ADVISORY COMMITTEE ON INFANT AND MATERNAL MORTALITY (ACIMM)

Hybrid Meeting

Health Resources and Service Administration Building

5600 Fishers Lane

Rockville, MD 20857

Thursday, June 27, 2024

9:30 a.m. - 4:00 p.m.

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P R O C E E D I N G S

Welcome and Call to Order

CHAIR PETTIFORD: Good morning everyone. This is Belinda Pettiford, and I hope you had a wonderful evening last night. You didn't have a homework assignment, but we did ask you think about the workgroups, so I do hope you had a great time. I know several of us went out to dinner.

We were walking back over from the building to the hotel, so I feel like we've done our part of learning our way around the Rockville area, so hopefully you had great evenings as well.

Just as a quick reminder, or just an update, I feel like we had a great meeting yesterday. It was a full day, and we have another full day today. But yesterday, you know, we had really good conversations, and were able to get updates from some programs that are being led by the Maternal and Child Health Bureau, CDC and others.

I think many people enjoyed the session, that Ashley Hirai and Michael Warren did on the data, and really reminding us of the connection with the maternal and infant data. I've heard several of you that wanted copies of those slides, and I think we're working to try to get those slides for the briefing books, so they will be coming.

We had a really good update on the Healthy Start Program, which is interesting because as we were doing this great presentation and update on Healthy Start Program, we found out yesterday that the House when they released their budget, they zeroed Healthy Start out of the budget, so here we go again. They did that last go around, and a lot of work had to go on with the National Healthy Start Association and others, and I think AMCHP- -was supporting it to try to make sure the funds came back in, but they zeroed it out again.

That same budget zeroed out Title X, and many of you, especially if you're with state programs, you know what the state federal Title X program is. And there were some eliminating of some teen pregnancy prevention funds, so we know how all of these funds are important to the work we're doing to improve maternal and infant health in our country.

So just know, we've got a lot of work to do, and this meeting is just part of it. So, I don't know if any of our members, ex officio, or appointed, if anyone has any questions from yesterday's meeting? Anything anyone want to share?

We wrapped up yesterday afternoon letting people share one word as to how they thought the day went, and many of you shared that, but I don't know if anyone had time to think about it a little more last night, and you've got a word you want to share this morning. Thank you, Jacob, I see your hand.

DR. J. WARREN: So, I almost said it yesterday, but I'll say it again now, especially with that update, Belinda, and my word is "now," because there's just a lot of now things going on. I feel like the need is greater than ever, so that's why we need to be doing this work now.

It's exciting that we have all the new members onboard, so now is the time and the opportunity to do it, and now that we know that we're facing those same headwinds that came up before, it's even more so now that we need to be focused on this work, so thank you.

CHAIR PETTIFORD: Thank you so much, Jacob. “Now” Now will be our word of today. We've got a lot of work, and we cannot wait on it because others are not waiting for us to figure it out. They're moving ahead with their own decisions, so “now” is our word.

I think the other word I remember, Janelle used yesterday during her public comments, was we need to be bold. And so, we need to be remindful of that, that this is work that many of us have been working on for years, and we want to see some improvement, so again, we need to be bold in our recommendations.

I see "inspired," Marya put inspired in the chat. Thank you. Charlan put "impact," in the chat. Thank you. Wonderful. Well, let's keep those words in mind as we go through today. Again, we have another full day. We have several really good, interesting presentations coming up today. We have some focus on maternal and

infant mental health today, so we have presentations on both.

We also have a presentation from California Department of Public Health on their Black Infant Health Program, where they've seen some really good outcomes. And then we're going to spend this afternoon having time for our workgroups to meet. Again, we do ask everyone to join at least one workgroup.

There will be options for virtual participation, and everyone will be in their own room for the workgroup. And we're asking the workgroup to come back with some of their draft recommendations at the end of the meeting that they will share with the larger group. So, I'm expecting us to have a great day, and I hope the rest of you all are onboard with that as well.

So now, I'm going to pass it over to Vanessa, so she can give us some updates on next steps with the Committee.

Committee Business: Fall Meeting Dates and Agenda Items

MS. LEE: Thank you, Belinda, and good morning everyone. Good to see you again. We're just going to take some time to do some Committee business. During this segment of the meeting we generally try to give updates related to the Committee, check in on any support you may need, and then start thinking ahead and planning for the upcoming meetings.

And so, we are looking, as you've been hearing, at an October meeting, so the dates we had put in a Doodle poll, I think

after the April meeting. We had a couple of dates in October that we were asking folks to weigh in on, and it looks like the majority could do October 16th and 17th.

I know for the new members this is new information. You weren't appointed when we did the Doodle poll, so if you could just check your calendars, and we're looking at Wednesday, October 16th and Thursday, October 17th, in D.C. We weren't able to secure space. Actually, all the rooms were booked here in Parklawn for those dates, so we actually did find space in the Humphrey Building, which is where HHS headquarters is, and where the Secretary's Office is, so that's actually kind of exciting. We have a main room and some breakout rooms, so if the workgroups want to meet, we did secure those as well.

I was just talking with Belinda, and we're thinking of a one and a half day meeting, so that folks could travel home at the end of day two. So, I think the way that's looked in the past for new members is Tuesday, the day before the Committee meeting starts would be your travel day.

So, you're traveling to D.C. on Tuesday, October 15th. We'd start early on October 16th, go a full day, and then on day two, the 17th, we probably end around 2:00 at the latest, maybe a little before depending on the agenda items you all want to cover. But we think if we wrap up by 2:00 in D.C. everyone can get to the airport

and get onto their flights back home.

Any questions or thoughts? Belinda, anything you want to add about the possible October meeting?

CHAIR PETTIFORD: No. I think that date is -- I put a note in the chat for those of you who are virtual, that if you cannot do October 16th and 17th, if you're going let me know, so we'll at least know how to prepare, but it will be a hybrid meeting, so if you just can't be in Washington, D.C., but you're available that day, that we'll have an option there for you to participate virtually.

And so, the meeting will be in Washington, D.C., again, not here in Rockville, Maryland. So most will likely fly into DCA, the Reagan Airport, and then the Humphrey Building is not too far from the airport because once you get to the airport, it probably will be a way that we can get the vast majority of the people out that day.

MS. LEE: Thank you. And then Hannabah, correct, just to confirm, it's going to be in the D.C. area. The next time we tentatively are thinking of going off-site, or out to an actual community, would be the Spring of 2025, and so Belinda and I again were just kind of conferring. It might be a March meeting again.

We did April of 2024 this year in St. Louis, but the Spring meeting in 2025, if we wanted to capture the group of members that are rolling off in March one more time in person, then we would

want to do a March -- early March meeting. We looked up, it's March 15th, but several of the members roll off.

And that's also the month you all want to submit your recommendations.

CHAIR PETTIFORD: Trying to go to that meeting in Alaska, we'll see what we can do. And thank you to those that have put your notes in the chat, to let us know your availability for October 16th and 17th. We'll be in touch.

MS. LEE: Okay. So, we'll start to think about possibly the March 2025 meeting being off-site, and the last for some of the members that are currently onboard. And then after March we tend to do a summer meeting, like we are now in June, and that tends to be back in Rockville at HRSA headquarters. So, that would be sort of the next year out.

I'm not getting any questions. Okay. So, as we think about the October or Fall meeting, Sarah and the team here at MCHB, along with Belinda, we did want to hear any thoughts on speakers, or topics, presentations or presenters that we could start to explore or support you in obtaining for the October meeting.

I know two speakers that we had to hold off on because they were either not available - I- guess they were just not available. Zea Malawa in San Francisco, she has it's called the Abundant Birth Project. She actually presented to the Committee back

in 2020 on her Racism as a Root Cause Framework, the RRC Framework, but her Abundant Birth Project is to improve economic stability, or security in Black and Native Hawaiian Pacific Islander moms in San Francisco.

And I think she's presented at some of the national conferences. But her project has been up and running now long enough that she has some evaluation results that Belinda thought might be helpful for the Committee to hear as we think about some of those social drivers of health. Is there anything else you wanted to add on to Dr. Malawa?

CHAIR PETTIFORD: Yes. I did get to hear Dr. Malawa's presentation on the AMCHP Conference in April. And it's to work on guaranteed income is the program that they've been working on where individuals who are pregnant, and/or parenting for a certain timeframe after delivery, they have been basically adding to their income to make sure that they get a livable wage.

I can't recall the actual amount, but I think it is based on what their current income is. There's some kind of sliding scale, but they've done some evaluation of the effort. And there are a couple of other states that are doing problems around guaranteed income, so we thought we would have a conversation with Dr. Malawa first, but then I know there are a couple of other sites.

I want to say there's someone in Delaware maybe that's

doing a similar program, just to get more information on how that program is working, so thanks.

MS. LEE: Thank you. And then the other speaker that was of interest, but she couldn't join this meeting was Dr. Veronica Gillispie-Bell. Charlan, I know your group at CDC works closely with her, but she had -- she's on the Louisiana PQC. She's also part of the MMRC I believe. She's an OB/GYN in Louisiana and has worked with some of the rural communities.

She spoke at our broadband access and why it matters to maternal health when HHS did that webinar with the FCC, so she could kind of cover a variety of topics that are current with the Committee right now. And I'm just checking the chat. Okay. Yes, and back to a travel question. Thank you, Belinda.

MCHB, correct, would arrange everyone's travel, and you'll get more instructions about looking into your preferred flights, and things like that, and we would secure the hotel, and work with our logistics contractor on other pieces, but yes, MCHB will do all of your travel arrangements for you as appointed Committee members.

And that's a good question. We may maybe as we get closer to the October meeting do just a short kind of like travel related webinar for you all, especially the new members, just so you're aware of the federal government travel rules and policies, since again, you all are technically special government employees as appointed

members, so you do have to follow our HHS travel rules and policies.

Okay. Thank you. Dr. Marilyn was saying her travel approval is pretty tough in the states, so it has to be months in advance. We could talk with Julisha, currently is our management analyst, who has been helping us coordinate ACIMM travel, so we can talk with her about our internal timelines.

We also have a pretty tough process, Marilyn, as you would imagine, and there's specific dates and things like that as well that we have to meet, so we'll look into that when we can start working with all of you on your travel for October, since you have approval processes back home that you have to work through.

So, back to October agenda items topics, speakers are interested in, especially as you get closer to -- I know, Belinda, you were saying at the October meeting the hope is that they will narrow down every further, if needed, the recommendations in each workgroup.

So thinking of that time you have together in October in person, while working on narrowing down, is there information you need or want, that you wouldn't be getting in your workgroup meetings between now and October. Oh, go ahead, Jacob.

DR. J. WARREN: I wondered about I think it might have been -- my memory is a little fuzzy. It might have been at the very beginning when I rolled on a couple years ago in this group, or maybe

it was a different one. We had a presenter that talked about how to craft policy recommendations, so it wasn't topical, but it was more about you know, the image is burned in my brain, the picture of the chair with the short legs on the backs, it had to go on the steps, and it was about how to craft the recommendations in a way that's actually going to be impactful.

So, I don't know if there is something we can think about in October where it's more about how to craft policy recommendations, than specific topical areas, since we will be right in the throes of that after October.

MS. LEE: Correct. Thank you, Jacob. We were thinking in the room is it the Framework's Institute speaker?

DR. J. WARREN: I think it was, yeah.

MS. LEE: Okay. And for the new members, as you know all of our meetings are recorded, so we can pull back up her slides for you. They are posted on the website if you want to look around. Yeah, what meeting was that? Was that June? Oh yeah, it was a virtual meeting, so it must have been December of 2023.

CHAIR PETTIFORD: I think it was two meetings at that time. Right.

MS. LEE: Because June we were here in the building.

CHAIR PETTIFORD: No. It was virtual, but she joined virtually.

MS. LEE: Sweeney, I think Julia Sweeney, okay. We'll put the slides in the chat, Sarah is going to pull them up, but it was Frameworks Institute, if any of you have heard of that organization, and she did a presentation on framing, and specific language, how it resonates with various groups and their research on that, the words we use. Thank you, Jacob, and then I see Marie.

DR. RAMAS: Yeah, with that same tone I heard several presentations from the Ripple Foundation, which is a group that focuses on more futurist concepts. How do you create policy standards, strategies that are more encompassing, and that have a longer scope in range than what we typically might see.

I wonder if they might be an interesting group to just share in that type of framework of thinking. Often times we get bogged down on very concrete and short-term activities, whereas, you know, if we can craft recommendations that have longevity and sustainability, then it can outlive whatever administrations, or whatever you know, Committee members are available.

So, that might be something that we can consider as well, again, as we're thinking about writing our recommendations, and thinking how our recommendations can outlive those around this table as well. I can share that information on the chat.

MS. LEE: Great, thank you, Marie, that would be really helpful. I saw Kate, Phyllis, and then I'll go back to online. Oh

Kate, okay. Phyllis?

MS. SHARPS: The reason I thought she might be good is because Maryland is a state that has high Black population with high infant mortality rates, but we also have rural, and we also have -- and they just come out with a new state comprehensive plan, so how do you address all of those populations which have very different needs, and she's local.

MS. LEE: Yes. Thank you, and for those who may not have heard before the mic went on, Shelly Choo, the Title V MCH Director for the State of Maryland, yes. We definitely are in touch with her. She also, or Maryland also has one of our state maternal health innovation program grants, and I did notice Prince George's County in Maryland is one of those top counties with the most Black infant deaths due to disparity.

I'm just checking the chat. Marya had chatted in about March of Dimes and the Mom and Baby Network. It's been a while, Marya, since we had March of Dimes present, so we're definitely happy to look into that. I know they just had their summit in June in Chicago. I don't know if any of you all were there, but they might have some good updates after their own summit took place.

DR. ZLATNIK: They just released a birth equity sort of roadmap report, and then I don't know, a couple months ago released an environmental justice report, so they're doing interesting work.

MS. LEE: Yes. Thank you, and they could recap for the group their framework that they're operating under. Marya, yes, environmental justice, racial equity, access to quality healthcare, a lot of the same pillars that this group is looking at. Marilyn, have we ever had anyone on perinatal periods of risk analysis for localities. I know PPOR for those familiar with that.

CHAIR PETTIFORD: I don't think we've had anyone for PPOR because it's been some time. We just have to think who that would be.

MS. LEE: Yeah. If you all have recommendations on how a good speaker would be for PPOR, perinatal periods of risk.

DR. KACICA: Yeah, I can find out because I think it's useful when you're looking at both maternal and infant death and where you can intervene, and it's sort of local, so it gives you know some structure to it.

MS. LEE: Marie. I see your hand.

DR. RAMAS: Yeah. This just came to mind again. I haven't heard too much around trans health when it comes to birthing and deliveries, and I'm just not sure what information is available around trans healthcare, whether it's chest feeding, or access to care, education, on how to best support our trans patients and populations, so I wonder if that would be something of interest, so that we can be more inclusive.

Black, trans, femme, people have the highest death rate of the trans community, both by suicide and by homicide, so I think that would be an interesting aspect from an equity standpoint.

MS. LEE: Thank you. And Jacob mentioned in the chat March of Dimes. Their CEO did do a presentation for the rural workgroup a couple months ago on the maternity care deserts report, and some of their other work.

We have a copy of her slides. I've been looking for Sarah down there, but she did give us a copy of her slides. We didn't post that because the rural work, while open to the public, we don't have to post things, but we can certainly share that with the new members, and others that may not have seen the presentation.

Marie, I noted yours. And then I think when Sarah gets back, we did have a number of parking lot items on our agenda as well, but just thinking back to process for the AI, American Indian, Alaskan Native recommendations, you know, that final in person convening before you all submitted your recommendations.

You really took that time to get community input, hearing from the field any last sort of reactions, comments to the draft recommendation, so just thinking about groups, you may want to either advocate on behalf of the population, or directly from the population ideally.

Thinking about that for the October meeting, that may be

your last chance. I mean you'll have the online meeting in January, but you're kind of finalizing at that point. So, I don't know if you guys remember the September meeting on tribal land is when you got a lot of that final testimony from people with lived experience, the tribal serving organizations, so thinking about those that served Black and African American families, or really are aware of the, you know, the issues and things.

