

There's not really a difference as it is right now when asking about tobacco and differentiating between commercial tobacco and traditional tobacco. Even the way you do data collection and in conversation and in relationship building I just think that we really desperately need that data.

And again, that video talked about needing more of this data and it would be really important to support Tribal PRAMS efforts or even to have almost like a template that communities can use when they're looking at collecting this data in Native communities. Also, the funding opportunities, like here in Montana, we are really trying. We don't have a lot of local community-based organizations and that's where a lot of these funding opportunities are for. We have HMHB. We're a statewide org, but we don't have any organizations that we can directly apply because they're really in the making.

We have had some amazing work in training indigenous doulas in the state and to reclaim some of that birth support and we know that's really going to be healthful, especially in our rural communities and the fact that we have to leave many of our Reservations to give birth and to seek prenatal care.

Having an indigenous doula is so important and a lot of that work and the RFPs that I am seeing are for groups that are already established and not necessarily for getting support in helping start a group locally that is separate from Tribal health

and Indian Health Service because there are different reasons why it just needs to be separate, supported by the tribe, of course, but its own entity.

And I also wanted to echo too about the importance of having an American Indian or Alaska Native, probably both people on the Committee. So, yesterday I know it was an emergency why Dr. Palacios couldn't be here, but it's just very uncomfortable in 2023 now to witness a conversation completely about American Indian people, indigenous people without any representation. And when we don't have that indigenous perspective, we sometimes come from a place from saviorism or we don't understand the full historical and cultural context of what is happening or why, and we tend to look at native communities as if they are sick or as if there's something with us or as this being native along puts you at risks for these issues and I think it's really important when we're talking about this work is to highlight the strengths and to have our work be strength-based and focus on all of the protective factors that are prevalent within Native American culture when we're talking about addressing maternal child health issues.

So, I just wanted to highlight that and again just echoing pretty much all of the recommendations in the Making Amends Report, but specifically wanted to call out those recommendations and talk about how they related to the work that I'm trying to do. So, thank you for your time.

MS. LEE: Thank you, Dr. Stiffarm. We do still have some time. We're in this segment until 3:30, so are there any comments, questions, for Dr. Stiffarm from the Committee Members? I see Ada. Thank you, Ada, from CDC.

DR. DIEKE: Hi. Good afternoon, everyone. Thank you, Amy, for your comments on the health equity lead for the CDC's Division of Reproductive Health. And I was also formally on the PRAMS team and so thank you for your insight and some of your recommendations as it relates directly to Tribal PRAMS. We have opportunities to listen to the American Indian, Alaskan Native population in our work and then the feedback that you've provided is going to be very helpful. So, I just wanted to say thank you for that.

MS. LEE: Thank you, Ada. And Belinda?

MS. PETTIFORD: Thank you, Amy, so much for your comments today. They were well received by myself, but I want to make sure that others know that we are in the process of waiting for new Members to be appointed. We are hopeful that with the new appointments. We don't know who they are, but this conversation around making sure we're more inclusive with our appointments has been occurring for the last several years and probably beyond that. So, we're hopeful, I am hopeful that with the next round of appointments that we will make sure that there is at least one Native American, Alaska Native person represented because I

totally understand what you're saying, you know, there's nothing about us with us is the whole concept, so thank you for brining that up and thank you for making sure, as did Janelle and Ed and Magda and others that the Making Amends Report still stays on our radar, so thank you.

MS. LEE: Thank you, Belinda. And I'll just scan one more time any hands raised. Okay, I'm not seeing any new hands. Thank you again, Dr. Stiffarm, for your time and for being with us today.

I don't think we have any other public commenters that wanted to provide oral comments to the Committee. Any written comments that we did receive you'll have seen in your briefing book. So, with that, we'll close this segment and I'll turn it back to Belinda.

MS. PETTIFORD: Thank you so much, Vanessa, and thank you to those who were able to make public comments today. We appreciate it, and as a Committee, we do value the feedback and the input that you all provide, so thank you.

As we look at the agenda now -- actually, before we go there, I see one of our Ex-Officio Members that was able to join us a little late yesterday. I want to give her a chance to come off camera and introduce herself because she's one of our newer Members representing SAMHSA, so Nima Sheth, do you want to come on camera and say hello and tell us a little bit about you or tell us

your favorite holiday tradition if you celebrate a holiday this time of year?

DR. SHETH: Thanks, Belinda. I'm so sorry that I've been in and out these two days and this is wonderful and I'm so happy to be part of this. I do apologize because I had so many overlapping commitments, but I'm Nima Sheth. I'm a senior medical advisor, a psychologist by training with a public health background. I've been at SAMHSA for a few years.

My portfolio here is primarily around maternal behavioral health, which includes mental health and substance use, and I also serve as the Associate Administrator for Women's Health, so that is our women's service FACA or advisory committee and run a number of projects in women's behavioral health here at SAMHSA while also co-chairing the Maternal Mental Health Taskforce with OASH.