We had talked about like the HBCUs, as sort of the Greek Life.

CHAIR PETTIFORD: We did. We talked about encouraging or asking some of the HBCUs or other minority serving institutions. We talked about the National Pen-Hellenic Council, maybe be getting a representative of the predominantly Black fraternities and sororities that are doing work in some of these areas as well.

And so there may be other people that we want to invite to listen in, but also maybe to give us an overview of the work that they're doing in the communities around the country. So those are both great.

MS. LEE: And I think that by the September travel meeting there was a couple recommendations already drafted enough that you could share with some of your networks, or experts to get direct feedback.

It's always helpful if they have something to react to.

So, if you have thoughts about that for October, getting specific feedback on anything that is drafted at the October meeting, again, particularly from people with lived experience, or lived expertise, that would be helpful. Marie? I don't know if that's your hand from before?

DR. RAMAS: It's a new one. I'm on fire this morning.

MS. LEE: Okay. Sure.

DR. RAMAS: With this being an election year, I wonder how we can amplify the work that we're doing with legislators, and how we can if there are any recommendations on how we can amplify the work, the recommendations that we have to at hand for those who are in office, or in our local settings.

So, I know we all have a very vast network in our circles of influence, but I'd be curious to know if there are other modalities that we can help amplify this, especially for the sensitivity in this particular year.

CHAIR PETTIFORD: So, Marie, this is Belinda. I just want to make sure I'm understanding when you say amplify do you mean encourage them to join the meeting, or to start having conversations with them about recommendations? I just want to understand what your request is.

DR. RAMAS: I understand that my local legislators, they may be aware of this Subcommittee, but they may not know, their staff

may not know the specifics in the recommendations, and the depth that we have provided recommendations to the Secretary in the past.

So, I'm asking, you know, would October be a good opportunity for us to learn what would be the best mechanisms, because we're not lobbyists obviously. What would be the best mechanism to share our work for those who are policy makers and influencers in our states. I hope that's clear.

CHAIR PETTIFORD: No. That is helpful, so basically making sure within our own networks, that policy makers are aware that ACIMM exists, and then the work that we're developing around recommendations for these three specific areas.

DR. RAMAS: Correct.

CHAIR PETTIFORD: Is that correct? Okay. No. But that's a good point, thank you, Marie. And I see Sherri has her hand up here, and then we'll come back to you Charleta and then Kate.

DR. ALDERMAN: Thank you. Someone, when we think about -- start thinking about the community voice, as someone who really has one foot in the community, and one foot in the work is Kimberly Porter. She is -- runs a doula nonprofit in Oregon, and she identifies as an African American woman as well, and she is a champion for doulas, as well as a champion for advocating for how that service can be paid by Medicaid, which under Oregon's Medicaid waiver.

So, I think she might be valuable in insights on infant mental health, on the work that doulas do, and how the struggles and the opportunities for getting it actually paid for. I think she might be very informative.

CHAIR PETTIFORD: Wonderful. You could pass her contact information over that would be great. And then I think Charleta, you have your hand up? I think you're muted, Charleta. You may have just stepped away, oh there you are. Thank you.

DR. GUILLORY: I'm sorry. I may be a little bit off in terms of the recommendation because I noticed that most of the suggestions are more generalized, big picture, but Dr. Rachel Hardeman, who heads the Public Affairs, the public -- it's not Public Affairs, Public Health Institute at the University, I think it's Minnesota.

But she actually did a study in Florida, and I found it very interesting. It was actually on CNN. It was about concordance care within the neonatal intensive care units, and found that really Black physicians caring for Black babies had better outcomes. I'm not sure if, you know, how defined this needs to be, but I found that it was very interesting in terms of the information that was presented.

And she, with her background would be an excellent person, at least to listen to, as we develop, and making sure that the

workforce that we have already talked about yesterday, would really make it, and how it would make a difference in bedside manner and taking care of babies at that level, so Rachel Hardeman, Ph.D., MPH.

CHAIR PETTIFORD: Thank you so much. If you've got her contact information, Charleta, if you would send it this way that would be great.

DR. GUILLORY: I will, thank you.

MS. LEE: And Kate?

DR. MENARD: This is just really a follow-up on what Jacob suggested, and then Marie talked about. They're quite related. It would be wonderful in October if we could kind of workshop with the speaker from Frameworks to take what we've drafted, and turn it into, you know, she was great. I mean she was inspiring in terms of like turning what we write as scientists, or whatever, into language that would be received well, so that would be my thought, to really kind of dig down on it, you know.

MS. LEE: And just to make sure, you said give her something to react to. Is that what you're saying? Okay. Yep. I know we are over our time, apologies. Again, we didn't know we'd have this great new group of six additional members, which therefore adds to the amount of time we need for feedback and input, so I hate to move us on, but I know that workgroups are ready to orient the new members on their progress.

And, as I said in the chat, just keep sending us your ideas, topics, what you need, how we can support you at that October meeting. And I did get a question in the chat about the AI/AN, and recommendations, and was that sort of a standing agenda item. It is.

So good question, and just for the new members, some of the typical standing agenda items we have based on our Chair, is a Healthy Start segment, so that we can either provide program updates, or dig into something related to Healthy Start.

Because as Belinda said, this is the group that would advise us on that federal program, along with others like Title V, MIECHV, the 2030 Healthy People Objectives, and there's always time for Healthy Start.

And then we also always have a standing segment on federal updates, so if there's a particular agency, or optic within HHS, or for the partners with HHS that you want to learn more about, you want to hear what are they doing around maternal infant health, we are happy to work with the Committee on securing those speakers.

Typically MCHB is one of the federal updates, but we don't always have things to share, so we tend to lean on our federal ex-officios to also bring us any updates from their agencies or offices that would be relevant to all of you. So, federal updates, Healthy Start, and a report out on progress being made around American Indian, Alaskan Native recommendations.

And we may start to weave in others. As we showed you, there were several reports before, even the AI/AN that we've analyzed, so there was the COVID-19, but the ones focused on BIPOC populations that came out in 2021, we haven't revisited for a while.

And again, we could provide updates on that, but we do like to spend some time at each meeting sharing with you all what's happening related to the recommendations, so that again, you know these are not just sitting on a shelf. They are actually helping to inform our work.

Lee, was there anything you wanted to add? I know you joined us a little late, but we were just wrapping up Committee operations and updates. Okay. Okay. Thank you all. We'll keep monitoring the chat.

CHAIR PETTIFORD: Thank you. We also know we didn't take the time, but we'll figure out if we have time today, that we do have like a shared place, or shared platform for where all our documents are, so we will try to walk you through how to access that shared platform, especially as we're starting to do our writing, so that everyone will have access to the information. So, we'll look for time on the agenda later for that.

Workgroup Orientation and Overview

CHAIR PETTIFORD: But jumping back to the actual agenda, and right, we're a little behind. We wanted to use this time to

provide some orientation for the three workgroups. And so, I want to make sure that I gave the Co-Chairs of the workgroups time. This is your opportunity to kind of share a little bit about what your workgroup has been doing. You have a pitch to encourage others to join your workgroup.

And since we only have now about 20 minutes, I am going to stop talking, and let you all do that. Anyone volunteer to go first? I'm looking at three Co-Chairs sitting right in front of me, and nobody is looking up. Okay, Kate. Kate looked up first, so I saw her.

DR. MENARD: Actually, I'm going to defer to Jacob, because he's going to do the quick update. We're going to go quick.

DR. J. WARREN: Okay. I'll go fast, you all. I'm from the south, so it's kind of hard to talk fast, but give me a second.

DR. MENARD: The Chairs will do it.

DR. J. WARREN: Okay, so yeah, Kate and I have been working over the past several months to narrow down some on four areas of recommendation in the rural health spaces. So, those four topic areas that we've been working on are rural MCH workforce on rural regionalization of maternal and infant care on rural hospital closures, but also labor and delivery unit closures, kind of zoom in and out of it, because we know that labor and delivery units are some of the first things that are closed.

Sometimes to stabilize a hospital, so hospital stabilization isn't necessarily what we're talking about, it's also labor delivery stabilization. And then also use of telehealth to support MCH in rural areas, things like tele-MFM.

So, we've been narrowing those items down some in the workface base, we're looking really across the provider spectrum, so we're looking at everything from doulas to MFMs, and everything in between.

We've had a lot of conversation about the role of midwives, and the role of FQHCs in expanded care in rural areas, so those are some of the areas we're likely going to be working on recommendations around, and the regionalization space, looking at midwifery led birthing centers, how to use telehealth as a method for regionalization, but then also looking at some of the existing policy and payment practices that impact our ability to even regionalize in rural areas.

So, things like the advantages of maybe unbundling payments now because that's kind of discouraging across system care models. The hospital closure front, we talked about again, labor and delivery specifically, how to look at OB readiness and skills maintenance, and low-volume settings in rural areas, and other ways that we can help support that to prevent closures.

And then also, we've been exploring the concept of the

rural emergency hospital model, which was set up different from critical access hospitals, and is there a way for us to look and making recommendations around some type of designation for hospitals as a critical access labor and delivery unit, or something similar that maybe has some policies supporting that front.

And then telehealth is the one we're still exploring, we haven't got a lot of depth there, but part of what we've talked about is telehealth in the role of remote patient monitoring.

We've had some great speakers, healthcare quality payment reform, CEO of March of Dimes, and one of our colleagues did a really great presentation on the new maternity care deserts, and really receptive to some of our feedback about, it doesn't always necessarily reflect rural areas very well.

An example here in Wyoming we have counties that are the size of states, so if you do it at the county level, it doesn't necessarily represent that, so we've had some talk about how to really represent rural and frontier deserts, because it's very different from urban areas. And then NHI work in some nurse midwifery presentations.

So, come join us. We want all, we love all, but those are the spaces that we're working in, and looking forward to building those into recommendations. Kate, did I miss anything?

DR. MENARD: I think that's great.

CHAIR PETTIFORD: Thank you so much. I see hands are going up. Just keep in mind if you're interested in the rural health work around the rural health systems issue, the workgroup you will want to join is with Jacob and with Kate, so just drop it in the chat, and we'll make sure you are connected to that workgroup.

And so, Marie, I see your hand going up next. Does that mean you're going to present on the social determinants or health, or the social drivers of health workgroup?

MS. RAMAS: Yes. Sure. And then Sherri is my Co-Chair, which we've been working really big, so something with the social determinants is that it's not new, particularly when we talk about Black maternal health, and so Sherri and I have been intentional about trying to find best practices that we can amplify in our recommendations.

We've had some really great speakers and programs that have been highlighted in our group. We've met several times. One of those things is incorporating nutrition support for both high risk patents, and clinical teams through innovations, and so how do we help support our birthing individuals, and the infant dyad doing nutrition?

I had a great speaker from Mother of Fact, which is a group that provides nutrition education via telehealth services in a comprehensive way, and also helps with billing, both inpatient and

outpatient, and we've had some great presentations as well from our own ex officio, Caroline Dunn as it relates to nutrition.

We also looked into reimbursement for RN-led community health work, and Family Connects was highlighted as a program that helps with perinatal home visiting programs, which we know is so important, particularly for our high priority populations.

Another area that we have focused on is, you know, not only how do we have good programs, but how do we create funding models that can be replicated, because then they can be sustainable, and they can be scaled. So another area is funding opportunities through evidence-based practices, and we had a presentation from Embrace Organization, really impactful, and then thankful for Sherri's input as our on-hand pediatrician, and infant advocate.

And kind of looking into the child/parent psychology and psychotherapy, and Sherri, I'd love if you can just share some of the avenues we've been exploring as it relates to the birthing and infant dyad and isolation and psychosocial areas.

DR. ALDERMAN: Yes, this is Sherri from Oregon. Yeah, it's been really a very interesting subgroup, and very much grateful to have had the opportunity, and continue to have the opportunity to work with you, Marie. We have been really kind of stretching the envelope in terms of how social determinants, or social drivers of health are defined.

And as Marie said, we are looking at systems level, we're looking at the dyadic level, and everything that we possibly can in between as well. We are seeing that there are some social drivers of health that are not typically thought of immediately, such as isolation. And isolation, especially during pregnancy and in the perinatal period, which is what we're focusing on, has a tremendous effect on both physical and mental health.

And so, we are really trying to look outside the envelope to see what recommendations that would be evidence based could address that, and be a promotion of healthy, physical and mental development as well as prevention. And we also are keeping in mind trauma-informed approaches.

Our American population sadly, a majority of us, have experienced trauma, and keeping that in mind is beneficial for engaging and providing recommendations that will lift the health and wellbeing of those who have experienced trauma, as well as those who haven't applicable to them.

One thing that we are very excited about is that later this morning we will have Dr. Lieberman, who is a champion in a long-standing history of moving the dial on infant mental health, specifically in the dyadic relationship to disrupt the trans-generational transmission of trauma, and promote the health and wellbeing of infants, and the caregivers for those infants, so we're

excited about that this morning.

DR. RAMAS: Thanks, Sherri. So if you're interested in being a disruptive innovator when it comes to historically comfortable topics, that I would say that comes over again and again, then please do contact us. We are looking into best practices again across the country, how do we leverage technology.

These are some things that we are going to be exploring, thinking about mitigation factors to you know, preventing delayed treatment, onset of treatment and care, and looking at subpopulations mentioned earlier, so patients, birthing individuals who have opioid use disorder for instance, and the disparities across that are just some of the things that we'll be exploring over the next several months. Thanks, Belinda.

CHAIR PETTIFORD: Thank you so much, Marie, and Sherri, so now you have a choice to make. Already. So, now you get another choice. So, now we're going to hear from Phyllis or Joy, Phyllis, around the preconception, interconception workgroup.

MS. SHARPS: Yes, I am Phyllis Sharps, and Joy is on the screen, I believe. We are the Co-Chairs of the preconception, interconception care. I would say our discussion has been very broad. We're casting our net very wide, to kind of look at all of, you know, really be acquainted with what it is, and what we could do differently.

We started off our discussion with Sarah Verbiest, whose- done quite a bit of work in reproductive and sexual health, both looking at the history at what's been done at federal level, and our proposed framework for reproductive wellbeing. We've also hoping, wanting to enlarge the population, so we -look we heard from PRAMS for dad.

We heard from Black Health Equity Initiative from Planned Parenthood Federation of America. We had a presentation for maternal and fetal medicine perspectives, and Upstream, which you've heard yesterday. They came to our workgroup also. We have discussed a variety of topics in terms of messaging, and lack of information, and access to care.

Issues around reproductive health priorities, hesitancy to provide care, particularly in the context of where we are now with states' rights, and the dismantling of Roe vs. Wade. We have talked about can we be broader, and looked at a frame of reproductive health and wellbeing, rather than just zoning in on contraceptive methods.

We looked at federal restrictions that may impact the way we deliver reproductive healthcare and information. We've discussed the Medicaid expansion, and how that can be used to ensure well women's visits, particularly after the delivery. We've looked at other populations, such as women with chronic conditions that are now reaching, and that may have the ability to have -- to be a birthing

person, so what are their needs around preconception and interconception care.

Teen and young adult populations, we looked at gender, and sexually diverse populations, and also male partners. We've discussed the political and social determinants of health that may impact access and quality of preconception and interconception care.

We also reviewed previous recommendations from this Committee, and as a result from the April meeting in St. Louis, we heard many suggestions, and again, to address some of the misinformation, and lack of knowledge about methods and fertility management and outcomes of such procedures.

Access to information, particularly in terms of broadband access, computer and other digital devices, and we've also suggested that we consider what would be the metrics for measuring outcomes of preconception and interconception care. More than just carrying the number of prescriptions, or than the number of methods, what would be some of the quality indicators on patient satisfaction indicators.

Surveillance systems, such as PRAMS and other existing databases, what should be in there that would capture what we're doing in the space of preconception and interconception care. And then of course, messaging that's culturally appropriate, that recognizes different levels of literacy, that can talk about without offending beliefs and values related to intendedness, birth spacing,

and other use of methods.

So, if you want to do something bold and exciting, come join us.

CHAIR PETTIFORD: Thank you, and I think Joy is on, so Joy, anything you want to add to Phyllis's?

DR. NEYHART: Good morning. I don't have a whole lot to add. Thank you, Phyllis, for being the most amazing lead. We look at when we were looking at, especially preconception, a big issue of course is, the overreaching lack of infrastructure for the social determinants of health, and so if we back up, if we really want to have lasting recommendations, we have to back outside of the smaller programs, and make recommendations on infrastructure.

One of the things that I'm most interested in is how Medicaid expansion has improved the health of women who are able to access it 12 months postpartum, because if we can dial in on those statistics, we can maybe make that part of a recommendation to make it a nationwide thing, rather than a state decided thing, but with evidence, so we're not sort of you know, treading on state's rights.

But otherwise, we've got a lot of work to do, so come join us. Thanks.

CHAIR PETTIFORD: Thank you, Joy. Thanks, Phyllis and Joy, and thanks to all of the workgroup leads. We have some great decisions to make, and for today you only need to pick one, so please

reach out to the workgroup leads, and question in the chat. I'm trying to pull it up.

How do we form the workgroups? This was many meetings ago. I want to say June of last year, a year ago. A year ago when we were meeting here, and we started kind of prioritizing the areas of focus that we thought could see positive movement, and improving black, African American, maternal and infant health, these are the areas that rose to the top.

So, it was a discussion with the workgroup. We had several presentations around it. We've had, you know, good conversation, and a good model as we were looking at the American Indian/Native American process, and how we went through that to make sure we were elevating a specific community, or a specific population, and then also looking at the data.

So, that's where it came from, Hannabah. Hopefully that answered your question. And I see Kate has a question here in the room.

DR. MENARD: Belinda, not so much a question, it's just taking it back, I mean a comment on taking it back just a step further.

CHAIR PETTIFORD: Sure.

DR. MENARD: For the new members. I was a new member when we were finishing up the work on the previous recommendations, and

you know, my mind I was in awe of all the hard work that had been done, and learned so much from that group.

And then when that was completed, we needed to really kind of Belinda came onboard as our new Chair, and led a conversation with our group about well, what next. You know, what's the next big thing. And the data really, as you said, drove the importance of focusing on the black, African American population, and health outcomes.

And from there it went on with the discussion. So, I just kind of wanted to give that context on how we landed on this, and where we are. And, also, I'm struggling admittedly a little bit since I'm the Rural Workgroup Committee Co-Chair, with the reality that a lot of the indigenous people live in rural areas, how does this fit together.

And I lean back on the reality that we're really moving all those recommendations forward as best we can, and still paying attention to that as we consider our rural work, but really kind of focusing on the Black and African American population, the difference we can make there, so that's the context.

CHAIR PETTIFORD: Thank you for that addition, Kate. And I do agree that, you know, a lot of this is really around we follow the data, and what is happening next. But as other recommendations come forward, we don't forget our previous recommendations.

And I think someone asked the question early around what are some standing items on our agenda, and one of the items that we make sure we keep on our agenda, is any updates on the recommendations that move forward around Native American and Alaskan Natives.

So, we wanted to keep that, and we are, you know hopeful that the next iteration of the workgroup we're going to keep up with recommendations that this workgroup comes, move forward to the Secretary, and what work is continuing to be moved forward on those things.

So, any questions before we switch into our speaker mode for today? No questions. Great questions. Comment in the chat? Again if you're one of our new members, we need to pick a workgroup, at least one for today. Okay.

Emerging Issue: Maternal Mental Health

CHAIR PETTIFORD: So, now I'm going to move on our agenda over to Emerging Issue. We have a couple of emerging issues today, but our first emerging issue that we wanted to focus on was the issue of maternal mental health. We're very fortunate to have with us today two speakers that can give us an update, and share some of the work they're doing in this arena.

First, we have Nima Sheth with us. Nima is the Associate Administrator for Women's Services within the Substance Abuse and

Mental Health Services Administration, otherwise known as SAMHSA. So, I am passing it over to Nima, and I see you there. Thank you, Nima.

DR. SHETH: Thanks. I'm also joined by my colleague, Dr. Dorthy Fink, who is going to start I believe. Dorothy are you on?

DR. FINK: Yes, I am.

DR. SHETH: Awesome. So, we will start with Dorothy and then move on to the strategy.

DR. FINK: Great. Good morning everyone. Thank you for this opportunity. We're going to talk today about both the report to Congress and the national strategy, which were recently released by the Department, through the Task Force on Maternal Mental Health.

And so, if you could go to the next slide, please. Sure. Okay, great. So, we're very grateful. Many of you here at the table and on the line have been part of this work for the Taskforce on Maternal Mental Health, and through both federal members, and non-federal members, it was really an incredible year how people came together to ensure that we could announce both the report to Congress, and the national strategy last month.

And so, I want to just take a step back. When we think about all the incredible initiatives, the administration and the Secretary's real support for our work in maternal health, really from all aspects, and you know, when we look at how we've aligned our

national strategy and our report to Congress, we just show here a number of the initiatives that are going on across the Department.

And just an example from that maternal and infant health perspective that we have worked together with, and that we build upon with the documents that were just released last month, both the report to Congress and the National Strategy. Next slide please.

So, here you can see for the report to Congress, there were a number of aspects that we covered, and really the way this work was implemented was through the SAMHSA FACA, the Advisory Committee for Women's Services. And their findings on maternal mental health conditions and substance use disorders in the U.S. are related to federal programs and best practices.

The report to Congress itself describes current data on the prevalence of maternal mental health conditions and substance use disorders, as well as pregnancy related death and disparities. It also highlights best practices through evidence-based, evidence-informed and promising. Next slide please.

Other highlights for the report to Congress include federal programs, services, current coordination with focus on gaps and opportunities for improved collaboration. The overarching themes for the listening sessions that we had that informed the report to Congress and national strategy really emphasized opportunities for both state and local partnerships.

The reports also cover the state of national policies and programs related to maternal mental health and substance use disorder. Next slide. So, I wanted to just give an example. You know, we talk so much about, you know, the overall report, but kind of diving into one of the examples that really shows a great collaboration between OASH and HRSA is our talking postpartum depression campaign, which we launched last year when this maternal mental task force first came out.

And, you know, this is a campaign that's really looking to empower women to seek help for PPD by destigmatizing PPD for increased awareness to symptoms, visibility of reliable sources, and understanding of ways to access care. And so, here you can see the primary target population, and really looking and reaching populations who are most at risk for developing PPD and utilizing a lived experience of diverse women across the country.

And then you can see as well our secondary audiences, which really looked at the spectrum of anyone who comes in contact during pregnancy and postpartum. Next slide. And so this just goes into a little bit more about the campaign, and you know, we can access this through the tool kit.

We have a number of resources with English and Spanish that can be printed, and really the call to action around this is to reach out to the National Maternal Mental Health Hotline led through

HRSA.

And so, we were so grateful to have both of these projects come out at a similar time, and that you know when you have an awareness campaign you want to be able to say not just here's your awareness, but where can you go, and so we are so grateful to our HRSA colleagues to have this incredible resource, and we want to do everything we can to make sure the message gets out.

And so, the HRSA hotline is on all of the materials. And then the next slide, you can see a little bit more. I hope this video will work, and it is one of the examples from this campaign. There's a number of lived experiences that we highlight, and I'll hope that it works here, let's see, okay great.

I'll just say really we had really an emphasis on the lived experience through the entire planning for this campaign, and really the campaign was able to identify some incredible stories to highlight, and what was need about it was the audience sent in patient research that went into it to really be able to say, you know, what are some of the different segments that people will fly into once they answer questions about how they think about PPD, and how they feel comfortable seeking help.

(Video Playing.)

DR. FINK: So, this is just a short little clip, but we just wanted to show you all a quick example, but we'd love to go

through all of them, but I also appreciate the time that we have today, but please go check them out. That was just a quick highlight of a group discussion with a number of the people who have come together to share their lived experience, but there are videos for each of the people featured that were shown there.

And it's great there are the longer five-minute clips, and then quick 30 second clips to just really draw people in, meet people where they are, and I'm happy to share more about the audience segmentation research that it went into figuring out, you know, how do people approach postpartum depression, and how are ways that real people actually seek help, and there are a number of different approaches that we really try to highlight in the different people highlighted.

So, please check that out. Next slide please. And so just to wrap up, in terms of what's coming next. So, the campaign was released last fall, and now, you know, we've heard a lot of great feedback from many of you saying well, you know, of course postpartum depression is one aspect of maternal mental health.

There are many other areas which we are of course addressing through the report to Congress and the national strategy, but we want to share with you all that there's going to be a number of pilot projects that are going to be ensuing as part of this campaign, and really, we're going to be thinking about different

pilot sites to assess behavior change among women, who are at risk for PPD who use these campaign materials.

And then we're going to also look at a cohort of healthcare providers to assess knowledge and referral behaviors, looking at other focus training for the whole array of maternal mental health conditions. And so, really encourage you all to share that. We want to do everything that we can to get information out there, and get as much awareness as possible for the hotline, and all the incredible work that HRSA has led through that.

And so, that's an example of what's in the report to Congress. So many incredible things are within the report to Congress, and then I'm now going to turn it over to Dr. Sheth to go through the national strategy, which really is bringing everyone together on both federal and non-federal partners to look at what is the vision in the next month and years, so Dr. Sheth.

DR. SHETH: Thanks, Dr. Fink. It's so exciting to hear about all of these ongoing efforts that really are, you know, taking this strategy forward and building. I mean pre-existing to the strategy, but are building on continuing to build on the strategy.

And as Dorothy showed that, you know, the strategy builds on a number of initiatives that had already been going on, and just demonstrates the administration's commitment to this particular issue.

So, I'm going to cover the strategies best I can in the time that we have, and then I will also cover a couple of initiatives that are building on the strategies that are coming out of SAMHSA, and a couple other places, so next slide.

So, the vision of the strategy really was to make sure that we are -- there's a large focus on integration, and making sure that we're no longer -- we're trying to get to a point where mental health is health, right, and there's no distinction, and that there's really integration of mental health and substance abuse services in the perinatal populations across the board, everywhere you go, whether that's emergency rooms, pediatrics, you know, OB/GYN, et cetera, and then there's also support in the community. Next slide.

The audience is the federal government, but it's also the federal government's partners, right, and so within federal government there's a lot of things that specifically speak to Congress, but also to federal agencies, and then also to public private entities, industry advocates.

Because that work really can't be done without those partners, and the nice thing about this task force is that it's under a federal advisory committee, so it can -- it's not really a U.S. government document, and so it can be a little bit more flexible, and bold in what it's saying.

It's not, you know, and it really truly has a voice of

those outside of government, as well as those inside government. Almost half of the folks on the task force are folks that are outside of government in these different categories of industry, advocacy, professional societies, individuals with lived experience like Dr. Fink said.

We really prioritize that and the community. Next slide. So, this image kind of summarizes all of the pillars and the strategy as a whole. So at the top we have a whole person in dyad, perinatal mental health and post care.

And I will say that the Congressional language points out dyadic care and multigenerational care, but our task force really took it a step further to make sure that that was pointed out, was integrated throughout all of the different pillars and the recommendations.

So, I won't read through these because we're going to go through them, but the cross-cutting principles are important on the outside here, so equity and access, federal collaboration. The Congressional language really calls out a call to action for more federal coordination and collaboration.

So, that had already been happening, of course, to a large extent, but we want to strength that strategy. Then trauma informed approaches, and then relevant support. Next slide. So, pillar one is to build the national infrastructure that prioritizes perinatal

mental health and wellbeing.

So, this first -- so each pillar has several priorities. Each priority has several recommendations, and then each recommendation has a why section that gives the rationale for choosing that particular recommendation out of all of the things that we could have chosen, because of course we can't cover everything in the recommendations.

But, and then it also has a how, and then the how section starts to lay a little bit of a roadmap of how to get to that particular recommendation, so it is important because it outlines a lot of what the existing models that can be scaled, a lot of best practices that we need to replicate, or some ideas as to how to get to that particular recommendation.

So, that's how the strategy is organized if you haven't seen it already. And so here I'll just cover the priorities for the same of time, and then try to talk a little bit about what kind of recommendations are in each of these priorities. So, in 1.1 we have recommendations that are primarily focused on integration.

So, the first one calls for like I said, universal integration across the board wherever possible, everything from screening to treatment. And it also calls for six months of paid family leave, and universal childcare across the board, and then embedding childcare within healthcare facilities.

So, it's really looking at infrastructure type changes that we need to make. I really appreciate all the hearts and the clapping, so thank you. And then the priority 1.2 focuses on reducing disparity, so it has a number of other recommendations, also calls for recognizing historical racism, and structural trauma, and a lot of those different factors around the cause of disparities and how to address those.

Also, there's a call to expand the task force past 2027, or keep the task force going on past 2027 through turning it into a coordinating committee. Next slide. So, pillar 2 is all about accessibility, affordability, and then equitable services. So, across the priorities we see, so the first one focuses on screening and diagnosis, and linkages, so it's about creating safe spaces to screen and education and talk through different issues.

And wherever possible we included gender based violence, social determinants of health and trauma, because it's not always inherent in thinking about perinatal services, so we really tried to call those out separately to make sure that people are integrating those as much as possible.

And so, under 2.1 we talk a little bit about how to incorporate screening, and how to make sure screening is reimbursed, and financed appropriately. And then 2.2 is you know, talking about innovating care models, so for example, increased flexible scheduling

for patients, home based care, increased telehealth infrastructure is a lot of what is in priority 2.2.

And also making sure that, you know, that the affordability and reimbursability piece so that, like Medicaid reimbursement is expanded and increased, and that we look at commercial insurance as well as Medicaid.

So we do call upon government to provide more incentives to work with commercial insurance, to that increased reimbursement. And then also increasing reimbursement and coverage for non-clinical workforce, like community health workers, doulas, peer support workers, and integrating them here across the board.

And then 2.3 is really talking about our workforce, so it's all about workforce, so it's saying we want to build our capacity. We want to increase the number of people in our workforce. We want to increase their expertise as well, so it talks about the technical assistance that we provide within government, making sure that we're utilizing the right curricula.

It also talks about how we want to be involved with training curricula from the onset, to make sure this topic is involved, is integrated in the training for all the relevant professionals across the board, not just physicians, but you know, all allied health fields essentially, and that it calls for expanding workforce programs, like existing workforce programs, increasing

their funding, and more of those individuals in the workforce.

And that the clinical and non-clinical workforce, so we continue to say that throughout. Next slide. So, pillar 3 is all about data and research and accountability, so it's a really impressive pillar, so on priority 3.1 there's a lot of things that are mentioned here as well, five recommendations.

And the first one starts out with outlining the national research agenda, it has really impressive topics to look at, so I would suggest looking through that how section, and it talks about kind of creating a committee to then oversee that research agenda.

There's also a couple recommendations around data linkages, and accessibility of data, making sure there's a centralized clearing house that has accessible data. It also calls for the increased participation of perinatal populations in research. It's consistent with the U.S. Preventative Services Task Force Recommendations.

And you know, ensuring that we are looking at past abuses that have been done, and research, making sure those are not replicated in any way, that we are kind of holding ourselves to the highest ethical regard. It's also recognizing what different groups with higher risk factors and under resources communities have gone through with research in the past.

And unfortunately, honestly it still happens. So that is

called out and recognized, even though at the same time as calling for more participation, research in a very respectful way. And then accountability focused on improving, continues quality improvement, but also the PQCs in each state, and the MMRCs in each state and territory. Next slide.

So, pillar 4 is around more on primary prevention, promotion and primary prevention at the community level, and then education and engagement with communities. So in 4.1 we talk about primary prevention strategies, like centering pregnancy, through a rose program or PRAT, or even taking models like the hair model that came out of the University of Maryland, or like friendship benches for example, to then replicate and adapt in this particular space for perinatal mental health and substance use.

And then better ways to have community level detection that doesn't rise to the level of needing to go to the office or clinical space, or where everything is necessarily pathologized. And then, 4.2 talks about kind of like the national campaign that could be started, ways in which government could really engage communities, and specific strategies that have worked in the past that we can scale up. Next slide.

So, pillar 5 is about lived experience. So, as Dr. Fink was saying, we had a lot of focus on lived experience. We had a lot of focused on the task force that have lived experience, and then we

also had colleagues within the USDS that did a research sprint with those with lived experience as well as providers.