So, technically, the co-chairs are Dr. Delphin-Rittmon and Admiral Levine. I serve as the SAMHSA POC for that, along with Dr. Fink from OWH. I also work in implementation Science Refugee and Forced Migration and Measure and Base Care separately in our -- which is another -- .

So, some things that I'm involved with, prior to this, I was at Georgetown University Hospital primarily doing a lot of clinical interventions where I did see women in perinatal trauma and women's trauma issues, so this is just a really, really

important topic and hoping that we can continue to do more.

Favorite holiday tradition I would say maybe -- I don't know. We tend to travel a lot for the holidays. We go to my husband's place in Cincinnati, his family's place. We go to my family's place in Chicago and this year we're going to Houston as well to see more family. So, lugging around with us a four-year-old and an 18-month-old, so that'll be interesting, three cities of travel with them, so it'll be interesting. Happy to be here and thanks for having me.

MS. PETTIFORD: Thank you so much and welcome to this awesome team, so we appreciate it and good luck with all of your travels during the holiday season. I shared yesterday I'm fortunate I don't have to travel. People come to me, so I am in a better place, thank you, but have fun.

Next Steps & Assignments

MS. PETTIFORD: So, as we get close to wrapping up this meeting for today, I did want to take a little time to reflect, so just think through yesterday, we had a lot going on yesterday. We had some wonderful presentations, but we really didn't get a chance to ask questions. And we've got our presenters. They're on standby prepared to answer any questions.

And I think the one other area that we didn't talk about was the framing work, so I wanted to open it up right now to see what are your thoughts, what are your takeaways from yesterday

and today. We do have a couple of next steps for our workgroups that I'll talk about, but before we go there, I want to open it up to see if anyone has any special takeaways.

I will say, for me, yesterday it was the entire day. It was a lot going on, but each presentation seemed to build on the next and so there was no part of our day yesterday that I didn't feel like was helpful information to us, either as a larger SACIM or either through a specific workgroup, so it was good. We had really good presentations and presenters who are willing to stay engaged.

But I do think the conversation and the information that Julie Sweetland shared with us from Frameworks was critical because as we're making these recommendations, we don't know what Administration we're making these recommendations to, so we need to make sure. We anticipate, depending on the time you know you never know because this will be an election year in 2024, so I want us to make sure we are framing our recommendations in a way that we can get support from the masses, that we are making sure people are clear on our recommendations, and that we're always centering mom, infants, and the family and making sure individuals of reproductive age have the support that they need.

So, I want us not to forget that framing conversation and the discussion, that we didn't really get to the discussion, but at least the information we received from Frameworks

Institute. And I think Julie was going to send over -- I think she actually put it in the chat yesterday, one of the articles for consideration, so we'll make dure that gets to all of the Members if you didn't see it yesterday.

But what about others? Any takeaways that the rest of you have? Yes, Kate?

DR. MENARD: I'm glad you brought it up. So, there was so much good information shared yesterday, but that framework discussion from Julie I thought about that a lot afterwards. In framing our recommendations for the next Administration is really important. I wonder if we have the opportunity to even engage her or her team with looking at the way we write because listening to it, it all makes so much sense and it's not the first time I've been encouraged to think that way, but then doing it is a little bit a different story. So, that was one question.

Really, one particular thing that I know we would really benefit from framing it and finding the better language that I've giving a lot of thought to is risk appropriate care and levels of care and how the idea of having levels of care is all about closing rural hospitals, which it's not, but it's not received that way. And it's all about how you communicate these things, right, and we have so much to learn from her and her associates. Thank you for bringing it forward and maybe it can at least let her review whatever -- writes.

MS. PETTIFORD: We'll do some follow-up to see if we have a way of engaging them a little bit more. Yes, Phyllis? So, thank you, Kate.

DR. SHARPS: I was going to follow up to Kate's comments because we talked a little bit about that in our workgroup that preconception care. And one of the challenges that Sarah did talk about in her presentation, as well as we've talked about, is how you message some of the recommendations or the care ideas when you want to be clear, but you also want to respect women's rights to make decisions and their autonomy and we have such diverse groups that we would be speaking to or messaging, so I think that that's going to be a challenge for this workgroup also.

I think we're in a time when people's intents are good, but it's very easy to alienate or not have the right words for certain audiences.

MS. PETTIFORD: Thank you, Phyllis. I appreciate that, great points. Others? And your comments don't have to be about frameworks or framing the message. It could just be about what you heard yesterday.

I think, Steve, you shared several times, and several of you all shared in the chat yesterday Jeff Strickler's presentation around rural hospital closures and others of you all put information there, so I think that was one of the other areas

that I think I saw conversation going back and forth in the chat. Others? This is others mean ex-officio too.

(No response)

MS. PETTIFORD: I think this team is trying to get their break time back from yesterday at the end of today and I totally understand. Thank you all.

Well, if not other takeaways and no other thoughts, a couple of things. We will be meeting with the leads, co-leads of the workgroups as soon as possible in January. We might be able to get them in, in December, but we will definitely do it in January. If we could figure out how to do it in December, we will, but I just want to make sure. We do need to make sure we've got all of the dates for the meetings for the work groups and so we will move some of that work forward very soon.