And it was just phenomenal. They created this report that discussed kind of all the perspectives and voices of those with lived experience. The specific quotes are actually integrated throughout the report to Congress and the national strategy, and then there's in priority 5.1 all of the particular recommendations that came out of those interviews lined up.

And then in 5.2 we also line them up with the recommendations that came through in the task force. So, it wasn't planned that way, but everything that they suggested actually overlapped with what the task force suggested. And we did of course ask the task force to integrate that report, but because everything was done so quickly, there wasn't even necessarily that much time for iterative review of other documents.

And so, these pretty much naturally lined up, which was really nice to see that those with lived experience had the same recommendations as those on the task force. And moving forward, we're going to continue to do more work on that, in the implementation space. Next slide.

So, next steps is implementation planning, so we are creating a tracker similar to the maternal health blueprint tracker that will track each recommendation. We're in a process right now of

meeting with each agency to talk through which recommendations they could primarily contribute to, but we also have a lot of non-federal folks that we'll be meeting with, and talking through recommendations with.

And then most likely we'll still have sub-groups that have Co-Chairs, and workgroups that will take on overseeing the implementation of the entire strategies. We're really excited about that. And then there's going to be a report to governors as well.

We're not sure of the exact timeline, that's not Congressionally mandated, it just has to be there, and we really want that to look like a hopefully somewhat of an implementation of plan of a strategy at a state level, and making sure we incorporate things at the state level that may not have been incorporated.

Although through the strategy, I should say, there's always a role for states, and we've spoken directly to states when possible, and especially talked about the rule of partnering with states, and collaborating with states, and providing support for states. So that is specifically called out in the strategy, so we want to build on those pieces in the governor's report.

And then there should be annual updates to the national strategy and the report to Congress. And I believe that might be the last slide. Is there another slide? Is there? Okay, thank you. Yeah, and I'll just say quickly, so two programs I just want to cover

that just came out like hot off the press, like they're just listed as the women's behavior health technical assistance center.

So, this is a national consultation based center that's going to help providers of all different backgrounds and health professions to serve women's behavioral health needs better, so mental health and substance us.

And it's going to be consultation style, so they have a clinical case consultation system that they'll set up. They will have learning communities, they'll have online learning modules that will be focused on active learning strategies, and focus on prioritizing adult learning, and then the different topics they're going to cover.

One of the primary areas will be perinatal mental health and substance abuse, but also menopause, puberty and comorbid medical illness with mental health, so women that might have lots of women's related medical conditions, as well as mental health and substance use conditions, and then equity related issues, and making sure that they're looking at the needs of groups that have higher risk of mental health and substance use disorders.

And then the second program is a maternal community-based services program, so it is essentially a linkages program that is going to follow mothers in the perinatal period that get referred for mental health or substance use conditions, and follow them for a year

postpartum to make sure that they get into care, that there's no gaps in care.

So, they will go into the hospital, see these women, do a warm hand off with a consultation to the primary team. Immediately have prescribers and therapists as part of their team to provide treatment right away, and then immediately refer to a longer, kind of more sustainable treatment program.

And then have social services through case management as well as the same time, so there should be no kind of drops in care as we know that postpartum, 30 days, is like when people, you know, end up getting dropped. And so these grants will follow these women for a year and make sure that they're getting good care, that they're happy with their treatment, that they're improving.

So, that is a pilot program. It's six grants, each at $500,000.00 per year for five years, so that just came out if anyone wants I'll send the links over, but we're very excited about those things. We're definitely building on the work of the strategy. So, I'll pause there, and turn it back to you.

CHAIR PETTIFORD: No. Thank you so much, Nima and Dorothy, for your presentations. We appreciate it. We will take a moment to see if we have maybe one or two questions. Yes, Sherri?

DR. ALDERMAN: I'd like to commend you for your work, and your effectiveness, and your focus on promotion and prevention using

a dyadic approach, that's very commendable. My question is how you define dyadic. And the reason I ask that question is because I have heard from very accomplished people in medicine who are beginning to embrace an infant mental health approach, and are defining dyadic work as doing maternal screening because as we all know, that very much impacts the baby.

Without considering the baby, and when we are identifying perinatal depression, or prenatal depression, and addressing that, a kind of unspoken assumption that the baby automatically gets fixed.

And what we set up is an opportunity to really rebuild that dyadic relationship, and cut through what may be in the case of the caregiver, feelings of guilt, and then the energy with treatment to be able to cut through that, and begin to intentionally engage with their baby.

And the baby already impacted by the relationship that involved depression are not responding, and we could have further unintended consequences, adverse consequences, impacting that dyadic relationship, which calls for highly experienced, high expertise on how to truly look at the dyadic relationship.

So, I'm curious how we are defining dyadic work in the work that you lead. Thank you.

DR. SHETH: Actually that's a great question, and I think, and Dorothy please jump in here too because I think, you know, dyadic

in this context, there isn't a form, there kind of a definitions text box, but we did not define dyadic like, you know, formally here, but the way that it's been referred to, and the way that it's been kind of envisioned, and the strategy is that it does very much involve the parent, the mother and the baby.

And so, ideally that service is for both, and intervention is for both, would be able to be done at the same time, would be billable at the same time, and would be effective. And so, but also if you think about it really it's mom, baby and then their relationship, right, which is I think what you're saying.

So, sometimes to improve the relationship between the two, or the intervention, the kind of the care sometimes requires yet kind of a separate intervention, right, or a separate even provider, and so for example, you might have a prescriber that's helping mom. You might have a pediatrician that's helping baby, in the case of substance use.

But you may need a therapist to really help the dyad, in relation to the actual dyad, right, because as its own entity. So, that's the way we've looked at it. And we actually have one recommendation I forgot to mention. It's about non-punitive, and non, kind of harmful screening and treatment practices around stigmatizing, you know, issues within perinatal mental health specialty substance use.

We call out substance use and suicide screening in particular, but even for mental health. So we really call out these non-commutive approaches, and that one in particular really focuses on more the dyad as well. So, I hope that that's helpful, but that's the goal here, we really want to build that out.

In this iteration we were only able to have a scope of a perinatal period, which is you know, pregnancy and one year after, but we want to build on that to think about zero to three. And really also think about multigenerational.

So, if it's not just mom, that's a primary caretaker or parent, and we've kind of touched on adoptive parents, and things like that, but we want to expand on that too, but whoever is the primary caretaker.

Whoever else is primarily involved with the infant should also be able to get that care, right, so that's why we've also said kind of multigenerational and family care. I hope that helps answer.

DR. FINK: That's great, and then I'll just add in to, you know, I think when we are looking at this, you know, we're keeping on top of the literature, and thinking about the latest that has come out, looking at, you know, perinatal mental health and screentime for the child, or just you know, so many different aspects of things you don't think about, but you know if the mom is, you know, trying to figure things out, find a provider, get treated for the postpartum

depression, or whatever have you in that postpartum time period, you know, what's happening.

Where is the -- what is being given to the baby? And if we have the default of screens, what does that mean then, are we even thinking about it, or maybe someone doesn't have full blown, you know, overt postpartum depression, or there's just, you know, in that in between phase of oh my gosh, I'm overwhelmed, here's the screen.

You know, how are we thinking about those things across the whole spectrum, and so it's a great point. And like Nima said, as we build things out and truly bring in the zero to three time range, we'll be considering that as well, so thank you.

CHAIR PETTIFORD: Thank you, both. Marilyn, I hate to ask you to do this, but can you drop your question in the chat because our next presenter is already here, and on a timeframe?

DR. KACICA: Sure.

CHAIR PETTIFORD: Specific timeframe, thanks so much, and we'll make sure that question gets to you, but thanks again, Dorothy and Nima, we appreciate your time. We will get a copy of the report. I don't think we have actually seen the report, but we will get a copy of the report to make sure that the Committee has it, but thanks.

Okay. And now I'm going to, and I'm sorry, you will not get your break, but if you need to take your own personal break just

do it, and come back quickly. But I'm going to turn it over to Sherri, because she's going to actually introduce our next presenter, and moderate this session.

Emerging Issue: Infant Mental Health

DR. ALDERMAN: Thank you, Belinda. I have the distinct pleasure of introducing everyone to Dr. Alicia Liberman. Alicia, and she has given us her permission to refer to it as Alicia, good morning, Alicia. This is early for you on the west coast, and I will start with reading your very brief bio relative to all of the expertise and experience that you bring to us today.

So, Alicia Lieberman is a Ph.D. psychologist, at the Irving B. Harris Endowment Chair in Infant Mental Health. She's a Professor at the University of California San Francisco Department of Psychiatry and Behavioral Sciences, and Director of the UCSF Child Trauma Research Program.

She directs the Early Trauma Treatment Network, a Center of SAMHSA National Child Traumatic Stress Network, funded since 2001, with a mission to increase access and raise the standard of care for trauma exposed young children and their families across the United States.

She is the Senior Developer of the Child Parent Psychotherapy, an evidence-based treatment for traumatized children ages birth to five, with an international reach in Australia, Hong

Kong, Israel and Europe, and nationally disseminated in 40 plus states through 2,000 plus rostered clinicians, and 100 plus CPP trainers.

Child parent psychotherapy has been successfully extended to the perinatal period as the perinatal child/parent psychotherapy. Her research involves treatment, outcome studies in pregnancy and with traumatized young children from low income and under representative minority groups.

She's the author of the Emotional Life of the Toddler, described as groundbreaking, and now in its Second Edition to mark its 25th year in continuous print. She is also the author of numerous professional books and articles on pregnancy and early child mental health.

Born in Paraguay, she received her professional training in Israel, and the United States. Her cross-cultural experience as a Jewish Latina informs her commitment to increasing access and raising the standard of care for low income and minority children and families.

She is a Board Member Emeritus of the Zero to Three Board of Directors, and a Board Member and past Board Chair for the Irving Harris Foundation.

She's the recipient of numerous awards, including the 2023 Holly Smith Award, UCSF Award for exceptional university service,

2020 Zero to Three Lifetime Achievement Award, and 2016 Renee Spitz Award for Lifetime Achievement with the World Association of Infant Mental Health, and 2016 Hero Award for the San Francisco Department of Public Health.

So, Alicia, on behalf of the Committee, and our public attendees, welcome to our meeting, and I will hand it off to you, thanks for being here.

DR. LIEBERMAN: Thank you so much for giving me this opportunity. It is a great honor to address this Committee. And I'm just delighted also to be following in my Nima Sheth, because so much of what we hear we learn from the work that we have done as part of the National Child Traumatic Stress Network, which funded us since 2001 to really spread perinatal to generation, multigenerational, implemental health work.

I am very grateful to be addressing you at a time where the United States is in the really extremely sad position of being the industrialized nation with the highest incidence of maternal mortality. World standing, that holds a close racial and ethnic groups, but is particularly egregious for its disproportionate impact on Black birthing people and their babies.

The need for reparative action, as you know so well, is urgent, and babies, birthing parents and their families cannot wait. I thank you for your important function in crafting and giving

momentum to the actions that we need to take as individuals and as a nation.

Let's see. You cannot start screening while the other participant is sharing it says. So what does that mean then?

MS. MEYERHOLZ: You should be able to share now.

DR. LIEBERMAN: Okay. So, let me see. I should be able to share now. Do you see me?

MS. KELLY: I can also share your slides, and you can just say next slide if that's easier.

DR. LIEBERMAN: Would you mind? Okay. Thank you so much. I'm glad that we had a backup plan in case this happened. Thank you. So, to definite infant mental health, and Nima spoke about it, the dyadic definition of mental health, which I will confirm.

I like to think of infant mental health as the baby growing well, and learning well. And that means engaging with the parents and caregivers in ways that promote the baby's trust and relationships, pleasure in social interactions, and interest in learning about the world.

These trends give the baby resilience to cope with the process of everyday life by turning to the people they love, to manage pain, and to recover from frustration and stress. These are the universal principles of infant mental health. Although, cultures differ in the specifics of how these principles are expressed and

pursued.

Across countries however, babies are completely dependent on the adults in their lives to survive and thrive, and for that reason their emotional health is intertwined with their caregiver's ability to protect and respond to their signals of need. A longitudinal study at the University of Minnesota, by two pioneering researchers, Alan Ruff and Byron Eklund followed low income mothers and babies for 40 years.

Now, starting with the grandchildren of the original mothers. And they provided scientific data that has been replicated in other studies since then showing that when mothers respond to their baby's signals of need in the first six months of life, the baby's show more secure attachment at age 1, with secure attachment defined as the baby's ability to rely on the parents for protection and emotional regulation, and emotional safety, particularly in situations of stress.

Secure attachment in turn predicted many other measures of healthy development in later years. Toddlers who were securely attached were more engaged in problem solving, and were able to use a researcher better when they could not solve the problem themselves.

In the preschool years they had better cognitive functioning, better relationships with peers and teachers, more self confident exploration, more emotional regulation, and fewer

behavioral problems. This study, and other studies I followed also showed that secure attachment tends to be transmitted from generation to generation.

When they became parents the children who were securely attached were more likely to have securely attached children, although this depended a lot on their social circumstances as well, and this will tell us, that like we have said, there is no such thing as a baby. There is no such thing as a parent. There is only a baby and a parent in the context of society.

The strengths, the sources for support that society provides. And in the study conversely, parents who were anxiously attached to babies were more likely to have anxiously attached babies. And within this group there was also, and the reason this is so relevant for infant mortality, is that there was a sub-group of babies who were abused.

And this sub-sample had mothers that were particularly harsh and punitive, and where the babies were anxiously attached. Now, among the mothers who treated their babies, 70 percent had been themselves abused as children. And the 30 percent of mothers who broke the cycle of abuse, had access to at least one of these following factors:

A supportive adult, other than the caregivers while they were growing up; a current partner who was supportive of the

pregnancy and the baby, which means that we cannot forget the daddies, the fathers, in thinking about infant mental health, or they have been in therapy for at least six months at some point in their lives.

And in addition, they had thought deeply about what had happened to them, about their abuse. They had integrated that experience into their sense of self, and they had developed a condition that they wanted to raise their children differently.

And these are all factors that we have incorporated, the field has incorporated, we at my program have incorporated into the treatments that we have developed. Next slide please. Thank you. We can think of infant mental health as actually beginning in the womb because a mother's physiology and emotions have a profound influence on the developing fetus.

This is called fetal programming, and fetal brain development responds to the conditions of the intrauterine environment, the birthing parent’s daily nutrition, exercise, stress levels and emotional life.

A recent research review found that maternal adversity before the baby's conception, before the baby's conception, and maternal stress during pregnancy made separate and independent contributions to RSA, which stands for respiratory sinus arrhythmia, which is a biological marker of infant self regulation that amazingly

is associated with physical health and psychiatric outcomes into adulthood.

So, what's happening to the fetus really matters across the lifetime. Next slide please. And we cannot overlook the roles of poverty and racism as environmental stressors that are powerful social determinants of health, social drivers of health, and affect people and infant physiology.

Poverty and racism are chronic, including an also heightened individual risk factors, including unwanted pregnancy and intimate partner violence, or IPV. A recent survey of calls to a national domestic violence hotline showed a sharp increase in reports of sexual coercion, and active partner interference with birth control and abortion since Roe vs. Wade was eliminated.

These risk factors increase the birthing parent’s risk for traumatic stress and depression, which often co-occur, even though we tend to only screen for depression. I am a big advocate for screening for PTSD as well because depression and PTSD often co-occur, and decrease the birthing parent’s ability to form an emotional connection with their baby in the womb.

In a study of Healthy Families America Home Visiting Program with first-time pregnant people, 30 percent had clinical depression, but 70 percent reported at least one episode of violent trauma, with an overlap of the two conditions predicting less

emotional connection with the fetus, and higher risk of child abuse after the baby was born.

Trauma and depression also contribute to substance abuse, as Nima said, which harms fetal development, and is a major contributor to infant abuse and neglect, and to foster placement right after birth. Next slide please.

Babies bring their own contributions to the parent/child relationship. The areas of the brain that register danger and safety signals are nearly mature at birth. And infants show fear in response to stimuli associated with danger throughout our evolution as a species, and these are for example, being alone, unfamiliar people, darkness, loud noises and looming objects.

Three core existential fears that stay with us through our lifetimes start in the first 18 months of life, the fear of being left, the fear of not being loved, and the fear of being hurt. When young children trust their parents, these fears are tolerable because they are followed by repair of the blow up of the conflict, and the baby is reassured, the alienation, the fear, the anger don't last forever.

When children are anxiously attached on the other hand, these fears are intensified, because the parents’ punitive or dismissive attitudes confirm and reinforce the children's worries that they will be left, that they're unlovable, that they will be

hurt.

Effective infant mental health treatments need to target both parental behaviors that exacerbate the normal fears, and the infants and the child's responses to fear and focus, as Nima said in the parent, in the baby, and in their relationship to prevent the baby internalizing chronic anxiety, traumatic stress, and other emotional disorders and repeating the parents' own conditions. Next slide please.

We all hear attributions to each other, which are subjective perceptions, when we attribute personality traits that are sometimes accurate, but are also often reflections of our own subjective experiences. And parental attributions through their children begin during pregnancy, when parents daydream about what the child will be like.

Positive attributions are an expression of love. Negative attributions, on the other hand, show that the parents ambivalence maybe enacted through behaviors that harm the child's basic emotional health.

A woman who was eight months pregnant, for example, in clinical work said about her fetus, "He's so manipulative. He knows when I want to sleep, and that is when he starts moving, just to bug me."

That shows you how intertwined this mom's experience of

her own having been banished, uncared for was now being transmitted to her perception of the baby in the womb, the fetus. A father to be, more worrisome even, commented about the position of his breach baby. "I told her I would beat her up if she forces her mom to have a C-Section."

And I managed to ask him what do you think she will do if you beat her up? I think he will be frozen with fear. Did that happen to you? And then he told me about a particular way in which his father had beaten him up, and it was a graphic demonstration of the intergenerational transmission of maltreatment and potential mortality.

Next slide please. Even in worrisome clinical conditions, we need to look for strength, goodness and hope, and this slide gives you a measure that is called the benevolent factors, BCEs, in counter distinction to ACES, which was developed by Angela Narayan, to identify sources of resilience in pregnant parents.

ACEs, and we can go to the next one as well, thank you, include social determinants of health, such as food, and housing sufficiency, and also emotional supports, such as at least one caring adult, and social support, such as safe neighborhood and well functioning schools.

And the research findings, using this measure, shows that even with high ACES, even with ACES 4, 5, 6, 7, having four or more

of these ACEs, serve to alleviate the impact of trauma and predict lower emotional stress, such as PTSD in pregnant parents that we have been working with. Next. Thank you.

I will now describe three effective interventions that were developed by my team in collaboration with colleagues at UCSF. And what these three interventions have in common is that they were all influenced by the principles of child parent psychotherapy, which as Sarah said, is an attachment-based trauma informed to a generation treatment for children aged zero to 5, that we particularly implement with racially and ethnically diverse low income families.

And it has been supported by five randomized studies in two independent research settings, one at UCSF, and one at the University of Rochester, with Sherri Toth, Judy Manly and Dante Cicchetti, but also clinical studies.

And one of the most exciting findings that is going to be released on July 8th is that babies who were receiving child parent psychotherapy, showed a decrease in epigenetic accelerated aging, which is a marker of stress that predicts cancer, diabetes, cardiovascular disease later in life after 20 sessions, compared to a group for similarly traumatized babies that did not receive child parent psychotherapy.

This is a study by Nicki Bush, Alice Sullivan and their colleagues. But in addition to this particular finding, CPP also is

associated with dozens of social and committed measures on mental health, and maternal depression, PTSD and marital satisfaction.

So, these three studies, three interventions have been influenced by the principles meeting together with a parent and a child to address the parent, the child, and their relationship. And I'll start with TRIADS in the next slide please.

TRIADS is an acronym for trauma and response inquiry about ACES stress and strengths, and it originated with Dr. Nadine Burke Harris, a Black pediatrician, working in predominantly Black neighborhood in San Francisco, who realized the high incidence of ACES in their population, and who became the first California Surgeon General.

And in that position she launched a statewide initiative in 2019, to use primary care screening for ACES as a tool to decrease trauma-related health conditions among medical pediatric and adult populations in California. And we use the core intervention of child parent psychotherapy to create a streamline tool that we are now applying.

It was initially applied in 48 medical clinics throughout California that reached 250,000 medical recipients, and it now continues to be disseminated through asynchronous videotape learning in the trial's website, and in workshops and seminars.

And what essentially it asks for is for primary care

providers to engage in a caring, loving, interested conversation with their patients, asking about the presenting medical conditions, the distress, and then asking about what happened to you? What things have been sources of stress in your life, and ACES screening?

But where there is a psychological education about the fact that the prescribers of morbidity and early mortality often have their roots in early life, and in the stresses of early life before age 18, that might lead to behaviors like substance use, like eating too many sweets, or comfort foods, that in the moment give comfort, but that actually have long term negative repercussions for health.

And then asking what helps you? What are sources of strength for you? And using those sources of strength to incorporate into the treatment plan, and we're finding that when those conversations occur, there is a greater likelihood of people actually abiding by the treatment plan. Next slide please.

So, essentially what we're saying is you don't need to be a therapist to be therapeutic, to have a healing effect. And that affects people in every system of care, and in everyday interaction because how we treat our patients is as important as what we do for them in concrete ways.

And the healing conversations convey an interest connection and empathy, and normalizes trauma, since it happens to all of us, and nobody is to blame because shame is a universal

response to trauma, which is why patients tend not to disclose it to anybody, including their primary providers.

And everybody has sources of strength that can be leveraged to alleviate the stress, and the baby to be born in perinatal circumstances, is an enormous source of hope and possibility, which leads us then to the next treatment that I want to highlight, which is perinatal child parent psychotherapy, which is an extension to pregnancy of child parent psychotherapy.

And it was initially developed by me and three other Latina immigrants. I'm from Paraguay and my co-authors Manuela Diaz, Gloria Castro, and Griselda Pliver Bucio, are from Peru and Mexico, and we initially implemented it with monolingual recent immigrant Latina women, but has now been extended to other racially and ethnically diverse birthing parents.

And we found that intimate partner violence was a prevalent preventive problem, along with poverty, traumatic migration, community violence, and histories of ACES to the point that we have 13 types of adversities on traumas in the parents that we treat.

And the baby's father is invited whenever the birthing parent is receptive, and we make safety a big focus of the primary focus of intervention. The treatment includes attention to the TRIADS formulation that I just described, to help the parents

understand how the pain of their traumatic experiences affect their emotional life, their life choices, and how the lingering effects of those experience are now coloring their attitudes to the pregnancy, and their unborn baby through the parental attributions that I just described earlier.

And the relief that parents to be experience as they get to know themselves better is expressed in comments like, "You mean I'm not crazy?" "You mean my baby does not need to become an abuser?" "You mean I'm not destined to become an abuser?" And in that vein, there is the seed of healing. Next slide please.

And the healing that comes from reconnecting with the early pain of being abandoned, feeling unloved, and being hurt by their parents and caregivers, and from the healing that comes from practicing new ways of self-care has shown significant improvements in depression. Next slide please. PTSD and increases in protected parenting attitudes.

And I hope you saw that there is no overlap between this course at the beginning of treatment, and at the end of treatment. That is how much improvement is. And we believe that this is a very graphic demonstration of the value of focusing on their relationship to the pregnancy, and its connection to the early origins of pain, as an avenue to intergenerational healing, both for the parent, and for the baby.

Next slide please. Now I want to focus on EMBRACE, which is a program for Black birthing parents that Dr. Makita Mays called a love letter to Black mamas when she was developing it, and now includes a partner intervention called Daddy-cated, for Black fathers who wanted it for themselves because they said this is great that we hear this program EMBRACE that is dedicated, that is focusing on the birthing parent. We need something for our own pain.

For our own unrecognized trauma, for how we're carrying the burden of what happened to us from generations and generations through racism in the past, and in the present, and through marginalization through chronic stress, poverty, et cetera.

And EMBRACE and daddy-cated are implemented by a team of Black service providers in the UCSF department of OB/GYN, which is chaired by Dr. Andrea Jackson, who is committed to bringing safety and health to Black births. Dr. Jackson asked me to let you know that she welcomes follow up- questions from this Committee.

I had hoped that she could be part of this presentation, but her schedule did not permit it. And I will now go to the next slide please. The critical components of EMBRACE, the first critical component is group prenatal care. Two hours, lasting about 14 sessions, that with a curriculum that includes topics like racial stress, weathering, and racial birth disparities, and another module that is called parenting while black.

Before EMBRACE, less than 1 percent of participants in group prenatal care were black. Now, Black birthing parents have a group of their own, and they feel that being able to speak about their racial ethnic cultural experience in a group that shares those experiences is extraordinarily healing in and of itself.

This next slide please. The second critical component is race concordant care and racial responsiveness, a component that is associated with lower death rates in neonatology, primary care, and cardiology, and I'm sure you know the statistics that are associated with non-race concordant care, and how race concordant care can go such a long way to healing that health disparity.

And the third component, next slide please, is integration of behavioral health into the OB/GYN experience, and the way that they're doing it, after a pilot with perinatal child parent psychotherapy and mental health components would opt-in.

They found, Markita and Andrea found that making it opt out, in other words, making one on one individual mental health sessions an integral component of EMBRACE was much more effective by normalizing that mental healthcare is an integral component of prenatal care, of overall healthcare.

And now, a social worker or psychologist facilitated the sessions, and then incorporate mental health and emotional wellness into each session, and also meet one on one. Now, I'd like to go

through the outcomes. Next slide please.

In a pilot study the outcomes kind of speak for themselves. Compared to the U.S. average, EMBRACE participants have lower C-sections, higher gestational age, higher birth weight, and longer time breastfeeding. And the next slide please.

For lowrisk pregnancies, the NTSV, Nulliparous, Term, Singleton, Vertex were apparently the standard for ultimate outcomes is less than 23 percent of pregnancies. You see that the RUCSF, that is pretty much within the range, except for Black births that are not have the EMBRACE, which where the rate of Csection is almost 36, is more than 36 percent.

But for the Black EMBRACE families, it is 26 percent in this early implementation. Yes, thank you, the CMQCC is the 23.6 percent, and that is what we're hoping will be a target that is met in the next iteration of EMBRACE.

And so, this leads me to the recommendations in the next slide please. The lessons that we've learned, and the message that is offered. One of the big drivers of perinatal disparities is not only the social determinants and racism, and poverty, but also the lack of providers that are race concordant, language concordant.

I can't tell you about 9 out of 12 of our staff are bicultural, bilingual in Spanish, and even then we have enormous waiting lists. The same is true for race concordant Black families

where the representation of providers of color among the health professionals is less than 10 percent.

And so, and yet we have a great deal of trouble providing stipends for trainees, social workers, doulas, psychologists who are committed to providing perinatal care to underserved populations. And so, it is imperative to fund training to create a workforce of perinatal mental health providers that are committed to Black families and communities of color.

It's also extraordinarily important to find programs that engage in partnerships between primary and mental health. One of the great satisfactions in our work is to hear psychologists and social workers embedded in OB/GYN in the birth center, in the OB/GYN high risk parenting, birthing parents, who are using substances, who have an overlap of ACES that lead to depression, PTSD, psychosis, borderline personality disorder, which really is another name for chronic post-traumatic stress.

There needs to be no daylight between primary care for pregnant parents and mental health. It's like in EMBRACE. It has to be opt out rather than opt in. The third finding two generation evidence based, family-oriented treatments that are culturally concordant with underserved communities, and that are family oriented, where the birthing parents, their partners, the grandparents, the caregivers, the village, is involved as needed be.

One of the things that we do in child parent psychotherapy are perinatal child parent psychotherapy. Start with what we call a foundation of base, where we meet with the parents for a few sessions to ask who helps you? Who do you want to be part of intervention?

And it can involve the siblings, for example. Sometimes there's a huge age gap with a 13-year-old feeling like I don't need this baby in my life that is coming. I'm having acting out behaviors, where the birthing parent feels divided between what the other preadolescent needs, and what she needs, and what the fetus needs.

And we're bringing them together to talk about how to be available and responsive to the needs of everybody is really the focus. And the last recommendation is that given the prevalence of adversity and trauma, trauma-oriented treatment, training, being aware of what trauma does to the body and to the soul, and to the mind, needs to be part and parcel of all trainings, and all interventions because those are the treatments that have the best record of interrupting the intergenerational transmission of trauma.

And I want to thank you again for this opportunity, and if you have questions I will be more than happy to answer them.

DR. ALDERMAN: Thank you so much, Alicia, this is Sherri again. This has been so powerful, that information that you provide, the experiences and the stories that you've told, and your

recommendations that are evidence based. Thank you for permission for us to have a question and answer session.

So at this point, I'd like to open it up to those who have a question, and I will watch for hands, or feel free to unmute yourself.

DR. LIEBERMAN: Thank you, Sherri.

DR. ALDERMAN: Yeah. Okay. I see Jacob, so Jacob, would you like to provide your question or comment please?

DR. J. WARREN: Thank you so much. Thank you for this wonderful presentation, Alicia. I really appreciate the critical work that you're doing in this area. I was struck by your work on BCEs. I love the positivity and aspects that that brings because often when we discuss trauma it is so focused on the negativity.

I was wondering if you looked at all in the how the BCEs play out with post-traumatic growth potentially within the maternal portion of the dyad?

DR. LIEBERMAN: We are in the midst of doing that research.

DR. J. WARREN: Great.

DR. LIEBERMAN: And I will tell Angela, who is now at the University of Denver, that you asked about that, and that will give her impetus, but that is very much post-trauma growth is really our north star, so thank you for that.

DR. J. WARREN: Thank you.

DR. ALDERMAN: Are there other questions? I'm sure there are, please feel free to raise your hand, or to unmute. I'm not sure if I'm seeing everyone. Marya please?

DR. ZLATNIK: Hi Alicia, I'm Marya Zlatnik. I'm actually an MFM at UCSF, and I thank you so much for your work. I'm wondering, you know, we are working to train more providers of color, and that's obviously something that this group has because we've spent quite a bit talking about it yesterday.

I mean providers in general, but also race concordant providers. Do you know from EMBRACE, have they been able to study at all how important it is for different people on the team hearing for the pregnant person, you know, how important is race concordance for each person?

Is there any data about, you know, if you have a race concordant doula, does that help in a situation where the obstetrician is not race concordant, or vice-versa? Do you have any data on that?

DR. LIEBERMAN: You know, this is a -- thank you for asking that question. Right now, here is what I would refer you to Dr. Jackson, for that question, and to Markita Mays, because they are in the nitty gritty of everyday. Right now, the way in my conversations with them it's a very complex process to even implement

a program like this.

So, this is a long-term commitment where the nuances of questions such as what you ask will come in time. Right now the importance of documenting the effectiveness of implementation, recruiting it, getting referrals, making sure that people know about it, and are able to refer.

And getting the funding to implement it, that is where the part of the belly is. And the questions of how does it compare with other forms of intervention I think necessarily need to come later, but thank you for raising that, and I will pass it on to Dr. Jackson, and you can also contact her directly. She generously said please let people contact me and Markita said the same thing.

DR. ALDERMAN: All right. So, we have time for perhaps one more question, and I will hand it off to Kate.

DR. MENARD: Thanks for that. Kate Menard, I'm a maternal master specialist for those that don't know. My question really what's resonating with me really strongly is that my question is about integration. You know, behavior health into the care, the prenatal care providers are very much considered, you know, primary care for our pregnant population.

That idea of no daylight between primary care and mental health is I just, I love the way that really resonates to me. Mental health is health, right. It's challenging. A lot of the -- one of

the themes that's coming across all three of our priorities is workforce right.

It's just there in each of them, and we talk about training programs, and residency programs, and kind of starting at high school, or even before high school, getting people into healthcare workforce in various ways, but that is such a long-term investment, and our word of the day is "now."