I always have to thank Sarah and Vanessa for keeping us centered and grounded and all of the amazing work that they do behind the scenes that many of you probably don't know about, but I see a lot of activity and I know and I'm extremely grateful for that.

We do need to talk about our April meeting, though. So, in April, we had planned to be in person. We're hoping to be St. Louis, so we're going to hang out with ShaRhonda. We've got two dates we're looking at right now, so I would love for folks to pull out their calendars to see if either one of these works. So,

that will be our next meeting will be in April. It will be in person.

In June, we will also meet again, so just keep in mind April and June. In June, we will likely be going back to Rockville. It will be the plan. But in April, we want to go on the road where we can have more community engagement and hear the voices of individuals with lived experience and be in the room with them.

So, right now we're looking at either April 2nd through 4th, which will be the early part of April. And then the other date we're looking at is April 30th through May 2nd. So, if you all can look at your calendars and drop in the chat. Thank you, Vanessa for dropping it in, drop in the chat to let us know if either, both, or one over the other works for you. April 2nd through April 4th, or April 30th through May 2nd.

Let's see, April 2nd through the 4th is coming up. Thank you, Steve, either works for you. Wonderful. And please hold both times until we could figure it out because we have not gotten in depth conversation with ShaRhonda. Thank you Emma. Is Monday through Wednesday possible? I think we were looking at not doing a Monday because that meant people had to travel on Sunday. I think Monday was going to be the travel day versus Sunday, so if we do April 2nd through 4th, people would need to travel on Monday, April 1st. Do people prefer to travel on Sunday?

MS. LEE: Belinda, I know that others have asked this, but that Sunday before April 2nd is March 31st, which is Easter Sunday this year for those who that's important to. We had a number of questions of when Easter fell this year, so it is Sunday, March 31st this year.

MS. PETTIFORD: I see Kate saying April 2nd to 4th is spring break for schools, okay, and people may have children. So Maria, when you say Monday through Wednesday, is that the same, whether we look at April 2nd or whether we look at April 30th? Thank you, ShaRhonda.

Some of you have not dropped anything in the chat, which I need to hear from you.

MS. DIEKE: Belinda, I will check with Dr. Charlan Kroelinger, since she's the ex-officio, so I'll double check with her.

MS. PETTIFORD: Thank you, dear. I appreciate that. I definitely need to hear from the appointed Members, even if I don't get all of the Ex-Officios today. Thank you. So, it looks like people are saying -- we're getting a mixture. We're getting a mixture. Most people are saying either one will work. Joy, you can only do April 2nd through 4th?

DR. NEYHART: No, I can be flexible.

MS. PETTIFORD: You could be flexible. Thank you, dear.

DR. NEYHART: You're welcome.

MS. PETTIFORD: Thank you, Alison. And Marie, we'll wait to hear from you. It looks like most people -- I may be reading this wrong, so somebody check behind me. It looks like most people could do the latter one. They want to be further away from Easter, or they have conflicts. Just keep in mind if we do the end of April, early May, in June we'll be coming back again. So, I just want to know that that is limiting how much time between the meetings and that's why we were looking at early April, but we'll figure that out when we get there because we only get to one meeting at a time.

Okay, all right, we can pull this from the chat, and we can follow up with anyone that did not get a chance to respond, and we will get that date out because we want to put a hold on your calendars very soon. So, we will look at what was put in the chat, make sure everybody that is here has had a chance to respond because we do need to start working with ShaRhonda soon. Okay, anything else for the good of the body?

(No response)

MS. PETTIFORD: I'm trying to give you part of your 20 minutes back from yesterday that you did not get for break. I think I owe you about 23, 24 minutes, so this might balance out. Any thoughts, questions, concerns?

(No response)

MS. PETTIFORD: This has been a really good meeting.

It's a lot that happens that happens in these meetings, whether we're in person or whether we're virtual and I appreciate everyone's engagement. I like to see people on the camera, but I know sometimes people have to go off camera, but I do feel like people are engaged, so that means a whole lot.

If no one else has anything to share, Vanessa, Sarah, anything that we need to hear from you all, or Lee?

(No response)

MS. PETTIFORD: We're good.

MR. WILSON: Nothing at this time.

MS. PETTIFORD: Well, thank you all so very much for your time, your expertise, your feedback, your energy for all of this. This is an awesome group to work with. I appreciate everything that each of you do and what you bring to this table because this work is too important for us not to prioritize it in this country.

We know it is critical that we work to improve infant and maternal health in this country and definitely to do what we can to reduce the number of deaths that are occurring. So, if nothing else, for those of you who celebrate any type of holiday in the month of December, I wish you well, whether you're celebrating Hanukkah, Kwanzaa, Christmas, whatever you're celebrating or something else that I may have missed, I hope you have a wonderful rest of the year. We look forward to seeing

everyone. I cannot believe in just a couple of weeks it will be 2024. Look forward to seeing everyone in 2024. And thank you for your time and your energy. Have a great rest of your day. Thanks everyone.

(Whereupon, the meeting was adjourned)