So, my question for you is how do we take, you know, your training to out of training, 40, 45, 50 year old providers, and get them onboard with trauma informed care, and this importance of -- I mean even having them become prescribers is challenging. And kind of sitting at a webinar doesn't work. You know, we've tried that in many ways. Do you have thoughts on how we can --

DR. LIEBERMAN: What doesn't work? I'm sorry.

DR. MENARD: You know, webinars.

DR. LIEBERMAN: Oh, webinars, yes.

DR. MENARD: And post-graduate courses, and these sort of things. It just isn't, it's not working. We're trying that and it's not working. Do you have thoughts on how we could do that better?

DR. LIEBERMAN: You know, I think we would all agree is quick and cheap doesn't necessarily lead to quality long-term, sustained. So, when problems are complex, I think we have to buckle up and offer complex answers as well, right? And try to streamline

them so that they are pragmatic and realistic.

I'm very grateful to SAMHSA, because through the National Child Traumatic Stress Network we learn a form of training, clinicians that are in the field already, through the learning collaborative model, which is what we have used to, you know, to train 2,000 providers now across 40 states in child parent psychotherapy, reaching tens of thousands of families.

And we're going to do that with perinatal child parent psychotherapy, we're in our third iteration of a learning collaborative model where you meet for 12 hours at the beginning to give people the basics of a treatment, and then you meet with them on Zoom, on a caseworker's presentation where you talk about implementation.

What are the ports of entry? What is the case formulation? What does this family need? And you guide the clinician to start using evidence-based models, and we have a certification process, our rules and process, and people are flaking to it because there is such a need.

Such a recognition in the field of the need for continuing education, and I think that that is a very realistic way of getting more people into this kind of treatment. Thank you for that question, it's a very important one.

DR. ALDERMAN: Well, thank you, Alicia. It's been

tremendous to have you hear, and you have one thing that we have been really struggling with, and in a very positive way is the issue of isolation, and you've reminded us that isolation is environmental. Isolation is also psychological, and it begins in infancy.

Hopefully it's prevented from beginning in infancy, maybe I should say. So, very much appreciate you being so generous with your time and your knowledge, and your experience with us, and you have really helped us inform the recommendations that we will be passing on to the Secretary.

DR. LIEBERMAN: Thank you much. Thank you for having me. Thank you for, Dr. Pettiford, the members of the Committee. This has been the best thing that happened to me, being able to address you. Okay, bye-bye.

DR. ALDERMAN: Take care.

DR. LIEBERMAN: Bye-bye, you too.

CHAIR PETTIFORD: Thank you all, and thank you so much. We're going to now go into a short lunchbreak, and I do mean short. So at 12:30 please feel free to bring your lunch back, but at 12:30 we do need to start our next session. They're on a time crunch as well as we are, so we'll see you back shortly, thanks.

California Department of Public Health: Black Infant Health Program and Perinatal Equity Initiatives

CHAIR PETTIFORD: So, welcome back everyone from lunch. Hope you enjoyed it, or are continuing to enjoy it, so if you need to be off camera to finish your lunch, we understand. We are pleased to have with us today our next presenters.

We are fortunate to have Niambi Lewis, who is the Chief Perinatal Health Equity Section with the California Department of Public Health. Good to see you Niambi. And then Niambi is bringing with her Franchesca Saulson, who is one of the program participants. We think she will be joining shortly as well.

So, Niambi, we will turn the session over to you.

MS. LEWIS: Thank you so much, and thank you for having me. So as Belinda said, my name is Niambi Lewis, I'm the Chief of the Perinatal Equity Section here at the Department of Public Health in California. Next slide please.

So today I'm just going to briefly go into the disparities. I know we all know what they are, and then I'll share some of our program overviews, and then share a couple promising practices with you all. Next slide.

So, I'd like to start our presentations with sharing what a health disparity is, which is the differences in health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, education or income, disability or functional impairment, or geographical location, or the

combination of any of these factors.

And we'd just like to start with a health disparity is, so you can understand why we have these programs in California. Next slide. So, the good thing with California and the United States, our infant mortality rates have consistently been lower than the national rate. In California, and the U.S. overall, racial and ethnic disparities, so Black infants die at the rate of the infants of other races and ethnicities.

But California's overall infant mortality rate is among the lowest in the nation, and our data for 2022 indicates that California's rate is the fifth lowest nationally. Next slide please. So, you'll see in these next couple of charts we are comparing the California rates with the United States rates, and as I states, they are trending lower.

But what you'll see in the next slide is that the infant mortality rates for Black infants is higher, and so this is -- we still continue to see the disparity. Next slide. And, this is the same for our pregnancy related mortality, that again, our rates, our ratio have consistently been lower than the national ratio.

But again, we see the disparities of black, pregnant and birthing people, with them dying at three to four times the rate of those of other races and ethnicities. And then we noticed that pregnancy related deaths from COVID caused the ratio to increase

considerable.

But again, National Vital Stats indicate that California's maternal mortality burden is the lowest in the United States, next slide. And so again, you'll see how California compares to the U.S. overall, and then you'll see that kind of jump, and those are the pregnancy related deaths related to COVID. Next slide.

And again, while we have lower rates, we still notice the disparity, both in the United States and in California. Next slide. And so, when we're describing disparities, what you see is the disparity. You see those rates. But under the rates are all of these other contributing factors for housing, poverty, limited access to care, smoking, but at the root of all of those underlying issues is structural racism.

Next slide. So, what we like to remind people is that race is not a risk factor in maternal health. Racism is. Racism is really the reason why we see these disparities, and we like to highlight this, and share it as a part of our programs. Next slide.

And, we recently released, September of last year, the Centering Black Mother's Report, which further delineated structural racism as a contributing factor for disparities, and some of the other contributing factors that women in our state are faced with, including neighborhood conditions, chronic stress, and the lack of access to high quality and respectful care. Next slide.

And so, we've done some research, including that Centering Black Mother's Report, and we know that the current science supports the idea that social factors play a prominent role in birth outcomes. And so, we really focus in our programming for Black women here, reducing stress, increasing social support, building empowerment, and then improving the conditions for Black women across the life course. Next slide.

And so, we have two programs, and I'll go into what those programs do. Our first was the Black Infant Health Program. This is actually a group of postpartum moms in San Francisco. Next slide. Our goals in Black Infant Health are to improve the health among African American mothers and babies, to improve the black, white disparities in maternal and infant health, and to empower children to make healthy choices for themselves and their families.

Our target population is currently African American women 16 years or older at the time of enrollment.

CHAIR PETTIFORD: Yes, I think our presenter froze, so we're going to give her a moment. We will give her a moment to just rejoin the meeting.

MS. LEWIS: My apologies.

CHAIR PETTIFORD: No problem. We saw you freeze. We were waiting for you, you're good now.

MS. LEWIS: I appreciate you waiting. Okay. Next slide

please. And so, our program currently is across the state. What we've done is we were very intentional about how we are supporting Black women in our state, and so you'll see this table of where the majority of Black births are occurring in California right now, and that is where we have located each of our locations, with the exception of Solano.

Solano is currently not receiving Black infant health funds, they just elect -- they opted out, but this is where we just try to be very intentional about how we're providing resources, and so each of these places where the Black births are the highest, we have Black infant health locations. Next slide please.

And so, our program is also governed by these four concepts. So, being culturally relevant, and for us that means not just being black, but really understanding the culture of Black women, and the things that they encounter in America as a culture. And so, we released with our model and with our staffing books at the local level and at the state.

Our program was participant centered, and so we really focus and prioritize what women need when they come into the program, and so we do have a set model, but we really try to ensure that women really lead their experiences with their one-on-one support, and even their participation in the group model.

We are strength based, and so we really highlight each

participant's strengths. Sometimes we have women that come in that feel like they don't have strengths, and our job as facilitators at the state is building a program that they identify their strengths, and then utilize those to help them in their lives.

And then we are a cognitive skill building program, so we encourage each of the participants to think differently about their behaviors to learn, and really rely on each other in their groups to think about their behavior, and how to apply it to their own lives. Next slide please.

We chose a group intervention because we found that research told us that group interventions seemed to be a better strategy, or a more effective strategy for Black women, for improving birth outcomes. The issues that are brought up in group are common across all participants.

They all have some connection to the issues, and then there's also decreased isolation, and increased social support. And so, for those women who feel very isolated, they have the group to come to, to help mitigate some of that isolation. And then there's improve health seeking behaviors and more effective social skills.

And all of this is really to mitigate the negative impacts of stress on these women. And then we found that participating in groups can help women make different choices about their health, and so we present the information, but we really rely on the women in the

group to talk to each other, and share their own experiences for women to ultimately make the best decisions about their health for themselves.

It increases their sense of control, which can improve health and wellness. It helps them improve their coping skills, and they help others with the knowledge and information that they're learning. Next slide. And so we have these program pillars, which is our program is a little unique, that we do focus on all of the health outcomes.

We highlight SIDS, preterm birth, all of the things that are pertinent to Black women during their pregnancies, but the program is really structured around providing social support, improving stress reduction, and enabling women to feel empowered.

And so our short-term outcomes are to promote social support, develop effective stress reduction strategy, empowering Black birthing people to build resiliency, promoting health knowledge, and healthy behavior, and connecting women with social services, and providing some levels of community engagement. So, globally we want people to know about the program, but understand the disparity.

We want to make sure that women get referrals as they need them. As I said, we promote all of the health knowledge and behaviors, breastfeeding, STD rates, all of those things that impact

pregnant women. But at the same time, we're promoting social support, providing stress reduction strategies, and empowering Black birthing people. Next slide.

Another thing that makes our program unique is part of our staffing requirements, so this is all of the staffing. Each site has a program coordinator, they have an outreach liaison dedicated to just being out in the community and bringing women in, a data entry person keeps the data up to date.

Our thing here is if it's not in the system, it didn't happen, and so we need someone to help make that happen. The family health advocate follows the woman doing case management or one on one support. And then our group facilitator facilitates the group.

And then where we're a little bit different is that we require each of the countries implementing Black infant health to have child watch personnel. So, one of the barriers to service is often not having childcare, and so we have just incorporated that into our program. We require a mental health professional, so that women have assessments as they come in, mental health assessments.

And then ongoing have the support of a mental health professional, and then we also have a public health nurse that is required. And so, if there's anything that's happening medically, they have a trusted medical person dedicated to providing them service to help them notice any risk factors, and then be able to

prescribe those to their medical professionals that they are outside of the program.

And so, we really have like it's a critical part of our program, and has really been an important part for us. Next slide. I'll just walk through how our participants go through the program. There's recruitment, and they can sit to be a part of the program, or they decide that it's not for them.

At that point they have an option to not be a part of the group, and go on to one on one support, only if the group is just not for them, or they opt to not be a part of the program at all.

Regardless if they decide to be a part of the program, we still provide them with information around the disparities most likely to impact Black women, and that's like hypertension, and the SIDS rate, STDs, breastfeeding. We give them all of that information, whether they enter the program or not.

If they decide to enter they are enrolled in a group, a cohort that comes in. We've model of our program around centering pregnancy, but we didn't have the strict guidelines about where people are at in their pregnancy because we don't follow them clinically, and so when we come in less pregnant, or more pregnant, up to 30 weeks, and they're participating in the group, during the group they have their life planning, which is one on one support, but it's their life planning.

And they decide what that looks like for them. They choose their goal. They decide how they want case management to happen. They have their babies. When they have their babies they are visited by the nurse. The nurse actually goes over their birth plan before they have their babies, and then she does a home visit after they have their babies, and they find that that's really critical in that first six weeks.

And then they come back to do the postpartum scale, and just really are making sure that the women is- giving women in our model six months to come back postpartum if they elect because culturally, some people don't want to bring their babies out very early-, and we want to respect that.

And so, women have up to six months to come back into the postpartum group. They participate in postpartum, and they still are followed with case management, and then they graduate the program. Next slide.

And so, we do an evaluation of our model between 2015 and '18, that was before the pandemic, and so we'll have to do another one soon, and what we found is we followed about 18 -- 18, yes, 18 outcomes.

And what we found is that we have the largest improvement in practical and emotional support, smoking cessation, food insecurity, stress management techniques, depressive symptoms, and

babies sleeping on their back. So, we know that our prenatal group model is achieving its intended outcomes.

And we found that there was significant positive change in 13 of the 18 health and health related outcomes examined. So overall, we see that result support that our programs and policy strategy to improve the health of Black working people and their families. Next slide.

I don't know if Franchesca is on, but this will be a great point to let her share her experiences.

CHAIR PETTIFORD: I think Franchesca is on. Franchesca, if you're on, if you'll just unmute yourself. So Franchesca, you're still muted. Okay. We'll give you a second, no problem.

MS. SAULSON: Hello? Hi, you guys hear me?

CHAIR PETTIFORD: We can, thank you so much for joining us.

MS. SAULSON: Thank you. Good morning. Yes, I just signed in, so I heard part of that, and I do agree that being a part of the Black Infant Health Program does really help educate one, Black mothers, but also support because I feel like after I lost my son, I lost Elijah when he was 37 weeks and 5 days, so I was very far along.

And the support that was available from my hospital at that time was pretty much non-existent. I was referred to a

psychiatrist, and I feel like after that time taking psychiatric medication wasn't so much a help, it was kind of just a numbing agent.

And having a community that is understanding and supportive of you, and understands what you've been through, and kind of just is there to hear you, and like I said be there to support you, it's the world.

Because coming from a Black family, I guess there's different dynamics, but also in the healthcare system there's just kind of an empty space for us, and I feel like the Black Infant Health Program definitely helps fill that void. And they were amazing for me to have as support. If that helps a little bit.

CHAIR PETTIFORD: Thank you, Franchesca, we really appreciate you sharing part of your story. Thank you.

MS. SAULSON: Thank you, guys.

MS. LEWIS: Thank you, Franchesca. And so, now I'll talk about our other program, our Perinatal Equity Initiative. I'm just checking on time, okay, I could get through it. Next slide please.

So, what happened was we had BIH. It's been in existence since 1989. BIH is a group model, it's a model that we deliver from the state, and we recognize that the group model is not for everyone, and we also continue to see the disparity, despite having good outcomes, but disparity exists.

And so, we started to think like how else can we support Black women in the state? And so, in the Budget Act of 2018, the Governor established new initiative, the Perinatal Equity Initiative, to expand the scope of interventions provided under BIH. And so, we developed a new program, and there are evidence based, evidence informed, or strategies that reflect promising practices based on local needs and resources. Next slide please.

So, our goals are the same for PEI to improve birth outcomes. The target population is a little different because at the interventions, we'll talk to it in a second, but still are designed to support pregnant and parenting Black women and their partners. And then we have 8 million dollars in a general fund for state fiscal year to support the Perinatal Equity Initiative.

Next slide please. And so, the initiative is really designed -- I'm a social worker by training, so I liken it to a wraparound program, so our group model is central for BIH, and then counties that have Black Infant Health Programs can elect to have to if they want to be funded, choose two other interventions to implement.

And they got to choose from group prenatal care, fatherhood or partner strategies, home visiting, preconception or interconception care, or an innovative option that they decide that prepared medical and social, which many elected to do.

Community based doulas or midwives. We have some counties doing a personal support model, and then some chose to do an implicit bias strategy, and so you'll see the local health jurisdictions next to the interventions that they selected. Next slide please.

So each LHJ is required to implement two of those five interventions. They are required to develop a public awareness campaign. They have to maintain a community advisor's board, and this was a little, like one of my favorite parts about the program, the legislation outlines that the counties are essentially asking for the funding, and so they have to maintain the community advisory board, and they have to implement these interventions through a community based organization.

And so, it really makes sure that the community is involved, and that they're aware of the intervention, and really provide voice to how the county should be supporting Black mothers and their communities.

We also utilize those results in the accountability framework, to monitor progress, and then they meet bimonthly for our learning collaborative calls to share best practices and successes, and then barriers to implementation. Next slide.

And so these are just a couple pictures of our public awareness campaigns. They are done differently. Again, the community advisory boards really support how those campaigns look,

and they're different across the state because communities are different across the state.

And so, they are really designed to speak to what the issues are. The disparity is all over the state, but it really shows up differently in some communities, and so the campaigns reflect back. Next slide.

Again, we use the results-based accountability, and part of that is even though we have the broader category of an intervention, each of the models that each county is implementing is different, and so we needed to still be able to track that even though all the models are different. Everything is different, so results-based accountability, that framework was the one that seemed to work best for us. Next slide.

And then again, the learning collaborative, they're bimonthly now, and they started off monthly, but now that people are implementing, when we started this effort right independent, so 2020 is when they started implementation, so we have to do a quick shift from in person to online, and help them build off their programs.

But they have had these learning collaborative calls. It is really a place, like when someone is doing well, or someone had researched their fatherhood effort, and the assets that are working, and then other people adopt it if it makes sense for them, and so they're really informative meetings. Next slide.

And so, I'll just finish with some of our promising practices. We, like I said, having the language written for programs into state legislation gives us the ability at the program level to be sure that the needs are being met in the communities. There's a lot of pushback sometimes about programs that are written specifically for a certain population, and when it's written to legislation, we just refer back to that.

Like we understand that maybe it doesn't make sense to you, but it's written in legislation, so you just can continue to move forward. We encourage racial concordance and staffing. Our staff at the local level, our staff at the state level, reflect the population that's being served, and we found that builds trust.

That time for building rapport is shortened, and we are able really to get and provide the services that participants need. Requiring the community advisory boards for community buy in and support.

Like no one knows better about the community than the community themselves, and so when we require for counties and local agencies to have community boards, to get the buy in that we find that they provide resources that even the state can't provide, right?

They know who to connect the county staff to, and it's been just a wealth of knowledge having the community advisory boards attached. They're also like become by just regular referral sources

because they're there. We found that maintaining the standard we have to have some standard for evaluation, but also understanding that every community is different. Some of the needs are different, some of the ways that counties operate are different.

And so, we maintain the standards for evaluation, but we really allow flexibility whenever we can, so that people can do the things that make sense for the participants in their jurisdictions. And then we require, like I said for DEI, they have to partner with community-based organizations, that I cannot speak enough to how different that is at the community level.

Like having the community organizations be able to provide the services because they're known, they're known in the communities. The women already know those places often, and so it just becomes a natural connection, and we just find that the work gets done a little easier, and a little smoother, and in the way that the community wants it to be done.

And then we like to provide funding that allows for resources to eliminate barriers to service, and I know that seems like what are these things, but what it all boils down to is that if we know that there are barriers to service, transportation is the barrier, we require Lyft in our participants.

We require each of our jurisdictions to offer door to door service for each of our agencies to require door to door service. We

saw that childcare was a barrier, we required that they provide childcare. If we could ever provide funding that allows for resources to help people get into the services, we do that.

And so, that is all that I have. I'm a little overtime. I appreciate you all having me, and I'm open to any questions if you have them.

CHAIR PETTIFORD: Thank you so much, Niambi. But actually, before we go to questions, I want to give Franchesca another opportunity to speak. I think she had a little bit more that she wanted to share.

MS. LEWIS: Oh, I'm sorry, Franchesca. Yes, please.

MS. SAULSON: Can you guys hear me?

CHAIR PETTIFORD: Yes, we can, yes.

MS. SAULSON: I just wanted to hear everyone's, what everyone has to say. Sorry, I was more speaking about my window later. I wanted to kind of hear everything and what was going on today, and then have my time to share my story a little bit later if that's okay.

CHAIR PETTIFORD: Franchesca, I do apologize. I think we've got a time zone issue we're dealing with. We were saying 12:30 - 1:00, we were basing it on our 12:30 to 1:00 here on the East Coast, and not your coast, I'm following you now.

MS. SAULSON: That's okay.

CHAIR PETTIFORD: Are you good with sharing a little more now?

MS. SAULSON: Yeah, yeah, that's totally fine.

CHAIR PETTIFORD: Thank you.

MS. SAULSON: So, I just want to say thank you guys all for giving me the opportunity to share, and be a part of this, and be able to be a voice so that we can keep making positive changes, and hopefully decrease the mortality rate for infants, babies and mothers because not only did I lose my son at 37 weeks and 5 days.

And I know that since this is a painful topic to talk about, and it's also something that I feel like in the healthcare system I mean we all know statistically that Black mothers, Black fathers, Black individuals don't get the same treatment, even though we would like to.

And this organization, and you guys are definitely working towards making that a difference, but I found out that my grandmother and all of her sisters have lost a child. And she has three sisters, three of them -- so including my grandmother, that's four women, three of them had lost a child to stillborn. One of them had lost one to SIDS, and even though we may say oh, that was in the '60's, and we also see with our numbers that the healthcare system hasn't changed much.

Yes, we want to make changes, and we are making changes,

and doing things like this conference are working to make changes. But I think that this is just a part of my thank you as to helping to make changes in the right direction, to decrease the rates.

But I did see firsthand that a lot of my health concerns when I was pregnant were getting ignored, and they were just -- I was just told to be strong and stick through it, and you know sometimes that happens. And when you're carrying a boy sometimes it's a little harder.

And fast forward to two and a half years later, I'm pregnant with another boy, and I found out that I have some type of heart condition, and I changed hospitals, and I've gotten a doctor that wants to figure out what's going on, and why my son died. So, it just shows me that there is something that's wrong.

Can I put my finger on? I mean yes, but can I make a change by myself? No. So, I thank you guys for being the backbone to making that change, and making changes that will be for the future, and for further children.

And I think that just to put it out there, I think that a great thing that we need to happen for the future, and for mothers that have gone through this because I know that some people look at miscarriage and stillborn as a big difference, but really it's just a gestational age difference.

And to me as a mother, once you find out that your

pregnant you start planning for the future, whether it's a baby shower, a name, whatever it is, you start planning for that baby. And whether you lose your child before you find out the gender, or before you hear a heartbeat, it's still extremely devastating.

And I feel like that kind of gets brushed over, so I think that it's very important for families to receive therapy. And I know a lot of hospitals, going through the healthcare system, were kind of put into other organizations that offer therapy.

Like, I was at UCSF, and I got six free sessions. And although that was amazing to get six free sessions, it was kind of like I get to let a little bit of steam off, and then I get left to grieve alone. And they were free to other organizations that can help you.

But when you go through something so devastating as losing a child, it's extremely hard to have finances, one to pay for therapy, or two, to even - I couldn't- wrap my mind around applying for disability at that time, and I had applied for paid family leave.

I got denied, and there's no real specific guidelines as to what to do when that happens, and I think that hospitals need to be prepared for that, so that they can guide you through the proper channels to get you the proper help because I'm very lucky and blessed that I didn't want to commit suicide, or you know, have a drug addiction, or you know, anything other than that.

I just wanted to get better. And even just the minimum, bare minimum of wanting to get mentally healthy again, and take care of my living child was extremely difficult, and it took me a very long time to be able to fill out proper paperwork. And you can't -- I feel like you can't always depend on that mother, or that father to have dependable family members, or depending community because that community is also bearing the loss.

Whether you know, whether it's in any sense, and I guess just I think it would really help if we had, you know, social workers go into hospitals and teach people how to also talk to doctors and medical professions about cultural differences, and how to talk to people properly because I feel like a lot of the things that we go through as a community are judged, and we're just kind of like oh, Black women are strong, you guys have been dealing with this for years.

And that's not fair. And a lot of other people get, you know, adequate treatment, and we deserve that too, whether we be full Black, mixed, a quarter Black, we all get treated differently, and it's not fair. And if we were treated equally to other cultures, races, the statistics would be staggeringly lower.

And I feel like that goes for my story too. And I feel like it would have made a big difference in past generations in my family as well. And I guess that's it. I know we have the time

limit, and I don't want to go over. I want to respect the time, but thank you guys again, and I hope that sharing my story, and sharing my outlook on things helped the situation.

CHAIR PETTIFORD: Franchesca, thank you so very much for taking the time to share your story with us. Please know that we can't do this work without you. We need your story, and the fact that you took the time and agreed to share your story is so important to us.

I can only imagine what you've gone through and continue to go through, but we appreciate your willingness to let us listen, and let us hear about it because it helps. It truly helps inform the work we are doing, and the fact you're willing to share is helping so many others, so thank you so very much for taking the time to be with us this afternoon while mourning your son.

But I also want to open it up briefly to see if there were any questions for either Franchesca, or Niambi. No questions, we thank you both so much for your time, and we may be in touch. You never know. Thanks, have a good rest of your day.

Move to Breakouts

CHAIR PETTIFORD: We're going to now switch over to the next part of our agenda as we get ready to move into our breakout sessions. Just before we go into our breakout sessions though, I really would like for the Committee members particularly, whether

you're appointed or Ex-Officio, I'm going to turn it over to Sarah Meyerholz because I want to make sure everyone is aware where we're storing all of our documents on a shared platform, so passing it over to Sarah.

MS. MEYERHOLZ: Thank you, Belinda. This should be brief. Let me just share my screen. This is in response to a request, I think last December about having a place where we can store documents for workgroups, so that you all can work together on them. We tried box, that didn't work very well, and I didn't have the funds.

So, now we've moved on to SharePoint. This is a Team site. Everyone should have received the link, except for the new members. You don't have access yet. I will send a message to everyone with guidance on how to get to this page and access it. But it's very straightforward.

This is the landing page. If you scroll down we have all of our workgroups listed here. I'm going to go to rural health because I know there's information in there. Again, very self-explanatory. You'll find any agendas from the workgroups. I will drop them in there, and then any resources will be dropped in here.

And as you can see, you do have access to upload resources yourself as you can see Kate has done today. And I think you should also have access to start a new document, for example, if you want to

start like an Excel document, or word document, you should have access to do that.

This is also going to be linked on our password protected member site, so I will share all the information. If you want to set like five minutes aside to meet with me, and we can troubleshoot any issues you might have accessing the site, please let me know.

CHAIR PETTIFORD: Thank you so much, Sarah. Now, we're going to transition into our breakout rooms. Remember, you just need to select a workgroup that you'd like to join today and give us about ten minutes because we're going to have to move, those of us that are in person, we are moving to different rooms. So it is now 1:15. We will start back with the workgroups at 1:25. Thanks.

Workgroup Report Out & Next Steps/Assignments

CHAIR PETTIFORD: Okay. So can you all hear me now? Thank you. I was just talking away. Thanks everyone, I think we're getting audio there. So, thank you all for joining the workgroups. I hope you had good conversations as we did in the workgroup that I attended.

So at this time we're going to have time for our workgroup leads to do a report out on what occurred in their workgroups, where they are with recommendations, and then we'll open it up after each workgroup presents to just get some additional feedback from the larger group.

So each workgroup basically has at this point about 10 minutes. You can use less of that time if you like. Please try not to use more, and so that we'll have time for some questions. And we will start with Preconception and Interconception. Phyllis and Joy.

DR. SHARPS: Okay. We had about 12 members, which is -- and we did a recap of some places that we've already been, and basically we have a conceptual visualization of the recommendations, and they probably fall into, or we're going to try to group them into now and long-term.

They generally fall into categories of training resources, workforce diversity, and diversity in terms of workforce diversity in terms of racial concordance, and workforce diversity in terms of perinatal workforce and expanding other providers, other than physicians, so providers like doulas, midwives, nurse practitioners, community health workers.

That would be a comprehensive team, and all will be prepared to deliver some aspect of reproductive healthcare in terms of either education, counseling or services. So, we wanted to start off with a recommendation around removing barriers to access to care and resources typically related to prenatal -- preconception, interconception care, but we also want to check with the social determinants workgroup to see where they are.

We thought about also framing and beginning our discussion

by applying a holistic life force framework for reproductive health and wellbeing, and that may be recommendations about what should be in a standard. What would be the critical elements of a reproductive healthcare visit and/or reproductive healthcare plan, and are there some documents that are existing, or that we could build on that would outline what reproductive care, healthcare looks like across their lifespan?

We then again, I think I've covered the workforce issues. We could discuss primarily funding that would invite more BIPOC providers across all the physicians, and advance practice nurses, midwives, for professional training, and perhaps doulas, and then maybe training that for instance, for doulas and home visitors that might be within existing funded programs for maternal and child health.

We talked about what would be metrics and quality indicators, a recommendation for reproductive healthcare. So beyond just how many, you know, methods, or birth control pills, or that kind of thing, are there quality indicators, and could they be without creating additional burden, but could they be incorporated into funding programs like Healthy Start, or existing surveillance databases like PRAM, so that we also can begin to see nationally what's happening in this healthcare space or prenatal, preconception and interconception care?

And then we are going to recommend a widespread and intentional education campaign about reproductive healthcare across their lifespan, and to consider women or potential birthing people with chronic healthcare to make sure that they are treated -- and people -- that their providers are prepared to talk to them about preconception or care.

And that it would be inclusive of all potential folks that could be in the birthing space that could be culturally appropriate, so it may not be a one size fit all campaign, that it had to address literacy issues, that it would be multi-media, and that it would address issues related to digital access, and that it would be available in every potential space that a birthing or postpartum type parenting person would be receiving care.

And that there would be information about how they would like to go with their reproductive healthcare clinic.

CHAIR PETTIFORD: Thank you so much, Phyllis. Joy, anything you wanted to add to it?

DR. NEYHART: Oh, I don't think I could top Phyllis.

CHAIR PETTIFORD: Thank you, Joy. So any questions from any of the Committee Members? Any other Members have questions? I know a question came up when you were asking, what does the social determinants of health group, what is their conversation going on? And they actually had some of the conversations that we need to

follow up on preconception and interconception.

I've also heard from several of you that it looks like workforce diversity may end up being like one of those overarching issues as we're looking at. It may end up being an area that we focus on, but it doesn't end up, we may have to figure out how we're going to make it a recommendation, I should say, as part of the areas that you want to focus on.

Because it seems like it's one of those issues that can cover any other workgroup, and any of the work we're trying to do, so it may give you an opportunity to have another recommendation that you don't have to put it in your own workgroup. We can go there with workforce diversity, I've kind of heard in many places. But questions, comments? Thoughts? Are you on?

DR. SHARPS: Not only diversity in terms of racial, but I think diversity in terms of the providers who are providing care too.

CHAIR PETTIFORD: Great point. Thank you. It's getting quiet later in the day I guess. No questions, or comments? I don't see anything going in the chat. Okay. Well thank you all for your presentations, I appreciate it. So now I want to move over to Rural Health. I don't know if that's Jacob, or if that's Kate, or you all divided it up doing it together. Jacob, it sounds like it's you. You didn't speak up after that.

DR. J. WARREN: Right. Okay. So we had a really great

group meeting. We decided, and we were talking what we're going to talk about in the next few months, we decided we're going to meet every other day, so really appreciate every other day for the next six months to go where we need to go.

But no, really great participation, lots of good ideas. Appreciate the new people joining as well to bring fresh perspectives, so we tried to get this down into some more global statements of recommendations that we want to get more specific, that's really hitting more on the teams with any of the topics that we already identified.

So, when we looked at workforce, so thank you so much for allowing us to have that not count against us in our maximum number of recommendations. You know, we definitely have a lot. We have one that we'll probably never take with us because, you know, it's pretty specific, it reaches everyone.

But we have a general recommendation that we're trying to build related to the diversity of the workforce in both senses, the way that Phyllis discussed it, where it's the diversity of the provider and the provider mix diversity aspect.

And so, you know, but looking as we grow in a more broader world MCH workforce by improving training, employability and billability, so we're trying to hit on these three things, bedside nursing, doulas, and CHWs in particular, as a way to address

inequities because we know CHWs and doulas in particular really have an impact on inequities.

But also as we look at building rural workforce, those are levels of providers in the air that we might more readily be able to stand up and expand in rural, at some of the higher levels of care.

The other recommendation that we were building toward is something much more specific to midwifery because there's such a big impact it can have, again everywhere, but particularly rural as well.

So, looking at how we expand out in the rural midwifery workforce, and support authorization of midwives to practice and build at the whole scope of their training, so something around those runs. On the regionalization and risk appropriate care piece, we were still sort of toying around with those separate ideas.

We kind of discussed them together, but they're really different, but the broader perspective that we're looking at right now is still looking at how we can advance overall systems, and regionalized and risk appropriate care in rural areas by recommending new payment structures, because that's a giant area right now.

And looking at how to report out some of the policies that discourage inter-provider collaboration, inter-system collaboration and then we talked a little bit recently about interstate collaboration because particularly in rural, often you're crossing state lines actually to receive your care.

So, if we're talking regionalization, we have to look at how we're regionalizing across state lines as well. Then looking at hospital closures and maternity deserts, you know this is very broad and not specific, but looking at implementing new ways to both financially and logistically save lives in labor and delivery units, and prenatal care systems that were all hospitals.

So, as I mentioned this a bit yesterday I believe, but looking at how we're not kind of unintentionally unstabilizing rural hospitals like closing labor and delivery, and so how do we -- we look at that specific stabilization aspect, but then also the logistics of maintaining provider standards on all of that.

And then on the telehealth side, looking at how we can expand access to, in the financial feasibility of, providing labor and delivery, and neonatology and perinatal mental health services, via telehealth in rural areas, because it would be great for us to have all those provider types in every county and rural area, but that's just not going to be something that's possible, so how we will get -- how telehealth can fill those gaps, and what are some of the specific policies that we need to look at that would help ensure that?

Again, just a little bit out of scope on federal recommendations, but one of the things there is again that cross state lines because if we're trying to provide telehealth service

across state lines, the state's licensure is a giant barrier.

CHAIR PETTIFORD: Thank you, Jacob. Kate, anything you want to add to it, okay. Any questions or comments from the rest of the Committee? Yes, Marie?

DR. RAMAS: Yes. Lots of overlap I think between the three groups, so one of the things I was wondering, and we've talked about it before in the whole is restriction of credentialing, particularly for family physicians in providing maternity and neonatal care.

So, I'd be interested in making sure that we don't leave out the importance of the role of particularly family physicians and credentialing in these kinds of settings, and I see your head nodding, and I'm sure it was part of discussions, but I think it's a crucial aspect that we need to continue to put in the forefront together on the federal side.

Many do not remember that family doctors also provide maternity and neonatal care.

DR. J. WARREN: Thank you so much, Marie. I did not actually capture that, and I apologize. The recommendations even with doulas and CHWs, we included FM MDs in that, and how we're having that scope protected, recognized and appropriately consummated.

DR. RAMAS: I appreciate you.

CHAIR PETTIFORD: Thank you for your question, Marie. Anyone else with a question? Jacob, when you all were referring to midwifery, were you talking about all midwives? Were you narrowing it to certified? Are you looking at licensed professional midwives? Are you just doing midwives in general?

DR. J. WARREN: Our discussion has been pretty broad. That was my narrowing it a little later just to look at how it might scale across the whole country is that the state-specific licensure becomes a challenge, but I think that is open for us.

CHAIR PETTIFORD: Thank you. Yes, Kate?

DR. MENARD: One other thing that we spoke about that just might be something other groups would consider, as we spent just about ten minutes talking about once we have these in place, what other criteria we're going to use to narrow them down? And we sort of generated a list of those things, which I think we're to share that with our group.

One of the ones in the feasibility, actionability, were the letters.

CHAIR PETTIFORD: Thank you. That debate would be helpful to share what you all are working on for the rest of us because it could be beneficial, so thanks. No other comments? I see Marie is already queuing herself up to present next, so we'll have our Social Determinants of Health, the Social Drivers of Health workgroup

present next, Marie.

DR. RAMAS: Thank you, Belinda, thank you. As per usual, we had a very iterative meeting time, and I think three or four general themes was the concept of home visits and extrapolating from that: how can we expand on the definition of home visits? Who performs home visits? And then how is it reimbursed effectively? So that they are incentivized more.

We discussed how there are many best practices that we have highlighted in various presentations, both from USDA standpoint, thank you Caroline, and from the perinatal and neonatal side.

However, potentially a bolder recommendation would be to make this ubiquitous, meaning that any federally funded project needs to provide resources and evidence that these best practices are somehow being addressed, and being provided for the patients or the people that are being touched.

So, that was one thing in home visits, that's the background. So, that's one thing. The second thing is the criminalization of a patient experience, particularly around mental health, and so we talked about mental health, both from a medical term, but then it also includes substance use disorder.

And then subsequently how Black patients particularly are being referred to social services, DCYF, the Department of Child and Family Services, and so that can also create downstream effects as

far as bonding, access to care, and you know, severe repercussions for the birthing period.

And so, going a little bit deeper into when we talk about mental health services how are we one, how are we screening for that in a way that is translatable across systems, across state lines, from an insurance standpoint, and how can we translate those screening mechanisms and those services to the postnatal and neonatal side.

So, from a mental health perspective we have some digging into, and I think some opportunities to do some further investigation. What services, what best practices are available, and what can we really, you know, recommend to create more equitable distribution of resources for particularly our Black patients.

And I think the broader third category that we also touched upon was the concept of using social drivers of health as screening mechanisms, and then using those screening tools to then afford opportunities and resources for birthing parents that may have complications with the neo needs.

And so, we talked about how the NICU, for instance, can be a food desert for some patients, meaning that you can't bring food in. If you have other socioeconomic issues or problems, you may not be able to have access to food, and then there's this concern about isolation as a result, parents and birthing individuals that may not

have adequate social resources and supports, such that they would need to work.

They would need to be outside of the neonatal unit, and hence, affecting bonding with the newborn and the infant. So, those are three broad categories. I think our charge as a group because particularly social drivers of health, it is a socialized word, and you know, concept.

How can we, one, bring new ideas? And then how can we push the envelope as far as what's already being done, so that we can make sure that there's some measure of movement that's calculatable.

So, it's refreshing to hear from our other groups about standardization, finding objective points of progress. I think that's important, and we have some real, I think, interesting caveats here that we can maybe expand upon and create some meaningful drivers that can show progress in these areas from a social determinant standpoint.

To everyone else's point, there is tremendous overlap, and so workforce, something that we talked about in the different measures of workforce. Something that we haven't really cracked the code with is how do we incentivize the work to be done from a system standpoint, and so, you know, payment and you know grant funding and what not, you know, can help to bridge that gap as well.

So, Sherri, is there anything else that I may have missed

from our general discussion? And certainly, we'll be meeting on a monthly basis, so that we can, you know, dig into this a little bit more, and be able to have more concrete recommendations at our next meeting. Sherri, if you're talking, I can't hear you.

CHAIR PETTIFORD: She's coming on now.

DR. ALDERMAN: Great. No, I think you covered it very well, Marie. Thank you very much.

CHAIR PETTIFORD: Thank you, Marie and Sherri. I will say that I sat in that workgroup as well, and I think connected to the screening piece that you were referring to, Marie, there was conversations going on in the chat around how they can, and so it may be a screening issue, and then housing can be an area that was connected.

I also think there was conversations in that group around with the home visiting, just making sure that we're looking at home visiting a little differently from the standpoint of being culturally aware that not everyone is comfortable with a home visit.

And so, really as we're trying to, you know, remember our focus around Black African American maternal and infant health, trying to think through the best way to move some of this work forward.

So, I did enjoy the conversation in that workgroup, so I'll be visiting the other ones soon. So any questions for the

social determinants of health, or social drivers of health workgroup?

DR. ZLATNIK: I would say to that point as well, Belinda, and probably our rural health group can resonate with this. You know, making sure that we have asynchronous modalities for people to receive services because in person options may not always be the best, and it may not always be the most convenient for a patient to come into a physical facility as well.

So that was something else that we discussed, and there was some examples of apps, for instance, that patients could use to self-screen, which increased the amount of Black and brown individuals getting screening in the neonatal setting, so I wanted to make sure we added that too.

CHAIR PETTIFORD: Thank you, Marie. No questions or comments for the workgroup? Okay. Apparently, we have to move these meetings to the beginning of the day while the energy is still higher. Okay. No questions or comments. Again, I thank all three of the workgroups for meeting.

I hope everyone has found a workgroup and found a home. You will automatically be added to the calendar invites. It seems like everyone, at least between now and October will be meeting monthly. I know Jacob was thinking about every other day, but it might be a bit much right now, Jacob, but we'll see. We'll see who shows up and who doesn't.

As we continue, I want to just talk a little bit about next steps. One is around, you know, we really need to continue focusing on the recommendations, and again, you may be starting out with ten recommendations, but at some point we will have to narrow it down, so that we could, you know, make these manageable recommendations.

We can try to make them smart when we can, as far as having some timeframes on it when possible, realizing that we may not control all of that. I will be scheduling one on one chats with the chairs, probably in August to give you a chance to have a meeting in July, and so that we can have some follow-up conversation, and then in August we'll just schedule the one-on-one time to just check in and see how things are going before we get ready for our October meeting.

For the new members that have joined, you will be getting one-on-one meetings with me in July, so be prepared with your questions. And if you have not decided on a workgroup at that time, we can talk about it a little bit more. Please plan to join at least one workgroup. Again, workgroups are meeting monthly for the most part.

But any thoughts, questions, at this time? Any feedback anyone wants to provide, other than you all apparently are trying to get out a few minutes earlier than 4 o'clock.

DR. SHARPS: So, Belinda, when do you, and I'd love to open this up if I may. So, because we have so many overlapping themes, how do we reconcile that because there are I think that there might be some opportunity potentially in the preamble, so to speak, of the recommendations, just laying down these are some general foundational concepts that are just understood within the document.

So, I'm just curious do you think that can be a way that we can make sure that we address those overarching intersectional themes, and then focus on more actionable objective recommendations in each of the sections?

CHAIR PETTIFORD: Thank you, Marie, for asking that question. Yes, you know, just like I brought up the issue of workforce diversity, I think that would be kind of in the opening of the report to talk about the importance of it, maybe even make some suggestions on ways to make sure we are doing that.

But then it would be one of the very specific strategies that all further into the document, into the report, so yes. I think what would be helpful is I hope to get some of that by having the one-on-one with the workgroup, so it may be with the workgroup leads, that we meet in August, and I need to apparently send out a Doodle poll next week to get on August calendars.

We meet in August to be able to narrow down what you're thinking your recommendations will be because at that point is when

we could probably see some of the overarching recommendations that are coming up, some things that are popping up in all three workgroups, or two of the three workgroups.

We also could potentially look at doing time to with just the workgroup leads, along with myself, and you know, Vanessa and Sarah, just to talk through some of them if it's not coming through as clearly as we want to, but I will rely on the workgroup leads to kind of help think through that case.

Yeah. I think there will be several overarching ones, but I, you know, the first one that came to mind was the workforce diversity, having heard from it, and all of your presentations. Other thoughts? I just hope we get our calendars soon. I'll get that started.

Meeting Evaluation and Closing Observations

CHAIR PETTIFORD: So, as we prepare to wrap up then, I think it would be helpful if each of us just took a moment to share one thought, one observation we've had from yesterday and all day today, and that is not a requirement, so if you don't feel comfortable doing it, don't come off mute and do it, but I would ask that if each of you would just take a moment and share, you know, what have your thoughts been yesterday, today, the direction that we're going in, and moving forward. Anyone want to jump in and share anything?

Thank you, Marilyn, we did talk about someone from

Framework Institute, and helping us kind of finesse, so we will go back to that as well.

DR. RAMAS: I can start, Belinda. In the beginning of this journey we talked about really creating recommendations that are lasting, that are actionable, and that are bold, and so I'm thinking about timelessness, that the recommendations that we consider should exceed and expand beyond our tenures here around the table.

And that if we can focus on those kind of themes, then you know, it would be very difficult for folks not to want to implement in actionable ways, so timelessness I think would be my word.

CHAIR PETTIFORD: Thank you, Marie. Anyone else have a word to share? Yes, Jacob?

DR. J. WARREN: I think I will go with energy. It's been really great to have the new Members coming onboard because, you know, for those of us in our third year, we've been talking about you all coming since we started, so it's really just exciting to have the new members in.

And even in our workgroup conversations, just to have that new influx of perspectives, and ideas, and sort of getting the freshness back into the conversation brought a really great energy, I think, to our conversations. I want to thank all the new Members. We're really excited to have you.

CHAIRMAN PETTIFORD: Thanks, Jacob. Steve, you've been

quiet on this, it's good to hear your voice.

DR. CALVIN: Sure. No, I'm grateful for all the new Members, and the other Ex Officio, and Committee members that joined us because there's such a diversity of experience and skillsets, so it's really encouraging.

CHAIRMAN PETTIFORD: Thank you, Steve. Anyone else? Yes, Charleta?

DR. GUILLORY: For me the word is still collaboration. For someone who now is important, but for someone who's been here a while, and have seen that the numbers of Black infant mortality, for sure during the last 10 years has not moved, except for the little bit that it's going up.

I want to paraphrase something that is stuck in my mind since yesterday, and I don't know you said it, Belinda, but it was what are we missing? What are we missing that we need to do? And so, today I was well, I was listening to everything. And as Marie came out and talked about more bold things, yeah, it is time for boldness.

We can't continue doing the same things. We build on that, of course, but what are we missing? And that's what's stuck in my mind, the repeating and repeating again. Thank you.

CHAIR PETTIFORD: Thank you so much, Charleta. And Phyllis?

DR. SHARPS: So I have two words. Of course, the bold, but boldness that would shift the way we have done things, a newer approach, a more inclusive approach that will address these persistent problems that we've been having.

What is that adage? We keep doing the same thing over and over again with the same results. It's time to think about some different ways of doing things.

CHAIRMAN PETTIFORD: Thanks, Phyllis. Yes, Lee?

DR. WILSON: Mine's a little less. So, one of the things that I really appreciated was today when the groups were sort of marketing the importance of their breakout group, and why you want to be involved in our discussion, please jump on the bandwagon. And I thought that it really conveyed a sense of importance and passion for the topics that are being considered so I thought was great.

CHAIRMAN PETTIFORD: Thanks so much, Lee. Yes, Kate?

DR. MENARD: I'm going to put up the word unencumbered. You know, I think we've had a lot of conversations about the old way, kind of picking up on what Phyllis had said and others. But gosh, we get into the way of thinking this is the way it is, there's a lot of reasons why that won't work, you know. We just need to get passed that if we're going to make a change, so unencumbered by our old way of thinking.

CHAIRMAN PETTIFORD: Thank you, Kate. And I want to give

someone an opportunity that wants to say something. I will say, of course, the last two days I think what moved me the most was Franchesca and her willingness to tell her story.

And I think we are always reminded, and we try to include it in our meetings, the importance of just listening to people who have been impacted because they're living this each and every day. We're coming up with recommendations, but they're living this. And to be able to listen to them.

You know, Franchesca, she joined the Social Determinants of Health Workgroup today, so she came on into that session as well. She has sent me a message to say could she join a workgroup, and I said sure. Pick one and just come in, and so she joined that one and was able to share some more.

So, I think the more we listen to individuals that have been impacted, the voices of people of lived experience, I think that helps drive us in the direction we need to go. And I think that piece is so important, and in fact, that this group is open to that.

You know, not every place you go listens. Not every place you go even has it on the agenda, but the fact that we're doing it, realizing just one person sharing her story, but it was a very powerful story, and Sherri, I saw your hand go up.

DR. ALDERMAN: Yeah, what really shines bright for me is how many times infant mental health was mentioned and dyadic work,

that's really exciting to be amongst those who see the importance of infant mental health, and the essential component being the health and wellbeing of those caregivers. It's very heartwarming and inspirational.

CHAIRMAN PETTIFORD: So, you feel right at home, didn't you, Sherri?

DR. ALDERMAN: Thank you.

CHAIRMAN PETTIFORD: Okay. No one else? Anyone else have anything they want to share? Okay. Then, I thank everyone for their time, their energy. I do agree bringing in the new members, you all have been awesome to be able to contribute quickly to the conversations and to give really good input and feedback, so we appreciate that.

And we will continue to appreciate you all, so thank you for your time and commitment, and thanks everyone, for two full days of devoted to the work of improving Black maternal and infant health. There's a lot more work we need to do, we should all do, we can do, and as they say, you know, if you keep doing the same thing the same way, you're going to keep getting the same results.

And many of us have been doing this for quite a while, so thank you all for your time, your energy. For those that are traveling, please travel home safely, and be on the lookout for some emails in the next week or so, okay. Thanks everyone, take care.

(Whereupon the ACIMM Meeting adjourned at 3:42 p.m.)